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**Frequently Asked Questions (FAQs) and Answers**

**Objectives for Section 800**

1. Identify Resources;
2. Determine eligibility while elevating resources;
3. Addresses the process of completing necessary documentations.

## 800.1 Introduction -Resources

The purpose of this chapter is to describe how resource eligibility is determined for an applicant or recipient (A/R) for the Medical Assistance (MA or Medicaid) program. This chapter presents the policies and procedures for considering the available liquid and non-liquid resources of assistance unit (AU) members and for determining resource eligibility of AU members requesting retroactive and/or current MA coverage. It describes the

various types of resources that are countable or excludable for the resource eligibility determination.

## 800.2 Terms and Concepts Related to Resources

Resource definition:

Resources are defined as accumulated, available personal wealth for which an individual:

- Has an ownership interest;
- Has the legal right, authority, or power to sell, transfer, or liquidate the resource or the individual's ownership interest in the resource; and
- May convert to cash or currency for the individual's or household's support and maintenance.

Resources include cash, personal property, real property, or other liquid and non-liquid items. "Resource" is a term that is also used in the context of evaluating disposals and trust funds. Refer to those selections of this chapter for the meaning of the term in such contexts.

There are two basic types of resources: liquid and non-liquid.

- Liquid resources are cash, bank accounts, and other financial instruments that can be easily and quickly (e.g., within 20 working days) converted to cash or other currency. Examples of liquid resources include cash on hand, financial institution accounts (checking, saving, saving certificates, money market accounts, certificates of deposit), stocks, bonds, mutual fund shares, accumulated dividends for a countable resource, cash value of life insurance policies, trusts, and annuities. Liquid resources other than cash are evaluated according to the individual's equity in the resources.

- Non-liquid resources are real, personal, or business property or other items which are not cash and cannot be easily and quickly (e.g., within 20 working days) converted to cash or other currency. Real property means property that is fixed or immobile, such as land and buildings. Personal or business property includes items for personal, household, self-employment, machinery, tools, motor vehicles, livestock, and farm animals. Other examples of non-liquid resources include mortgages, promissory notes, and other formal, written loan agreements for which the AU member is a lender. Non-liquid resources are evaluated according to their equity value, except as otherwise specified in this chapter for the type of resource.

Certain types of resources are excludable, which means they are not counted or considered when determining financial eligibility. These exclusions are subtracted from the AU's total resources. The remaining resources are the countable resources. Some

resource exclusions are specific to Aged, Blind, or Disabled (ABD) coverage groups, some are specific to Families and Children (FAC) coverage groups, and most are used for both categories. The various resource exclusions are discussed in detail in this section and in the Medical Assistance Resource Countability Table (See Attachment A).

### 800.3 General Requirements for Consideration of Resources

The A/R or the A/R's designated representative is required to:

1. Report to the eligibility CM:
    - The identity, type and current value of all resources in which each AU member or member's spouse has an ownership interest;
    - The amount of any debts or other encumbrances against each resource; and
    - Any changes in resources within 10 business days of the change.
2. Provide to the eligibility CM as requested:
    - Sufficient documentation and verification of each resources;
    - An explanation, with appropriate verification, to reconcile any inconsistency identified by the eligibility CM in reporting resources; and
    - An accounting and reasonable documentation of previously held resources, consisting of convincing testimony or other evidence, to verify whether the:
        - Resources are no longer available; and
        - Disposal of previously held resources requires a penalty period, if the A/R is applying for long-term care of waiver eligibility.

For the resource eligibility determination, the eligibility CM:

1. Considers all of the resources reported by the A/R or representative, or otherwise discovered by the eligibility CM, for AU members or a member's spouse;
2. Determines for each resources owned by AU members or a member's spouse:
    - Whether the resource is countable as being available to the owner and not a type of excludable resource; and/or
    - The resource's current equity value or cash value and the AU member's or spouse's ownership interest in that value;
3. Compares the AU's total countable resources to the appropriate resource standard for the coverage group and household size; and
4. Promptly notifies the A/R and any representative of the eligibility determination and the amount of any excess resources.

If resources are a factor of eligibility for the AU's coverage group, resource eligibility exists when the AU's total countable resources are within the applicable resource

standard for the coverage group and household size. Resources are considered based on their value as of the first moment of the first day of the period under consideration.

- If the AU's total countable resources are within the applicable standard as of that moment, the AU is resource-eligible for Medical Assistance for the entire month.
- If the AU's total countable resources exceed the applicable standard as of that moment, the AU is ineligible for Medical Assistance for the entire month. Then, the AU remains ineligible until the total countable resources are within the resource standard as of the first moment of the first day of a subsequent month.
- For a determination of current eligibility, resources of the A/R and other AU members are considered as they existed on the first moment of the first day of the current period under consideration.
- If retroactive eligibility is requested to cover services received during the three-month period before the month of application, resource eligibility is determined as of the first moment of the first day of each retroactive month.

If the value of the AU's total countable resources changes after the first moment of a month, the change is considered as of the first moment of the next month and does not affect eligibility during the month of the change.

- The value of the AU's total countable resources may increase because a countable resource gains value, a new household member is added to the AU, the AU acquires an additional resource or replaces an excludable resource with a countable resource, etc.
- The value of the AU's total countable resources may decrease because a countable resource loses value, a member dies or moves out of the household, the AU disposes of a resource or replaces a countable resource with an excludable resource, etc.

Resources are only countable if they are available to the owner. A resource is available if there is no legal impediment to the sale, transfer, or liquidation of the resource—i.e., if the owner has the legal right, authority, or power to dispose of the resource or his or her ownership interest in the resource.

- Even when withdrawal carries a financial penalty or has implications for other purposes (e.g., increased taxes, reduced profits, or estate planning), these consequences are not considered impediments to withdrawal or reasons for a resource to be considered as unavailable.
- The total amount that may be withdrawn, sold, transferred, or liquidated is the amount considered available to the owner

## (a) Excluded Resources

If a property right cannot be sold, transferred, or liquidated, the property is not considered available as a resource and so is excluded. Resources are excluded from consideration if they are unavailable to the AU, such as:

- Resources that the owner does not have the legal authority to sell, transfer, or liquidate under any circumstances, regardless of penalty;
- Jointly-owned resources if there is an impediment because of a co-owner's refusal to sell, transfer, or liquidate the resource, which prevents the transaction; or
- Non-liquid resources against which a lien has been placed as the result of a business loan, if the AU is prohibited from selling the resource by the security or lien agreement with the lien holder or creditor.

Consideration of Resources- Applications Received and Redeterminations Initiated On or After January 1, 2004

Certain types of income and resources are required by federal law to be excluded when determining eligibility for needs-based public benefits programs. The Departments have identified additional types of income and resources to exclude from consideration for all programs, or at least excluded for the Medical Assistance (MA) Families and Children (FAC) coverage groups, Temporary Cash Assistance (TCA), and Food Stamps. Also DHMH has identified FAC eligibility policies to change to match TCA policies.

For Aged, Blind, or Disabled (ABD) coverage groups, MA is required either to follow the federal eligibility policies for Supplemental Security Income (SSI) or to use the authority under Section 1902(R)(2) of the Social Security Act to implement less restrictive policies. DHMH has identified ABD eligibility policies to change either to match SSI policies or to be less restrictive.

ABD coverage groups include the H, L, and S tracks, as well as X02 if ABD rules are used. FAC coverage groups include the E F, and G tracks; T01, T02, and T99; and X02 if FAC rules are used. Eligibility rules of the Maryland Children's Health Program (MCHP) in COMAR 10.09.11 are used for consideration of income and resources for the D and P tracks, T03-T05, and X01.

See the attached Medical Assistance Resource Countability Table. It contains an alphabetized list of all the resource types and identifies whether each type is countable or excluded for FAC and ABD.

I. Exclude from Consideration as a Resource for FAC and ABD

- Crime victims' compensation for expenses incurred for losses suffered.
- Disaster relief, assistance, or maintenance from a federal, state, or local agency or from a disaster relief organization; exclude for both FAC and ABD. For ABD, lift the 9-month limit on such assistance.
- Earned Income Tax Credit (CARES valid value "EC"); exclude refund received or partial payment advanced. See FIA Action Transmittal 03-49.
- Escrow or other dedicated financial institution accounts: exclude as inaccessible those funds placed in an escrow account (e.g., rent or utility security deposit)
- UGMA, MUTMA, UTMA, and other custodian accounts for a minor child: count as the child's resource if the funds are accessible to be used for the child's benefit through the child's parent or other account custodian.
- Vehicles:
    - FAC excludes all vehicles.
    - ABD excludes automobiles, SUVs, trucks, and motorcycles, but counts boats, trailer recreational vehicles, and airplanes.
- Federal Statute excludes certain income benefits from consideration for needs-based public benefits program. Income received from such programs is also excluded as a resource (e.g., Agent Orange Compensation Exclusion Act of 1986, congregate public housing services or wages under the Cranston-Gonzales National Affordable Housing Act of 1990, National and Community Service Trust Act of 1990 and 1993, Radiation Exposure Compensation Act of 1990, Rick Ray Hemophilia Relief Fund Act of 1998, Veterans' benefits for children with certain birth defects who were born to women Vietnam War veterans, Vietnam veterans allowances for children with spina bifida, vocational education assistance under Carl D. Perkins Vocational Education Act of1990, subsidies for expenses but not on-the-job training payments under the Workforce Investment Act, Youth Build Program under the Housing and Community Development Act of 1992).

II. Changes in Methodology for Resource Consideration for FAC and ABD

- Burial/funeral arrangements:
    - For FAC and ABD exclude all irrevocable or revocable burial/funds, plans, agreements, trusts, insurance, or contracts ("IB", "IF", "RC", "RF") and interest earned on such funds. The fund must specify that a funeral home will receive all the proceeds and be for the actual anticipated costs of the burial/funeral of an assistance unit (AU) member or a member's spouse.
    - For ABD exclude up to a total of $1,500 in burial savings accounts and other liquid resources for each AU member, that are designated for burial/funeral but do not specify that a funeral home will receive all the proceeds. Count the amount exceeding the cap. Delink this ABD exclusion from the rules for excluded life insurance (previously ABD reduced the burial fund exclusion by the amount of excluded life insurance). For FAC, these liquid resources are countable.

- For FAC and ABD exclude burial spaces for each AU member and a member's immediate family.

- Income-producing property ("PL", "PM") (e.g., home, business or other non-home property-buildings, land, farm machinery, livestock, tools, equipment).
  - For FAC and ABD:

    Use TCA and Food Stamps rules in FIA Action Transmittal 02-69 to exclude the property as a resource when that property annually produces income consistent with its fair market value (i.e. what is charged for the use of comparable property in the same geographic area). The income received is counted as rental property income or self-employment. Otherwise, the property is counted as a resource, according to the fair market value for the sale of comparable property in the same geographic area.

    - Exclude if associated with excluded home property;
    - Exclude non-business property that is essential to self-support;
    - Exclude tools and equipment necessary for employment;
    - Exclude real or personal property that is directly used to maintain or use an income-producing vehicle.

- For FAC only: exclude real property that is not the primary residence and is listed for sale with a realtor. (ABD counts if it is not excluded as income- producing property.)
- Life insurance policies ("LI"):
  - FAC: exclude all life insurance policies
  - ABD:
    - Continues to exclude the current cash value if the original face value was no more than $1,500. The current cash value is counted if the original face value exceeded $1,500.
    - Policies without a current cash value are excluded.
    - Exclude a life insurance policy if it is irrevocably assigned to be used solely for the funeral/burial expenses of the insured.

- Loans:
  - FAC excludes all loans received by the applicant/recipient (A/R) as the borrower (e.g., personal, business, reverse mortgage, home equity). FAC also excludes the payment

of principal received by the A/R as the lender (e.g., mortgage).

- ABD counts as a resource the payment of principal received by the A/R as the lender a formal, contractual loan (e.g., mortgage). ABD excludes payment received for an informal loan (e.g., loan to family member or friend to pay rent).
- ABD counts as a resource loan (e.g., personal, business, reverse mortgage, home equity) received by the A/R as the borrower if the money is retained after the month of receipt and was not excluded as income in the same 6-month period under consideration.

III. Exclude from Consideration as a Resource for FAC

- Bank Account for a child ("SV"): exclude up to $2,000 in a separate bank account for the earnings of a child under age 21 (ABD) continues to count.)
- Individual Development Accounts (IDAs): exclude money deposited in such accounts and the interest earned. See FIA Action Transmittal 03-49.
- Retirement and Pension Funds: exclude money in retirement and pension funds-401(k) public or private pension funds and plans, 457 plans, etc. Only count Individual Retirement Accounts (IRAs) and Keogh plans (if the Keogh is for a self-employed person and involves no contractual obligation with anyone who is not a household member). See FIA Information Memo 02-75. When payments are received after retirement or these funds are liquidated, the money is counted as income upon receipt. (For ABD, continue to count retirement and pension funds as a resource if accessible, even if there is a penalty for liquidating. Exclude if the funds are inaccessible.)

**(b) Encumbrances**

"Encumbrances" means a lien, mortgage, or other legal claim against a property, usually resulting from a debt owed by the property owner, which affects or limits an owner's absolute and unqualified title to the property. An encumbrance prevents the property from being transferred or sold until the debt is satisfied.

**(c) Consideration Periods**

Income that accumulates and is retained beyond the month of receipt is considered a resource in all subsequent months, unless it is counted as income for the same period under consideration. An amount is considered as either income or a resource, not as both, for the same period under consideration (i.e., the three-month retroactive period before

the application month or the period of at most six months used for determining current eligibility).

- If money is received as income during the current period under consideration, it is considered income.
- If money was received as income during a previous period and is retained into the current period under consideration, it is considered as a resource, according to the policies for the form that it now takes (e.g., earned income deposited in a countable checking account or in an excluded burial fund).
- If a lump-sum benefit or payment is prorated and counted as income for the period under consideration, it may not be considered as a resource for the same period (e.g., lottery winnings deposited in a checking account).
- Income to which a person is entitled but does not receive and which is allowed to accumulate may be considered a resource in the months subsequent to the month when the individual was entitled to receive the money (e.g., stock dividends).

Money that is retained or accumulated from excluded or disregarded income (see Section 700 of this manual) is also excluded from consideration as a resource, unless:

- There are specific policies in this section for counting this money; or
- The money is commingled with countable funds and cannot be separately identified.

## 800.4 Consideration of Motor Vehicles as a Resource

- Families and Children (FAC) coverage groups follow Food Supplement Program (FSP) and Temporary Cash Assistance (TCA) rules to exclude all vehicles.
- Aged, Blind, or Disabled (ABD) coverage groups only exclude the types of vehicles used for daily living and employment needs—e.g., automobiles, service utility vehicles, trucks, and motorcycles. For ABD groups, "luxury" or recreational types of vehicles are still counted as an "other liquid asset" –e.g., a collection of antique vehicles, boats and their trailers, recreational vehicles, campers, and airplanes. Since CARES is programmed to exclude all vehicles for all programs, enter in CARES the countable vehicles for an ABD AU with a code of "CO" (liquid asset countable for cash and/or MA). Narrate in CARES.

## 800.5 Determination of a Resource's Value and the Ownership Interest

An available resource is evaluated in two ways: (1) value; and (2) ownership interest. The countable value of a resource is the owner's share (ownership interest) of the resource's

current equity value or cash value. The various types of resources have different methods of valuation and different forms of ownership. When evaluating real property, for instance, the eligibility CM must determine the person's current equity interest in the property, and understand the forms of ownership peculiar to real property. Each type of liquid resource (e.g., savings and checking accounts, life insurance, trusts) has unique considerations for ownership and valuation.

The following concepts are used for determining the value of a resource:

- "Equity interest" means an owner's share of the equity value of a resource.
- "Equity value" means the fair market value of a resource. The equity value includes the amount of any tax withholding or other deductions associated with liquidation or sale of the resource. However, the equity value does not include the amount of any legal debt or other encumbrances on the resource or the cost of a penalty for early withdrawal.
- "Fair market value (FMV)" means the price for which a property or other resource can reasonably be expected to sell on the open market in the geographic area at the present time. The sales price for comparable resources in the same geographic area may be used as a resource's fair market value. The highest bid received for a property that is sold at auction is considered the property' fair market value. However, the auction must be publicly advertised within a reasonable geographic area for a reasonable length of time, conducted by a professional auctioneer, and made fully accessible to the public.
- "Owner" means an individual who has an ownership interest in a resource.
- "Ownership interest" means the portion of a resource that belongs to the owner.

The following concepts are used for determining ownership interest:

- "Joint ownership" means that an account or other resource has two or more individuals named as owners, and that any of the owners may withdraw the funds or may sell, transfer, or liquidate the resource. When two or more persons are named as co-owners of a resource, a joint interest exists. There are three types of joint interests:

(1) Joint Tenancy
- Each owner has an undivided, pro-rata share.
- Each owner may transfer his/her interest.
- Created by such words as "joint tenancy with rights of survivorship".

- When one owner dies, his/her interest passes automatically to the surviving owner.

(2) Tenancy in Common
- Each owner has an undivided, pro-rata share.
- Each owner may transfer his/her interest.
- Created by no specific words – the only necessity is for two or more names as owners.
- When one owner dies, his/her interest becomes part of his/her estate.

(3) Tenancy by the Entireties
- Each owner has an undivided, one-half share.
- Only the entire interest may be transferred to a third party.
- Created by no specific words – the only necessity is for a husband and wife to be named as owners. It lasts only so long as the co-owners are married.
- When one owner dies, his interest passes automatically to the spouse.

Life Estate or Life Interest means that ownership is conveyed to one party; the remainder, under the condition that another party called the life tenant is permitted to use the property until death. Upon the death of the life tenant, the property immediately passes to the remainder. A life estate may be "with powers" or "without powers". Refer to the Life Estate section for details on the treatment of these types of life estates.

### 800.6 General Resource Eligibility Requirements

Regulations require an applicant/recipient (A/R) or representative to report all resources on which A/R's name appears as owner either individually or jointly whether or not the applicant considers himself or herself the owner. The same applies to the legally responsible relatives of the A/R (spouses and parents) whose names appear on the resource whether or not the A/R's name also appears. The A/R must provide verification of the owner type and value of the resource as well as encumbrances (debts) against the resource in order for the equity value to be determined.

Because of the impact of excess resources on eligibility, it is necessary that the eligibility determination be prompt, complete, and accurate. A prompt, complete and accurate written notice of ineligibility must be provided. A prompt determination of excess resources is necessary to allow the applicant to make an informed decision on what action to take to deal with the excess resources. The case manager should not suggest options but should be able to clearly and completely answer any questions the applicant may have. If there are apparent reasons for ineligibility other than excess resources, those reasons should also be included in the letter.

It is necessary that each application include an in-depth review of the resource situation of each assistance unit member. This should not be limited to the questions and answers on the application form, which serve as triggers for an in-depth evaluation. For example, if an applicant was on private pay in a long-term care (LTC) facility prior to applying for Medicaid, the simple verification of that fact does not satisfy the resource evaluation requirements. It is necessary to verify the original amount and source of the funds used for private pay, how and when payments were made to the facility, the amount, etc. The case record and CARES narrative should contain sufficient verifications and documentation to assure that resources were properly reduced to the applicable resource standard. For a LTC or waiver case, there should also be sufficient evidence that there was no disposal or transfer of resources for less than fair market value.

Every effort should be made to accurately evaluate total resources, even if the value of one resource is sufficient to render a decision of ineligibility. If an A/R fails to provide the information needed to determine the exact amount of excess resources, include a statement to that effect in the notice of ineligibility, along with a list of resources for which the values were not determined. Include complete details in the case record and the CARES narrative.

Federal income tax returns may be requested to substantiate that all income and resources have been reported. Some types of income (e.g., interest, dividends, rent) indicate the existence of resources. Therefore, there should be reasonable consistency between the A/R's reported income and resources. Once all resources are identified, the eligibility CM must determine whether each resource is countable or excludable. Then, the total of the countable amounts is compared to the appropriate resource limit in Schedule MA-2, MA-2A, or MA-2B in the Appendix of this manual.

**(a) Resource Eligibility**

Resource eligibility exists when the AU's total countable resources are within the applicable resource limit as of the first moment of the first day of the month. The appropriate resource standards are used in Schedule MA-2, MA-2A, and MA-2B of the Appendix, based on the number of assistance unit members. Resources are not a factor of eligibility for certain coverage groups, such as low-income children who are determined eligible in the P-track for the Maryland Children's Health Program (MCHP) or D-track for MCHP Premium, or pregnant women who are determined eligible for MCHP in the P02 or P11 coverage group. Resources will only be considered if FAC coverage group is only determined eligible through spend-down (799). Resources are not a factor for any remaining FAC coverage groups.

**(b) Resource Ineligibility**

An A/R is not eligible for any month in which the AU's total countable resources exceed the applicable resource standard as of the first moment of the first day of the month. If resources increase or are reduced during a month, the A/R's eligibility is not affected until the following month. Then the A/R's resources are evaluated based on their countable value as of the first moment of the first day of the month.

If a recipient has any increase in resources, the recipient is required to report this change within 10 days. The LDSS/LHD must determine if resources are still at or below the appropriate level in Schedule MA-2. If resources exceed the standard, the case is closed with timely notice. If the recipient fails to report excess resources in a timely manner, all months in which resources exceed the standard must be reported to the Division of Recoveries and Financial Services Administration for recovery of erroneous payments.

**(c) Prepayment of LTC Expenses – Applicants**

For LTC applicants, resources may be reduced by prepayment of LTC expenses. An LTC patient may make an advance cost of care payment from excess resources in a given month in order to become resource eligible the following month. Eligibility is possible for the subsequent month if the payment reduced resources to the allowable amount in Schedule MA-2. Payment may begin on any day of the month that the person becomes eligible but the LTCF may not request a begin pay for any date that has been pre-paid. The purpose of this policy is to alleviate the hardship situation and the administrative problems associated with an applicant who is expected to have excess resources at the end of the month of application but is unable to pay the full cost of care for the following month. Under this policy, the LTC facility may request payment to begin the day after the pre-paid amount has been exhausted for care received.

Examples (both examples involve excess resources):

- Applicant is admitted to an LTC facility in March and is on private pay. By July, the applicant's remaining resources are sufficient to pay the cost of care for the full month of July and ten days in August. Anticipating August ineligibility, he pays for the month of July and turns over the remaining excess to the facility in July as an advance payment for ten days of care in August. The facility submits a 257 to the LDSS/LHD requesting payment to begin in August 11th. If all other factors of eligibility are met, the person's eligibility and the 257 begin payment are effective August 11, the first day that a program payment is required.

- Using the same case situation as that in the above example, the applicant pays the excess resource to the facility in August instead of July. The LTC facility submitted a 257 requesting payment to begin August 10. In this situation, the applicant is not eligible in August because he still had excess resources under his control during the first day of the month.

**(d) Reduction of Excess Resources – Recipients**

If a recipient is found to have excess resources and timely and adequate notice is given to terminate eligibility, but resources are subsequently properly reduced prior to expiration of the timely notice period, eligibility may be continued uninterrupted.

If a recipient in an LTCF is determined to have excess resources, determine the exact amount of the excess resources and cancel the case in accordance with timely and adequate notice requirements. However, inform the recipient/representative of the option to pay the excess amount to the Division of Recoveries and Financial Services. Before discussing this option, make sure that the program has paid on the recipient's behalf an amount at least equal to the amount of the excess resources.

If the recipient reduces his resources to the eligibility limit within a 30 calendar day administrative period, the period may be reinstated in the Program without loss of benefits. The 30-day administrative period begins the date of the notice of ineligibility to the recipient. The date of the notice should be the date the local department completes the eligibility determination and determines the exact amount of the excess resources. The notice to the recipient should be processed for mailing on the same day. Since that date is associated with the 30-day administrative period, it is important that there be consistency in the use of that date on all forms and notices and in all case activity and recording.

It is not necessary that a recipient decide immediately whether he wishes to reimburse the Program, nor is it necessary for the recipient to notify the local department of his/her decision to reimburse the Program.

<u>Procedure to Follow--Reimbursement Requirements</u>

This procedure applies to recipients whose ineligibility is based solely on excess resources which meet the above requirements. (Note that his procedure is not applicable to lump sum income such as inheritances or settlements.) In all such cases, the CM must discuss with the recipient/representative the reimbursement option and the conditions and consequences of reimbursement. The recipient also needs to understand the possible loss of coverage if reimbursement is not made within the 30-day administrative period or if

the resource is disposed of for less than fair market value. The CM must complete and provide to the recipient/representative a copy of DES 100, "Explanation of Ineligibility due to Excess Resources" and DHMH form 4342, "Reimbursement of Excess Resources", regardless of whether a decision of reimbursement has been made.

Phase 1 – LDSS/LHD Activity

If the recipient meets the reimbursement requirements, the CM will take the following action regardless of whether the recipient has made a decision to reimburse the Program:

- Complete the top section of the Form 4342. File the last copy in the case record as verification of issuance.
- Give the remaining copies of the Forms 4342 and 100 to the recipient.
- Explain the Form 100 procedures to the recipient/representative.
- Close the case in accordance with timely and adequate notice requirements.
- Send Forms 4228 and 100.

Phase II – Reimbursement Requirements Met

- Upon receipt of Form 4342 from the Division of Recoveries showing reimbursement within the 30-day administrative period, reopen the case effective the month of cancellation. (The effective date should be such that the recipient loses no Program coverage).
- Follow other standard procedures i.e., case record activity, notice of eligibility, etc.
- If reimbursement was made but not within the administrative period, evaluate the reasons for the delay. If extenuating circumstances or a misunderstanding justified the delay, an exception may be made to reopen the case without loss of benefits per the above instructions.

Phase III – Reimbursement Requirement Not Met

If the LDSS/LHD does not receive a notice of reimbursement, no action is required on the closed case until the person reapplies. Upon reapplication, follow standard procedures to determine eligibility based on the new application date. The person is ineligible throughout each month of cancellation in which excess resources existed.

If the recipient decides to reimburse the Program, he/she simply writes a check and mails it to the address indicated on the notice. The division of Recoveries will send both the representative and the local department a receipt for the payment.

## 800.7 Real Property (Home Property)

The principle place of residence, or home, of an A/R is generally excluded as a resource. "Home" is defined as any property in which a member of the AU or any person whose income and resources are considered has an ownership interest and which serves as the individual's "principle place of residence". It is the shelter that the person considers his fixed or permanent residence and to which, whenever absent, the person intends to return.

Only one residence may be considered home property for an assistance unit. Real property may be excluded as home property even if the A/R is temporarily absent from it, providing the A/R intends to return and maintains it as the principle place of residence. It does not matter how soon the person intends to return. The individual's "principle place of residence" is verified based on the address used on the official documents, such as bank statements, driver's license, and tax forms.

There is no limit on the acreage of home property, which includes any land which appertains to the home and any other buildings located on such land. To appertain to the home, the real property must adjoin the plot on which the home is located and not be separated from it by intervening real property owned by others.

Where real property adjoins the plot on which the home is located and has contact with that plot, it does not matter if there is more than one document of ownership (e.g., separate deeds). It also does not matter that the home was obtained at a different time from the rest of the real property or that the holdings may be assessed and taxed separately. In considering whether real property appertains to the home plot, do not consider easements or public rights of way (e.g., streets, roads, utility lines) which run through or by the land and separate the land from the home plot or from the rest of the land. Watercourses, such as streams and rivers, do not separate land, but are included in the term "land". Land parcels which are adjoined side-by-side, corner-to-corner, or in any other fashion are considered to appertain to each other.

If the individual (and spouse if any) moves out of his or her "home" without the intent to return, the "home" becomes a countable resource because it is no longer the individual's "principle place of residence." If the individual moves into an assisted living facility, the facility becomes the "principle place of residence", unless it is documented that the individual is there for a short-term stay such as for respite care. The individual's equity in a former "home" becomes a countable resource effective the first day of the month following the month it is no longer his or her "principle place of residence."

When a recipient sells an excluded home property or has another type of cash settlement on it (e.g., insurance claims), the recipient has 90 days from the date of settlement to commit the money for another excluded home property, in order for the money to be excluded as a resource.

**(a) Substantial Home Equity and Exclusion of Long-Term Care Coverage**

For applications received on or after April 1, 2007 for coverage of nursing facility or home and community based (HCB) waiver services, the eligibility CM must evaluate the institutionalized individual's equity interest in the individual's home property if the individual is determined eligible based on:

- An initial determination of nursing facility or (HCB) waiver eligibility; or
- A reapplication for nursing facility or waiver eligibility after a termination of nursing facility or waiver coverage.

The home equity must then be evaluated at each subsequent redetermination of the individual's nursing facility or waiver eligibility (for applicants who applied and were found eligible after April 1, 2007).

If the institutionalized individual's equity interest in the home property (reduced by any bona fide, legally binding, documented encumbrances secured by the home) exceeds any amount, Medicaid will not pay for long-term care services received by the individual in a:

- Nursing facility;
- Medical institution with a level of care equivalent to a nursing facility; or
- HCBS waiver.

The individual may still be determined Medicaid eligible in an H, L, or T track coverage group or as Medicaid community eligible (e.g., as a medically needy recipient or a Supplemental Security Income beneficiary), so that Medicaid will pay for other State Plan services received by the individual. However, so long as the individual's equity interest in home property exceeds $525,000 by any amount, the individual may not be covered by Medicaid for nursing facility or equivalent institutional services or for HCB waiver services. Beginning in 2011, the federal government will annually adjust the home equity cap for inflation.

Under five circumstances, the home equity evaluation is not performed or the penalty is not imposed for an institutionalized individual:

(1) If the individual applied for nursing facility or HCB waiver eligibility before April 1, 2007, was determined eligible, and has not had a break in nursing facility or waiver eligibility since then; or
(2) For any non-home property owned by the institutionalized individual; or
(3) For any property owned solely by the community spouse; or
(4) If at least one of the following individuals lawfully resides in the home: The institutionalized individual's
    - Spouse;
    - Son or daughter younger than 21 years old, or
    - Son or daughter of any age, who is disabled or blind as determined by the Social Security Administration or the State; or
(5) If the excess home equity may not be accessed by the institutionalized individual for legal or financial reasons, and the Department of Health and Mental Hygiene determines, according to the following policies and procedures, that the exclusion of long-term care coverage would cause undue hardship for the institutionalized individual:
    - Any hardship that would be caused to the A/R's spouse or to any other individual or entity (e.g., loss in revenues for the nursing facility) is not relevant for the Department's determination of whether undue hardship exists.
    - The procedures and documentation are similar to what is required in this Section for an undue hardship waiver of a penalty period for asset disposals.
        - The institutionalized individual, the representative, or the individual's nursing facility provider (if authorized by the individual or representative to act on their behalf in this matter) must apply to the eligibility CM for a hardship waiver.
        - The eligibility CM provides the submitted information to the Division of Eligibility Policy at the Department of Health and Mental Hygiene.
        - Within 15 days of receiving all of the submitted information, the Division informs the eligibility CM whether a hardship waiver is approved and, if not, the reason for denial.
        - The eligibility CM sends the appropriate notice(s) of the decision to all involved parties.

- The hardship waiver is granted if the Division of Eligibility Policy is convinced by the documentation provided that the exclusion of long-term care coverage would:
    - Put the institutionalized individual at risk of serious deprivation, rather than merely causing inconvenience to the individual or possibly restricting the individual's lifestyle; and
    - Cause the institutionalized individual to be deprived of food, clothing, shelter, or other necessities of life, or medical care such that the individual's health or life would be endangered.

Equity interest means the current fair market value or current assessed or professional appraised value (whichever is less) of the individual's ownership interest in a property, after subtracting any bona fide, legally binding, documented encumbrances secured by the home property. If the home's equity is shared by co-owners, the individual's share is calculated by dividing the total equity interest by the number of shared owners in proportion to their interest in the property. If the institutionalized individual co-owns the home property with the community spouse, the institutionalized individual is considered to own both of their shares in the property.

If the institutionalized individual or the individual's spouse incurred an encumbrance or debt that is secured by the home property, the amount still encumbered or owed is subtracted when calculating the institutionalized individual's equity interest in the property – e.g., if the individual owes a mortgage or received money from a reverse mortgage, home equity loan, or other loan; or the property has a lien. The amount subtracted is the documented amount of the principle still owed for the mortgage or the mortgage, home equity loan, or other loan; or the property has a lien. The amount subtracted is the documented amount of the principal still owed for the mortgage or the documented amount still owed for a lien or for a loan secured by the home. If the costs for obtaining the encumbrance (e.g., inspections, monthly servicing fees) are paid out of the loan proceeds and become part of the outstanding debt, these costs reduce the home equity. If the individual paid for those costs separately, the costs do not reduce the calculated home equity.

To determine whether a loan is a legitimate transaction, the eligibility CM at the eligibility determination and at each subsequent redetermination must request and review documentation of:

- The property's current equity value (e.g., most recent property tax assessment); and

- The written and signed loan agreement and its terms, payment schedule, money received, payments and current balance.

If the individual cannot prove to the CM's satisfaction that loan the loan is bona fide, the loan may not be used to reduce the home's calculated equity value.

If there is a legal impediment to the individual's transferring or selling the property, such as if there is a lien or if a co-owner (e.g., spouse, family member) refuses to sell, the home equity is still evaluated. However, this may be considered a reason to approve a hardship waiver.

The DES/LTC 812, Home Equity Value Worksheet, located in MA Manual Section 10, Appendix B, must be used to manually calculate the home equity value; and must be maintained in the case record. If Medicaid coverage of an institutionalized individual's nursing facility or HCB waiver services is prohibited due to the individual's substantial home equity, the individual's Medicaid long-term care, HCB waiver, or community eligibility is still finalized on CARES. Then, the eligibility CM must indicate, through a DES/LTC 813 faxed to DHMH if necessary, that a span must not be opened on MIS recipient screen 4 for coverage of nursing facility services or on screen 8 for HCB waiver services.

If substantial home equity is discovered at a redetermination, the CM must assure, by faxing a DES/LTC 813 to DHMH if necessary, that the individual's span is closed on MMIS recipient screen 4 for coverage of nursing facility services or on MMIS recipient screen 8 for HCB waiver services. The individual's Medicaid eligibility, however, is not affected.

Example 1:
Mr. A, a widower, resides in a nursing facility and applies for Medicaid long-term care eligibility in May 2007. He states that he intends to return home. He owns home property that he purchased three years ago for $450,000. He still owes $25,000 for a mortgage on the property. The most recent property tax assessment values the property at $600,000. Therefore, the current value of his equity interest is $575,000 ($600,000 - $25,000). Mr. A is approved for Medicaid eligibility, since the home property is excluded as a resource. However, he is denied Medicaid coverage of his nursing facility services because his equity interest in the home property exceeds $525,000. He is determined eligible on CARES in coverage group L98, and an eligibility span for L98 is opened on MMIS recipient screen 1 through the interface. The eligibility CM faxes a DES/LTC 813 to DHMH, to void a span on MMIS recipient screen 4 for coverage of nursing facility services.

Example 2:
Miss B applies for enrollment in the Older Adults Waiver in May 2007. She lives at home in a property valued at $525,000 in a recent property tax assessment. She paid off the mortgage last year by cashing in her stocks and bonds. Last month, she took out a reverse mortgage for $35,000 and spent the money on remodeling the kitchen. Therefore, the current value of her equity interest is $490,000 ($525,000 - $35,000). Miss B is approved for Medicaid eligibility coverage of her waiver services because her equity interest in home property does not exceed $525,000.

Example 3:
Mrs. C applies for Medicaid coverage of nursing facility services in April 2007. She and her husband own a home valued at $1,250,000 in a recent property tax assessment. Since Mrs. C's husband lives in the home, it is not subject to the home equity assessment. Mrs. C is determined eligible for Medical Assistance and for coverage of nursing facility services.

**(b) Home Property of an Institutionalized Individual**

For an individual who is absent from the home due to institutionalization in a long-term care facility, the individual's "home" is still the property in which the individual (and spouse, if any) has an ownership interest and considers as the fixed or permanent residence. The home property may be excluded as a resource if the individual intends to return and the property is not held in a life estate with full powers. The excluded home property may be in Maryland or another state. A resident of a Maryland long-term care facility (LTCF) can intend to remain in the LTCF for an indefinite period while still intending to return to home, in-state or out-of-state, at the end of the institutional stay. Regardless of the individual's intent to return, the home may still be excluded as home property if a spouse or dependent relative (as defined below) of the institutionalized individual continues to live in the home.

To determine if an A/R has substantial home equity:

- First, determine if the property is countable or excludable. If the property is countable, then determine the institutionalized individual's equity interest in the property's current fair market value, after subtracting any bona fide encumbrances.
- Second, determine the individual's resource eligibility and overall Medicaid eligibility.

- Third, if the individual is Medicaid eligible, determine if a lien should be placed on the property. Never place a lien in order to exclude otherwise countable real property.
- Fourth, determine whether long-term care coverage should be excluded because the institutionalized individual's equity interest in the home property exceeds the maximum allowable amount ($525,000).

The DHMH Form 4255 (Statement of Intent to Return) must be completed for all LTC applicants, regardless of whether there is a spouse living in the home. This is because, in addition to the home's excludability and the applicability of lien procedures, the applicant's answer to the Statement of Intent to Return will determine whether to evaluate the applicant's resources under COMAR 10.09.24.08G (does intend to return) or 10.09.24.08H (does not intend to return). The statement of intent may be made and signed by either the institutionalized individual or the representative.

The property of an institutionalized individual is excluded as the home if the institutionalized individual intends to resume living in the home property, documented by the signature on DHMH Form 4225. Whether the expressed intent is reasonable is irrelevant as far as excludability of the home property is concerned.

The home property is excluded a resource, regardless of the institutionalized individual's intent to return, if it is occupied by the A/R's:

- Spouse; or
- Any one of the following relatives if determined to be medically or financially dependent on the institutionalized individual:
    - Adult or minor child, stepchild, grandchild;
    - Adult or minor sibling, including step or half;
    - Parents, including step and in-laws, and grandparents;
    - Aunt/uncle and niece/nephew.

If the institutionalized individual expresses the intent not to return to home property, and a spouse or "dependent relative" does not reside in the property (or dies), it is a non-excluded, countable resource which must be evaluated in accordance with the appropriate provisions of this section, unless other provisions of this section cause it to be excluded.

If the decision is that the property is a countable resource, its current equity value (after subtracting encumbrances) should be added with other countable resources to determine the individual's resource eligibility. The individual's equity in a former "home" becomes a countable resource effective the first day of the month following the month it is no

longer his or her "principle place of residence" or "home property". The individual's principle place of residence is verified based on the address used on official documents, such as bank statements, driver's license, and tax forms.

Factors to Consider in Determining Occupancy and Dependency of Relatives

"Dependency" in this provision applies to the relative's own financial and/or medical condition which results in the relative's need to live in the home of the institutionalized person. It does not mean that the relative is or was actually a dependent of the institutionalized person.

The LDSS/LHD will make a decision on the relative's occupancy and dependency based on the following considerations:

- The A/R's unmarried son or daughter younger than 21 years old will be considered financially dependent without documentation other than age.
- The A/R's aged (65 years or older) son or daughter will be considered medically dependent upon documentation of age alone.
- A son, daughter, or other relative (as specified above) who was previously determined blind or disabled by the Social Security Administration (or by DHR's State Review Team as part of an MA eligibility determination) will be considered medically dependent without further documentation.
- If the relative's medical, mental, emotional condition, or age are such that requiring the relative to make other living arrangements would create hardship and the relative occupies the home, the conditions of dependency and occupancy are met as follows:
    - If the relative's financial circumstances are such that requiring the relative to move would create financial hardship and the relative occupies the home property, the relative is considered to be financially dependent; or
    - If the property is and has been the relative's residence for at least 2 years prior to the institutionalized person's admission to a LTCF, and the relative does not own or maintain another residence, the relative is considered to be financially dependent.

Local departments may require reasonable verification of occupancy circumstances or conditions of dependency, as follows:

- Begin with having the relative submit a written statement of occupancy and condition of dependency. Verification of income and resources of a relative may be required to determine if a relative is financially dependent to the extent that the shelter arrangements in the immediate geographic area are greater.
- A severely handicapped or incapacitated person, though not blind or disabled, may suffer emotional or physical trauma if required to make

other living arrangements. The relative may be required to verify any of these conditions with a statement from a physician.

- A relative who claims to have lived in the home for at least 2 years prior to the institutionalized person's admission to a LTCF may be required to provide evidence of this.

1. Lien on Home Property

If the decision is to exclude the home property, determine if the lien provision applies. However, never place a lien in order to exclude otherwise countable real property. The lien process can only occur after an institutionalized person is determined to be MA eligible in a long-term care category.

- While the A/R's spouse lives in the home, the home is excluded as a resource and a lien is not applicable, regardless of the A/R's response on the "Statement of Intent to Return".
- If the A/R's response on the "Statement of Intent to Return" is "no" and the home is not occupied by the spouse or a "dependent relative" (as defined above and also in COMAR 10.09.24.08), the home is counted as a resource. If a "dependent relative" occupies the home, it is excluded as a resource, and the CM must then determine if a lien is applicable. A lien is not applicable if the "dependent relative", as specified on the "Lien Worksheet, Part II" (and also in COMAR 10.09.24.08.15), is the applicant's:
  - Spouse;
  - Child under 21 years old;
  - Son or daughter who was previously determined blind or disabled by SSA or SRT; or
  - Sibling who has an equity interest in the home and was residing in the home for at least 1 year immediately before the date of the applicant's admission to a LTCF.
- If a lien may be applicable, proceed with the Medical Review process to determine if there is a likelihood that the applicant will return home. If yes, a lien should not be applied. If no, proceed with imposition of the lien on the home and any other real property.
- If the answer to the "Statement of Intent to Return" is "yes", there is no spouse or dependent relative in the home, and the home is deeded as a Life Estate with full powers, the home is a countable resource and no lien applies.
- If the home is subject to a lien, so is any other real property owned by the applicant. If the home is not subject to a lien, neither is other real property.
- Deny eligibility if the applicant or representative objects to a lien.
- The lien will be lifted if the recipient is discharged from the LTCF and resumes permanent residence in the home. Residence at any other location

(e.g., assisted living facility, child's home) will not cause the lien to be lifted.

- If the spouse or dependent relative dies or vacates an excluded home, use the "Statement of Intent to Return" to reevaluate the home for excludability and applicability of a lien.

2. Sale of Home Property Before Completion of Lien Process

Local departments are expected to follow the lien procedures, when appropriate, for the home or other real property. If, for any reason, the home or other real property of a recipient is sold before completion of the lien process, the following procedures apply to the treatment of the proceeds from the sale:

- Determine the amount of MA payments on the recipient's behalf. This information may be obtained by calling the DHMH Division of Recoveries and Financial Services at 877.634.6361.
- Instruct the recipient/representative to reimburse the Program by check in the amount of MA payments on the recipient's behalf. The check should be made payable to:
  - "Department of Health and Mental Hygiene";
  - "DHMH"; or
  - "MA Recoveries";

  The check should be mailed to:

  Department of Health and Mental Hygiene
  Division of Recoveries
  201 W. Preston Street
  Baltimore, Maryland 21201

  Or

  Department of Health and Mental Hygiene
  Division of Recoveries
  P.O. Box 13045
  Baltimore, Maryland 21203.

Entrance Deposit in a Retirement Community

Certain retirement communities for the elderly provide "residence and care" contracts which provide a person or couple with residence within that community in a setting appropriate to the person's needs. This setting may be an independent apartment, a supervised environment or a long-term-care setting. This contract requires the resident to pay an entrance fee which is kept on deposit by the community. Most often this fee is paid for by funds obtained from the sale of real property that the person or couple previously used as their home. These funds are usually not fully available to the person or couple unless they terminate the life care contract and give up their residence. Because the home exclusion is intended to protect the residence of an institutionalized person and

the person's spouse, the exclusion does not apply to other sums of money on deposit with the community if the A/R or spouse may obtain the funds without affecting his/her right to reside in the community.

**(c) Other Real Property**

If a piece of real property cannot be excluded, it must be counted. It is not permissible to place a lien on countable real property in order to omit the value of the property from the resources calculation. The lien provision is a post- eligibility requirement meaning that it can be implemented only after all factors of eligibility including resources had been met. When non-excluded real property causes an A/R to be overscale in resources, eligibility does not exist: therefore post-eligibility processes may not be implemented.

**(d) Valuation of Real Property**

The countable value of real property is based on the A/R ownership interest in the equity value. Equity value means the fair market value less the amount of encumbrances. Fair Market Value is verified by a current property tax assessment or a recent professional appraisal. An encumbrance is verified by the mortgage or loan agreement and a statement of the outstanding principal as of the month for which eligibility is being determined. Ownership interest is verified by the deed.

When it is demonstrated that property cannot be sold, this will affect Fair Market Value. This determination can be made only when there is a bona fide effort to sell the property at a price not more than the current assessed or appraised value. This condition must be verified by the realtor who is handling the sale, or if the owner himself is selling the property, by documentation of newspaper ads and other efforts to sell the property.

The open market means that all interested buyers must be offered the opportunity to purchase the property. When the best bona fide offer is substantially less than the appraised or assessed value, there must be an opportunity for other interested parties to make a better offer. The best of three bona fide offers from the open market will be considered the Fair Market Value.

The geographic area in which the property must be advertised is that covered by the media including television and newspaper where the property is located. Property that has multiple listings through a realtor is assumed to meet this criterion. Otherwise, the A/R must demonstrate the effort to sell throughout the area.

Any bona fide offer to purchase the property, regardless of whether it is accepted, must be reported within 10 days, since such an offer does represent marketability. If this offer is substantially less than the appraised or assessed value, documentation must be submitted to confirm the conditions that made this offer reasonable. The property must then be offered at a lower comparable price to solicit additional bona fide offers. Any bona fide offer in excess of Schedule MA-2 will render the A/R ineligible unless the property is excluded on some other grounds.

When the bona fide effort to sell results in no offers, the Fair Market Value of the property is zero, although a property that cannot be sold on the open market is valued at zero, it is not excluded. A lien must be imposed on the property effective the date eligibility is granted. Since the bona fide effort to sell must be on-going in order to continue to meet the above criteria, the case must be flagged for frequent review. The on-going effort to sell and the responses to that effort should be re-verified at least quarterly.

## 800.8 Life Estates

A life estate, life interest, or life use, means that ownership of an asset, usually real property, is conveyed to one party, called the "remainderman", under the condition that another (usually the person conveying the property) is able to use the property for the duration of his/her life. Usually a life estate is created by the words "for and during the term of his natural life", or similar phrase. Unless specifically noted in the deed, the person to whom the life estate was granted (the "life tenant") does not have the ability to sell, transfer or encumber the property. The life tenant is entitled to live in the property, as well as collect any income the property generated, even if this is not specified.

Upon the death of the life tenant, the property passes directly to the remainder without going through probate procedures.

Some life estates list additional powers for the life tenant and some life estate deeds will include "full powers", meaning the life tenant has, in addition to the powers noted above, the power to sell, give or otherwise convey the property, except by wiling the property to someone other than the remainderman.

### (a) Life Estate with Full Powers

The value of a life estate with full powers is the full fair market value of the property. This is because the life tenant is free to sell the property and retain the funds for his/her own use. If this happens, there is nothing left to pass to the remainderman.

When an A/R holds a life estate with full powers in his or her former home property and the only basis for exclusion is his/her intent to return, then the property may not be excluded as former home property.

### (b) Life Estate Without Powers

Unless specifically noted in the deed, a life tenant does not have the power to give the property away or sell the property. A life tenant does, however, have the right to live in the property or otherwise use it in any way that might be beneficial, unless a restriction is stated in the deed. The life tenant is also entitled to any income the property generates.

Based on verifications obtained over a period of time throughout Maryland, it has been determined that most life estates with limited powers are not marketable in this State at

this time. This is true only of residential, non-income producing, non-rental property. Under these conditions, the value of a life tenant's share of a life estate with limited powers should be considered a countable resource with a fair market value of $0. Please note that this is not an exclusion.

If the property in which an A/R has a life estate without full powers is sold, the life tenant is entitled to his or her share of the fair market value. Multiply the equity value (fair market value less any debts against the property) by the appropriate life interest factor in Schedule MA-7 to obtain the countable resources to the A/R. This resource becomes countable at the moment a bona fide offer to purchase the property is made and is accepted by the seller, which occurs prior to the actual settlement date. The A/R and representative must be made aware of the requirement to report, in a timely manner, any decision to sell a property in which the A/R has a life interest and eligibility must be re-determined based on this information.

### (c) Valuation of a Life Estate Interest

For non-residential property, rental property, or property outside the state of Maryland, the value of a life estate without powers is determined based on the actuarial tables (MA-7) or a professional appraisal.

To determine the value of a life interest using Schedule MA-7, Life Estate and Remainder Interest Tables, take the following steps:

- Determine the fair market value of the property.
- Find the line for the person's age as of the last birthday.
- Multiply the figure in the life estate column for that age by the current market value of the property to determine the life interest.
- Record the computation and documentation in the case record.

## 800.9 Life Insurance

A life insurance policy is a contract. Its purchaser (the owner) pays premiums to the company that provides the insurance (the insurer). In return the insurer agrees to pay a specified sum to a designated beneficiary upon the death of the insured (the person on whom or on whose life the policy exists).

Face Value (FV) is the amount of basic death benefit contracted for at the time the policy is purchased. The face page of the policy may show it as such, or as the "amount of insurance", "the amount of this policy", "the sum insured", etc. A policy's FV does not include:

- The FV of any additional purchase which is added after the policy is issued;

- Additional sums payable in the event of accidental death or because of other special provisions; or
- The amount(s) of term insurance when a policy provides whole life coverage for one family member and term coverage for the other(s).

A policy's cash surrender value (CSV) is a form of equity value that it acquires over time. The owner of a policy can obtain its CSV by turning the policy in for cancellation before it matures or when the insured dies. A loan against a policy reduces its CSV.

A dividend is a share of any surplus company earnings which the insured may periodically pay to the policy owner.

Additional purchases are amounts of insurance purchased with dividends and added to the same policy, increasing its death benefit and CSV. The table of CSV that comes with a policy does not reflect the added CSV of additional purchases.

Dividend accumulations are dividends that the policy owner has constructively received but left in the custody of the insurer to accumulate as interest like money in a bank account. They are not a value of the policy per se; the owner can obtain them at any time without affecting the policy's FV or CSV.

Life Insurance- ABD

Under ABD regulations the cash surrender value (CSV) of life insurance with a maximum face value of $1,500 (not including additional purchases) for each member of the AU is excluded. For a face value of more than $1, 500, either on a single policy or combined policies, you will need to establish the CSV and dividend accumulations of all policies. This information must be obtained in a written verification from the insurance company.

When the total face value of all policies (except "term" insurance) on any person exceeds $1,500, the entire case surrender value of these policies shall be counted as a resource. Cash surrender value includes additional purchases and interest. Dividend accumulations are considered separately and are countable regardless of the accountability or excludability of the policy.

Dividend accumulations cannot be excluded from resources under the life insurance exclusion, even if the CSV of the policy that pays the accumulations is excluded from resources. Unless these accumulations can be excluded under another provision (e.g. as set aside for burial), they are a countable resource.

### (a) Ownership of Life Insurance

Life insurance policies are considered to belong to the insured unless the policy states that someone other than the insured owns the policy. For questionable ownership (e.g., in cases

of minors), clarification can be made with the insurance company. Regardless of who pays the premiums, therefore, the insured is the owner unless otherwise established.

If the A/R assigns his or her life insurance benefits to a mortician or funeral director, that assignment is always revocable (Health-Occ. § 7-405 (f)). Ownership of the life insurance policy remains with the A/R, and the A/R retains the right to redeem the policy for cash. In such a case, the policy is subject to the resource limitations and exclusions applicable to any life insurance policy.

**(b) Irrevocable Assignment of Life Insurance Policy to Fund Funeral or Burial Services**

In order for a life insurance policy to be an acceptable means of funding funeral or burial services and, therefore, excluded as a resource, an assignment of the policy must accompany the life insurance policy and contain the following provisions:

- The life insurance policy (policy number) is irrevocably assigned to the applicant's representative (representative's name) on the condition that the representative must use the proceeds from the policy solely for the funeral or burial of the insured. (Dated signatures of the insured and the representative are required.)
- This assignment is permanent and cannot be revoked, amended or terminated. A copy of this assignment was mailed to (name of the life insurance company) at (address of the life insurance company) on (date).
- Statement that the right to surrender the policy for cash or to obtain a loan against the policy has been waived.

Term Insurance

"Term" or burial insurance policies which do not have a cash surrender value will not be included when determining the total face value of an individual's policies. These policies will be totally excluded regardless of any other countable or excluded insurance.

## 800.10 Burial Arrangements-ABD

Burial Funds (Accounts and Revocable Contracts)

A burial fund is a revocable burial contact, burial trust, or other burial arrangement, cash, account, or other financial instrument with a definite cash value clearly designated for burial expenses and kept separate from non-burial related assets. Burial funds may take the form of pre-need funeral contracts, saving accounts, stocks or other burial expenses and are maintained separately from other non-burial related resources. There is a maximum of $1,500 burial fund exclusion per ABD A/R. A burial fund will be treated either as a burial account or a burial contract, each of which is defined below.

Burial Accounts

A burial account is any resource meeting the above definition of burial funds except a prepaid burial contract.

Burial Account of $1,500 or Less

Up to $1,500 may be designated as funds set aside for the burial of each member of an ABD unit (A/R and spouse). To be excluded, the funds must satisfy the definition of "burial fund" above. If at the time of application the applicant has burial funds of $1,500 or less which satisfy this definition, all funds as well as any interest or dividends accruing to the funds, are excluded.

Burial Account in Excess of $1,500

- If at the time of application the applicant has burial funds in excess of $1,500, all funds may or may not be excludable.
- Determine the original amount of the account set aside for burial. If the original amount is $1,500 or less, then the entire account, including accumulated interest and dividends, is an excludable resource.
- If the original amount is greater than $1,500, exclude from the original account $1,500 plus all accumulated interest or dividends. Any remaining amount is a countable resource and must be added to other countable resources and measured against the applicable standard in Schedule MA-2.
- If total countable resources are within the applicable standard, the applicant is resource eligible; however, the applicant must reduce the burial fund to the allowable portion which includes the accrued interest and dividends and maintain the fund in a separate, clearly identifiable account.

If total countable resources exceed the allowable amount, the applicant is ineligible.

## (a) Revocable Burial Contracts

A burial contract, or pre-need arrangement, is an agreement between a purchaser and a licensed provider of funeral services to provide specified goods and services for a specific price. The purchaser may make a lump sum payment or may pay for the goods and services in installments. For Medical Assistance purposes, the value of the contract is the amount paid by the purchaser to the provider. Revocable burial contracts of up to $1,500 may be excluded as burial funds. Excluded burial contracts may not be comingled with non-burial related resources. Any interest earned on excluded burial contracts or spaces is excluded as income. If excluded funds and/or spaces are commingled with non-excluded funds, the interest income on the non-excluded fund is also excluded.

### (b) Excluded Burial Funds Used for Another Purpose

If any excluded burial funds, interest or appreciated value on burial funds are used for any purpose other than the burial of the person for whom the funds were set aside, the unit may be determined ineligible due to excess resources effective the month in which the withdrawal was made. Any Program payments made during ineligible months are subject to recovery as erroneous payments.

### (c) Burial Spaces (ABD & FAC Spend-Down)

The term "Burial Space" includes gravesites such as burial plots, crypts, mausoleums, niches or other customary repositories for the deceased's bodily remains and opening and closing of the gravesite for burial. The term also includes any improvements to the gravesite such as headstones, markers and plaques. Caskets, urns, liners and vaults are also considered burial spaces.

An A/R with a contract to purchase any of the above items is considered to own the items; therefore the items may be excluded if the contract is paid in full.

One gravesite per individual A/R or two per couple is excluded. Additional gravesites may be excluded for use by members of the A/R's immediate family on a one-for-one basis. Immediate family includes the A/R's minor or adult children, siblings, parents (i.e. natural, adoptive or step relatives) and spouses. This does not include members of a non-ABD spouse's family.

If an individual or a couple states that he/she owns more than one (or two) gravesite(s), a written statement indicating for whose use the additional space(s) is/are intended must be obtained. The statement must show that person's name and relationship to the A/R. If the statement shows that the gravesite(s) is/are intended for the use of the A/R, his/her spouse or another member of the A/R's immediate family, the gravesite(s) is/are excluded from the A/R's countable resources.

If the gravesite is not intended for use by a member of an A/R's immediate family, it may be excluded as a resource if:

- The plot is owned jointly and the joint owner refuses to permit the sale of the plot; or
- The company from which the plot is purchased requires a move from the State in order to sell the plot.

In both cases, a written statement must be obtained from either the joint owner or the burial company documenting the A/R's restriction on selling the plot.

In addition to the gravesite (i.e. burial plot, mausoleum or niche), other burial spaces, such as a casket and liner, may also be excluded for the A/R and spouse.

### (d) Irrevocable Burial Funds (ABD & FAC)

Maryland law allows funeral directors to establish irrevocable burial contracts. An irrevocable contract is fully excluded regardless of value as is any interest earned on such a contract. Upon documentation that a contract is irrevocable, the entire amount may be excluded. Not all burial contracts in Maryland are irrevocable: therefore, the case record must contain documentation to verify irrevocability in order to allow this exclusion.

The existence of an excluded, irrevocable burial fund or contract does affect the burial space exclusion. Since a paid up contract for the purchase of items which meet the definition of burial spaces fulfills the requirements for exclusion as burial spaces, an individual may have both an irrevocable contract as well as a paid up contract for the purchase of burial spaces. The funds from both contracts may be commingled.

Burial Arrangements-FAC Spend-Down

One burial plot for each family member may be excluded and the equity value of funeral agreements up to $1,500 for each family member may be excluded. "Family member" means each person included in the assistance unit and the parents and spouse of a unit member who is excluded from the FAC unit because he/she is ABD or technically ineligible.

## 800.11 Bank Accounts and Other Assets

Accounts include, but are not limited to, savings accounts, checking accounts, share accounts, draft accounts, investment accounts, certificates of deposit and money market funds. These accounts may be held at banks, credit unions, saving and loan associations, investment firms, brokerages or any other financial institution. Bank accounts are evaluated on the basis of the balance on the first moment of the first day of the month. The value should not include income deposited on the first day of the month. Any withdrawals made on the first day of the month are included in the balance for the day.

### (a) Note for Checking Account

Outstanding checks may be deducted from the account's first-of-the-month balance if the A/R can furnish proof that the check was written in the prior month. Acceptable documentation is the cancelled check, a carbon copy of the check, or a legitimate business receipt from the payee. The check book register is unacceptable, as is the subsequent month's statement of cleared checks which provide no proof of the date the check was written. If none of the acceptable documentation is available, the A/R must obtain a photocopy of the check.

### (b) Singly Owned Accounts and Assets

Accounts and assets in the name of the A/R only are considered fully available to the A/R. There is no opportunity to rebut this ownership regardless of the original source of the funds. Person listed on an account or other ownership documents as power of attorney, custodian, guardian, trustee, representative payee or fiduciary are not considered co-owners of an account or asset and, therefore, are not given the opportunity to establish an ownership interest. Any transaction that limits the availability of these funds to the A/R must be considered under the disposal provisions.

**(c) Jointly Owned Accounts and Assets**

"Joint" means that more than one person is listed as the owner of an asset. The CM must use actual ownership documents to establish and to verify ownership, e.g. passbook, certificate, deed, title, etc. (An account statement might not list all the owners.)

Joint account may carry the following wording:

- "Joint account for John Jones and Mary Brown, subject to the order of either";
- "Joint account for John Jones, Mary Brown and Jane White";
- "Joint account for John Jones and Mary Brown, subject to the order of both";

While these and other similar phrases are common, it is not necessary that these phrases appear in order for an asset to be considered a joint account. For example, a certificate may simply list "owners: Jane White and Kelly Green". What is necessary for an account to be considered "joint" and "available" is that there is more than one owner, and that the A/R or spouse has withdrawal rights or the authority, acting alone, to liquidate the entire asset. If the documentation submitted is unclear as to the number and names of owners, then the A/R must submit documentation from the financial institution to establish these facts.

i. Joint Assets with Spouse as the Only Co-Owner

- When a married A/R lives with his/her spouse, all assets jointly owned by the couple are considered available to the A/R.
- When an applicant's eligibility is considered under the spousal impoverishment provisions:
    - All jointly owned assets are considered in both the assessment and the initial determination of eligibility.
    - When eligibility has been established and the post-eligibility transfer requirements have been met, all assets listing the recipient as a co-owner will be considered available to the recipient.

ii. Jointly Owned Assets with A/R, Spouse and others

- If a jointly owned asset exists between an applicant and a non-applicant other than the applicant's spouse, the full value of the asset will be considered available to the applicant.

- If an asset is jointly held between the spouse of an applicant and a non-applicant, the full value of the asset will be considered available to the spouse of the applicant.
- If an asset is jointly held between an applicant the spouse of an applicant and a non-applicant, the full value of the asset will be considered available to the applicant.

### 800.12 Rebuttal of Ownership Interest

COMAR 10.09.24.08J(4) attributes all funds in a joint account to the applicant or spouse unless it can be demonstrated that the non-applicant, non-spouse, or co-owner actually contributed funds to the account. If it can be so demonstrated, then the accounts are to be equitably apportioned as set forth below.

The results of this methodology are:

- Resource eligibility may be computed by subtracting the non-A/R co-owner's share; and
- Withdrawal of the apportioned amount by the non-A/R co-owners does not result in imposition of a penalty period.

The full value of jointly owned assets will be considered available to the A/R or the spouse of the A/R (as specified above) unless:

- The non- applicant co-owner demonstrates to the Department's satisfaction that he/she made regular and proportionate contributions of his/her own funds to the account. In this case a pro-rata share will be considered available to the applicant.
- The non-applicant co-owner demonstrates, through rebuttal, an ownership interest that is representative of the non-applicant's contribution to the accumulation or purchase of the asset.

### (a) Explanation of "Regular and Proportionate"

The "Regular and Proportionate" provision is intended to allow a pro-rata apportionment among account owners when evidence is presented that both or all co-owners have commingled their funds on an ongoing basis over an extensive period of time. In order to obtain a pro-rata division of an account under this provision, the A/R must demonstrate that both of these conditions, regular and proportionate, are met.

- "Regular" means that the contributions to the account were made at fixed intervals or in a demonstrable pattern of frequency, throughout a reasonable period of time. The 30-month period prior to the month of application is considered a reasonable period of time during which such a pattern should exist.
- "Proportionate" means that the funds contributed by each co-owner are approximately equal.

- In a shared living arrangement where the A/R or A/R spouse co-owns a household account with another occupant, and it is demonstrated that this account is used for shared household expenses, the contributions of the non- A/R or non-A/R spouse co-owner will be presumed to be proportionate. (The regularity of such contributions must still be demonstrated.) An account with a balance of more than $5,000 will not be considered a "household account.'
- In all other cases, it must demonstrated that the contributions of the non-A/R or non-A/R spouse co-owner represent an amount not less than 75% of the person's pro-rata share, were the account divided on such a basis. To determine this, take the following steps:

1. Divide the account balance by the number of co-owners.
2. Multiply the result by .75.
3. Total the contributions made by the non-A/R or non-A/R spouse co-owner.
4. If the sum of Step 3 is equal to or greater than the product of Step 2, the contributions will be considered proportionate.

(The regularity of contributions must still be demonstrated in order for a pro-rata share to be attributed under the "regular and proportionate" provision.)

It is expected that the most common application of the "regular and proportionate" provision will be to "household accounts" in shared living arrangements. The policy is designed to be liberal enough that applicants and case workers will not be burdened by inordinate accounting activity when the account in question is relatively small and the account is very active. For accounts where larger amounts of money are involved, the "regular and proportionate" provision may be applied but the evidence required to meet the "proportionate" requirement is more stringent. Note that it is not required that the A/R account for <u>every</u> deposit the non-A/R non-spouse co-owners have made, or that the contributions of all co-owners be <u>precisely</u> equal. What is required is that each co-owner demonstrates that he/she has made regular and proportionate contributions to the account on an ongoing basis and over a long period of time. Under the "regular and proportionate' provision, when <u>both</u> tests are met, the funds in the joint account are divided on a <u>pro-rata</u> basis among the co-owners. When both the "regular and proportionate" tests are not met, the apportionment of the account may still be considered under the "other ownership interest" provision. The amount attributed may be more or less than a pro rata share, and the amount attributable to each non-A/R co-owner may not necessarily be the same. Because large sums of money may be involved in this type of rebuttal, the provision does not allow for approximation or assumptions.

The "other ownership interest" provision is intended to enable persons who have made bona fide contributions to a joint account or asset to access the amount of money contributed without penalty. A common application of this provision is expected to be to accounts where the non-A/R co-owner has made a substantial contribution on a one-time-only or occasional basis and has not yet withdrawn those funds. In considering whether

these circumstances exist, the CM must carefully examine the documentation submitted and may need to request additional information to substantiate the A/R's claim. For example, a deposit slip in and of itself may not specify that the funds deposited belonged to the non-A/R co-owner. If there have been withdrawals from the account, it may be necessary to determine who made those withdrawals and how the funds were used in order to ascertain whether the non-A/R co-owner has already withdrawn his or her share.

The worker may take into consideration the plausibility of an A/R's explanation regarding financial transactions. This does not obviate the need for documentation but should provide guidance to the worker as to the extent and type of verification required. Generally, the amount and type of verification should be based on the amount of funds involved, the obscurity or implausibility of the explanation of account activity, the complexity and number of account transactions, the age of the transactions, and whether professional assistance was required to accomplish the transactions. "Records" constructed "after the fact" are unacceptable.

Required Documentation

The entire value of a jointly held asset is considered available to the A/R and/or the A/R spouse co-owner. The burden of proof is on the A/R to demonstrate otherwise. If, in any case, the A/R fails to present convincing evidence to support a rebuttal, the LDSS will determine eligibility based on COMAR 10.09.24.08J(1)-(3), i.e. the entire value of the asset will be considered available to the A/R. As for any decision, an A/R may appeal the LDSS decision.

**(b) Change in Ownership Documents**

Following the ownership determination of pro-rata or other interest in a joint asset, the ownership interests must be reflected in the account's legal ownership documents (passbook, title, deed, etc.). If the A/R's assets are within the applicable standard the person may be certified but a 745 alert must be set up for review within 30 days of the date eligibility is determined to insure that the required changes in ownership documents have been completed.

The required new ownership documents must preclude the A/R's access to any funds except those designated as belonging to the A/R. Likewise, the name of the former co-owner must be removed from the asset or, if not, the designation must preclude withdrawal rights or liquidation by the co-owner. The co-owner's name may remain on the account as guardian, power of attorney, fiduciary, representative, etc., which permits withdrawal only on behalf of the A/R, so that the asset will be fully attributed to the A/R. These transactions must be verified by presenting the new documents to the eligibility CM.

**800.13 Annuities**

An annuity is a contractual right, which is not employment-related, that is purchased by or for an individual using that individual's money, to receive fixed, non-variable payments of money or money's worth at fixed intervals for a lifetime or specified number of years, as established by a contract with an issuing entity in exchange for financial consideration. An annuity may be revocable or irrevocable. The annuity contract will specify whether the purchaser can cash in the annuity or receive any portion of the money and, if so, the circumstances under which such a withdrawal or payment may be made.

Regardless of whether an annuity is countable as a resource, the A/R or representative, as a condition of Medicaid eligibility, must disclose, at application and at each redetermination, a description of the ownership interest that the A/R or the A/R's spouse has in any annuity or similar financial instrument. Any income received from the annuity or similar financial instrument must be reported. Also, the A/R or representative must report to the eligibility CM within 10 business days the purchase of an annuity or any transaction that affects the course of payment from the annuity or changes the treatment of the annuity's income or principal.

In accordance with the requirements of this Section, the eligibility CM determines whether the annuity is countable as a resource. If the annuity may be cashed in, withdrawn, sold, transferred, or liquidated, the available amount is considered as a countable resource based on its full current fair market value. The annuity may only be excluded if the A/R or representative provides documentation from the issuing entity, verifying that the annuity is irrevocable and that the money used to establish the annuity is not available in any amount under any circumstances, other than by regular payments issued in accordance with the annuity's written terms.

Payments received from an annuity are considered as considered countable income, regardless of whether the annuity itself is considered a countable or excludable resource or whether the transaction establishing the annuity is subject to penalty.

If all or part of an annuity or its income stream is made unavailable or is otherwise transferred for less than fair market value, the eligibility CM must determine whether the purchase or other transaction is a disposal subject to a penalty. For individuals, including SSI recipients, who are institutionalized in a nursing facility (or medical institution with a level of care equivalent to a nursing facility) or in a home and community-based services (HCBS) waiver, the eligibility CM determines whether the purchase or other transaction involving an annuity (e.g., transfer of the annuity or its income stream, change in payments) should be penalized because there is uncompensated value (see the sub-section in this Section about 'Disposal of Assets for Less Than Fair Market Value"). <u>This review for a penalty is conducted regardless of whether the annuity is countable or excludable as a resource.</u>

- If, based on actuarial projections of the purchaser's life expectancy, (see the Period Life Table in Schedule MA 9-A of the Manual's Appendix), the full amount invested in the annuity is expected to be paid out to the purchaser during

the purchaser's anticipated lifespan, the fair market value has been received. Therefore, the purchase is not subject to penalty.

- If, however, actuarial projections in conjunction with the contract's terms indicate that the full investment will not be returned during the beneficiary's lifespan, the purchase is subject to penalty. The penalty for the uncompensated value is computed based on the difference between the investment and the anticipated return.

**(a) Federal Deficit Reduction Act of 2005- Requirements for Annuities**

The following policies from the federal Deficit Reduction Act of 2005 apply to an annuity (or similar financial instrument specified by the Centers for Medicare and Medicaid Services (CMS)) that is purchased on or after February 8, 2006 and is reviewed for a determination or redetermination on or after April 1, 2007 of an institutionalized individual's eligibility (including an SSI recipient) for long-term care (LTC) services in a:

- Nursing facility (NF);
- Medical institution with a level of care (LOC) equivalent to NF; or
- Home and community-based services (HCBS) waiver.

1) By virtue of applying for and receiving the above long-term care services, an institutionalized individual is considered to agree that the State of Maryland is the remainder beneficiary in the preferred position specified below for any annuity (or similar financial instrument specified by CMS):

   - For which the institutionalized individual or the individual's community spouse has an ownership interest; and
   - Which was purchased on or after February 8, 2006, with the institutionalized individual's or community spouse's assets; and
   - Which is reviewed for a determination or redetermination on or after April 1, 2007, of the institutionalized individual's eligibility for nursing facility or HCBS waiver services.

   The State of Maryland must be named as the remainder beneficiary in the position after only the individual's community spouse and/or the institutionalized individual's child who is younger than 21 years old or disabled (as determined by the Social Security Administration or the State), for the total amount of Medicaid payments (not just the LTC payments) on the institutionalized individual's behalf. The annuity's terms must also specify that the State is named in the first position if the community spouse, the child, or the representative disposes of the remainder for less than fair market value.

   - Therefore, for an annuity owned by the community spouse, the state must be named in the first position, unless the institutionalized individual has a minor

or disabled child. The State may not be named behind the institutionalized spouse or any other individual.

The entity that issued the annuity must confirm the State is named as a preferred remainder beneficiary in the correct position. If the institutionalized individual or community spouse does not agree to these terms for Medicaid coverage of nursing facility or HCBS waiver services, the institutionalized individual may still be determined Medicaid eligible in an H, L, or T track coverage group or as Medicaid community eligible (e.g., as a medically needy recipient or a Supplemental Security Income beneficiary). However, a LTC span may not be opened on MMIS recipient screen 4 for coverage of services in a nursing facility. Also, a waiver span may not be opened on MMIS recipient screen 8 for coverage of HCBS waiver services. The recipient would still be covered for all other Medicaid services. If necessary, the eligibility CM must send a DES/LTC 813 to the DHMH Division of Recipient Eligibility Programs (DREP), to assure that the information is correctly entered on MMIS.

2) The following requirements apply for an annuity (or similar financial instrument specified by CMS):

- In which an institutionalized individual or the individual's community spouse has an ownership interest; and
- Which was purchased with the institutionalized individual's or community spouse's assets on or after February 8, 2006; and
- Which is reviewed for a determination or redetermination of the institutionalized individual's nursing facility or HCBS waiver eligibility on or after April 1, 2007.

If these conditions are met, the DHMH Recoveries and Financial Services Division will notify the issuing entity:

- Of the State's right as a preferred remainder beneficiary for the total amount of Medicaid payments on the institutionalized individual's behalf (nor just for the amount of LTC services paid by Medicaid); and
- That the issuing entity is required to notify the Recoveries Division if the amount of income or principal being withdrawn is changed from the amount most recently disclosed to the State, or of any type of transaction specified below under #4 that may be subject to a penalty. The appropriate actions(s) must be taken by the eligibility CM and/or State in response to any change.

3) Unless the State of Maryland is named as a remainder beneficiary in the preferred position specified below, the purchase of an annuity (or similar financial instrument) by an individual or the individual's spouse with the individual's or spouse's assets is penalized as a disposal for less than fair market value, if the annuity:

- Was purchased on or after February 8, 2006; and

- Is reviewed at a determination or redetermination of nursing facility or HCBS waiver eligibility on or after April, 2007; and
- Was purchased on or after the institutionalized individual's applicable look-back date.

A penalty period is imposed for the institutionalized individuals' coverage of NF or HCBS waiver services, in accordance with the section about 'Disposal of Assets of Less Than Fair Market Value." The amount penalized is the annuity's full value at its purchase.

A penalty is not imposed if the State of Maryland is named as the remainder beneficiary, for the total amount of Medicaid payments on the institutionalized individual's behalf, in the:

- First position; or
- Next position after only the institutionalized individual's community spouse or any of the institutionalized individual's children who are younger than 21 years or disabled (as determined by the Social Security Administration or the State). The terms if the annuity must also specify that the State is named in the first position if the spouse, child, or representative disposes of any of the remaining annuity for less than fair market value.

For example, a penalty is imposed on the institutionalized individual's Medicaid LTC coverage if the State is named in a position behind the institutionalized spouse on the community spouse's annuity.

4) The purchase or other transaction specified below involving an annuity (or similar financial instrument) may be considered as a disposal for less than fair market value if:

- The institutionalized individual (not the community spouse) has an ownership interest in the annuity; and
- The annuity was purchased with the institutionalized individual's assets; and
- The purchase or transaction:
  - Occurred on or after the institutionalized individual's look-back date; and
  - Occurred on or after February 8, 2006; and
  - Is reviewed for a determination or redetermination of the institutionalized individual's nursing facility or HCBS waiver eligibility on or after April 1, 2007.

The following transactions involving an annuity or similar financial instrument may be subject to a penalty:

- Purchase of an annuity;
- Addition of principal to an existing annuity;
- Elective withdrawal from an annuity;

- Request to change the annuity's distribution (e.g., change in who receives income from the annuity);
- Election to annuitize the contract; or
- Another action that changes the course of payment from the annuity or changes the treatment of the annuity's income or principal.

The amount that is penalized is the full value of the purchase or other transaction.

See section "Disposal of Assets for Less Than Fair Market Value."

A penalty is not imposed if the annuity:

a) Meets the requirements in the Internal Revenue Code (IRC) of 1986 as:
   - An individual retirement annuity (IRC §408(b)); or
   - A deemed Individual Retirement Account (IRA) under a qualified employer plan (IRC § 408 (q)); or
b) Was purchased with proceeds from:
   - A traditional IRA (IRC §408 (a)); or
   - An account or trust which is treated as a traditional IRA (IRC §408 (c)); or
   - A simplified retirement account (IRC §408 (p)); or
   - A simplified employee pension (IRC §408 (k)); or
   - A Roth IRA (IRC § 408 (a)); or
c) Meets all of the following requirements:
   - Provides for payments in approximately equal amounts during the annuity's term to the annuitant, with no deferral and no balloon payments, to the annuitant, annuitant's spouse, or annuitant's child who is younger than 21 years or disabled (as determined by the Social Security Administration or the State); and
   - Is:
     - Irrevocable; and
     - Non-assignable; and
     - Actuarially sound, based on actuarial projections for the purchaser's life expectancy (see Schedule MA 9-A).

To prove that annuity was established under any of the Internal Revenue Code provisions specified in the paragraph a) or b) above, the institutionalized individuals or representative must provide the eligibility CM with documentation from the entity that issued the annuity. To evaluate whether an annuity meets the conditions listed in paragraph c) above, the eligibility CM reviews the annuity's written terms and determines the purchasers' life expectancy (see the Period Life Table in Schedule MA 9-A of the Manual's Appendix). If the full amount invested in the annuity is expected to be paid out to the purchaser during the purchaser's anticipated lifespan, the annuity is considered actuarially sound.

These requirements are not applied to an annuity purchased by or on behalf of the community spouse with the community spouse's assets. Therefore, if an annuity

purchased by or on behalf of the community spouse does not meet these requirements, it is not penalized for these reasons. However, a penalty period may be imposed for other reasons specified in this Section.

For annuities purchased before April 1, 2007, routine changes and automatic events that do not require any action or decision after this Deficit Reduction Act section of the Manual's effective date of April 1, 2007, are not considered transactions subject to penalty (e.g., death or divorce of a remainder beneficiary). For example, if an annuity purchased in 2005 specifies that distribution begins two years from the date of purchase, and payouts begin as scheduled in 2007, this is not a transaction subject to penalty, because no action was required to initiate the change after this Section's effective date. Changes, which occur based on the annuity's terms enacted before this Section's effective date, and which do not require another decision, election, or action to take effect, are likewise not subject to a penalty. Also, changes that are beyond the owner's control (e.g., change in law, the issuer's policies, or terms of the annuity based on factors like the issuer's economic condition) are not considered transactions subject to penalty.

## 800.14 Trusts

A trust is a legal instrument, valid under state law, created other than by a will, by which a grantor transfers property to one or more trustees who have the fiduciary responsibility to hold, manage, and administer the trust's resources and income for the benefit of the grantor or certain designated beneficiaries. Any arrangement in which a grantor transfers property to a trustee or trustees with the intention that it be held, managed, or administered by the trustee(s) for the benefit of the grantor or certain designated individuals (beneficiaries), is a trust.

The term "trust" includes any legal instrument, agreement or device that is similar to a trust, in that it exhibits the general characteristics of a trust but which may not be called a trust under State law. These include, but are not limited to, escrow accounts, investment accounts, partnerships, pension funds and other similar entities managed by an individual or entity with fiduciary obligation.

For purpose of this section, "trusts" will not include trusts established through a will, escrow accounts established as a mandatory condition for obtaining a mortgage on excluded home property, escrow accounts established from security deposits required by the Applicant, Recipient, or Spouse (A/R/S) landlord as a condition for leasing the home, pension funds to which the A/R/S did not contribute as a mandatory condition of employment, and pension funds to which the A/R/S did contribute as a mandatory condition of employment, or pension funds to which the A/R/S contributed while still employed. However, such funds will be counted as resources when they are available to the A/R/S. An A/R/S will not be required to relinquish home property or the right to occupy the home in order to make mortgage escrow accounts or security deposits or similar funds available as resources.

### (a) Who's who in Trusts?

The Grantor is the person who set up the trust and placed his or her assets in it. The Grantor is sometimes called the Settlor.

The Trustee is the person who is responsible for taking care of the assets placed in the trust and insuring that the assets are used as the Grantor has specified. There can be more than one trustee, and a trustee can be an entity such as an insurance company or bank. A trustee holds a fiduciary responsibility to manage the trust's corpus and income for the benefits of the beneficiaries.

The Beneficiary is the person or person for whom the trust was created and on whose behalf the funds must be used or who can benefit in some way from the trust. There can be more than one beneficiary. A trustee who is entitled only to reasonable compensation for managing the trust is not a beneficiary.

An individual may have more than one role in the trust arrangement: e.g., a person could be both grantor and beneficiary, or grantor and trustee. The explanation of trusts which follows is applicable in the context of Medical Assistance eligibility and is not meant to be a summary of trust law generally.

**(b) What's In a Trust?**

The Corpus means the assets or income that is placed in the trust. The corpus could be a single bank account or could include a combination of accounts, stocks, real estate, and etc. The corpus is also called the principal.

Trust income is the amount of money the corpus generates. Usually this is interest but it could be rents, dividends, etc.

A payment may be made either from the corpus or the income. A payment is any disbursal from the trust or income generated by the trust which benefits the party receiving it. A payment may include actual cash or property disbursements as well as non-cash or property disbursements such as the right to use and occupy real property.

**(c) What Kinds of Trusts are there?**

A Revocable trust can be dissolved and the grantor can get his/her assets back. This includes a trust that can only be modified or terminated by a court since the grantor or his/her representative can petition the court to terminate the trust.

Some trusts contain clauses which provide, for example, that if the beneficiary leaves a nursing facility or other health care institution, the trust automatically terminates. Termination clauses make a trust revocable (even if the trust is titled "irrevocable" or uses that term in the document), with the result that the entire trust is deemed available to the A/R. The full amount in a revocable trust is countable.

An Irrevocable trust means that the grantor cannot terminate the trust and get the assets back. The trust terminates only at the death of the beneficiary. Assets placed in an irrevocable trust may be countable depending on factors such as the date the assets were placed in trust, whether the trust is discretionary, and who the grantor and beneficiary are. Assets placed in an irrevocable trust that are not countable are considered a disposal subject to penalty.

All trusts are either revocable or irrevocable.

A Discretionary trust means that the trustee has the right to decide if, when and how the funds from the trust are to be used. The amount distributed from the trust to or on behalf of the A/R is considered income.

An Exculpatory Clause is any clause that limits the trustee's discretion to disburse trust funds in any way to secure government aid or assistance. As an example, language that limits the distribution of income from a trust to an amount $20 dollars less than the state's maximum income standard would be exculpatory language.

A Medicaid Qualifying Trust (MOT) means the applicant or spouse is the grantor and the applicant or spouse is also a beneficiary. See the Section below entitled "Medicaid Qualifying Trusts" for specific instructions on how to treat this kind of trust.

A Testamentary Trust is a trust that has been established by the grantor's will. It is available only upon the death of the grantor.

An Income Trust is a trust that is established to hold an individual's income. See the section on "Income Trusts" for specific instructions on how to treat this kind of trust.

A Burial Trust is a trust established to pay for funeral expenses and burial. Such trusts should first be evaluated as excludable burial arrangements. If the trust cannot be excluded under the burial fund exclusion policy, it must be evaluated in accordance with the policies and regulations pertaining to other trusts.

**(d) Documentation**

In order to determine the kind of trust the A/R has and the applicable policies, a copy of the trust document must be obtained. This document must also list all assets originally and currently deposited in the trust. These assets are sometimes listed on a separate sheet as an appendix or addendum. Sometimes this list includes only a description of the asset, e.g. the address of real property or a certificate of deposit number. In this case, it is necessary to obtain additional documentation to determine the actual value of the assets.

A trust often requires the trustee to file a Fiduciary Report. A Fiduciary Report is a document that is filed with a court periodically to give an accounting of the trustee's handling of the trust. It will include the beginning value of assets, any income accrued, any disbursement made, and the current value. This report should be obtained in order to verify income countable to the A/R and current assets in the trust.

If the trustee is not required to file such a report, other documentation must be obtained to verify income, disbursements, and the current status of the trust. Records compiled by the trustee must be accompanied by supporting documents, such as bankbooks, cancelled checks, receipts, etc.

**(e) Evaluation of Trusts**

A trust may represent a countable asset, a source of income or a disposal subject to penalty. In order to properly evaluate a trust, many factors must be taken into consideration. The first factor to consider is whose money went into the trust. A trust may not be considered as resource for an A/R if some or all of the funds going into the trust were from the resources or income of the A/R or the A/R's spouse.

The second factor to consider is whether the trust is a countable resource. Ownership of the trust must be determined and whether the trust's funds are accessible to the owner. A trust may only be counted as a resource for an A/R if it meets the definition of a resource, because it is accessible to the A/R or the A/R's spouse as the owner. Creation of a trust or other activity related to a trust during the past 60 months (e.g., change of ownership, change from being inaccessible to accessible, addition or reduction of assets in the trust) must be investigated.

If the trust is not accessible to the A/R or the A/R's spouse, it must be determined whether the trust should be considered a disposal subject to penalty based on whose money went into the trust. If the A/R's or spouse's money went into an inaccessible trust, a penalty period may need to be imposed. Take special note of how to review a trust for determining whether a penalty period is applicable.

The third factor to consider is the date the trust was established. The rules for treatment of trusts established on or before August 10, 1993 differ from rules for trusts established after that date. The following policies and procedures are based on the date the trust was established.

RULES FOR TREATMENT OF TRUSTS--Pre- OBRA '93

This section is applicable to trusts established on or before August 10, 1993. It does not apply to trusts established after that date. A trust established on or before August 10, 1993, but which is funded, added to, or otherwise augmented after that date is treated under the pre-OBRA rules. However, the funds placed in the trust after that date may be considered disposals. In all cases, the A/R must document when assets were placed in the trust. A trust is only treated in accordance with this policy if the resources or income

of the A/R and or the A/R's spouse formed all or portion of the trust corpus. Also, it must meet the definition of a "resource", as being accessible to the A/R or the A/R's spouse.

**(f) Medicaid Qualifying Trusts**

The policies discussed below are based upon the Consolidated Omnibus Budget Reconciliation Act of 1985, HCFA Medicaid Letter 92-54, and Section 3215 of the State Medicaid Manual.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) amended section 1902 of the Social Security Act to provide that assets in certain trusts would countable for the purpose of determining eligibility for Medical Assistance. These trusts are called "Medicaid Qualifying Trusts."

"Medicaid Qualifying Trust" (MQT) means a trust or similar legal device established (other than by will) by a person and/or a person's spouse under which the person and/or spouse may be the beneficiary of all or part of the payments from the trust, and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the person or spouse. MQT treatment applies to trusts regardless of who are permitted to exercise any discretion with respect to the distribution to the person or spouse. MQT treatment applies to trusts regardless of whether the purpose of the trust is to enable persons to qualify for Medicaid; whether they are revocable; and whether the discretion of the trustee is actually exercised. Burial trusts, educational trusts or medical trusts may be considered MQTS's. A trust established by a guardian or legal representative including a parent, falls under the definition of an MQT.

A "similar legal device" is any arrangement, instrument or device which is not called a trust or which does not qualify as a trust under State law, but which has all of the other characteristics of a Medicaid Qualifying Trust. Any arrangement where the applicability of MQT policy is questionable should be referred to the Division of Eligibility Services for review.

In the case of a Medicaid Qualifying Trust, the amount to be considered a resource is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the beneficiary, assuming the full exercise of discretion by the trustee or trustees. Distributions are considered available regardless of whether they are actually made. This includes amounts distributable directly to the beneficiary or payable to third parties on the beneficiary's behalf, such as insurance companies, vendors, care givers, medical care providers, etc., or to reimburse anyone for payments to any of these parties.

Points to Remember:

- A Medicaid Qualifying Trust is a countable resource regardless of:
    - Whether it is revocable; or

- Whether it has been is established for purposes other than to enable a person to qualify for Medical Assistance; or
- Whether the discretion of the trustee or trustees is actually exercised.

In an ABD case, if the A/R or spouse is the grantor in a revocable trust, count the full amount of the trust as an available resource even if the trust is an MQT. This is because the MQT rules are not intended to conflict with ABD rules; the MQT rules merely allow counting as available to the A/R a limited portion of the trust. Since, in these circumstances, the entire trust would already have been counted under existing ABD rules, the MQT rules do not have an effect.

If the full amount of the trust cannot be counted as above; an MQT is evaluated as a resource in the first of two steps:

- Determine the maximum amount of potential payments to or on behalf of the A/R under the MQT. Because there are no "use" limits on an MQT, count all potential payments including burial funds, educational funds and medical funds. The amounts of potential payments that may be made by the trustee are described in the trust and may be limited by exculpatory clauses. Ignore exculpatory clauses and count the entire distributable portion of the trust as available to the beneficiary.
- In the second step, actual payments from the trust must be evaluated as either resource or income. Consider actual payments from the corpus of the MQT as a resource. When funds are distributed from the corpus, the value of the corpus is reduced but the funds are countable as a cash asset; therefore distribution does not reduce the overall value of assets in a given month. The burden is on the A/R to demonstrate that the distribution is from the corpus rather than income. Income distributed from the trust is income in the month received. Actual payments to a beneficiary from an MQT should be used in calculating an individual's contribution to the cost of care. Income retained into a subsequent period under consideration is a resource. Trust income, if not disbursed in the month received, will be counted as a resource in the subsequent month.

### (g) Exception for the Mentally Disabled

If the beneficiary is a mentally disabled person who resides in an intermediate care facility for the mentally disabled, the trust will not be considered an MQT if it was established before April 17, 1986 and is solely for the benefit of the mentally disabled person.

### (h) Undue Hardship

The counting of a Medicaid Qualifying Trust may be waived if it is determined that denial of eligibility would work an undue hardship on the A/R. This determination may be made only by the Division of Eligibility Services. An undue hardship will not be granted if the A/R or his/her representative assisted in establishing the MQT. An undue

hardship will be granted only upon documentation that the A/R will be denied life-sustaining medical care, that all legal recourse to obtain disbursements from the trust have been exhausted, that the trustee has been charged with the failure to meet his or her fiduciary responsibility and appropriate legal action has been taken, and that the A/R and/or spouse have no additional assets, countable or excludable that could be used to purchase the required medical care.

**(i) Revocation, Distribution or Alterations**

If an MQT is revoked or if the entire corpus and accrued income is disbursed to the A/R, the amount received is still considered a resource. If the funds are distributed to someone other than the A/R, this action must be evaluated as a disposal to determine if a penalty period is applicable. In either case, if the MQT resulted in ineligibility in a prior month, eligibility may not be established for the prior month even if the trust is later revoked.

**(j) Income Trusts**

Apply the MQT analysis to determine the amount of potential payments to be considered as a resource. The amount of actual payments is considered as either income or a resource, as appropriate.

If the A/R receives the income before placing it into a trust, it is countable income. Merely rerouting the income check to the trust rather than the individual is not sufficient to permit the income not to be counted as available to the individual. To qualify as non-countable income the individual must relinquish all ownership and control over the income in question and permanently assign such ownership and control to the trust. Anything less than total and permanent divestiture of ownership and control will permit the State to count funds going to the trust as income to the individual. While private pensions and similar resources may be assignable to a trust, Federal benefits, pensions, etc., are not, thus an individual receiving SSI benefits, a VA pension, a Federal civil service pension or any other Federal pensions cannot shelter such income by reassigning it as a payment to a trust.

Income which is diverted to a trust and thus does not first pass through the hands of the recipient is not counted as income to the recipient when determining eligibility. If however, it is diverted into an MQT, it will be counted as income if distributed in the month received, and if not distributed, will increase the countable value of the MQT.

**(k) Trust as a Transfer**

Money that is placed in a trust established on or before August 10, 1993 may be considered a transfer for less than Fair Market Value. If the grantor is the A/R or spouse, the trust should be evaluated to determine if a penalty period is applicable. Amounts in a trust are either still available and can be counted as a resource (MQT), or are no longer considered available and can be treated as having been transferred to another. Any portion of the trust deemed available under the MQT provisions will not be considered as

having been transferred. Income placed in a trust on or before August 10, 1993 is not a transfer of assets.

## 800.15 The Omnibus Budget Reconciliation Act of 1993

RULES FOR TREATMENT OF TRUSTS ESTABLISHED AFTER AUGUST 10, 1993
OBRA'93

The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) amends section 1917 of the Social Security Act as it pertains to the treatment of transfers of assets and treatment of trust funds.

The following rules do not apply to testamentary trusts, excludable irrevocable burial trusts, and certain trusts for disabled persons.

The following rules apply to trusts established after August 10, 1993 regardless of:

- Whether the corpus of the trust consists either entirely or in part of the assets of the A/R/S (for the purpose of this discussion the abbreviation A/R/S shall be read as "Applicant or Recipient and/or the Spouse of the Applicant or Recipient");
- Who established the trust, whether it was the A/R/S, their legal guardians or representatives, a court, insurer, etc.;
- The purpose for which the trust was established;
- Whether the trustees have or exercise any discretion under the trust;
- Any restrictions on the circumstances under which disbursement can be made;
- Any restrictions when disbursement can be made; or
- Any restrictions on the use of disbursements.

This means that any arrangement which includes the basic elements of a trust and contains assets (income or resources) of the A/R/S can be counted in determining eligibility for Medical Assistance. No clause or requirement (exculpatory clauses) in a trust, no matter how specifically it apples to Medical Assistance or other Federal or State programs, precludes a trust from being considered under these rules.

Trust Corpus

If the assets of the A/R/S form all or a portion of the trust corpus, the trust will be treated in accordance with this policy. A trust containing any assets of the A/R/S will be presumed to consist entirely of the assets of the A/R/S unless the A/R presents convincing documentation to the contrary. If the trust does contain assets of another commingled with assets of the A/R/S, only the portion attributed to the A/R/S will be considered under this provision.

Under the provision of OBRA '93, "asset" means both income and resources; therefore, a trust consisting of either or both is considered under the provision. Assets also include

income or resources to which the A/R/S is entitled but does not actually receive, if they are not received because of any action taken by the A/R/S or their legal representatives or anyone acting at the request of any of these people. If the A/R/S or their legal representatives deliberately fail to take an action and this failure precludes or delays receipt of an asset by the A/R/S, this will be considered an action in itself and the income or resources will be considered an asset belonging to the A/R/S.

**(a) Who Established the Trust**

If a trust is established by any of the following, it is subject to these rules:

- The A/R;
- The spouse of the A/R;
- The legal representative, guardian, or anyone authorized to act in place of or on behalf of the A/R/S including any court or administrative body; or
- Anyone acting at the request or direction of any of those listed above, including any court or administrative body.

**(b) Purpose of the Trust**

The purpose for which a trust is established does not affect its treatment under these rules. These rules are applicable regardless of the circumstances under which the trust was created and who the beneficiaries are. These rules are therefore applicable to educational, health, special needs, non-excluded burial trusts or any other type of trust.

**(c) Discretion of Trustee**

These rules apply to discretionary trusts, regardless of the amount or kind of discretion the trustee(s) are given. These rules apply regardless of whether or not the trustee(s) exercises any discretion they may have. These rules also apply to trusts where the trustee(s) have no discretion.

**(d) Restrictions on Distributions**

Restrictions on distributions from the corpus or income of the trust do not affect their treatment under these rules. This means that any language that specifies when distributions may be made, how they may be made, the circumstances under which they may be made, the amount that may be disbursed, the use of disbursements, etc., may be disregarded as they will not affect the applicability of these rules.

**(e) Date of Establishment**

These rules apply to trusts established after August 10, 1993.

**(f) Revocable Trusts**

All funds placed in a revocable trust are considered a resource. In addition, if any funds are disbursed from the corpus or income, to or on behalf of the A/R, these amounts will also be considered income. Any payments from the revocable trust, to or for anyone other than the A/R, are considered transfers by the A/R subject to the same penalties as if the payments were made by the A/R personally.

**(g) Irrevocable Trusts**

- If any payment at all, under any circumstances (regardless of how remote), may be made from the trust, and there is no portion of the trust from which payments cannot be made, then the entire trust is a countable resource. This is true regardless of whether the specified circumstance currently exists. In addition, if any funds are disbursed from the corpus or income to or on behalf of the A/R, this amount will also be considered income. Any payments from the trust to or for anyone other than the A/R are considered resources disposed of and are subject to penalty.

- If there are no circumstances under which a payment may be made from any portion of the trust to or on behalf of the A/R then the entire value of the trust (corpus and income) is considered a disposal subject to penalty. This amount is not reduced by any payments that may be made from the trust of a later date. Payments made from the trust for whatever purpose, even to the grantor, will be included in the value of the trust in determining the amount of disposal. Thus, the amount disposed of is the total of the original amount placed in trust and all subsequent additions including trust income and interest.

- Combinations: If, in a single trust, there is a portion of the trust, e.g., corpus or income, or limited amounts that can be disbursed to or for the benefit of the A/R under any circumstances no matter how remote, then that portion is treated as a resource available to the individual. The remaining portion of the trust, i.e., that from which no payments can be made under any circumstances, is treated as described in the paragraph above.

  When determining whether payments can be made from the trust, it is not necessary to determine when payments can be made. Where a trust provides in some manner that a payment can be made even though payment may be some time in the future, treat the trust as providing that payment can be made from the trust.

**(h) Trust as Both Income and Resources**

The treatment of trusts differs from the treatment of other resources in that the same asset can be considered both income and resource. In evaluation of a resource such as a bank account owned by the A/R, the account is evaluated as a resource, and when funds are withdrawn and used, this is considered a reduction of the resource and the withdrawal is not considered income. When evaluating a trust, however, any amount determined to be a resource in accordance with the above rules will also be considered income to the A/R when a payment is made to the A/R or used on behalf of the A/R.

Payments are considered to be made to the A/R/S when any amount from the trust including an amount for the corpus or income produced by the corpus is paid directly to the A/R/S, or to someone acting on his/her behalf, e.g., a guardian or legal representative.

Payments made for the benefit of the A/R/S are payments of any sort including an amount from the corpus or income produced by the corpus or paid to another entity so that the individual derives some benefit from the payment.

Example:

Such payments could include purchase of clothing or other items, such as radio, television, etc., for the individual. Also such payments could include payment for services the individual may require, or care, whether medical or personal, that the individual may need. Payments to maintain a home are also payments for the benefit of the individual.

A payment for the benefit of the individual is counted under this provision only if such a payment would ordinarily be counted under the SSI program.

Example:

Payments made on behalf of an individual for medical care are not counted in determining income eligibility under the SSI program. Thus, such payments would not be counted as income under the trust provision.

(i) Use of Trust Rules vs. Transfer Rules for Assets Placed in Trust

Placing an asset in a trust generally results in a penalty for a disposal for less than fair market value; however, there are specific provisions for the treatment of income or resources placed in trust. These provisions sometimes result in imposition of a penalty period. When the trust provisions and the general transfer rules are both applicable, do not compute a penalty twice based on the same transaction. Instead, give the trust provisions precedence over the general transfer provisions (which may require that the trust assets be treated as a disposal subject to penalty).

## 800.16 Exceptions to OBRA '93

### (a) Trust for Disabled Persons Under Age 65

A trust containing the assets of a disabled A/R under age 65, which meets all of the following criteria, is not subject to consideration as an available resource or as a resource disposed if:

- The trust was established by one of the following:

  - a parent;
  - a grandparent;
  - a legal guardian;
  - a court; and
- the trust contains the provision that, upon the death of the A/R, the amount remaining in the trust will reimburse the State for all Medical Assistance payments made on behalf of the A/R; and
- the trust was established for the sole benefit of a person who:
  - is under 65 old; and
  - is considered disabled as per COMAR 10.09.24.02B (19).

When a trust is established for a disabled individual under age 65, the exception for the trust discussed above continues even after the individual becomes age 65 as long as the individual continues to be disabled as defined by SSI. However, such a trust cannot be added to or otherwise augmented after the individual reaches age 65. Any such addition or augmentation after age 65 will be treated as a transfer of assets for less than fair market value.

The disability of the person for whom the trust is established must be verified by receipt of SSA disability payments, SSI, or by the State Review Team (SRT).

The second criterion above is met only if the language of the trust is specifically approved in writing by the office of the Assistant Attorney General. Any trust that may be revoked or altered does not meet this criterion. It is the responsibility of the drafter of the trust to obtain this documentation prior to establishment of the trust. Any trust not accompanied by the approval of the Attorney General (AG) does not meet the necessary conditions and will be treated in accordance with all other provisions of OBRA '93. A trust is considered to be for the sole benefit of a disabled individual under age 65 if the transfer is arranged in such a way that no individual except that individual can benefit from the assets transferred in any way, either at the time of the transfer or at any time in the future. However, the trust may provide for reasonable compensation for a trustee or trustees to manage the trust.

If a beneficiary is named to receive the asset or whatever is left of it at the time of the individual's death, the transfer or trust will nevertheless be considered to have been made for the sole benefit of the individual, if the Maryland Medical Assistance Program is named as the primary beneficiary of the asset up to the amount paid for services provided to the individual, with the designated beneficiary or beneficiaries receiving any amount that remains.

**(b) Trusts Established by Non- Profit Association**

A trust which contains the assets of a disabled individual and which meets all of the following criteria is not subject to consideration as an available resource or as a resource disposed of.

1) The beneficiary (A/R) is a disabled persons as defined in COMAR 10.09.25.02B (19);
2) The trust is established by a non-profit association;
3) The trust is managed by the non- profit association;
4) A separate account is maintained for each beneficiary of the trust but the accounts are pooled for purposes of management and investment;
5) The accounts in the trust are established solely for the benefit of a disabled A/R by the disabled A/R or by a:
   - Parent;
   - Grandparent;
   - Legal guardian; or
   - Court; and
6) The trust contains the provision that, upon the death of the A/R, the amounts remaining in the A/R's account and not retained by the trust will reimburse the State for all Medical Assistance payments made on behalf of the A/R.

The second criterion above, non-profit status, must be verified by documentation submitted by the organization. The sixth criterion above is met only if the language of the trust is specifically approved in writing by the office of the Attorney General (AG). Any trust not accompanied by the AG's approval does not meet the necessary condition and will be treated in accordance will all other provisions of OBRA '93. It is the responsibility of the A/R to provide documentation of the non-profit status of the organization and the appropriate approval of the recovery provision.

Resources Placed in an Exempt Trust

Resources placed in a trust which is exempt under a) or b) above are considered unavailable effective the first of the month in which they were placed in trust.

Payments from Exempt Trusts

Any payment from an exempt trust is considered income under the ABD regulations and is considered available to cost-of-care (C.O.C.) if countable. A payment from an exempted trust may be considered a disposal for less than fair market value if the goods or services received are not commensurate with the expenditure.

**(c) Special Needs Trusts**

As with any other trust, a special needs trust may only be considered a resource for the A/R if some or all of the funds going into the trust were from the resources or income of the A/R or the A/R's spouse. Also, it must meet the definition of a "resource", as being accessible to the A/R or the A/R's spouse. To be not countable as a resource, a Special Needs Trust established after August 10, 1993 must meet all the following criteria below in 1-11 (as specified in COMAR 10.09.24.08-2C):

1. The trust is irrevocable. Any trust that may be revoked or altered does not meet this criterion and so is counted as a resource.
2. The trust states that the beneficiary is disabled under COMAR 10.09.24.05E. The beneficiary's disability must be confirmed by the Social Security Administration or by the State Review Team. If the beneficiary has not been determined disabled by SSA or SRT, the trust is counted as a resource.
3. The beneficiary of the trust is younger than 65 years old at the time of the trust is established. If the beneficiary was 65 or older when the trust was established, it is counted as a resource.
4. The trust was established by the beneficiary's parent, grandparent, legal guardian or a court. If the trust was established by any other person, it is counted as a resource.
5. The trust does not contain provisions that conflict with the policies set forth in COMAR 10.09.24.08-2. This means the trust must limit distributions to those that are for the sole benefit of the beneficiary. Also, no provision of the trust may thwart the Department's recovery, upon the death of the beneficiary, of Medical Assistance benefits paid on behalf of the beneficiary. If the trust conflicts with these policies, it is counted as a resource.
6. The trust provides that the Department shall receive all amounts remaining in the trust upon the death of beneficiary, or upon termination of the trust of any other reason, up to an amount equal to the total Medical Assistance benefits paid on behalf of the beneficiary. If the trust does not provide for State recoveries, it is counted as a resource.
7. The trust does not permit distribution of trust assets upon termination of the trust that would hinder or delay reimbursement to the Department. Aside from distribution of administrative costs for termination of the trust, the Department must have first claim to the trust assets, up to the amount of Medical Assistance payments. If the trust permits distribution of its assets when it is terminated, it is counted as a resource.
8. The trust does not place time limits, or any other limits, on the Department's claim for reimbursement under COMAR 10.09.24.08-2C(8). If the trust places a limit on State recoveries, it is counted as a resource.
9. The trust must contain all of the following provisions:
   a) Additions, including resources and income, may not be made to the trust after the beneficiary is 65 years old.
   b) Expenditures from the trust must be used for the sole benefit of the beneficiary and must be directly related to the beneficiary's health care, education, comfort, or support.
   c) The beneficiary may not serve as trustee or in any other capacity that would allow the beneficiary to influence or exercise authority or control over trust distributions.
   d) The trustee must administer the trust in accordance with all of the following provisions of Estates and Trust Article § 15-502, Annotated Code of Maryland:
      - The trustee may not have an interest in the trust's assets.
      - The trustee may not have discretion to use trust assets for the trustee's own benefit.
      - The trustee may not self-deal by selling trust assets to the trustee or buying trust assets from the trustee.

- The trustee may not loan trust assets to the trustee.

e) The trustee must not take more compensation than is allowed in the provisions of Estates and Trusts Article, §14-103, Annotated Code of Maryland.
f) Any leases or mortgages that the trust holds must contain a provision that they either terminate or become due and payable when the beneficiary dies or the trust is terminated.
g) If the trust owns titled property that is valued at more than $500.00, the property must be titled to the trust, except for securities which may be held in the name of a nominee.
h) If the trust owns an asset jointly with another, the ownership must be as tenants in common and the ownership agreement must provide that, when the trust is terminated, the property must be sold for fair market value or the other owners must purchase the trust's interest in the property for fair market value.
i) Trust assets may not be held as an ongoing business or enterprise, or as investments in new or untried enterprises.
j) Trust distributions may not be used to supplement Medical Assistance payments to any health care provider serving the beneficiary. The provider is required to accept Medical Assistance reimbursement as payment in full for the services billed.
k) Trust assets may not be used to compensate family members of the beneficiary for serving the beneficiary in any way, including:
    - Caring for the beneficiary;
    - Accompanying the beneficiary on travel;
    - Providing companionship to the beneficiary; or
    - Serving as trustees or on a trust advisory committee.
l) Trust assets may not be used to purchase gifts.
m) Trust assets may not be used to purchase a life insurance policy on the life of the beneficiary.
n) Trust assets may only be used to purchase a life insurance policy on the life of someone other than the trust beneficiary if the trust is the only beneficiary of the life insurance policy.
o) Trust assets may not be used to purchase an annuity on the life of the beneficiary, unless the annuity provides that:
    - The final payment to the trust must be made before the beneficiary is 65 years old; and
    - If the beneficiary dies before the final payments have been made, the remaining payments must be paid directly to the State until the total Medical Assistance benefits paid on behalf of the beneficiary have been reimbursed.
p) The trust may not loan trust assets without security, which may include an ownership interest in real or personal property of at least equivalent value.
q) The trust may only make loans if the loan agreement provides for immediate repayment in the event of the death of the beneficiary or termination of the trust for any other reason
r) The only real property in which the trust may invest is in a single home property, which is used as the residence of the beneficiary and is titled in the name of the trust. The trust may not disburse more than $100,000.00 for the purchase of

property, without the approval of the State circuit court in the jurisdiction where the beneficiary lives.

t) An annual accounting of the trust, including a listing of current assets, income and itemized distributions in the previous year must be sent to:

DHMH Maryland Medical Assistance Program
Division of Recoveries and Financial Services
201 W. Preston Street, 2nd Floor
Baltimore, Maryland 21201

u) Trust assets may not be used to pay funeral expenses of the beneficiary, but may be used to purchase an irrevocable burial contract for the beneficiary to cover the beneficiary's future funeral and burial expenses.

v) The trust may not receive payments from an annuity or a structured settlement that may provide lump sum or periodic payments, unless the annuity or settlement provides that:
   - The final payment to the trust is received before the beneficiary is 65 years old; and
   - If the beneficiary dies before the annuity or settlement is fully paid, the balance shall be paid directly to the State until the total Medical Assistance benefits paid on behalf of the beneficiary have been reimbursed.

   If the trust does not contain all of these provisions or violates any of them in any way, it is counted as a resource.

10. If any amendments are made to the trust, the amendments must comply with COMAR 10.09.24.08-2 and a copy of the amendments must be sent for review to the DHMH Division of Recoveries and Financial Services; and
11. If the trust agreement fails to comply with any provision of COMAR 10.09.24.08-2, the full value of the assets in the trust must be considered available and countable resources of the trust beneficiary for the purpose of Medical Assistance eligibility determination.

## 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 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. It just impacts Medicaid coverage for certain services received by an eligible recipient. During a penalty period, Medicaid will not pay for long-term care services received in a nursing facility or a 1915(c) waiver.

When an eligibility 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 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 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, such as 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:
    - Lives in the community, not in a long-term care facility; and
    - Is not enrolled in a home and community-based services 1915(c) waiver; and
    - Is not married to an institutionalized individual.
- '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 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 home and community- based services 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 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 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 "available."
- "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. 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.

For a determination of the A/R's financial eligibility, it does not matter whether the disposed income or resource would have been countable or excludable.

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 for medical services received, 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, the spouse, the adult son or daughter, or the parent of a minor child.

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 of this FMV. These actions include, but are not limited to:

- Making a gift or donation of assets (e.g., usually large gift to a family member, relatively sizable donation(s) to a church or charitable organization) that reduces the A/R's countable resources to the maximum resource limit;
- Paying someone else's bills (e.g., grandchild's college tuition, family member's mortgage);
- Purchasing something for someone else's use (e.g., house, car, television or other personal property);
- Selling or transferring assets for less than fair market value;
- Altering the ownership interest for an asset by adding new owners or removing an owner (e.g., adding a family member's name (other than the spouse's name) to the home property's deed or removing the A/R/S's name from the deed);
- Creating a life interest or a life estate without powers;
- Rendering an asset unavailable by establishing a trust, annuity, or other legal or financial instrument.

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 may be entitled;
- 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 if an inaction constitutes a disposal for less than FMV subject to penalty. For example, the cost of obtaining the asset may be greater than the asset's value, making the asset essentially worthless to the A/R/S. 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/S. 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 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 eligibility 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 eligibility 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 case worker's satisfaction that there was "good cause" for the delay in making the inter-spousal transfer (e.g., the case worker 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 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 eligibility 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 AIR, 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 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 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 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 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.

An individual may have more than one look-back date, depending on the:

- Type of asset transferred---trust or non-trust;
- Date of disposal---before or after February 8, 2006; and
- Date of the eligibility determination or redetermination---before or after April 1, 2007.

The look-back date is 60 months before an institutionalized individual's earliest effective date of MA eligibility in a nursing facility or 1915(c) waiver. The same policy is used for non-trust assets disposed on or after February 8, 2006, and considered for a MA eligibility determination or redetermination conducted before April 1, 2007.

**g) Deficit Reduction Act of 2005 (DRA)- Look-Back Date for Trust or Non-Trust Assets**

For trust or non-trust assets disposed considered for a MA eligibility determination or redetermination conducted, the look-back date is 60 months before an institutionalized individual's earliest effective date of MA eligibility in a nursing facility or 1915(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. One distinguishing feature of a life estate is that the life tenant may sell or otherwise transfer his/her life estate interest in the property. An individual who merely has the right to use someone else's property (e.g., a parent who is promised the right to live for life in the home after transferring ownership to his/her adult child) does not have an ownership interest in the property. Permissive use of property is not a legally transferable right (i.e., the parent may not sell to a third party his/her permissive right to live in the home).

Generally, a life estate gives the owner of the life estate interest (the life tenant, who may also be the grantor) the right, for his/her lifetime, to live in and otherwise possess and use the property, as well as to collect any income generated by the property. The life tenant may sell or otherwise dispose of the life estate interest but, usually, may not will the life estate interest to his/her heirs. The life tenant only has the ability to sell, transfer, or encumber the property included in the life estate if such powers are specified in the deed (i.e., life estate with full or limited powers).

Example:
Some life estate deeds include "full powers," meaning that the life tenant has, in addition to the rights noted above, the power to sell, give, or otherwise convey the property included in the life estate, except by willing the property to someone other than the remainderman.

- The extent to which the life estate is counted as a resource for MA financial eligibility depends on the availability and the ownership interest for the grantor/life tenant of the assets included in the life estate.
- The life tenant is entitled to any income the property generates. This income is countable upon receipt.
- The value retained by the grantor after establishing the life estate determines the extent to which the transaction establishing the life estate is considered a disposal for less than FMV.

If the life tenant sells or transfers the life estate interest, or if the grantor establishes a life estate interest for a life tenant other than the grantor or the grantor's spouse, this is considered a disposal of assets. The eligibility CM must determine what, if any, compensation was received for this transfer and must impose a penalty period based on the uncompensated value. The disposal's uncompensated value is the difference between the FMV of the life estate interest and the amount of compensation received. The life estate interest is calculated by multiplying the assets' equity value by the factor for the life estate interest based on the owner's age, from Schedule MA-7 "Life Estate and Remainder Interest Table" in the Manual's Appendix.

Example:
Mr. Walter placed his home property in a life estate without powers in February 2012. He transferred his life estate interest to his daughter as the life tenant, and received no compensation for this disposal. In April 2012, he entered a nursing facility and was determined MA eligible for coverage group L98. This transaction is a disposal subject to a penalty. When the life estate was created, the property was appraised for $250,000. There is currently a mortgage of $120,000 on the property. He is 85 years old. Using Schedule MA-7, the value of the life estate interest that was transferred is:

($250,000 -$120,000 =$130,000) x .35359 = $45,966.

The months of penalty are calculated as: $45,966 ÷$6,800 = 6 months.

The days of penalty in the last partial month are calculated as:

STEP 1: $6,800 x 6 = $40,800

STEP 2: $45,966 -$40,800 = $5,196

STEP 3: $5,196 ÷ $223 =23 days.

A penalty period of 6 months and 23 days begins on April 1, 2012. Mr. Walter is excluded from MA coverage of his nursing facility services until September 24, 2012.

MMIS recipient screen 1 reflects Mr. Walter's eligibility in coverage group L98 beginning April 1, 2007. A span may not be loaded to MMIS recipient screen 4 for coverage of nursing facility services until September 24, 2012. The eligibility CM must indicate, through a DES/LTC 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.

If the life estate is sold by the remainderman, the life tenant is entitled to his/her share of the proceeds. This amount is countable as a resource for the life tenant when a bona fide offer to purchase the property is accepted by the seller (which occurs prior to the actual settlement date). The life tenant's share is determined by multiplying the property's equity value (the FMV minus any encumbrances against the property) by the appropriate life estate interest factor in Schedule MA-7, based on the life tenant's current age.

> Note: The requirements of this section about life estates do not apply to purchases of property through a joint tenancy with the right of survivorship, or to any other arrangement that is not a life estate.

**(a) Life Estate Without Powers**

If an A/R or the A/R's spouse 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 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 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 ($6,800) in Schedule MA-6 of the Manual's Appendix. This gives the number of penalty months.

3. Divide the remaining amount by the daily amount ($223) 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 <u>not</u> penalized if:

- The amount paid for the life estate interest did not exceed its FMV at the time of the purchase; <u>and</u>
- 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 <u>not</u> 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

When a promissory note, loan, or mortgage for which the A/R is the lender is considered for the A/R's financial eligibility, the eligibility CM must determine whether payments of the principal received by the A/R are available and so are countable as a resource for determining financial eligibility. Payments of interest received by the A/R for the loan are countable as the A/R's income upon receipt. If the A/R did not receive 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.

Federal Deficit Reduction Act of 2005 (DRA)

For a Medicaid 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 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) and the borrower meet all of the following requirements, and payments are made according to the written terms:

- Are actuarially sound, in accordance with the A/R's life expectancy determined using Schedule MA 9-A "Period of Life Table" in this Manual's Appendix; and
- Are legally binding; and
- 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; and
    - With no deferral of payments; and
    - With no balloon-payments (i.e., token payments during most of the loan's term, with most of the amount payable in a lump sum at the end of the term).

If the A/R makes a loan that does not have all of these repayment terms, the loan is considered a disposal for less than FMV. 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 1915(c) waiver coverage.

### (a) Jointly Owned Assets

If an asset is held by an individual in common with another individual(s) in a joint tenancy, tenancy in common, joint ownership, or a similar arrangement, the asset or the

affected portion of the 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, that reduces or eliminates the individual's ownership interest, access, or control of the asset.

Depending on the circumstances, merely placing another person's name as a joint owner on an account or other asset might 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 eligibility 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 eligibility 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, or 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 eligibility CM must determine whether regularly received income (e.g., income stream) 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. For example, 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 calculated based on the amount of the lump sum payment. If the amount is too small for a full month's penalty, a penalty is imposed for a partial month.
- If a stream of income is transferred (e.g., income that would have been received on a regular basis is transferred), the eligibility 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" in the Manual's Appendix. 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 COMAR10.09.24.08-2B(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, with the date of disposal as of when the funds were added.

When determining whether payments can be made to the grantor from a trust, the eligibility 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 so is 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 so countable, when it is placed in the trust. An exception to this is an institutionalized individual's home. The transaction placing the home in a trust is penalized 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 eligibility 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 eligibility 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 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 waiver services. The eligibility CM must review MMIS recipient screen I 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 with the necessary changes to the DHMH Division of Recipient Eligibility Programs (DREP).

For long-term care or waiver applications filed on or after April 1, 2007, there will be no deduction from a recipient's available income for the cost of care for non-covered services received during a penalty period. Therefore, the amount deducted is $0, regardless of the costs incurred by the recipient for non-covered nursing facility or HCBS waiver services received during the penalty period.

**(e) Uncompensated Value of a Disposal**

To compute the length of a penalty period, the eligibility 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 for "love and consideration," for example, is not considered a valuable consideration, but is 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. 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, there must also be documentation of why the compensation was not paid at the time services were rendered, and then was not paid until the transfer in question.

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

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

The eligibility 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 eligibility 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 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 eligibility 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 15 of this Manual.

### (a) Length of Penalty Period

The DES/LTC 811, Transfer/Disposal of Assets Worksheet, located in MA Manual Section 10 must be used to manually calculate all penalty periods. The completed DES/LTC 811 must be maintained in the case record.

For each $6,800 in the uncompensated value of disposals, a full calendar month of penalty is imposed. (See Schedule MA-6 in the Manual's Appendix.) 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. For an uncompensated amount less than $6,800, a penalty period shorter than a month is calculated in terms of days. One day of penalty is assessed for each $223 of uncompensated value. Any remaining amount less than $223 is not penalized.

To compute the length of a penalty period:

- 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 $6,800.
- Divide the total, cumulative uncompensated value by the amount in Schedule MA-6 of the Manual's Appendix ($6,800). The unrounded result equals the number of full calendar months in the penalty period.

Example: $12,400 ÷ $6,800 =1 full month of penalty

- Divide by $223 any remainder from #2 that is less than the monthly figure in Schedule MA-6 ($6,800). 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 $ 223. A single disposal of an amount less than the average monthly cost of care ($6,800) will also result in a partial month penalty equal to one day of non-coverage for every $ 223 disposed.

Example: $3,800 ÷ $223 = 17 days of penalty

Complete 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 =1 months.
STEP 2: $6,800 x 1= $6,800
STEP 3: $12,400 - $6,800 = $5.600
STEP 4: $5,600 ÷ $223 =25 days

The penalty period is 1 months and 25 days.

Since the penalty is based on the factors found in Schedule MA-6 ($6,800 monthly and $223 daily), it is totally unaffected if the individual's actual nursing facility or waiver costs during the penalty period are less than or greater than those amounts. Also, the

individual's payments for nursing facility or waiver services during a penalty period do not reduce the length of the penalty period.

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 1915(c) waiver services during the penalty period, the eligibility CM apportions the penalty period between them.

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 and 1915(c) waiver services. 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 services. The eligibility CM should check MMIS recipient screens 1 and 4 to assure that this information is correctly transmitted by CARES through the interface and, if not, must send a DES/LTC 813 for the necessary corrections to the DHMH Division of Recipient Eligibility Programs (DREP).

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 and 1915(c) waiver services. 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, must send a DES/LTC 813 to DREP.

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 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.

- 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 eligibility 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 eligibility CM must indicate, through a DES/LTC 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) 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), in accordance with Chapter 13 of this Manual;

  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 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 1915(c) waiver services.

Example 2:
A recipient has a penalty period for assets disposed on or after the look-back date, before applying for Medicaid. 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."

-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 the 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).

-If convincing evidence is provided to the eligibility 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 eligibility 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.

If convincing evidence is provided to the eligibility 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 must establish, to the satisfaction of the eligibility CM, that the asset was transferred for a purpose other than to qualify for Medicaid. Verbal assurances are not sufficient that the individual was not considering or anticipating Medicaid coverage when the asset was transferred. Convincing evidence must be presented to substantiate the specific purpose for which the asset was transferred, as well as the reason it was necessary to transfer the asset in question (i.e., why there was no alternative but to transfer the asset for less than FMV).

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.

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

-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 does not include "in-kind" goods or services provided by or paid for by the individual who received the resource. 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 NR is ineligible for each month that the individual's total countable resources exceed the resource standard as of the first day of the month.

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 for any funds remaining after the State's claim is satisfied to be disbursed 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 successfully rebuts this presumption. The A/R or representative has the right to rebuttal by furnishing convincing documentary evidence to the eligibility CM that the disposal was exclusively for a purpose other than establishing or continuing Medicaid eligibility or avoiding Medicaid's liens or recoveries provisions. The burden of proof rests with the A/R. If the A/R or representative wishes to rebut the presumption, the eligibility CM must evaluate the evidence presented and determine the intent of the disposal. The evidence must include the following information:

- The A/R's age and his/her 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 may constitute evidence that the disposal was exclusively for a reason other than to qualify for Medicaid:

- The traumatic onset of a disability after the disposal by an individual younger than 60 years old (e.g., car accident);
- 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); or
- Disposals as relatively small gifts to family and friends for holidays or birthdays; or as relatively small and regular donations to a church or charity over several years.

The A/R's age and his/her health status at the time of the disposal are significant factors to consider when evaluating whether the A/R could have reasonably anticipated substantial medical expenses for the near future. The sudden onset of a disability for an aged person is likely to occur as part of the aging process. Therefore, it is unreasonable for an aged person not to anticipate illness and potentially high medical expenses.

**800.24 When Gifted Resources are Returned**

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:

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 with 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 $20,000.00

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 never be modified based on the payment of LTC or other expenses by or on behalf of the A/R during a penalty period. Payments to a LTCF during a penalty period are not considered compensation for a transferred asset. Rather, private pay during a penalty period simply meets the intent of the penalty. When calculating uncompensated value, do not subtract private payment, regardless of who made the payments.

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 so 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 eligibility 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" that follows).

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 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;
- That the institutionalized individual went to court or otherwise took action in law and equity to get back the asset, and has exhausted all remedies;
- That the individual's health and age did not indicate a predictable need for long-term care services at the time the asset was transferred.

The eligibility 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.

Generally, undue hardship is not considered to exist if the asset was transferred to the spouse, son, daughter, grandchild, or other relative. It is presumed that these family members can make arrangements to return the asset, provide the care, obtain a loan, or make other arrangements for the individual's care.

If a request with accompanying documentation is received for an undue hardship waiver, the eligibility 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 eligibility 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 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.
- Medical and other information about the institutionalized individual's service needs, relevant for the claim of undue hardship.

The DHMH Division of Eligibility Policy may approve 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 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 eligibility 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 eligibility 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.

### 800.26 Adverse Action Notice

In accordance with Chapters 12 and 13 of this Manual and COMAR 10.09.24.12A and C and .13A and B, a timely and adequate notice must be issued to the A/R and any representative about an adverse action taken by the Department. The policies in this section about the beginning date of a penalty period are not impacted by the requirement for a 10-day advance notice.

The adverse action notice about a penalty period must give the individual's effective date of Medicaid eligibility if the individual is an applicant, explain the reason for the penalty (the type and amount of assets disposed), specify the beginning and ending dates of the penalty period, and inform the A/R and/or representative of their right to appeal and request a fair hearing. The notice must specify that Medicaid coverage is only excluded for nursing facility and HCBS I915(c) waiver services, and that the recipient may receive all other Medicaid covered services.

The adverse action notice must also inform the A/R, any authorized representative, and the nursing facility (if authorized by the A/R or representative to act in their behalf) that

they may request an undue hardship waiver from imposition of the penalty, besides that they may request a hearing. They must be told to inform the eligibility CM if they wish to request this waiver, and then must provide the eligibility CM with the necessary information for the Department to evaluate the waiver request.

The CARES adverse action notice does not include this information; therefore, the eligibility CM must send:

- The manual DHMH 4235A (LTC) "Notice of Non-Coverage of Nursing Facility Services Due to Disposal of Assets for Less Than Fair Market Value" (See the manual long-term care notices at the end of Section l0 in this Manual); or
- A waiver "Notice of Ineligibility: Transfer Penalty" (See the Medicaid Eligibility Manual for the particular waiver).

The eligibility CM must assure that the information presented in the notice is correct and complete, and must make any necessary corrections or additions before issuing the notice. Also, the CM must suppress the CARES notice if a manual notice is sent, to assure that the customer does not receive two notices with different information.

## 800.27 Continuing Care Retirement Community

### a) Continuing Care Retirement Community

A Continuing Care Retirement Community, or a “CCRC” is a housing community that provides different levels of care based on what each resident requires over time. This is sometimes called "life care" and can range from independent living in an apartment to assisted living to full-time care in a nursing home. To be a CCRC, an entity must obtain a certificate of registration from the Maryland Department of Aging.

**b) Entrance Fee**

- An "Entrance Fee" is money paid to a CCRC by a resident as a lump sum or in installments.
- The "Entrance Fee" is paid in conjunction with a written agreement that governs the use, treatment, and refund of the money.
- The "Entrance Fee" assures a resident of continuing care in the CCRC for a term of more than 1 year, or for life.

**c) Resource**

A "resource" is defined by the Social Security Administration as "cash and any other personal property, as well as any real property, that an individual (or spouse, if any): owns; has the right, authority, or power to convert to cash (if not already cash); and is not legally restricted from using for his/her support and maintenance."

**d) When a CCRC entrance fee is countable as a resource**

For Medical Assistance applications or requests for spousal resource assessments received on or after January 1, 2006, all or part of the entrance fee shall be considered available to the resident, and therefore counted as a resource, **if** the CCRC provides written verification (to the Department's satisfaction) that all of the following criteria are met:

- The applicant or recipient (A/R) is eligible for a full refund of any amount remaining in the entrance fee, after subtracting any payments or transfers made by the individual, when the individual dies or terminates the continuing care agreement and leaves the CCRC;
- The entrance fee does not confer on the individual a real property interest in the CCRC (because if it did, the entrance fee would be considered as excludable home property);
- The A/R has the ability to obtain funds from the entrance fee, without moving from the CCRC facility, to pay the CCRC or another entity for support and maintenance if the individual's income and other resources are insufficient to pay for the support and maintenance;
- If the A/R has a child who is blind or disabled, the A/R has the ability to transfer unconditionally all or part of the entrance fee to that child; and
- If the A/R is institutionalized and married to a community spouse, the entrance fee, if it is considered a countable resource, shall be included in the assessment for the attribution of spousal resources and the CCRC shall permit transfer unconditionally of all or part of the entrance fee to the sole ownership of the community spouse in accordance with the law.

**e) When a CCRC entrance fee is excludable as a resource**

For Medical Assistance applications or requests for spousal resource assessments received on or after January 1, 2006, the entrance fee may not be considered as a countable resource, and so is excluded from consideration, if:

- All of the requirements listed in Section D, above, are not met;
- The CCRC imposes limitations, conditions, penalties, or otherwise restricts the individual's right to reside in the CCRC facility when the individual uses funds from the entrance fee to make payments or transfers in accordance with the law; or
- The A/R successfully rebuts (as determined by the Department) the CCRC's written verification that the money is available.

PROCEDURES

- If a CCRC entrance fee is reported as a resource when an individual requests a spousal resource assessment or when a Medical Assistance application is filed, the eligibility CM completes the top half of the certification form (DES 801) and gives the form to the A/R.
- The CCRC completes and signs the form and attaches verifications to support any claim that all or part of the entrance fee is available to the resident as meeting all of the conditions listed above. The CCRC submits the package for review to the LDSS at the address that appears on the top half of the certification form.
- The LDSS determines whether all or part of the CCRC entrance fee is countable as a resource. The LDSS provides its decision in writing to the A/R and CCRC.
- If the LDSS determines that all or part of the entrance fee is countable as a resource, the A/R is given 15 working days from the notice date to rebut the determination.
- If the A/R does not rebut the decision within 15 working days, the eligibility CM takes the necessary action for consideration of the entrance fee.
- If the LDSS determines that none of the entrance fee is available to the resident, the eligibility CM narrates in CARES and does not enter the entrance fee on CARES as a countable resource.
- If the A/R decides to rebut the LDSS decision within 15 working days:
    - The A/R provides additional information and verifications to the LDSS, who forwards all documentation to:

      DHMH
      Office of Eligibility Services
      201 West Preston Street, Room SS-10
      Baltimore, Maryland 21201.

- DHMH asks the CCRC to provide, within 10 working days from the notice date, additional documentation and evidence that support the basis for the CCRC's earlier written verification of the entrance fee's availability;
- The CCRC provides additional information and verifications to DHMH within 10 working days from the notice date;

- DHMH reviews the LDSS' previous decision and determines whether all or part of the CCRC entrance fee is countable as a resource; and
- DHMH provides its decision in writing to the A/R, CCRC, and eligibility CM.
- The eligibility CM takes the following actions based on DHMH's decision:
    - If the CM receives DHMH's approval to count a specified total amount of the entrance fee as a resource for the spousal resource assessment or Medical Assistance eligibility determination, the case worker enters the countable amount on CARES.
    - For eligibility determinations, the entrance fee is entered on the AST1 screen as "OC" (other countable assets).
    - Otherwise, the entrance fee is not entered on CARES and is not considered as a countable resource.
    - The case worker fully narrates in CARES.

Questions regarding this issuance should be directed to the DHMH Division of Eligibility Services at 410-767-1463 or 1-800-492-5231 extension 1463.

**Attachment A**- Certification of Availability

Maryland Medical Assistance
Certification of Availability
Continuing Care Retirement Community (CCRC) Entrance Fee

Section I: To be Completed by the Local Department of Social Services:

Applicant Name: _____ SSN: _____ DOB: _____
Address: _____ Telephone: _____
Date of Spousal Resource Assessment: _____ Date of Application: _____
Eligibility CM: _____ Telephone: _____
LDSS Address: _____
CCRC Name: _____ Telephone: _____
Address: _____
Amount of Entrance Fee Reported by the Applicant: $_____

Section II: To be Completed by the CCRC:

 The resident's entrance fee does not meet the Medical Assistance requirements below to be considered available as a resource to the resident.

 The resident's entrance fee does meet all of the Medical Assistance requirements below and should be considered available as a resource to the resident. Available amount: $_____

**Check all that apply. Attach evidence to support each certification.**

 The resident is eligible for a full refund (e.g., not only the net amount after subtracting the costs for refurbishing the unit for the next resident) of any amount remaining in the entrance fee, after subtracting any payments or transfers made by the resident, when the resident dies or terminates the continuing care agreement and leaves the CCRC.

 The entrance fee does not confer on the resident a real property interest in the CCRC.

 The resident has the ability to obtain funds from the entrance fee, without moving from the CCRC facility, to pay the CCRC or another entity for support, maintenance, and medical services if the individual's income and other resources are insufficient to pay for the needed services and items.

 If the resident has a child who is blind or disabled, the resident has the ability to transfer unconditionally all or part of the entrance fee to that child.

 If the resident is married to a community spouse and is either institutionalized or enrolled in a waiver, the CCRC permits the unconditional transfer to the community spouse's name of the amount of the CCRC entrance fee identified by the eligibility CM for transfer during the 90-day protected period after the eligibility determination.

CCRC Representative: _____ Signature: _____ Date: _____

DES 801

# Medical Assistance Resource Countability Table

This Resource Countability Table is provided as a quick, simple reference guide, and may not include all of the policy applicable to a particular resource type. Additional rules for a resource type may be found in COMAR 10.09.24 or the Medical Assistance (MA) Eligibility Manual. Please refer to the appropriate resource procedures in this Policy Alert or the MA Eligibility Manual for complete instructions when determining eligibility.

The chart is alphabetized for your convenience. If a type of resource is not specified on this table as excluded, it is countable. An "**EX**" under the "Countable For" column means the type of resource is excludable for the respective assistance unit. A "**CT**" means the type of resource is countable.

- Medical Assistance (MA) coverage groups using Families and Children (FAC) rules include those in the **E**, **F**, and **G** tracks as well as **T01**, **T02**, and **T99**.
- MA coverage groups using Aged, Blind and Disabled (ABD) rules include those in the **H**, **L**, and S tracks.
- Coverage groups in the **D and P tracks** as well as the T03-T05 and X01 (for MA, Maryland Children's Health program (**MCHP**) and MCHP Premium) are governed by COMAR 10.09.11 rather than COMAR 10.09.24 and do not consider resources when determining eligibility.
- Coverage group **X02** uses **FAC**, **ABD**, or **MCHP** rules for consideration of income and resources, depending on the nature of the assistance unit.

| Type of Resource | Count for FAC | Count for ABD | NOTES |
|---|---|---|---|
| **401-K funds** | EX | CT | Policy change for FAC to match, TCA and Food Stamps to exclude. ABD counts even if there is a penalty for liquidating, unless it is otherwise excluded. |
| **Accessible or liquid resource** | CT | CT | Count if the resource may be cashed in, redeemed, or otherwise accessed, even if there is a penalty for liquidating, unless it is specifically excluded. |
| **Annuities** | CT/EX | CT/EX | Count if it may be cashed in, exclude if it cannot be cashed in. |
| **Automobiles and other vehicles** | EX | CT/EX | **FAC** matches **TCA** and **Food Stamps** to exclude all vehicles. **ABD** excludes automobiles, SUVs trucks, and motorcycles but counts recreational vehicles, boats, and airplanes. |
| **Bank and other financial** | CT | CT | Count the following unless specifically excluded: |

| | | | |
|---|---|---|---|
| **institution accounts** | | | checking, savings, draft, share, investment, certificate of deposit, and money market accounts. Exclude outstanding checks. For exclusions, see escrow and other dedicated bank accounts and bank account for a child. |
| **Bank account for a child**--up to $2000 in a separate bank account for earrings of a child under the age of 21. | EX | CT | Policy change- for FAC to exclude to match TCA. |
| **Basic items** essential to day-to-day living such as clothing, furniture, household furnishings, appliances, health aids, educational material, children's toys, and other similarly essential items of limited value. | EX | EX | |
| **Bonds** | CT | CT | Count unless is excluded due to being inaccessible, etc. |
| **Type of Resources** | **Count for FAC** | **Count for ABD** | **NOTES** |
| **Burial/funeral fund, plan, agreement, trust, insurance, or contract**, which specify that a funeral home will receive all proceeds, for the actual anticipated costs of the burial/funeral of an AU member or a member's spouse. | EX | EX | Policy change for all programs to exclude both irrevocable and revocable burial funds, as well as interest earned on those funds. (Previously, ABD excluded irrevocable burial funds and had a cap of $1500 for revocable burial funds and liquid assets designated for burial. FAC had a cap of $1500 for burial funds and liquid assets designed for burial.) |
| **Burial savings** accounts and other liquid assets designated for burial/funeral | CT | CT/EX | Policy change for **FAC** and **ABD**: **FAC** to match **TCA** and **Food Stamps** to count these resources as accessible. **ABD** to exclude up to $1500 for each member of the AU, and will count what exceeds the cap. **ABD** will delink from rules for life insurance. (Previously, **FAC** and **ABD** excluded these liquid assets in combination with revocable burial funds up to $1,500. **ABD** reduced the burial fund exclusion by the amount of excluded life insurance.) |
| **Burial Spaces** for each member of the AU and a member's immediate family | EX | EX | |
| **Cash on hand** | CT | CT | Count unless is specifically excluded. |
| **Certificate of deposit** | CT | CT | |
| **Checking bank accounts** | CT | CT | Count unless is specifically excluded. |

| | | | |
|---|---|---|---|
| **Crime victims' compensation** for expenses incurred or losses suffered (see income exclusion) | EX | EX | policy clarification to comply with federal law |
| **Disaster relief assistance** (see income exclusion) | EX | EX | Policy change for ABD to life a 9-month limit to the exclusion. Policy clarification for **FAC** to exclude to comply with federal law. |
| **Dividends accumulated** | CT/EX | CT/EX | Count the accumulated dividends for a countable resource (e.g., stocks, life insurance for **ABD**). Exclude the accumulated dividends for an excluded resource (e.g., burial funds, life insurance for **FAC**). |
| **Earned Income Tax Credit** refunds and advances (see income exclusion) | EX | EX | Policy change to comply with federal law. |
| **Education Assistance** (see income exclusion) | EX | EX | |
| **Energy assistance (see income exclusion** | EX | EX | |
| **Escrow or other dedicated financial institution account**- funds placed in escrow account, e.g., rent or utility security deposit | EX | EX | Policy clarification to comply with federal law. Exclude as inaccessible. |
| **Farm property and livestock** | Ct/EX | CT/EX | Exclude if used only for the household's consumption. Otherwise, count according to the rules for income-producing property. |
| **Federal statute**- all types of resources excluded by federal statute for needs-based public benefits programs (see Income count ability Table) | EX | EX | Policy clarification to comply with federal law |
| **Ground rent** (see income-producing property) | CT | CT | Count as income-producing property according to the yearly fair market value of the ground rent or what the lease would bring on the open market. |
| **Types of Resources** | **Count for FAC** | **Count for ABD** | **NOTES** |
| **Home consumption**-value of livestock and home produce used for household's consumption | EX | EX | |

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|---|---|---|---|
| **Home property** including the associated land | CT/EX | CT/EX | Exclude if the customer, spouse or other specified family member lives in the home, if the customer is institutionalized and intends to return to the home, or if the home is in a life estate without powers. Otherwise, count. Count the home if the customer is institutionalized and the home is part of a life estate with powers. Count the home if the customer lives in an assisted living facility and a spouse or other specified family member isn't living in the home, or if the customer is admitted to a long-term care facility from an assisted living facility. Exclusion of the home property doesn't prevent a lien from being attached or executed. |
| **Home property**-proceeds from sale of a home | EX | EX | Exclude for up to 3 months if the home was excluded as home property, and if the proceeds are used to purchase another excluded home. |
| **Household goods, personal effects**, and basic items essential to day-to-day living. | CT/EX | CT/EX | Exclude, except count the equity value of non-essential collections of valuable personal effects such as stamps, jewelry, furs, antiques. |
| **Housing assistance** (see income exclusions) | EX | EX | |
| **HUD Section 8 and Public Housing Family Self Sufficiency Program**-Funds placed in escrow account for the program (see income exclusion) | EX | EX | |
| **Inaccessible resource** | EX | EX | |
| **Income** | EX | EX | If money is considered as income, it can't also be considered as a resource for the same period under consideration. After the month of receipt, money is considered as a resource if it is still retained when eligibility is next determined (current eligibility determination after a retroactive eligibility determination, eligibility determination after a period of ineligibility, next unscheduled or scheduled redetermination). |
| **Income-producing property**-home, business, or other non-home property (building, land, farm machinery, livestock, tools, equipment) | CT/EX | CT/EX | Policy change to use TAC and Food Stamps rules: exclude if it annually produces income consistent with the fair market value. Exclude if associated with excluded home property. Exclude non-business property essential to self-support. Exclude tools and equipment necessary for employment. Exclude real or personal property that is directly used to maintain or use an income-producing vehicle. (Previously, ABD excluded it if the customer has an equity interest of $6000 or less and the property produces a net annual return of at least 6% of the equity value. Counted the full equity value if it didn't produce a |

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| | | | net annual return of at least 6%. Counted the combined equity value in excess of $6000 if it produced a net annual return of least 6%. FAC counted income-producing real property but used ABD rules for excluding other types.) |
| **Type of Resource** | **Count for FAC** | **Count for ABD** | **NOTES** |
| **Indian lands, certain government payments to Native Americans, Indian judgment funds**. | EX | EX | Policy clarification to exclude to comply with federal law. |
| **Individual Development Accounts** (**IDA**s) (see income exclusion) | EX | CT | Policy change for **FAC** to exclude to match **TCA** and **Food Stamps** |
| **Individual Retirement Accounts** (IRAs) | CT | CT | |
| I**nheritance**-property of a deceased person | CT/EX | CT/EX | Policy clarification for **FAC** to match **TCA** and **Food Stamps** to exclude property in probate. **FA**C and **ABD** exclude property that does not go through probate or that is jointly owned. Otherwise, the property is counted or excluded based on the type of property. |
| **Joint accounts** | CT/EX | CT/EX | All funds in joint accounts are considered available to the customer and are counted, unless ownership is successfully rebutted. (see pp. 800-3-800-5 and 800-47– 800-57 of the MA Eligibility Manual) |
| **Keogh accounts** | CT | CT | |
| **Liens- non liquid assets** when a lien is placed against them as a result of taking out a business loan and the household is prohibited from selling the asset | EX | EX | |
| **Life estate** | CT/EX | CT/EX | Exclude if the life estate is specified as without powers or as inaccessible to the customer. Otherwise count. |
| **Life insurance policies** | EX | CT/EX | Policy change for **FAC** to match **TCA** and **Food Stamps** to exclude all life insurance policies. **ABD** excludes the current cash value if the original face value was no more than $1,500. **ABD** also excludes life insurance if it is irrevocably assigned to be used solely for the funeral/burial of the insured. Otherwise, **ABD** counts the full current cash value verified in writing by the life insurance company. **ABD** doesn't consider the policy's value or require verification if the policy clearly states that there is |

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| | | | no cash value. |
| **Loans and promissory notes**-payment of the principal received by the customer as the lender for a formal, contractual loan. | EX | CT | Policy change for **FAC** to exclude all loans. For **ABD**, payment received for the principal is counted as a resource. Payment of the interest is counted as income. However, payment received for an informal loan is not counted (e.g., loan to friend or family to pay a bill or make a purchase.) |
| **Lump sum** payments that are non-recurring (consider as a resource the month after receipt)- e.g., retroactive benefits payment, insurance settlement, inheritance, cash lottery prize, gift | CT/EX | CT/EX | Count unless otherwise excluded, such as if the lump sum is prorated and counted as income for the same period under consideration. |
| **Money Market accounts** | CT | CT | Count unless specifically excluded. |
| **Mortgage payments**-payment of the principal received by the customer as the lender | EX | CT | |
| **Mutual fund shares** | CT | CT | |
| **Personal Property** | CT/EX | CT/EX | Exclude unless countable, such as a valuable collection that is not needed to meet basic living needs (e.g., stamps, furs, jewelry, antiques). |
| **Type of Resource** | **Count for FAC** | **Count for ABD** | **NOTES** |
| **Plan for Achieving Self-Support** (see income exclusion) | EX | EX | Exclude resources of a blind or disabled person that are necessary to fulfill a Plan for Achieving Self-Support, approved by the Social Security Administration. |
| **Profit-sharing** plans that permit early withdrawal | CT | CT | Count unless specifically excluded. |
| **Real property**-buildings and land (see home property and income producing property) | CT/EX | CT/EX | Count recreational and other real property unless it is specifically excluded (e.g., excluded as home property or as income-producing property) |
| **Real property** that is not the primary residence and is listed for sale with a realtor. | EX | CT | Policy change for FAC to match TCA and Food Stamps. |
| **Receipts from the sale, exchange, or replacement of a resource** (see home property – proceeds from sale) | CT/EX | CT/EX | Count if the original resource was counted. Exclude if the original resource was excluded and the receipts are put back into another excluded resource (e.g., home property). Count any amount that is not put into an excluded resource. |
| **Refunds of federal income taxes** | EX | EX | |
| **Relocation assistance** – Uniform Relocation | EX | EX | |

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| Assistance and Real Property Acquisition Policies Act of 1970 or relocation assistance provided by a state or local government (see income exclusion) | | | |
| **Replacement received in cash or in-kind** for casualty losses of a lost, damaged, or stolen excluded resource (see income exclusion) | EX | EX | Exclude for 9 months from receipt |
| **Resource associated with excluded income** (see Income Count ability Table) | EX | EX | Exclude as resource if excluded as income, unless it is specifically counted as a resource (e.g., bank accounts) |
| **Resource likely to sell for an amount less than half of the household's resource limit** | EX | CT | |
| **Resource that has been prorated as income** | EX | EX | |
| **Retirement and pension plans** | EX | CT/EX | Policy change for **FAC** to match **TCA** and **Food Stamps** to exclude all but IRAs and Keoghs. **ABD** excluded if inaccessible, and counts otherwise. |
| **Retroactive payments under Title II (Social Security) or Title XVI** (SSI) of the Social Security Act | EX | EX | Policy clarification to comply with federal law. |
| **Reverse mortgage or home equity loan--** money received by the customer as the borrower | EX | CT | Policy change for **FAC** to match **TCA** and **Food Stamps** to exclude all loans. **ABD** counts as a resource if it is not spent by the month after receipt. |
| **Savings bank accounts or savings certificate** | CT | CT | Count unless specifically excluded |
| **Security deposit**, e.g., for rent or utilities | EX | EX | Policy clarification to exclude as inaccessible to comply with federal law. |
| **Special needs trust** (see trusts) | EX | EX | Exclude if certain conditions are met. Otherwise, it is counted. |
| **Stock**s | CT | CT | Count unless specifically excluded. |
| **Type of Resource** | **Count for FAC** | **Count for ABD** | **NOTES** |
| **Supplemental Security Income** recipient's resource | EX | EX | Contact the Social Security Administration if the recipient's total countable resources exceed $2000. |
| **Tools and equipment necessary for Employment** (see income-producing | EX | EX | |

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| property) | | | |
| **Trus**t (see also special needs trust) | CT/EX | CT/EX | Policy change for **FAC** to match **TCA** to exclude a trust account established by court order. Exclude for **ABD** and **FAC** if it is an irrevocable trust or is inaccessible to the customer, <u>if no funds of the customer or spouse formed the trust's corpus</u>, or if certain conditions are met. Otherwise, it is counted. See COMAR 10.09.24.08-2 for rules about Medicaid qualifying, special needs, and other trusts. Also see pp. – 800 -58 – 800-86d in the MA Eligibility Manual. |
| **UGMA, MUTMA, UTMA**, and other custodian accounts for a minor child | CT | CT | Policy clarification to count as the child's resource if the funds are accessible through the child's parent or other account custodian to be used for the child |
| **Vehicles** | EX | CT/EX | FAC excludes all vehicles.<br>ABD excludes automobiles, SUVs, trucks and motorcycles but <u>counts recreational vehicles, boats, and airplanes</u>. |
| **Welfare – to-Work Rental Voucher Program** – subsidy payments. | EX | EX | |

## Section 800: Frequently Asked Questions (FAQs) and Answers
## Resources

1. What is the Look-Back Date and Look- Date period?

   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 19I5(c) waiver. The look-back date is 60 months.

2. What are the three factors of evaluating a Trust?

   - The first factor to consider is whose money went into the trust;
   - The second factor to consider is whether the trust is a countable resources;
   - The third factor to consider is the date the trust was established.

3. If a trust contains the assets of a disabled individual, are those resources countable?

   No, the following criteria are not subject to consideration as an available resource or as a resource disposed of:

   - The beneficiary (A/R) is a disabled persons as defined in COMAR 10.09.25.02B (19);
   - The trust is established by a non-profit association;
   - The trust is managed by the non-profit association;
   - A separate account is maintained for each beneficiary of the trust but the accounts are pooled for purposes of management and investment;
   - The accounts in the trust established solely for the benefit of a disabled A/R by the disabled A/R or by a:
     - Parent;
     - Grandparent;
     - Legal guardian; or
     - Court; and

   - The trust contains the provision that, upon the death of the A/R, the amounts remaining in the A/R's account and not retained by the trust will reimburse the State for all Medical Assistance payments made on behalf of the A/R.

4. What does "resources" include?

   "Resources" includes cash, personal property, real property, or other liquid and non-liquid items. "Resource" is a term that is also used in the context of evaluating disposals and trust funds. Refer to those selections of this section for the meaning of the term in such contexts.

5. What are the procedures if a customer meets the reimbursement requirements?

   The CM completes the followings steps:

   - Complete the top section of the Form 4342. File the last copy in the case record as verification of issuance.
   - Give the remaining copies of the Forms 4342 and 100 to the recipient.
   - Explain the Form 100 procedures to the recipient/representative.
   - Close the case in accordance with timely and adequate notice requirements.
   - Send Forms 4228 and 100.