TRANSMITTAL LETTER FOR MANUAL RELEASES

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BENEFICIARY SERVICES ADMINISTRATION
DIVISION OF ELIGIBILITY POLICY
201 WEST PRESTON STREET
BALTIMORE, MARYLAND 21201

410-767-1463 or 1-800-492-5231 option 2 and request extension 1463

MANUAL: Medical Assistance **EFFECTIVE DATE: April 1, 2007**

RELEASE NO: MR-140 **ISSUED: March, 2007**

APPLICABILITY: Changes in consideration of resources for institutionalized individuals due to the federal Deficit Reduction Act of 2005 (Public Law 109-171)

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COMMENTS

Chapter 8

The federal Deficit Reduction Act of 2005 (DRA), enacted on February 8, 2006, made extensive changes to the Medical Assistance (MA) policies for determining long-term care eligibility, covering individuals in a nursing facility or 1915(c) home and community-based services (HCBS) waiver, and penalizing nursing facility or waiver recipients for disposals of assets for less than fair market value (FMV). As a result, this Manual Release revises introductory pages in Chapter 8, adds a new section about penalties for substantial home

equity, and replaces the sections about annuities and disposals to reflect current federal requirements. The DRA requirements have various effective dates, specified in the DRA. Since new or revised requirements may not be applied retrospectively to eligibility determinations, these changes are effective for new applications received, or redeterminations initiated, on or after the effective date of this Manual Release—April 1, 2007.

- **Substantial Home Equity**: The DRA specifies that MA may not cover nursing facility or 1915(c) HCBS waiver services for an otherwise eligible individual if the individual's equity interest in his or her home property exceeds $500,000. The equity interest is the value of the home property after all encumbrances on the home property are deducted from the total Fair Market Value (FMV). If the individual's equity interest in the home property exceeds $500,000, and the individual meets all other eligibility requirements, then the individual is covered for other MA services, but not for these long-term care services.
- **Annuities**: Like all other resources, the ownership interest that an applicant/recipient (A/R) or the A/R's spouse has in an annuity must be disclosed at application and each redetermination. Any transaction related to an annuity must be reported within 10 business days of the change. The DRA specifies new requirements for annuities that are purchased on or after February 8, 2006, and reviewed for a determination or redetermination of nursing facility or 1915(c) HCBS waiver eligibility on or after April 1, 2007. For annuities purchased on or after February 8, 2006, the State of Maryland must be named as a remainder beneficiary in a specific manner or "position", and confirmed by the DHMH Recoveries and Financial Services Division. If the State is not named in the correct preferred position, a penalty period is imposed and MA will not cover the institutionalized individual's LTC payments, but will cover any other MA services for which the individual is otherwise eligible. Certain transactions involving an annuity owned by an institutionalized individual, not the community spouse, are also subject to a penalty, based on the full value of the purchase or other transaction, such as if the payment terms are not actuarially sound (based on Schedule MA 9-A), or if the annuity includes a balloon payment.

- **Look-Back Date and Look-Back Period**: For disposals of assets on or after February 8, 2006 and considered for an eligibility determination or redetermination of long-term care eligibility on or after April 1, 2007, the look-back date is lengthened from 36 to 60 months before an institutionalized individual's earliest effective date of MA eligibility for nursing facility or 1915(c) HCBS waiver services. The look-back date marks the beginning of an institutionalized individual's look-back period.

- **Beginning Date of a Penalty Period**: For disposals for less than FMV that occurred on or after February 8, 2006 and considered for an eligibility determination or redetermination of an institutionalized individual's application for nursing facility or 1915(c) HCBS waiver services, the penalty period shall now begin on the effective date of the individual's eligibility, rather than beginning on the disposal date. During a penalty period, an individual who is determined MA eligible under long-term care or 1915(c) HCBS waiver rules is not covered by MA for nursing facility or 1915(c) HCBS waiver services, but is covered for other MA services.

- **Undue Hardship Waiver**: An individual, the individual's representative, or the nursing facility provider (if authorized by the individual) may ask the eligibility case worker to consider waiving the imposition of a penalty period. The waiver may be requested if the institutionalized individual would be placed at serious risk through deprivation of food, clothing, shelter, other necessities of life, or medical care such that his/her health or life would be endangered.

- **Purchase of Life Estate in Another Individual's Home**: If an A/R, on or after April 1, 2006, purchases a life estate interest in home property owned by another individual, the amount paid for the life estate may not exceed its FMV and the individual must reside in that property for at least 12 consecutive months. Otherwise, the transaction is penalized as a disposal for less than FMV, based on the full purchase price of the life estate.

- **Penalty for Promissory Notes, Loans, or Mortgages**: If, on or after April 1, 2006, the A/R is the lender for a promissory note, mortgage, or other loan, and the loan agreement does not meet certain requirements for repayment (e.g., is actuarially sound based on the A/R's life expectancy from Schedule MA 9-A), the transaction is penalized based on the loan's outstanding balance.

Chapter 8 Appendix
New Chart- DRA PHASE-IN LOOK-BACK CHART
This new chart provides the look-back periods that gradually increase from 36 months to 60 months starting with April, 2007.

Medical Assistance Schedules
- Schedule MA-6 is revised to include the daily amount for calculating a penalty period due to disposal of assets for less than FMV.
- Schedule MA 9-A - Period Life Table is updated with actuarial standards for life expectancy, issued by the Social Security Administration.

CARES REMINDERS/INSTRUCTIONS

CARES has not been updated to address the new DRA requirements for determining eligibility for long term care and Home and Community Based Services (HCBS) Waiver programs. It is therefore necessary that local staff follow the below instructions for all eligibility decisions for LTC and HCBS applications and redeterminations when the eligibility is calculated manually.

The forms listed below are contained in Chapter 10 of the Medicaid Manual and are being updated and issued in Manual Release 142, to follow this release.

- Manually Complete as Appropriate
  DES/LTC 811 Transfer/Disposal of Assets Worksheet
  DES/LTC 812 Home Equity Value Worksheet
  DES/LTC 813 Manual MMIS instructions for Screen 4 and/or Screen 8

- For all applications/redeterminations, complete the appropriate DHMH 4235 form:
  - 4235 NOTICE OF INELIGIBILITY DUE TO EXCESS RESOURCES w/ Attach. DES 100
  - 4235A NOTICE OF NON-COVERAGE OF NURSING FACILITY SERVICES DUE TO DISPOSAL OF ASSETS FOR LESS THAN FAIR MARKET VALUE
  - 4235B NOTICE OF NON-COVERAGE OF NURSING FACILITY SERVICES DUE TO SUBSTANTIAL HOME EQUITY
  - 4235C NOTICE OF NON-COVERAGE OF NURSING FACILITY SERVICES DUE TO ANNUITY

- Update the CARES narrative to reflect the manual eligibility processing.
- Finalize the CARES AU, suppressing the CARES notice.
- Create CARES 745 Alert

If you have any questions about these policies or procedures, contact the DHMH Division of Eligibility Policy and MCHP at 410-767-1463 or 1-800-492-5231 (select option 2 and request extension 1463). Questions regarding CARES processing should be directed to Cathy Sturgill at 410-238-1247 or via email at csturgil@dhr.state.md.us.

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APPENDIX

- 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 case worker as requested:
   - Sufficient documentation and verification of each resource;
   - An explanation, with appropriate verification, to reconcile any inconsistency identified by the eligibility case worker in reported 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 or waiver eligibility.

Responsibilities of the Eligibility Case Worker

For the resource eligibility determination, the eligibility case worker:

1. Considers all of the resources reported by the A/R or representative, or otherwise discovered by the eligibility case worker, for AU members or a member's spouse;
2. Determines for each resource owned by AU members or a member's spouse:
   a. Whether the resource is countable as being available to the owner and not a type of excludable resource; and/or
   b. 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.

General Principles for Consideration of 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 1st moment of the 1st 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 1st moment of the 1st 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 1st moment of the 1st 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 1st moment of the 1st day of each retroactive month.

If the value of the AU's total countable resources changes after the 1st moment of a month, the change is considered as of the 1st 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.

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 "principal place of residence." If the individual moves into an assisted living facility, the facility becomes the "principal 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 "principal 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.

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 case worker 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 **$500,000** by 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 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 $500,000 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 (DHMH) 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 Chapter 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 case worker for a hardship waiver.
    - The eligibility case worker 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 case worker whether a hardship waiver is approved and, if not, the reason for denial.
    - The eligibility case worker 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 professionally 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 interest 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. (See pages 800-4c – 800-5, 800-27 – 800-29, and 800-47 – 800-57 in this Chapter about how to determine ownership interest.)

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 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 case worker 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 case worker's satisfaction that 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 as a reason to approve a

hardship waiver.

The DES/LTC 812, **Home Equity Value Worksheet**, located in MA Manual Chapter 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 case worker 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 substantial home equity is discovered at a redetermination, the case worker 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 stills 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 $500,000. 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 case worker 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, since home property is excluded as a resource. She is also approved for Medicaid coverage of her waiver services because her equity interest in home property does not exceed $500,000.

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.

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 applicant or recipient 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 ($500,000) (see the section above with the requirements).

The DHMH Form 4255 (Statement of Intent to Return) must be completed for all LTC applicants, whether or not 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 4255. Whether the expressed intent is reasonable is irrelevant so far as excludability of the home property is concerned.

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

any funds except those designated as belonging to the applicant/recipient (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 case worker.

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 applicant/recipient (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 case worker 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 Chapter, the eligibility case worker 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 countable income, regardless of whether the annuity itself is considered as 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 case worker 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 case worker 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 Section in this Chapter about "Disposal of Assets for Less Than Fair Market Value"). **This review for a penalty is conducted regardless of whether the annuity is countable or excludable as a resource.**

- 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.

Federal Deficit Reduction Act of 2005 – Requirements for Annuities

The following new 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 that 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 case worker 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 (not 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 action(s) must be taken by the eligibility case worker 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 1, 2007; and
- Was purchased on or after the institutionalized individual's applicable look-back date.

A penalty period is imposed for the institutionalized individual's coverage of NF or HCBS waiver services, in accordance with the Section in this Chapter about "Disposal of Assets for 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 of 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. The

Chapter about "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 an annuity was established under any of the Internal Revenue Code provisions specified in paragraph a or b above, the institutionalized individual or representative must provide the eligibility case worker with documentation from the entity that issued the annuity.

To evaluate whether an annuity meets the conditions listed in paragraph c above, the eligibility case worker reviews the annuity's written terms and determines the purchaser's 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 to be 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 DRA Section of the Manual's effective date of April 1, 2007, are not considered to be 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.

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

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 - In this section:

- 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 applicant or recipient (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 (see Policy Alert 10-10 about Maryland's seven 1915(c) waivers).

Therefore, these requirements do not apply for a:

- Community resident who is not applying for coverage under a 1915(c) waiver; or
- 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 case worker 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 as 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 as countable or excludable for determining Medicaid financial eligibility.

For each disposal, the eligibility case worker 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.

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 applicant/recipient/spouse (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 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 the:
  - 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 applicant/recipient 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 as 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-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 eligibility case worker 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.

What are Disposals Subject to Penalty

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

back period:

- A resource was disposed for less than FMV. OR
- Income was disposed for less than FMV in the same month that it was received (i.e., prior to being considered as a resource if the money is still retained in the month after receipt). OR
- A stream of income (i.e., income received on a regular basis) or the right to a stream of income (e.g., pension) was transferred for less than FMV. Then, a determination must be made of the total amount of income that would have been received from this source during the individual's lifetime, based on an actuarial projection of the individual's life expectancy (see Schedule MA 9-A "Period Life Table" in the Manual's Appendix). The penalty is calculated based on the total projected income not received. OR
- The applicant/recipient/spouse (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 the FMV. These actions include, but are not limited to:

- making a gift or donation of assets (e.g., unusually 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 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.

Who Made the Disposal

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

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

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 case worker 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 case worker 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 in 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 is 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. For 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.

Date of Disposal

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

- For income disposed in the month that it is received, the month of disposal is the month of receipt.
- For income that is diverted or refused, the month of disposal is the month in which the income should have been received.
- For resources that are transferred, the month of disposal is the month in which the transfer occurred.
- For jointly owned assets, the month of disposal is the month in which an action was taken that reduces or eliminates the A/R's ownership, access, or control of the asset. This includes withdrawals or liquidations by joint owners other than the A/R, as well as changes in ownership.
- For a revocable trust, the date of disposal is the date that payment to someone other than the grantor was made.
- For an irrevocable trust, the date of disposal is the date that the trust was established or, if later, the date on which payment to the grantor was prohibited.
- For assets made unavailable by placement in an irrevocable trust, which cannot be accessed by the A/R 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.

Look-Back Date and Look-Back Period

The look-back date is the earliest date for which disposals for less than FMV by an institutionalized individual or the community spouse may be evaluated for penalty. 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 1915(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.

Look-Back Date for Non-Trust Assets Disposed Before February 8, 2006

For non-trust assets disposed before February 8, 2006, the look-back date is 36 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.

Look-Back Date for Trusts Subject to a Penalty Before February 8, 2006

For transactions involving a trust that are subject to a penalty and occurred before February 8, 2006, or are considered for a MA eligibility determination or redetermination conducted before April 1, 2007:

- The look-back date is 36 months before an institutionalized individual's earliest effective date of MA eligibility in a nursing facility or 1915(c) waiver if:
    - The trust is irrevocable but some or all of the trust can be disbursed under certain circumstances to or for the benefit of the grantor, and yet payments are made to someone else. Those disbursals are subject to a penalty.
- 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 if:
    - An irrevocable trust is established so that all or a portion of the trust cannot be disbursed to or on behalf of the grantor, then that portion is treated as a disposal; or
    - A revocable trust is established, and a portion of it is disbursed to someone other than the grantor or for the benefit of someone other than the grantor, then that disbursal is subject to a penalty.

Deficit Reduction Act of 2005 (DRA) - Look-Back Date for Trust or Non-Trust Assets Disposed On or After February 8, 2006

For trust or non-trust assets disposed on or after February 8, 2006, and considered for a MA eligibility determination or redetermination conducted on 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.

This longer look back period will be gradually phased in because this change only affects transfers on or after February 8, 2006. Beginning March 1, 2009, applicants will have to submit 37 months of financial records. The look back will increase by one-month increments until February 2011 when the look-back period will be 60 months for all transfers of assets.

For additional information, please refer to the ***DRA Phase-In Look-Back Chart*** *located in the Appendix, at the end of this chapter.*

Example:

Mr. Smith is approved for Medicaid eligibility in a nursing facility effective December 1, 2007. For non-trust assets and certain trusts disposed for less than fair market value before February 8, 2006, his look-back date is December 1, 2004 (36-month look-back). For certain trusts disposed before February 8, 2006, his look-back date is December 1, 2002 (60-month look-back). For all assets transferred on or after February 8, 2006, his look-back date is December 1, 2002 (60-month look-back). Once established, his look-back dates do not change.

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). For 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 case worker 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 times 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 2007. He transferred his life estate interest to his daughter as the life tenant, and received no compensation for this disposal. In April 2007, 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 ÷ $4,300 = 10 months.

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

STEP 1: $4,300x10 = $43,000

STEP 2: $45,966 -$43,000 = $2,966

STEP 3: $2,966÷$141 = 21 days.

A penalty period of 10 months and 21 days begins on April 1, 2007. Mr. Walter is excluded from MA coverage of his nursing facility services until February 22, 2008.

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 February 22, 2008. The eligibility case worker 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.

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) times 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 as 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 times 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 ($4,300) 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 ($141) 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 2007.

She was admitted to a nursing facility in July 2007. 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, 2007.

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 ÷$4,300 = 20 months of penalty .

STEP3: $4,300 x20 = $86,000

STEP 4: $89,557 - $86,000 = $3,557

STEP 5: $3,557 ÷$141 = 25 days of penalty in the last partial month.

A penalty period of 20 months and 25 days begins on July 1, 2007. Ms. Corddry is excluded from MA coverage of her nursing facility services until March 26, 2009.

MMIS recipient screen 1 reflects Ms. Corddry's eligibility in coverage group L98 beginning July 1, 2007. A span may not be loaded to MMIS recipient screen 4 for coverage of nursing facility services until March 26, 2009. The eligibility case worker 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

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 to be 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.")

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

For a MA application submitted or redetermination conducted on or after April 1, 2007 for nursing facility or HCBS waiver services, the eligibility case worker evaluates disposals that occurred on or after the A/R's applicable look-back date. If the A/R, on or after April 1, 2006, purchased a life estate interest for the right to live in property that belongs to another individual (e.g., son's or daughter's home), this transaction may be penalized as a disposal for less than FMV. The transaction is not penalized if:

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

Otherwise, if both of these conditions are not met, a penalty period is imposed for the

institutionalized A/R.

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

  Example:

  Mr. Smith paid $50,000 in September 2007 for a life estate interest in his daughter's home property, where he lived. He was admitted to a nursing facility in November 2007 due to failing health and was determined eligible for coverage group L98 effective November 1, 2007. Since he did not live in the home for 12 months, the life estate's entire purchase price of $50,000 is penalized, rather than just the remainder interest based on Schedule MA-7. The penalty period is calculated as:

  STEP 1: $50,000 ÷ $4,300 = 11 months of penalty.

  STEP 2: $4,300 x 11 = $47,300

  STEP 3: $50,000 - $47,300 = $2,700

  STEP4: $2,700 ÷ $141 = 19 days of penalty.

  A penalty period of 11 months and 19 days begins on November 1, 2007. Mr. Smith will not qualify for MA coverage of nursing facility services until November 20, 2008. The eligibility case worker 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.

- 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.

Example:

In April, 2007, Miss White (age 84) sold her stocks and closed her bank accounts to purchase a life estate interest in her son's home for $100,000. Her son used the money to pay off the mortgage. She lived in an apartment in the basement, which comprised one-fourth of the home's square footage. In April 2008, she was institutionalized in a nursing facility and was determined eligible in coverage group L98 effective April 1, 2008. The last property tax assessment valued the home as worth $400,000. Miss White's life estate interest in the property is valued as follows, using Schedule MA-7:

STEP 1: $400,000 ÷ 4 = $100,000 Miss White's interest in her son's home

STEP 2: $100,000 x .36998 = $36,998

STEP 3: $100,000 - $36,998 = $63,002

A penalty period for coverage of nursing facility services is imposed based on the difference between Miss White's payment for the life estate interest and its FMV.

The penalty period is calculated as follows:

STEP 1: $63,002 ÷ $4,300 = 14 months of penalty.

STEP 2: $4,300 x 14 = $60,200

STEP 3: $63,002 –$60,200 = $2,802

STEP4: $2,802 ÷ $141 = 19 days of penalty.

A penalty period of 14 months and 19 days begins on April 1, 2008. Miss White will not qualify for MA coverage of nursing facility services until June 20, 2009. The eligibility case worker 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.

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 case worker 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 on or after April 1, 2007 for nursing facility or HCBS waiver services, the eligibility case worker 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 as 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 to be 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.

Example:

In August 2007, Mr. Reilly, who is 85 years old, enters a nursing facility and is determined eligible in coverage group L98 effective August 1, 2007. In June 2007, he

loaned his daughter $100,000 to pay off her mortgage. They had a lawyer develop a loan agreement for the daughter to pay her father $1,000 per month. In July, his daughter made her first payment, so the outstanding balance is $99,000. Since his life expectancy according to Schedule MA 9-A is 5.20 years, his daughter is expected to pay $62,400 of the loan during Mr. Reilly's remaining lifetime. Therefore, the loan is not actuarially sound and must be penalized as a disposal for less than FMV, based on the outstanding balance of $99,000.

The penalty period is calculated as follows:

STEP 1: $99,000 ÷ $4,300 = 23 months of penalty.

STEP 2: $4,300 x 23 = $98,900

STEP:3 $99,000 - $98,900 = $100

STEP 4: $100 ÷ *$141 = 0 days of penalty.*

A penalty period of 23 months and 0 days begins on August 1, 2007. Mr. Reilly will not qualify for MA coverage of nursing facility services until July 1, 2009. The eligibility case worker 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.

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 be considered to belong to the individual. For 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 case worker 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 case worker 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.

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 case worker 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 case worker 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.

Example:

Mrs. Corddry is 90 years old and covered by MA in a nursing facility under coverage group L98. She wins the lottery for $80,000 in July 2007. She chooses to receive a payout of $1,000 per month for 80 months and transfers the right to that Mrs. Corddry has a life expectancy of 4.43 years (53 months), she would have received a payout of $1,000 x 53 months = $53,000 during her lifetime. She is penalized for this disposal of assets. The penalty period is calculated as follows:

STEP 1: $53,000 ÷ $4,300 = 12 months of penalty

STEP 2: $4,300 x12 = $51,600

STEP 3: $53,000 -$51,600 = $1,400

STEP4: $1,400 ÷ $141 = 9 days of penalty .

A penalty period of 12 months and 9 days begins on July 1, 2007. Mrs. Corddry will remain MA eligible in coverage group L98, but will not be covered by MA for nursing facility services between July 1, 2007 and July 10, 2008. The eligibility case worker 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.

Trust As a Disposal

When a countable asset is placed in a trust, this transaction is usually considered to be 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 10.09.24.08-2B(4)(c) and (5)(a)(ii)).
    - The date of disposal is the date of the payments.
    - The value of the disposal is the amount of the payments.
- If a trust is established or the trust's terms are changed so that funds cannot be disbursed from all or a portion of the trust's corpus or trust's income, under any circumstances, to, or for the benefit of, the A/R/S (grantor) who established the trust (see COMAR 10.09.24.08-2B(5)(b)).
    - The date of disposal is the date that the trust was established or, if later, the date on which payment to the grantor was prohibited.
    - The value of the disposal is based on the trust's value as of the date of the trust's establishment or the date that payments are prohibited, including the amount of

any payments made, for whatever purpose, from that portion of the trust on or after that date.

- o If the trustee or grantor adds funds to the trust's unavailable portion after these dates, this transaction is considered to be 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 case worker 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.

For 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 as 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.

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 case worker 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 case worker must determine whether to impose a penalty period. If a penalty period is established that has not

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 case worker must review MMIS recipient screen 1 and either screen 4 or 8, to assure that the information is correct on MMIS. If MMIS is incorrect, the case worker must send a DES/LTC 813 with the necessary changes to the DHMH Division of Recipient Eligibility Programs (DREP).

Deductions From Available Income For Noncovered Services Received During Penalty Period

For long-term care or waiver applications filed before April 1, 2007, there may be a deduction from a recipient's monthly available income for the cost of care for noncovered medical or remedial services received during a penalty period. The deduction is the amount of the allowable fees for the noncovered services exceeding $4,300 each month. For example, if the Medicaid fee for the recipient's nursing facility services is $5,300 for a month that the recipient was under penalty for disposal of assets, $1,000 may be deducted from the recipient's monthly available income for the cost of care ($5,300 - $4,300 = $1,000).

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 noncovered services received during a penalty period. Therefore, the amount deducted is $0, regardless of the costs incurred by the recipient for noncovered nursing facility or HCBS waiver services received during the penalty period.

Uncompensated Value of a Disposal

To compute the length of a penalty period, the eligibility case worker 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:

1. 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

2. 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 case worker 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 case worker 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 case worker 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 to be 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 or 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 becoming a countable resource, since it prevents a lien from being imposed.

Basic Principles for 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 noncoverage 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 case worker 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 Chapter 15 of this Manual.

Length of Penalty Period

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

For each $4,300 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. For 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 $4,300, a penalty period shorter than a month is calculated in terms of days. One day of penalty is assessed for each $141 of uncompensated value. Any remaining amount less than $141 is not penalized.

To compute the length of a penalty period:

1. Add the uncompensated value of all assets disposed by, or on behalf of, the individual or the individual's spouse on or after the applicable look-back date that have not yet been penalized. If there are a series of transfers, the penalty period is calculated based on the total uncompensated value of all the assets transferred, even if each transfer is less than $4,300.
2. Divide the total, cumulated, uncompensated value by the amount in Schedule MA-6 of the Manual's Appendix ($4,300). The unrounded result equals the number of full calendar

months in the penalty period.

Example: $12,400 ÷ $4,300 = 2 full months of penalty

3. Divide by $141 any remainder from #2 that is less than the monthly figure in Schedule MA-6 ($4,300). The unrounded result equals the number of days of noncoverage in the final partial month of the penalty period. Disregard any remainder less than $141. A single disposal of an amount less than the average monthly cost of care ($4,300) will also result in a partial month penalty equal to one day of noncoverage for every $141 disposed.

   Example: $3,800 ÷ $141 = 26 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:

STEP1: $12,400 ÷ $4,300 = 2 months.

STEP 2: $4,300 x 2 = $8,600)

STEP 3: $12,400 - $8,600 = $3,800

STEP 4: $3,800 ÷ $141 = 26 days

. The penalty period is 2 months and 26 days.

Since the penalty is based on the factors found in Schedule MA-6 ($4,300 monthly and $141 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 case worker apportions the penalty period between them.

Example 1:

Mrs. Swift is determined eligible for Medicaid coverage of nursing facility services effective December 12, 2007, and her eligibility in coverage group L98 is approved to begin December 1, 2007. As of December 1, 2007, 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, 2008. 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, 2008, which is when the penalty is scheduled to end and Medicaid payment may begin for their nursing facility services. The eligibility case worker 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, 2008, and his eligibility in coverage group L98 is approved to begin February 1, 2008. His wife died in a nursing facility in December 2007. She had an unexpired penalty period for disposal of assets that is scheduled to end June 1, 2008. 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, 2008 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, 2008, which is when the penalty is scheduled to end and Medicaid payment may begin for his nursing facility services. The eligibility case

worker 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 case worker 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, 2007 and last for four months. She has another penalty period that would overlap and begin on January 1, 2008, lasting for two months. Therefore, a combined penalty period is imposed that begins on December 1, 2007 and lasts for six months. MA will cover her nursing facility services beginning on June 1, 2008.

- 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, 2007 and last for 2 months. He has another penalty period that would not overlap because it would begin on September 1, 2007 and last for four months. Therefore, he will not be eligible for MA coverage of nursing facility services in June or July 2007; he will be eligible for NF coverage in August 2007; he will not be covered for September – December 2007; and then his NF coverage will resume effective January 1, 2008. The eligibility case worker 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 case worker 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, 2008. When her eligibility is redetermined in November 2007, another disposal is discovered for which the penalty period would have begun effective November 1, 2007 and last for four months. Since the previous penalty period has not expired, the new penalty period will begin on March 1, 2008 and last for four months until July 1, 2008 when her coverage will begin for nursing facility services. The eligibility case worker 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.

Penalty Begin Date

Disposals Made Before February 8, 2006

For assets disposed or trusts established before February 8, 2006, the beginning date

for a penalty period is based on the date that the transaction occurred. Therefore, for a transaction during a look-back period before the Medicaid application date, the penalty period may have expired by the effective date of Medicaid long-term care or waiver eligibility.

- For a single disposal, the penalty period begins on the 1st day of the month in which the disposal occurred.
- For multiple disposals that are penalized in the same penalty period, the penalty period begins on the 1st day of the month in which the earliest disposal occurred.
- For multiple disposals that are penalized in more than one penalty period, if the beginning date of a penalty period would fall within an earlier penalty period, the penalty period for the latter disposal must begin on the day immediately following the end of the previous penalty period.

Deficit Reduction Act of 2005 (DRA) - Disposals Made On or After February 8, 2006

For assets disposed or trusts established on or after February 8, 2006 and considered for a Medicaid nursing facility or HCBS waiver application submitted or redetermination conducted before April 1, 2007, the pre-DRA policies are followed as specified above for disposals made before February 8, 2006.

For assets disposed or trusts established on or after February 8, 2006 and considered for a Medicaid nursing facility or HCBS waiver application submitted or redetermination conducted on or after April 1, 2007, 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.

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.

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:

1. For certain transfers of home property, as described in the section below about "Disposal of Home Property."
2. 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; (see the "Sole Benefit" section that follows); 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).
3. If convincing evidence is provided to the eligibility case worker, 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 case worker, 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.
4. If convincing evidence is provided to the eligibility case worker, 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 case worker, 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.

5. If the full value of the transferred assets are returned to the individual (see the section below about "Assets Returned").
6. 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 A/R's resource eligibility must be redetermined on that basis. The A/R is ineligible for each month that the A/R's total countable resources exceed the resource standard as of the 1st day of the month.
7. If an undue hardship waiver is approved by the DHMH Division of Eligibility Policy (see the section below about "Undue Hardship Waiver").

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 A/R 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 an 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").

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 case worker 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

BSA – Division of Eligibility Policy

201 West Preston Street, Rm. SS-10

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).

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 case worker 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 case worker 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.

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 case worker 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 case worker 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, 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.

Assets Returned

Either a penalty is not imposed or a penalty is voided if the full value of the asset(s) disposed for less than FMV is returned to the individual. An asset is considered to be returned to the individual, and so the penalty period is made void, if all of the asset(s) in question, or its fair market equivalent, is returned to the individual (e.g., if the asset is now titled or deeded as it was when the individual was originally the owner). For example, if the asset was sold by the individual who received it, the full FMV of the asset is returned to the transferor in cash.

If all of the transferred assets are returned, the A/R's resource eligibility must be re-evaluated for the period under consideration, beginning with the month that the asset was originally transferred.

- The A/R is determined ineligible for MA (not just penalized by non-coverage of NF and 1915(c) waiver services) for any month in which the A/R's resources exceed the applicable resource standard as of the 1st day of the month. If MA claims were paid for an ineligible month, the case worker refers the individual for recoveries, in accordance with Chapter 15 of this Manual. The asset(s) may be used to reimburse the State for those services incorrectly paid.
- If the A/R is determined resource eligible for the period under consideration, MA will now pay for any NF or 1915(c) waiver services received during the voided penalty period. Providers should re-bill for any claims previously denied.

For dates prior to the return of the asset, Medicaid coverage may not be granted if the asset would have rendered the person resource over-scale during those months. Do not consider any outstanding debts when determining if the person would have been eligible in prior months (i.e., consider the individual to have owned the returned asset throughout each of those months).

The resource itself must be evaluated effective the month of the original transfer, and the A/R's Medicaid eligibility must be determined on that basis. The A/R remains ineligible throughout each month that the A/R's total countable resources exceed the resource standard on the 1st day of the month. If the Medicaid Program paid for services received by the individual during one or more months that the individual would have been resource over-scale if the asset(s) had not been transferred, the case is referred for recoveries. The excess asset(s) may be used to reimburse the State for those claims incorrectly paid.

Example:

In June 2007, Mrs. Poole removed her name from her savings account with $40,000 in deposits, and transferred ownership to her daughter. In August 2007, 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 ÷ $4,300 = 9 months of penalty

STEP 2: $4,300 x 9 = $38,700

STEP 3: $40,000 - $38,700 = $1,300

STEP 4: $1,300 ÷ $141 = 9 days).

The penalty period was 9 months and 9 days, lasting August 1, 2007 – May 10, 2008.

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 2007. She was determined ineligible because the $40,000 savings account made her resource over-scale. 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 only part of an asset, or its equivalent value, is returned, a penalty period can be modified but not voided. For example, if only half the value of the asset is returned, the penalty period may be reduced by one-half. However, 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:

Using the example above, if Mrs. Poole's daughter had withdrawn and spent $20,000 from the savings account before ownership was transferred back to her mother during October, the eligibility case worker would have redetermined Mrs. Poole's eligibility based on this reported change for a new period under consideration beginning November 1. If Mrs. Poole sent the DHMH Recoveries Division a check for the difference between her over-scale resources and the MA resource standard ($20,000 – $2,500 = $17,500) to pre-pay her nursing facility services, Mrs. Poole may remain MA eligible for coverage group L98 without a break in coverage. Her penalty period is recalculated, due to the partial return of $20,000 of the disposed assets. The penalty period is recalculated as: $20,000 ÷ $4,300 = 4 months. ($20,000 – ($4,300 x 4)) ÷ $141 = 19 days. The penalty period is shortened to 4 months and 19 days, lasting August 1, 2007 – December 20, 2007.

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.

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 case worker 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 case worker 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 case worker should mail a complete recording and documentation of the facts to:

Department of Health and Mental Hygiene
BSA – Division of Eligibility Policy
201 West Preston Street, Rm. SS-10
Baltimore, MD 21201

The eligibility case worker 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. Within 15 days of receipt of complete documentation, 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 case worker 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 case worker 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.

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 1915(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 case worker if they wish to request this waiver, and then must provide the eligibility case worker 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 case worker **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 Chapter 10 in this Manual); or
- A waiver "Notice of Ineligibility: Transfer Penalty" (See the Medicaid Eligibility Manual for the particular waiver).

The eligibility case worker 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 case worker must suppress the CARES notice if a manual notice is sent, to assure that the customer does not receive two notices with different information.

MARYLAND MEDICAL ASSISTANCE PROGRAM

SCHEDULE MA-6

Average monthly amount payable for care in a skilled nursing facility

Effective	**Average**
9/1/98	**$4,300**

Average daily amount payable for care in a skilled nursing facility

Effective	**Average**
9/1/98	**$141**

MARYLAND MEDICAL ASSISTANCE PROGRAM
Schedule MA 9-A
Period Life Table, 2002
Updated June 27, 2006

Exact Age	Male Life Expectancy	Female Life Expectancy	Exact Age	Male Life Expectancy	Female Life Expectancy
0	74.21	79.49	**38**	38.53	42.90
1	73.78	78.99	**39**	37.62	41.95
2	72.82	78.02	**40**	36.71	41.01
3	71.85	77.05	**41**	35.80	40.07
4	70.87	76.06	**42**	34.90	39.14
5	69.88	75.07	**43**	34.00	38.21
6	68.90	74.08	**44**	33.12	37.28
7	67.91	73.10	**45**	32.23	36.36
8	66.92	72.11	**46**	31.36	35.44
9	65.93	71.11	**47**	30.49	34.52
10	64.94	70.12	**48**	29.63	33.61
11	63.95	69.13	**49**	28.77	32.71
12	62.96	68.14	**50**	27.92	31.80
13	61.97	67.15	**51**	27.07	30.90
14	60.98	66.16	**52**	26.24	30.01
15	60.01	65.18	**53**	25.40	29.12
16	59.05	64.20	**54**	24.58	28.24
17	58.10	63.22	**55**	23.76	27.36
18	57.15	62.25	**56**	22.95	26.50
19	56.22	61.27	**57**	22.15	25.64
20	55.28	60.30	**58**	21.36	24.78
21	54.35	59.33	**59**	20.58	23.94
22	53.43	58.36	**60**	19.81	23.11
23	52.50	57.38	**61**	19.05	22.28
24	51.58	56.41	**62**	18.31	21.47
25	50.65	55.44	**63**	17.57	20.67
26	49.72	54.47	**64**	16.85	19.88
27	48.79	53.49	**65**	16.15	19.09
28	47.85	52.52	**66**	15.45	18.32
29	46.91	51.55	**67**	14.77	17.56
30	45.98	50.58	**68**	14.10	16.82
31	45.04	49.61	**69**	13.45	16.08
32	44.10	48.65	**70**	12.81	15.36
33	43.17	47.68	**71**	12.19	14.66
34	42.24	46.72	**72**	11.59	13.96
35	41.31	45.76	**73**	11.00	13.29
36	40.38	44.80	**74**	10.42	12.62
37	39.45	43.85	**75**	9.86	11.97

MARYLAND MEDICAL ASSISTANCE PROGRAM
Schedule MA 9-A
Period Life Table, 2002
Updated July 27, 2006

Exact Age	Male Life Expectancy	Female Life Expectancy	Exact Age	Male Life Expectancy	Female Life Expectancy
76	9.32	11.33	**98**	2.15	2.54
77	8.79	10.71	**99**	2.04	2.39
78	8.29	10.10	**100**	1.93	2.25
79	7.79	9.51	**101**	1.82	2.11
80	7.31	8.94	**102**	1.72	1.98
81	6.85	8.39	**103**	1.63	1.86
82	6.41	7.86	**104**	1.53	1.74
83	5.99	7.35	**105**	1.44	1.63
84	5.58	6.86	**106**	1.36	1.52
85	5.20	6.40	**107**	1.28	1.41
86	4.85	5.96	**108**	1.20	1.31
87	4.51	5.54	**109**	1.12	1.22
88	4.20	5.14	**110**	1.05	1.13
89	3.90	4.78	**111**	0.98	1.05
90	3.63	4.43	**112**	0.92	0.97
91	3.38	4.11	**113**	0.85	0.89
92	3.15	3.82	**114**	0.79	0.82
93	2.93	3.55	**115**	0.73	0.75
94	2.74	3.30	**116**	0.68	0.68
95	2.56	3.08	**117**	0.63	0.63
96	2.41	2.88	**118**	0.57	0.57
97	2.27	2.70	**119**	0.53	0.53

Notes:
The period life expectancy at a given age for 2002 represents the average number of years of life remaining if a group of persons at that age were to experience the mortality rates for 2002 over the course of their remaining life.
For updates, see: http://www.ssa.gov/OACT/STATS/table4c6.html

DRA PHASE-IN LOOK-BACK CHART

The federal Deficit Reduction Act of 2005 (Public Law 109-171) increased the look-back period on transfers of assets to 60 months for all transfers. Prior to the DRA, the look-back period on outright transfers was 36 months and 60 months on trusts. The longer look-back period will be *gradually phased-in* because this change only affects transfers on or after February 8, 2006. Beginning March 1, 2009, applicants must submit 37 months of financial records. The look-back will increase by one-month increments until February 2011, when the look-back period will be 60 months for all transfers of assets.

The following chart is designed to help clarify this process. The numbers in the parentheses indicate the number of months to look back. ***OBRA 93 lengthened the look-back period to 60 months for disposals involving trusts.**

Application Month:	April 2007	May 2007	June 2007	July 2007	August 2007	September 2007
Look-Back Period:	4/1/04 (36)	5/1/04 (36)	6/1/04 (36)	7/1/04 (36)	8/1/04 (36)	9/1/04 (36)
Trusts Look-Back:*	4/1/02 (60)	5/1/02 (60)	6/1/02 (60)	7/1/02 (60)	8/1/02 (60)	9/1/02 (60)
Application Month:	October 2007	November 2007	December 2007	January 2008	February 2008	March 2008
Look-Back Period:	10/1/04 (36)	11/1/04 (36)	12/1/04 (36)	1/1/05 (36)	2/1/05 (36)	3/1/05 (36)
Trusts Look-Back:*	10/1/02 (60)	11/1/02 (60)	12/1/02 (60)	1/1/03 (60)	2/1/03 (60)	3/1/03 (60)

Application Month:	April 2008	May 2008	June 2008	July 2008	August 2008	September 2008
Look-Back Period:	4/1/05 (36)	5/1/05 (36)	6/1/05 (36)	7/1/05 (36)	8/1/05 (36)	9/1/05 (36)
Trusts Look-Back:*	4/1/02 (60)	5/1/03 (60)	6/1/03 (60)	7/1/02 (60)	8/1/02 (60)	9/1/02 (60)
Application Month:	October 2008	November 2008	December 2008	January 2009	February 2009	March 2009
Look-Back Period:	10/1/05 (36)	11/1/05 (36)	12/1/05 (36)	1/1/06 (36)	2/1/06 (36)	2/8/06 (37)
Trusts Look-Back:*	10/1/03 (60)	11/1/03 (60)	12/1/03 (60)	1/1/04 (60)	2/1/04 (60)	3/1/04(60)
Application Month:	April 2009	May 2009	June 2009	July 2009	August 2009	September 2009
Look-Back Period:	2/8/06 (38)	2/8/06 (39)	2/8/06 (40)	2/8/06 (41)	2/8/06 (42)	2/8/06 (43)
Trusts Look-Back:*	4/1/04 (60)	5/1/04 (60)	6/1/04 (60)	7/1/04 (60)	8/1/04 (60)	9/1/04 (60)

Application Month:	October 2009	November 2009	December 2009	January 2010	February 2010	March 2010
Look-Back Period:	2/8/06 (44)	2/8/06 (45)	2/8/06 (46)	2/8/06 (47)	2/8/06 (48)	2/8/06 (49)
Trusts Look-Back:*	10/1/04 (60)	11/1/04 (60)	12/1/04 (60)	1/1/05 (60)	2/1/05 (60)	3/1/05 (60)
Application Month:	April 2010	May 2010	June 2010	July 2010	August 2010	September 2010
Look-Back Period:	2/8/06 (50)	2/8/06 (51)	2/8/06 (52)	2/8/06 (53)	2/8/06 (54)	2/8/06 (55)
Trusts Look-Back:*	4/1/05 (60)	5/1/05 (60)	6/1/05 (60)	7/1/05 (60)	8/1/05 (60)	9/1/05 (60)
Application Month:	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011
Look-Back Period:	2/8/06 (56)	2/8/06 (57)	2/8/06 (58)	2/8/06 (59)	2/8/06 (60)	3/1/06 (60)
Trusts Look-Back:*	10/1/05 (60)	11/1/05 (60)	12/1/05 (60)	1/1/06 (60)	2/1/06 (60)	3/1/06 (60)
Application Month:	April 2011	May 2011	June 2011	July 2011		
Look-Back Period:	4/1/06 (60)	5/1/06 (60)	6/1/06 (60)	7/1/06 (60)		
Trusts Look-Back:*	4/1/06 (60)	5/1/06 (60)	6/1/06 (60)	7/1/06 (60)		