304.01 TRUSTS AND TRANSFER OF ASSETS POLICY

Introduction

The following is a discussion of the treatment of income and resources which have been placed in, or are being distributed from, trusts, guardianships or conservatorships. The three classifications of trusts are described below. When the type of trust has been determined, refer to the applicable section in this chapter for policy pertaining to that trust classification. The trusts are discussed in the following order:

- OBRA-93 Trusts – applicable to trusts established on or after August 11, 1993, which is the date mandated by OBRA-93 federal legislation. OBRA-93 Trusts must meet certain criteria. If OBRA-93 criteria are not met, refer to the appropriate trust policy. The Deficit Reduction Act of 2005 (DRA) amended OBRA-93 trust rules and provides current operating procedures for trust issues. The specific provisions of the DRA are discussed throughout this section.
- Medicaid Qualifying Trusts - applicable to trusts established on or after March 1, 1987 through August 10, 1993 that meet MQT criteria. If MQT criteria are not met, defer to Standard Trust policy.
- Standard Trusts - applicable to trusts established prior to March 1, 1987 and/or trusts that do not meet the criteria of OBRA-93 or MQT trusts regardless of the date established.

Procedures for Clearing Any Type of Trusts, Guardianships, and Conservatorships

Trusts, guardianships/conservatorships are often complex documents involving state law and legal principles. They must be referred to the state office for clearance whenever a client or spouse either creates a trust or is the beneficiary of one. A copy of the trust agreement and all pertinent material must be submitted. This includes the amount charged for preparing the trust. An explanation from the attorney of how the trust benefits the applicant or recipient must also be provided in order for Medicaid to make a decision on whether the charge is allowable. The legal fee will be evaluated based on the benefit the trust provides. If Medicaid determines that the trust benefits the Medicaid applicant or recipient from a Medicaid perspective, a capped fee of $1,500.00 is allowed for preparing the trust document. The terms of the trust itself will be evaluated based on Medicaid trust and transfer policy as described in this chapter.

304.01.01. GENERAL TRUST DEFINITIONS

The following definitions apply to any/all types of trusts. Refer to the discussion of each type of trust for definitions which are specific to that trust classification.

Trust – A trust is a property interest whereby property is held by an individual (trustee) subject to a fiduciary duty to use the property for the benefit of another (the beneficiary).

Grantor – A grantor (also called a settlor or trustor) is a person who creates a trust. An individual may be a grantor if an agent, or other individual legally empowered to act on his/her behalf (e.g., a legal guardian, person acting under a power of attorney or conservator), establishes the trust with funds or property that belong to the individual.

The terms grantor, trustor, and settlor may be used interchangeably.

Trustee – A trustee is a person or entity who holds legal title to property for the use or benefit of another. In most instances, the trustee has no legal right to revoke the trust or use the property for his/her own benefit.

Trust Beneficiary – A trust beneficiary is a person for whose benefit a trust exists. A beneficiary does not hold legal title to trust property but does have an equitable ownership interest in it.

- **Primary Beneficiary** – the first person or class of persons to receive the benefits of a trust.
- **Secondary Beneficiaries** – the person or class of persons who will receive the benefits of the trust after the primary beneficiary has died.
- **Contingent Beneficiary** – a person or class of persons who will receive benefits only if a stated event occurs in the future.

Trust Principal (Corpus) – The trust principal is the property placed in trust by the grantor which the trustee holds, subject to the rights of the beneficiary plus any trust earnings paid into the trust and left to accumulate.

Trust Earnings (Income) – Trust earnings or income are amounts earned by trust principal. They may take such forms as interest, dividends, royalties, rents, etc. These amounts are unearned income to the person (if any) legally able to use them for personal support and maintenance.

GENERAL TRUST DEFINITIONS (Continued)

Totten Trust – A Totten trust is a tentative trust in which a grantor makes himself trustee of his own funds for the benefit of another. The trustee can revoke a Totten trust at any time. Should the trustee die without revoking the trust, ownership of the money passes to the beneficiary.

Grantor Trust – A grantor trust is a trust in which the grantor of the trust is also the sole beneficiary of the trust.

Mandatory Trust – A mandatory trust is a trust which requires the trustee to pay trust earnings or principal to or for the benefit of the beneficiary at certain times. The trust may require disbursement of a specified percentage or dollar amount of the trust earnings or may obligate the trustee to spend income and principal, as necessary, to provide a specified standard of care. The trustee has no discretion as to the amount of the payment or to whom it will be distributed.

Discretionary Trust – A discretionary trust is a trust in which the trustee has full discretion as to the time, purpose and amount of all distributions. The trustee may pay to or for the benefit of the beneficiary, all or none of the trust as he or she considers appropriate. The beneficiary has no control over the trust.

Testamentary Trust – A testamentary trust is a trust that is an integral part of a will and takes effect upon the death of the individual making the will.

304.01.02. OBRA-93 TRUST POLICY/DRA TRUST POLICY

Section 13611 of the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) amended Section 1917(d) of the Social Security Act to revise the treatment of trusts effective with trusts established after the date of enactment of OBRA-93, which was August 11, 1993. Trusts established before this date, but added to or otherwise augmented after this date, are treated under OBRA-93 Trust rules.

OBRA-93 Transfer of Assets policy is used in conjunction with OBRA-93 Trust policy and provisions of the Deficit Reduction Act of 2005 (DRA), which amended rules on transfer of assets for less than fair market value by broadening the spectrum of what is considered a transfer, the length of the penalty period, the look back period for transfers, the definition of assets and how penalty periods run consecutively rather than concurrently.

This section discusses OBRA-93 trust provisions, as amended by the DRA. Trusts that do not meet the criteria for OBRA-93 trusts or trusts established prior to 08/11/93 must be reviewed under the applicable trust policy.

Definitions

Trust - For purposes of this section, a trust is any arrangement in which a grantor transfers property to a trustee or trustees with the intention that it be held, managed, or administered by the trustee(s) for the benefit of the grantor or certain designated individuals (beneficiaries). The trust must be valid under State law and manifested by a valid trust instrument or agreement. A trustee holds a fiduciary responsibility to hold or manage the trust's corpus and income for the benefit of the beneficiaries. The term "trust" also includes any legal instrument or device that is similar to a trust. It does not cover trusts established by will. Such trusts must be dealt with using Standard Trust policy.

Legal Instrument or Device Similar to Trust - This is any legal instrument, device, or arrangement which may not be called a trust under State law but which is similar to a trust. That is, it involves a grantor who transfers property to an individual or entity with fiduciary obligations (considered a trustee for purposes of this section). The grantor makes the transfer with the intention that it be held, managed, or administered by the individual or entity for the benefit of the grantor or others. This can include (but is not limited to) escrow accounts, investment accounts, pension funds, and other similar devices managed by an individual or entity with fiduciary obligations.

Definitions (Continued)

Trustee - A trustee is any individual, individuals, or entity (such as an insurance company or bank) that manages a trust or similar device and has fiduciary responsibilities.

Grantor - A grantor is any individual who creates a trust. For purposes of this section, the term "grantor" includes:

- The individual;
- The individual's spouse;
- A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; and
- A person, including a court or administrative body, acting at the direction or upon the request of the individual, or the individual's spouse.

Revocable Trust - A revocable trust is a trust which can under State law be revoked by the grantor. A trust which provides that the trust can only be modified or terminated by a court is considered to be a revocable trust, since the grantor (or his/her representative) can petition the court to terminate the trust. Also, a trust which is called irrevocable but which terminates if some action is taken by the grantor is a revocable trust for purposes of this instruction. For example, a trust may require a trustee to terminate a trust and disburse the funds to the grantor if the grantor leaves a nursing facility and returns home. Such a trust is considered to be revocable.

Irrevocable Trust - An irrevocable trust is a trust which cannot, in any way, be revoked by the grantor.

Beneficiary - A beneficiary is any individual or individuals designated in the trust instrument as benefiting in some way from the trust, excluding the trustee or any other individual whose benefit consists only of reasonable fees or payments for managing or administering the trust. The beneficiary can be the grantor himself, another individual or individuals, or a combination of any of these parties.

Payment - For purposes of this section a payment from a trust is any disbursal from the corpus of the trust or from income generated by the trust which benefits the party receiving it. A payment may include actual cash, as well as noncash or property disbursements, such as the right to use and occupy real property.

Annuity - An annuity is a right to receive fixed, periodic payments, either for life or a term of years.

304.01.02A **TRUST PROVISIONS**

This section applies to any individual who establishes a trust and who is an applicant for or recipient of Medicaid. An individual is considered to have established a trust if his or her assets (regardless of how little) were used to form part or all the corpus of the trust and if any of the parties described as a grantor established the trust, other than by will.

When a trust corpus includes assets of another person or persons as well as assets of the individual, the rules in this section apply only to the portion of the trust attributable to the assets of the individual. Thus, in determining countable income and resources in the trust for eligibility and post-eligibility purposes, you must prorate any amounts of income and resources, based on the proportion of the individual's assets in the trust to those of other persons.

The rules set forth in this section apply to trusts without regard to:

- The purpose for which the trust is established;
- Whether the trustee(s), has or exercises any discretion under the trust;
- Any restrictions on when or whether distributions can be made from the trust; or
- Any restrictions on the use of distributions from the trust.

This means that any trust which meets the basic definition of a trust can be counted in determining eligibility for Medicaid. No clause or requirement in the trust, no matter how specifically it applies to Medicaid or other Federal or State programs (i.e., an exculpatory clause), precludes a trust from being considered under these rules.

Note: Exceptions to the countability of trusts as a resource do exist and are outlined later in the section.

304.01.02B TREATMENT OF REVOCABLE TRUSTS

In the case of a revocable trust:

- The entire corpus of the trust is counted as an available resource to the individual;
- Any payments from the trust made to or for the benefit of the individual are counted as income to the individual, provided the payment is counted as income under SSI cash assistance rules;
- Any payments from the trust which are not made to or for the benefit of the individual are considered assets disposed of for less than fair market value. Refer to OBRA-93 Transfer of Assets policy.

When a portion of a revocable trust is treated as a transfer of assets for less than fair market value, the look-back period in OBRA-93 transfer policy is 60 months. The 60-month look back period for assets placed in a trust is not phased in as it is for other types of transfers handled under DRA rules.

Note: Home property placed in a revocable trust loses its excluded status if the client is in an institution.

304.01.02C TREATMENT OF IRREVOCABLE TRUSTS

Payment Can Be Made Under Terms of Trust

In the case of an irrevocable trust, where there are any circumstances under which payment can be made to or for the benefit of the individual from all or a portion of the trust, the following rules apply to that portion:

- Payments from income or from the corpus made to or for the benefit of the individual are treated as income to the individual, provided the payment is counted as income under SSI cash assistance rules;
- Income on the corpus of the trust which could be paid to or for the benefit of the individual is treated as a resource available to the individual;
- The portion of the corpus that could be paid to or for the benefit of the individual is treated as a resource available to the individual; and,

Treatment Of Irrevocable Trust (Continued)

Payment Cannot Be Made Under Terms of Trust

- Payments from income or from the corpus that are made but not to or for the benefit of the individual are treated as a transfer of assets for less than fair market value. The 60 month look back period for transfer of assets applies.

When all or portion of the corpus or income on the corpus of a trust cannot be paid to the individual, treat all or any such portion or income as a transfer of assets under OBRA-93 transfer policy. In treating these portions as a transfer of assets, the date of the transfer is considered to be:

- The date the trust was established; or,
- If later, the date on which payment to the individual was foreclosed.

In determining for transfer of assets purposes the value of the portion of the trust which cannot be paid to the individual, do not subtract from the value of the trust any payments made, for whatever purposes, after the date the trust was established or, if later, the date payment to the individual was foreclosed. If the trustee or the grantor adds funds to that portion of the trust after these dates, the addition of those funds is considered to be a new transfer of assets, effective on the date the funds are added to that portion of the trust.

Thus, in treating portions of a trust which cannot be paid to an individual, the value of the transferred amount is no less than its value on the date the trust is established or payment is foreclosed. When additional funds are added to this portion of the trust, those funds are treated as a new transfer of assets for less than fair market value.

As indicated, when that portion of a trust which cannot be paid to an individual is treated as a transfer of assets for less than fair market value, the look-back period is 60 months.

304.01.02D PAYMENTS MADE FROM REVOCABLE OR IRREVOCABLE TRUSTS

Payments are considered to be made to the individual when any amount from the trust, including an amount from the corpus or income produced by the corpus, is paid directly to the individual or to someone acting on his/her behalf, e.g., a guardian or legal representative. Payments made for the benefit of the individual are payments of any sort, including an amount from the corpus or income produced by the corpus, paid to another person or entity such that the individual derives some benefit from the payment.

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

Note: A payment to or for the benefit of the individual is counted under this provision only if such a payment is ordinarily counted as income under the SSI program. For example, payments made on behalf of an individual for medical care are not counted in determining income eligibility under the SSI program. Thus, such payments are not counted as income under the trust provision.

Circumstances Under Which Payments Can/Cannot Be Made

In determining whether payments can or cannot be made from a trust to or for an individual, take into account any restrictions on payments, such as use restrictions, exculpatory clauses, or limits on trustee discretion that may be included in the trust. For example, if an irrevocable trust provides that the trustee can disburse only $1,000 to or for the individual out of a $20,000 trust, only the $1,000 is treated as a payment that could be made. The remaining $19,000 is treated as an amount which cannot, under any circumstances, be paid to or for the benefit of the individual.

On the other hand, if a trust contains $50,000 that the trustee can pay to the grantor only in the event that the grantor needs, for example, a heart transplant, this full amount is considered as payment that could be made under some circumstances, even though the likelihood of payment is remote. Similarly, if a payment cannot be made until some point in the distant future, it is still payment that can be made under some circumstances.

304.01.02E PLACEMENT OF EXCLUDED ASSETS IN TRUST

Section 1917(e) of the Act provides that, for trust and transfer purposes, assets include both income and resources. Section 1917(e) of the Act further provides that income has the meaning given that term in Section 1612 of the Act and resources has the meaning given that term in Section 1613 of the Act (income and resources as defined in SSI policy). The only exception is that for institutionalized individuals, the home is not an excluded resource.

Thus, transferring an excluded asset (either income or a resource, with the exception of the home of an institutionalized individual) for less than fair market value does not result in a penalty under the transfer provisions because the excluded asset is not an asset for transfer purposes. Similarly, placement of an excluded asset in a trust does not change the excluded nature of that asset; it remains excluded.

The only exception is the home of an institutionalized individual. Because Section 1917(e) of the Act provides that the home is not an excluded resource for institutional individuals, transfer of title to the home of an institutionalized individual in trust (revocable or irrevocable) results in the home becoming a countable resource.

304.01.02F UNDUE HARDSHIP PROVISION

When application of the Trust provisions would work an undue hardship, the provisions will not apply.

Undue hardship exists when:

- Application of the trust provisions would deprive the individual of medical care such that his/her health or his/her life would be endangered.
- Application of the trust provisions would deprive the individual of food, clothing shelter, or other necessities of life causing severe deprivation.
- The applicant or spouse or representative has exhausted all legal action to have the transferred assets that caused the penalty returned.

Undue hardship does not exist when:

- Application of the trust provisions merely causes the individual inconvenience or when such application might restrict his or her lifestyle but would not put him or her at risk of serious deprivation.

Undue Hardship Provision (Continued)

- The resource was transferred to a person (spouse, child, or other person) who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless it is established that the transferred funds cannot be recovered even through exhaustive legal measures.

Each case situation must be reviewed individually to determine if undue hardship exists. Generally, this provision is limited to financially and medically needy individuals with no possible means of accessing funds placed in a trust.

304.01.02G REVIEWING TRUST DOCUMENTS

In reviewing a trust, specialists must:

- Obtain copies of trust documents, including amendments and the required number of accountings;
- Make the following determinations:
  - Type of Trust, i.e., OBRA-93 Trust, Medicaid Qualifying Trust, or Standard Trust;
  - Whether the trust is revocable or irrevocable; and
  - Income released from the trust.
- Follow applicable policy and procedural requirements for clearing the trust and treatment of income.

300.01 EXCEPTIONS TO TREATMENT OF TRUSTS

The rules concerning treatment of trusts do not apply to any of the following types of trusts, i.e., the trusts discussed below are treated differently in determining eligibility for Medicaid. Funds entering and leaving these trusts are generally treated according to SSI rules or more liberal rules under Section 1902(r) (2) of the Act, as appropriate.

As noted in each exception below, one common feature of all of these excepted trusts is a requirement that the trust provide that, upon the death of the individual, any funds remaining in the trust go to the Division of Medicaid, up to the amount paid in Medicaid benefits on the individual's behalf.

300.01.01 SPECIAL NEEDS TRUSTS

A trust containing the assets of an individual under age 65 who is disabled (as defined by the SSI program) and which is established **for the sole benefit of** the individual by a parent, grandparent, legal guardian of the individual, or a court is often referred to as a Special Needs Trust. In addition to the assets of the individual, the trust may also contain the assets of individuals other than the disabled individual.

To qualify for an exception to the rules governing trusts in this section, the Special Needs Trust must contain a provision stating that, upon the death of the individual, the State receives all amounts remaining in the trust, up to an amount equal to the total amount of medical assistance paid on behalf of the individual.

When a Special Needs Trust is established for a disabled individual under age 65, the exception for the trust discussed above continues even after the individual becomes age 65. However, such a trust cannot be added to or otherwise augmented after the individual reaches age 65. Any such addition or augmentation after age 65 involves assets that were not the assets of an individual under 65 and therefore, those assets are not subject to the exemption discussed in this section.

To qualify for this exception to the rules governing trusts, the trust must be established for a disabled individual, as defined under the SSI Program. When the individual in question is receiving either Title II or SSI benefits as a disabled individual, accept the disability determination made for those programs. If the individual is not receiving those benefits, make a determination concerning the individual's disability.

SPECIAL NEEDS TRUSTS (Continued)

Establishment of a trust as described above does not constitute a transfer of assets for less than fair market value if the transfer is made into a trust established solely for the benefit of a disabled individual under age 65. However, if the trust is not solely for the benefit of the disabled person or if the disabled person is over age 65 transfer penalties may apply.

300.01.02 POOLED TRUSTS

A pooled trust is a trust containing the assets of a disabled individual as defined by the SSI Program in Section 1614(a)(3) of the Act, that meets the following conditions:

- The trust is established and managed by a non-profit association;
- A separate account is maintained for each beneficiary of the trust but for purposes of investment and management of funds the trust pools the funds in these accounts;
- Accounts in the trust are established solely for the benefit of disabled individuals by the individual, by the parent, grandparent, legal guardian of the individual, or by a court; and,
- To the extent that any amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the Division of Medicaid the amount remaining in the account up to the amount equal to the total amount of medical assistance paid on behalf of the beneficiary. To meet this requirement, the trust must include a provision specifically providing for such payment.

To qualify as an excepted trust, the trust account must be established for a disabled individual, as defined in Section 1614(a)(3) of the Act. When the individual in question is receiving either Title II or SSI benefits as a disabled individual, accept the disability determination made for those programs. If the individual is not receiving those benefits, make a determination concerning the individual's disability.

300.01.03 INCOME TRUSTS

This type of trust established for the benefit of the individual is limited to institutionalized clients, not those in a hospital setting. A recipient participating in the Home and Community Based Waiver program (HCBS) may also utilize an Income Trust for eligibility purposes. An Income Trust document is required. The Income Trust must meet the following requirements:

- The trust is composed only of the pension(s), Social Security, and other income of the individual, including accumulated interest in the trust; and,
- Upon the death of the individual, the Division of Medicaid receives all amounts remaining in the trust, up to an amount equal to the total medical assistance paid on behalf of the individual. To qualify for this exception, the trust must include a provision to this effect.

Income Included in an Income Trust

To qualify for this exception, the Income Trust must be composed only of income to the individual, from whatever source. The trust may contain accumulated income, i.e., income that has not been paid out of the trust. However, no resources, as defined by SSI, may be used to establish or augment the trust. Inclusion of resources voids this exception.

Income Not Included in an Income Trust

An individual's total income must go into the Income Trust each month. The only exception is for the types of VA payments that are not considered income, i.e., VA Reduced Pension benefits, VA Aid & Attendance payments and VA Pension payments attributed to Unreimbursed Medical Expenses.

Funding the Income Trust Account

All of a nursing home recipient's income, less deductions authorized by Medicaid, will be paid to the nursing home. In most cases no funds will be retained in the Income Trust account.

The recipient's cost of care, referred to as Medicaid Income, will be determined by the total gross income and the daily rate that Medicaid pays the nursing facility where the recipient resides. However, if the rate for the facility is less than the recipient's income, the recipient's excess income will fund an income trust account.

Funding the Income Trust Account (Continued)

Example: The recipient's countable income is $3,800 per month. The Medicaid daily rate for the facility where the recipient resides is $3,500 per month. The excess income of $300 per month must fund an Income Trust account. This example applies if income for only one month exceeds the Medicaid daily rate or if the income for all the months exceeds the Medicaid daily rate.

However, when the rate for the facility is more than the recipient's countable income, all of the recipient's income is payable to the facility and the Income Trust account will not be funded.

Example: The recipient's countable income is $2,500 per month. The Medicaid daily rate for the facility where the recipient resides is $4,500 per month. The recipient will pay the facility $2,500, and the Income Trust account will not be needed. However, a trust document is still required.

Home and Community Based Waiver (HCBS)

For individuals in the Home and Community Based Waiver (HCBS), the difference between an individual's total income and an amount that is $1 less than the current institutional income limit should fund the Income Trust account. The only allowable expenses from the amount funding the trust are actual expenses associated with the establishing the trust, which is limited to $500 or actual cost if less than $500. Bank charges associated with maintain trust accounts are limited to $10 per month.

Other Income Trust Issues

- Trusts that are not properly funded into an Income Trust account do not meet the criteria for a trust exception.

- When an Income Trust is no longer needed due to the client's death, ineligibility or some other change, the Division of Medicaid receives all amounts remaining in the trust account, up to an amount equal to the total medical assistance paid on behalf of the individual. To qualify for this exception, the trust must include a provision to this effect.

- The Income Trust agreement which is located immediately following this section can be copied for execution by the recipient and trustee. The only changes to this legally binding document that the Division of Medicaid will accept will be to add language regarding a successor trustee or co-trustee. Changes must be approved by the Legal Bureau prior to execution.

LONG-TERM CARE INCOME TRUST

THE _____ INCOME TRUST

WHEREAS, _____, hereinafter referred to as the Settlor, now has a monthly income that exceeds the current Medicaid income limits, and;

WHEREAS, the total monthly income received by Settlor is not sufficient to pay for expenses associated with long-term care services and related services, and;

WHEREAS, Settlor's other assets have been exhausted by Settlor's long-term care expenses, and;

WHEREAS, the principal purpose of this Trust is to receive all income payments due Settlor in excess of the Settlor's cost of care, including Social Security benefits, retirement benefits, interest, dividends, or other income. The Settlor's cost of care will be determined by the daily rate that Medicaid pays the nursing facility in which the Settlor resides. If the rate for the facility is less than the Settlor's income, the excess income will be used to fund the income trust. If the rate for the facility is more than the Settlor's income, the Settlor's total income, less authorized deductions, will be paid to the nursing facility. Any income in excess of the Settlor's cost of care will be retained as part of the Trust.

WITNESSETH:

This _____Income Trust Agreement is entered into between

_____, "Settlor", and _____, "Trustee", who agree as follows:

(A) The Trustee shall place all income in excess of the Settlor's cost of care into the Trust, and the Trustee shall hold such income under the following terms and conditions:

(1) Trustee shall retain the income in excess of the Settler's cost of care in the Income Trust Account.

(2) At the time of each review of the Settlor's Medicaid eligibility (at least annually) while this trust is in existence, if the Settlor's income exceeds the cost of care, the Division of Medicaid will notify the Trustee of the amount that should be accumulated in the trust. The Trustee will then be requested to make payment of this amount to the Division of Medicaid up to the total amount expended by the Division of Medicaid on behalf of the Settlor that has not previously been repaid to Medicaid. Failure to make the requested payments may result in the loss of Medicaid eligibility for the Settlor.

(3) This trust will terminate upon the death of the Settlor; when the Settlor's Medicaid eligibility is terminated; when the Settlor's income no longer exceeds the current Medicaid income limits; or when the trust is otherwise terminated. At that time, any income amounts accumulated in the trust shall be paid over to the Division of Medicaid, State of Mississippi, up to the total amount expended by the Division of Medicaid on behalf of the Settlor that has not previously been repaid to Medicaid.

(B) When requested, the Trustee shall furnish to the Division of Medicaid, State of Mississippi, an annual accounting to show all receipts and disbursements of the trust during the prior calendar year.

(C) The Trustee shall maintain the trust funds on deposit in a federally insured banking institution.

(D) No Trustee shall receive a Trustee's fee for services rendered to the trust, however, reasonable bank charges will be allowed.

(E) The Trustee shall give written notice to the Division of Medicaid, State of Mississippi when the Settlor dies or when the trust is otherwise terminated.

(F) The provisions of this Trust shall be interpreted under the laws of the State of Mississippi.

The effective date of this trust shall be _____.

IN WITNESS WHEREOF, this _____ Income Trust Agreement

has been executed on this the _____ day of _____, 20___.

_____
Trustee

_____
Settlor

STATE OF _____

COUNTY OF _____

Personally appeared before me, the undersigned authority in and for said county and state, on the _____ day of _____, 20___, within my jurisdiction, the within named _____, who acknowledged that (he) (she) executed the above and foregoing instrument.

_____
(NOTARY PUBLIC)

MY COMMISSION EXPIRES:

STATE OF _____

COUNTY OF _____

Personally appeared before me, the undersigned authority in and for said county and state, on the _____day of _____, 20___, within my jurisdiction, the within named _____, who acknowledged that (he) (she) (they) executed the above and foregoing instrument.

_____
(NOTARY PUBLIC)

MY COMMISSION EXPIRES:

TRUSTEE INFORMATION:

NAME: _____ SSN: _____

TELEPHONE NUMBER: _____

ADDRESS: _____

_____

RELATIONSHIP TO SETTLOR: _____

(Rev 6/08)

INCOME TRUST HELP SHEET

Section 1917 (d) of the Social Security Act (42 U.S.C. §1396 p (d) (4)) defines certain provisions that qualify as an exception for the purpose of an individual qualifying for Medicaid benefits. One such exception is an "Income Trust". This type of trust, established for the benefit of an individual in a nursing facility, must meet the following requirements.

1. The purpose of the trust is to allow an individual with excess income who has exhausted all available resources to become eligible for Medicaid. The trust may be used only for income belonging to the individual. No resources (assets) may be used to establish or augment the trust. Inclusion of resources voids the trust exception.

2. Funds subject to the trust are all income due the individual from all sources such as Social Security, pension benefits, interest and any and all other types/sources of income.

3. Income Trusts, once accepted by Medicaid, cannot be modified without Medicaid's approval. Trusts must specify that the trust will terminate at the individual's death, when Medicaid eligibility is terminated, when the trust is no longer necessary or in the event the trust is otherwise terminated. Trusts may need to be terminated prior to an individual's death due to changes in the client's income or changes in Medicaid policy regarding how certain income must be counted or in the event the individual is discharged from the nursing facility.

4. If the income of the Settlor is less than Settlor's cost of care at the nursing facility, all income of the Settlor, less authorized deductions, must be paid directly to the nursing facility. In that case no funds will be retained in the Trust. If the income of the Settlor exceeds the cost of care at the nursing facility, the Trust must retain the income in excess of the cost of care.

5. At the dissolution or termination of the trust, the death of the Settlor, loss of the Settlor's Medicaid eligibility or in the event that the Settlor's income no longer exceeds the current Medicaid income limits, the trust agreement must provide that all amounts remaining in the trust up to an amount equal to the total medical assistance paid by Medicaid on behalf of the individual that has not previously been repaid will be paid to the Division of Medicaid.

6. In addition the trust agreement must provide that at the time of each review of the Settlor's Medicaid eligibility (at least annually) while this trust is in existence, when notified by Medicaid, the Trustee must pay to the Division of Medicaid the amount that should be accumulated in the trust up to the amount expended by the Division of Medicaid on behalf of the Settlor that has not previously been repaid. Failure to make the requested payments may result in the loss of Medicaid eligibility for the Settlor.
7. The trust agreement must provide for an accounting to be sent to the Division of Medicaid when requested to show all receipts and disbursements of the trust during the prior calendar year when requested by Medicaid.

8. No fees are allowed to be paid to the Trustee for their service. In the event funds are retained in the trust, administrative fees are limited to $10 per month and are intended to cover any bank charges required to maintain the trust account.

9. Any disbursements not approved by Medicaid or provided for by the trust agreement will result in a loss of the trust exemption.

10. The trust instrument must specify an effective date. Unless the applicant is requesting retroactive eligibility of up to 90 days (which will require that the applicant have the funds necessary to fund the trust for that period) the effective date will be the date of execution. If a retroactive date is being sought the effective date will be determined through consultation with the Medicaid Regional Office. In that case the Regional Office should be consulted to determine the effective date prior to execution of the agreement.

11. Medicaid requires that the trust document be filed in the records of the Chancery Clerk.

An Income Trust is a very simple trust that accomplishes the specific goal of receiving income and disbursing it for the sole purpose of allowing an individual in a nursing facility with income in excess of Medicaid income limits to qualify for Medicaid. It is not intended to be a complex fiduciary trust. For more information, attorneys drafting an Income Trust may contact the Division of Medicaid's Legal Unit at (601) 359-6050.

HOME AND COMMUNITY BASED SERVICES WAIVER (HCBS)
INCOME TRUST

THE _____ INCOME TRUST

WHEREAS, _____, hereinafter referred to as the Settlor, now has a monthly income that exceeds the current Medicaid income limits, and;

WHEREAS, Settlor's other assets have been exhausted by the expenses of the Settlor's care, and;

WHEREAS, the principal purpose of this Trust is to receive all income payments due Settlor, including Social Security benefits, retirement benefits, interest, dividends, or other income, and to allow the Trustee to expend for the benefit of the Settlor each month an amount equal to no more than $1.00 less than the then current Medicaid limit, with any excess income to be retained as a part of the Trust.

WITNESSETH:

This _____Income Trust Agreement is entered into between _____, "Settlor", and _____, "Trustee", who agree as follows:

(A) The Trustee shall place all income due the Settlor into the Trust, and the Trustee shall hold such income under the following terms and conditions:

(1) Trustee shall distribute to the Settlor, or for Settlor's benefit, any amounts allowed by the Division of Medicaid, but the total amount

distributed each month shall not exceed an amount equal to $1.00 less than the then current Medicaid income limit.

(2) At the time of each review of the Settlor's Medicaid eligibility (at least annually) while this trust is in existence, the Division of Medicaid will notify the Trustee of the amount that should be accumulated in the trust. The Trustee will then be requested to make payment of this amount to the Division of Medicaid up to the total amount expended by the Division of Medicaid on behalf of the Settlor that has not previously been repaid to Medicaid. Failure to make the requested payments may result in the loss of Medicaid eligibility for the Settlor.

(3) This trust will terminate upon the death of the Settlor; when the Settlor's Medicaid eligibility is terminated; when the Settlor's income no longer exceeds the current Medicaid income limits; or when the trust is otherwise terminated. At that time, any income amounts accumulated but undistributed shall be paid over to the Division of Medicaid, State of Mississippi, up to the total amount expended by the Division of Medicaid on behalf of the Settlor that has not previously been repaid to Medicaid.

(B) When requested, the Trustee shall furnish to the Division of Medicaid, State of Mississippi, an annual accounting to show all receipts and disbursements of the trust during the prior calendar year.

(C) The Trustee shall maintain the trust funds on deposit in a federally insured banking institution.

(E) No Trustee shall receive a Trustee's fee for services rendered to the trust, however, reasonable bank charges will be allowed.

(F) The Trustee shall give written notice to the Division of Medicaid, State of Mississippi when the Settlor dies or when the trust is otherwise terminated.

(F) The provisions of this Trust shall be interpreted under the laws of the State of Mississippi.

The effective date of this trust shall be _____.

IN WITNESS WHEREOF, this _____ Income Trust Agreement has been executed on this the _____ day of _____, 20___.

_____
Trustee

_____
Settlor

STATE OF _____

COUNTY OF _____

Personally appeared before me, the undersigned authority in and for said county and state, on the _____ day of _____, 20___, within my jurisdiction, the within named _____, who acknowledged that (he) (she) executed the above and foregoing instrument.

_____
(NOTARY PUBLIC)

MY COMMISSION EXPIRES:

STATE OF _____

COUNTY OF _____

Personally appeared before me, the undersigned authority in and for said county and state, on the _____day of _____, 20___, within my jurisdiction, the within named _____, who acknowledged that (he) (she) (they) executed the above and foregoing instrument.

_____
(NOTARY PUBLIC)

MY COMMISSION EXPIRES:
TRUSTEE INFORMATION:

NAME: _____ SSN: _____

TELEPHONE NUMBER: _____

ADDRESS: _____

_____

RELATIONSHIP TO SETTLOR: _____

INCOME TRUST HELP SHEET

Section 1917 (d) of the Social Security Act (42 U.S.C. §1396 p (d) (4)) defines certain provisions that qualify as an exception for the purpose of an individual qualifying for Medicaid benefits. One such exception is an "Income Trust". This type of trust, established for the benefit of an individual participating in a Home and Community Based Services (HCBS) waiver, must meet the following requirements.

1. The purpose of the trust is to allow an individual with excess income who has exhausted all available resources to become eligible for Medicaid. The trust must be composed only of income belonging to the individual. No resources may be used to establish or augment the trust. Inclusion of resources voids the trust exception.

2. The trust must be composed only of income due the individual from all sources such as Social Security, pension benefits, interest and any and all other types/sources of income. The individual's right to receive income should not be transferred to the trust; instead, the individual must first receive the income and then place it into the Income Trust.

3. Income Trusts, once qualified, cannot be modified without the approval of the Division of Medicaid. Trusts must specify that the trust will terminate at the individual's death, when Medicaid eligibility is terminated, when the trust is no longer necessary or in the event the trust is otherwise terminated. Trusts may need to be terminated prior to an individual's death due to changes in the client's income or changes in Medicaid policy regarding how certain income must be counted or in the event the individual is discharged from the nursing facility.

4. The Trust must distribute to the Settlor, or for his/her benefit, an amount equal to not more than $1 less than the then current Medicaid income limit as approved by Medicaid. The trust should not specify the amount of the individual's income as this amount may change each year and the amount to be released from the trust will change to an amount equal to $1 less than the current Medicaid income limit.

5. At the dissolution or termination of the trust, the death of the Settlor, loss of the Settlor's Medicaid eligibility or in the event that the Settlor's income no longer exceeds the current Medicaid income limits, the trust agreement must provide that all amounts remaining in the trust up to an amount equal to the total medical assistance paid by Medicaid on behalf of the individual that has not previously been repaid will be paid to the Division of Medicaid.

6. In addition the trust agreement must provide that at the time of each review of the Settlor's Medicaid eligibility (at least annually) while this trust is in existence, when notified by Medicaid, the Trustee must pay to the Division of Medicaid the amount that should be accumulated in the trust up to the amount expended by the Division of Medicaid on behalf of the Settlor that has not previously been repaid. Failure to make the requested payments may result in the loss of Medicaid eligibility for the Settlor.

7. The trust agreement must provide for an accounting to be sent to the Division of Medicaid when requested to show all receipts and disbursements of the trust during the prior calendar year when requested by Medicaid.

8. No fees are allowed to be paid to the Trustee for their service. Administrative fees are limited to $10 per month intended to cover any bank charges required to maintain the trust account.

9. Any disbursements not approved by Medicaid or provided for by the trust agreement will result in a loss of the trust exemption.

10. The trust instrument must specify an effective date. Unless the applicant is requesting retroactive eligibility of up to 90 days (which will require that the applicant have the funds necessary to fund the trust for that period) the effective date will be the date of execution. If a retroactive date is being sought the effective date will be determined through consultation with the Medicaid Regional Office. In that case the Regional Office should be consulted to determine the effective date prior to execution of the agreement.

11. Medicaid requires that the trust document be filed in the records of the Chancery Clerk.

An Income Trust is a very simple trust that accomplishes the specific goal of receiving income and disbursing it for the sole purpose of allowing an individual participating in a Home and Community Based Services (HCBS) waiver with income in excess of Medicaid income limits to qualify for Medicaid. It is not intended to be a complex fiduciary trust. For more information, attorneys drafting an Income Trust may contact the Division of Medicaid's Legal Unit at (601) 359-6050.

304.01.04 ANNUITIES

Section 1917(d)(6) of the Social Security Act provides that the term "trust" includes an annuity to the extent and in such manner as prescribed by the Secretary. This section describes how annuities are treated under the OBRA-93 trust/transfer provisions, as amended by the DRA.

An annuity is defined as a contract or agreement by which one receives fixed, non-variable payments on an investment for a lifetime or a specified number of years. When an individual purchases an annuity, he generally pays a lump sum to a bank or insurance company and in return he is promised regular payments of income in certain amounts. These payments may continue for a fixed period of time (for example, ten years) or for as long as the individual or another designated beneficiary lives, thus creating an ongoing income stream. The annuity may or may not include a remainder clause under which, if the annuitant dies, the contracting entity converts whatever is remaining in the annuity into a lump sum and pays it to a designated beneficiary.

Annuities, although usually purchased in order to provide a source of income for retirement, are occasionally used to shelter assets so that individuals purchasing them can be eligible for Medicaid. In order to avoid penalizing annuities validly purchased as part of a retirement plan but to capture those intended to shelter assets, a determination must be made with regard to the ultimate purpose of the annuity, i.e., whether or not it is part of a bona fide retirement plan.

The purchase of an annuity by or for an individual using that individual's assets will not be considered under transfer of assets policy. The entire value of the annuity will be considered an available resource unless the criteria in Sections 301.01.04A and B are met. This policy applies to annuities purchased with the applicant's own funds by the applicant/recipient, spouse, guardian or legal representative and which name the applicant/recipient or spouse as the annuitant.

NOTE: Transfer of assets policy will be considered when an applicant or recipient's own funds are used to purchase an annuity for someone other than the applicant/recipient or their spouse

Refer to Sections 301.01.04A and B below to determine availability of an annuity as a resource.

304.01.04A TREATMENT OF ANNUITIES PURCHASED PRIOR TO 2/8/2006

An annuity purchased before February 8, 2006, by or for an individual using that individual's assets will be considered an available resource unless both of the following are met: (1) the annuity produces a net annual return of at least 6% of its equity value and (2) pays out principal and interest in equal monthly installments (no balloon payments) to the individual in sufficient amounts that the principal is paid out within the actuarial life expectancy of the institutionalized individual.

An annuity which does not meet the 6% rule, contains a balloon payment or is otherwise not actuarially sound will be considered an available resource. An annuity that is subsequently assessed under resources rules and determined to be inaccessible will be treated as a transfer of assets for less than fair market value.

304.01.04B TREATMENT OF ANNUITIES PURCHASED ON OR AFTER 2/8/2006

Disclosure Requirement

Effective 2/8/2006, at each application and review for Medicaid, all long term care applicants, are required to disclose any interest the applicant or community spouse may have in an annuity or similar financial instrument. This disclosure is a condition for Medicaid eligibility for long-term care services, including nursing facility services and Home and Community Based Waiver Services (HCBS) and applies regardless of whether or not an annuity is irrevocable or is treated as a resource.

Refusal to disclose sufficient information related to any annuity will result in denial or termination of Medicaid entirely, based on the applicant's failure to cooperate in accordance with existing Medicaid policies.

When an unreported annuity is discovered after eligibility has been established and after payment for long-term care services has been made, appropriate steps to terminate payment for long-term care services will be taken, including allowing for rebuttal and advance notice. In addition, an Improper Payment Report may be required to initiate recovery of incorrectly paid benefits.

Requirement to Name the State as Remainder Beneficiary on Annuities

The purchase of an annuity may be treated as a disposal of an asset for less than fair market value unless the Mississippi Division of Medicaid is named as a remainder beneficiary. This requirement applies to annuities purchased by the institutional applicant or Community Spouse and to certain annuity-related transactions other than purchases (discussed below) made by the applicant or spouse.

An annuity must name DOM as the remainder beneficiary in the first position for the total amount of Medicaid assistance paid on behalf of the institutionalized individual unless there is a Community Spouse and/or a minor or disabled child. If there is a Community Spouse and/or minor or disabled child, DOM may be named in the next position after those individuals. If DOM is named beneficiary after a Community Spouse and/or minor or disabled child, and any of those individuals or their representatives dispose of any of the remainder of the annuity for less than fair market value, DOM may then be named in the first position.

If verification is not provided which reflects DOM as remainder beneficiary in the correct position on annuities purchased by the Institutionalized Spouse or Community Spouse, the purchase of the annuity will be considered a transfer for less than fair market value. The full purchase value of the annuity will be considered the amount transferred.

Information Provided by Agency to Issuer

For any annuity disclosed for the applicant or Community Spouse, DOM must inform the issuer of the annuity of the agency's right to be named as a preferred remainder beneficiary and may require the issuer to notify the agency regarding any changes in amount of income or principal being withdrawn from the annuity. The issuer of the annuity may disclose information about DOM's position as remainder beneficiary to others who have a remainder interest in the annuity.

Annuity-Related Transactions Other than Purchases Made on or after 2/8/2006

In addition to purchases of annuities, certain related transactions which occur to annuities on or after February 8, 2006, make an annuity, including one purchased before that date, subject to all provisions of the DRA that went into effect on 2/8/2006.

Annuity-Related Transactions Other Than Purchases Made on or after 2/8/2006 (Continued)

Any action taken on or after February 8, 2006, by the individual that changes the course of payment to be made by the annuity or the treatment of the income or principal of the annuity, including:

- Additions of principal,
- Elective withdrawals,
- Requests to change the distribution of the annuity,
- Elections to annualize the contract and similar actions..

For annuities purchased prior to February 8, 2006, routine changes and automatic events that do not require any action or decision after the effective date are not considered transactions that would subject the annuity to treatment under the DRA provisions. Routine changes could be notification of an address change, or death or divorce of a remainder beneficiary and other similar circumstances. Changes which occur based on the terms of the annuity which existed prior to February 8, 2006, and which do not require a decision, election or action to take effect are also not subject to the DRA.

Treatment of Annuities in Determining Eligibility

An annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility or other long-term care services will not be treated as a transfer of assets for less than fair market value if the annuity meets the following conditions:

(1) The annuity is considered either:

- An individual retirement annuity (according to Section 408(b) of the Internal Revenue Code of 1986 (IRC); **or**
- A deemed Individual Retirement Account (IRA) under a qualified employer plan (according to Section 408(q) of the IRC);

(2) The annuity is purchased with proceeds from one of the following:

a. A traditional IRA (IRC Sec. 408a); **or**

b. Certain accounts or trusts which are treated as traditional IRAs (IRC Sec. 408 § (c)); **or**

c. A simplified retirement account (IRC Sec. 408 § (p)); **or**

Treatment of Annuities In Determining Eligibility (Continued)

- A simplified employee pension (IRC Sec. 408 § (k)); or
- A Roth IRA (IRC Sec. 408A).

OR

(3) The annuity meets **all** of the following requirements for every month eligibility is being considered :

a. The annuity is irrevocable and non-assignable; **and**

b. The annuity is actuarially sound; **and**

c. The annuity provides payments in approximately equal amounts with no deferred or balloon payments **and**

d. The annuity produces a net annual return of at least 6% of its equity value.

NOTE: Even if an annuity is determined to meet the requirements above and the *purchase* is not treated as a transfer, if the annuity or income stream from the annuity is transferred, that transfer may be subject to a penalty with the exception of transfers to a spouse or to another individual for the sole benefit of the spouse, to a minor or disabled child or to a Special Needs Trust.

Documentation of Qualifying IRS Annuities

To determine that an annuity is established under any of the various provisions of the internal Revenue Code that are referenced in items (1) and (2) above, rely on verification from the financial institution, employer or employer association that issued the annuity.

The burden of proof is on the institutionalized individual or his representative to produce documentation. If documentation is not provided, the purchase of the annuity will be considered a transfer for less than fair market value which is subject to a penalty. The full purchase value of the annuity will be considered the amount transferred.

Consideration of Income and Resources from an Annuity

Even though an annuity is not penalized as a transfer for less than fair market value, it must still be considered in determining eligibility, including spousal income and resources and in the post eligibility calculation, as appropriate. In other words, even if an annuity is not subject to penalty under the provision of the DRA, this does not mean that it is excluded as income or resource.

Requirements for the Community Spouse

Annuities purchased by the Community Spouse on or after February 8, 2006, must name DOM as first beneficiary. The Institutionalized Spouse may not be named as a beneficiary ahead of DOM. However, if there is a minor or disabled child, the child may be named as primary and DOM as secondary.

It does not matter if the Community Spouse's annuity is actuarially sound or provides payments in approximately equal amounts with no deferred or balloon payments. These provisions apply only to annuities purchased by or on behalf of the individual who has applied for medical assistance.

Estate Recovery

Annuities purchased on or after February 8, 2006, will be subject to Estate Recovery. The rules for the Institutional Spouse and the Community Spouse are the same for annuities purchased prior to this date.

NOTE: If an annuity does not meet the DRA requirements set out above or is not changed to meet them, the purchase of the annuity will be considered a transfer for less than fair market value and subject to a penalty. The full purchase value of the annuity will be considered the amount transferred.

304.01.04C DETERMINING WHETHER AN ANNUITY IS ACTUARIALLY SOUND

A determination must be made on whether the purchase of annuities, other than qualifying IRS annuities, is treated as a transfer of assets for less than fair market value. If the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary, the annuity can be deemed actuarially sound.

To make the determination regarding whether the annuity is actuarially sound, use the life expectancy tables located later in this section, compiled from information published by the Office of the Actuary of the Social Security Administration. The average number of years of expected life remaining for the individual must coincide with the life of the annuity.

If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive fair market value of the annuity based on the projected return. In this case, the annuity is not actuarially sound and a transfer of assets for less than fair market value has taken place, subjecting the individual to a penalty.

The penalty is assessed based on a transfer of assets for less than fair market value that is considered to have occurred at the time the annuity was purchased.

Examples

1. A male at age 65 purchases a $10,000.00 annuity to be paid over the course of 10 years. His life expectancy according to the table is 16.73 years; thus, the annuity is actuarially sound.
2. A male at age 80 purchases a $10,000.00 to be paid over the course of 10 years. His life expectancy is only 7.62 years; thus, the annuity is not actuarially sound.

Calculating the Uncompensated Value (UV) of Annuities (Pre-DRA)

Use the following procedures to calculate the uncompensated value of annuities purchased prior to February 8, 2006:

- Divide the purchase price of the annuity by the number of payout years. This equals the annual rate.
- Using the Life Expectancy Table, determine the number of years the individual is expected to live. Subtract the number of years from the number of payout years.
- Multiply the difference by the annual rate. This is the uncompensated value.
    - Purchase Price divided by Payout years = Annual Rate
    - Payout years minus Life Expectancy = Difference
    - Difference times Annual Rate = Uncompensated Value

Example:

For a man, age 80, who purchases an annuity for $10,000.00 prior to February 8, 2006, to be paid over 10 years, the uncompensated value is calculated as follows:

- The purchase price ($10,000.00) is divided by the number of payout years (10) to get the annual rate of $1,000.00.
- The number of payout years (10) minus the Life expectancy years (7.62) equals 2.38.
- 2.38 X annual rate of $1,000.00 = $2,380.00, the uncompensated value.

NOTE: If the annuity in the above example had been purchased on or after February 8, 2006, the full purchase value of the annuity $10,000.00 would be considered the amount transferred.

LIFE EXPECTANCY TABLES – MALES

Effective Month: April 2012

AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY
0	75.38	41	36.93	82	6.94
1	74.94	42	36.02	83	6.49
2	73.98	43	35.12	84	6.06
3	73.00	44	34.22	85	5.65
4	72.02	45	33.33	86	5.26
5	71.03	46	32.45	87	4.89
6	70.04	47	31.57	88	4.55
7	69.05	48	30.71	89	4.22
8	68.06	49	29.84	90	3.92
9	67.07	50	28.99	91	3.64
10	66.08	51	28.15	92	3.38
11	65.09	52	27.32	93	3.15
12	64.09	53	26.49	94	2.93
13	63.10	54	25.68	95	2.75
14	62.12	55	24.87	96	2.58
15	61.14	56	24.06	97	2.44
16	60.18	57	23.26	98	2.30
17	59.22	58	22.48	99	2.19
18	58.27	59	21.69	100	2.07
19	57.33	60	20.92	101	1.96
20	56.40	61	20.16	102	1.85
21	55.47	62	19.40	103	1.75
22	54.54	63	18.66	104	1.66
23	53.63	64	17.92	105	1.56
24	52.71	65	17.19	106	1.47
25	51.78	66	16.48	107	1.39
26	50.86	67	15.77	108	1.30
27	49.93	68	15.08	109	1.22
28	49.00	69	14.40	110	1.15
29	48.07	70	13.73	111	1.07
30	47.13	71	13.08	112	1.00
31	46.20	72	12.44	113	0.94
32	45.27	73	11.82	114	0.87
33	44.33	74	11.21	115	0.81
34	43.40	75	10.62	116	0.75
35	42.47	76	10.04	117	0.70
36	41.54	77	9.48	118	0.64
37	40.61	78	8.94	119	0.59
38	39.68	79	8.41		
39	38.76	80	7.90		
40	37.84	81	7.41		

LIFE EXPECTANCY TABLES – FEMALES

Effective Month: April 2012

AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY
0	80.43	41	40.97	82	8.31
1	79.92	42	40.03	83	7.77
2	78.95	43	39.10	84	7.26
3	77.97	44	38.17	85	6.77
4	76.99	45	37.24	86	6.31
5	76.00	46	36.32	87	5.87
6	75.01	47	35.41	88	5.45
7	74.02	48	34.50	89	5.06
8	73.03	49	33.59	90	4.69
9	72.04	50	32.69	91	4.36
10	71.04	51	31.80	92	4.04
11	70.05	52	30.91	93	3.76
12	69.06	53	30.02	94	3.50
13	68.07	54	29.14	95	3.26
14	67.08	55	28.27	96	3.05
15	66.09	56	27.40	97	2.87
16	65.11	57	26.53	98	2.70
17	64.13	58	25.67	99	2.54
18	63.15	59	24.82	100	2.39
19	62.18	60	23.97	101	2.25
20	61.20	61	23.14	102	2.11
21	60.23	62	22.31	103	1.98
22	59.26	63	21.49	104	1.86
23	58.29	64	20.69	105	1.74
24	57.32	65	19.89	106	1.62
25	56.35	66	19.10	107	1.52
26	55.38	67	18.32	108	1.41
27	54.40	68	17.55	109	1.31
28	53.44	69	16.79	110	1.22
29	52.47	70	16.05	111	1.13
30	51.50	71	15.32	112	1.05
31	50.53	72	14.61	113	0.97
32	49.56	73	13.91	114	0.89
33	48.60	74	13.22	115	0.82
34	47.64	75	12.55	116	0.75
35	46.68	76	11.90	117	0.70
36	45.72	77	11.26	118	0.64
37	44.76	78	10.63	119	0.59
38	43.81	79	10.03		
39	42.86	80	9.43		
40	41.91	81	8.86		

304.01.05 OBRA-93 AND DRA TRANSFER POLICY

Section 13611 of the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66), herein referred to as OBRA-93, amended Section 1917 (c) (1) of the Social Security Act to revise transfer of assets policy previously described in the Medicare Catastrophic Coverage Act (MCCA) of 1988 (P.L. 100-360).

Assets disposed of on or before the enactment of OBRA-93, which was August 10, 1993, will be evaluated under MCCA policy. Assets disposed of on or after August 11, 1993, will be evaluated under policy mandated by OBRA-93 and revised by the Deficit Reduction Act of 2005, effective February 8, 2006.

304.01.05A DEFINITIONS APPLICABLE TO TRANSFERS AND TRUSTS

OBRA-93 added and amended the following definitions of terms used in conjunction with transfer and trust policy.

Individual—As used in this instruction, the term "individual" includes the individual himself or herself, as well as:

- The individual's spouse, where the spouse is acting in the place or on behalf of the individual;
- A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse, and
- Any person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

Spouses—This is a person who is considered legally married to an individual under the laws of Mississippi.

Assets—For purposes of this section, assets include all income and resources of the individual and of the individual's spouse. This includes income or resources which the individual or the individual's spouse is entitled to but does not receive because of any action by:

- The individual or the individual's spouse;
- A person, including a court or administrative body, with legal authority to act in place or on behalf of the individual or the individual's spouse, or

Definitions Applicable to Transfers and Trusts - Assets(Continued)

- Any person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

For purposes of this section, the term "assets an individual or spouse is entitled to" includes assets to which the individual is entitled or would be entitled if action had not been taken to avoid receiving the assets. The following are examples of actions which would cause income or resources not be received:

- Irrevocably waiving pension income;
- Waiving the right to receive an inheritance;
- Not accepting or accessing injury settlements;
- Tort settlements which are diverted by the defendant into a trust or similar device to be held for the benefit of an individual who is a plaintiff; and
- Refusal to take legal action to obtain a court ordered payment that is not being paid, such as child support or alimony.

The above actions could result in an uncompensated transfer of assets. However, the specific circumstances of each case must be examined in order to determine if a transfer has occurred.

Resources—For purposes of this section, the definition of resources is the same definition used by the Supplemental Security Income (SSI) program, except that the home is not excluded for institutionalized individuals. In determining whether a transfer of assets or a trust involves an SSI-countable resource, use those resource exclusions and disregards used by the SSI program, except for the exclusion of the home for institutionalized individuals. This is discussed in more detail elsewhere in this chapter.

Income—For purposes of this section, the definition of income is the same definition used by the SSI program. In determining whether a transfer of assets involves SSI-countable income, take into account those income exclusions and disregards used by the SSI program. This is discussed in more detail in the chapter on income.

For the Sole Benefit of—A transfer is considered to be for the sole benefit of a spouse, blind or disabled child or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled 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.

Definitions Applicable to Transfers and Trusts (Continued)

For the Sole Benefit Of

Similarly, a trust is considered to be established for the sole benefit of a spouse, blind or disabled child, or disabled individual if the trust benefits no one but that individual, whether at the time the trust is established or any time in the future. However, the trust may provide for reasonable compensation for a trustee or trustees to manage the trust, as well as for reasonable cost associated with investing or otherwise managing the funds or property in the trust.

A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not the spouse, blind or disabled child or disabled individual is not considered to be established for the sole benefit of one of these individuals. In order for a transfer or trust to be considered to be for the sole benefit of one of these individuals, the instrument or document must provide for the spending of the funds involved for the benefit of the individual on a basis that is actuarially sound based on the life expectancy of the individual involved. When the instrument or document does not so provide, any potential exemption from penalty consideration for eligibility purposes is void.

An exception to this requirement exists for trusts discussed in "Exemptions to Treatment of Trusts." Under these exceptions, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the Division of Medicaid, up to the amount of Medicaid benefits paid on the individual's behalf.

When these exceptions require that the trust be for the sole benefit of an individual, the restriction discussed in the previous paragraph does not apply when the trust instrument designates the Division of Medicaid as the recipient of funds from the trust. Also, the trust may provide for disbursal of funds to other beneficiaries, provided the trust does not permit such disbursals until the State's claim is satisfied.

304.01.05B TRANSFER PENALTY DEFINITIONS

Under the transfer of assets provisions in Section 1917(c) of the Act, as amended by OBRA 1993, coverage of certain Medicaid services to otherwise eligible institutionalized individuals who transfer (or whose spouses transfer) assets for less than fair market value must be denied. This same transfer prohibition is applicable to HCBS individuals and their spouses. The following definitions apply to transfers of assets.

Fair Market Value—Fair market value is an estimate of the value of an asset, if sold at the prevailing price at the time it was actually transferred. Value is based on criteria used in appraising the value of assets for the purpose of determining Medicaid eligibility.

NOTE: For an asset to be considered transferred for fair market value or to be considered to be transferred for valuable consideration, the compensation received for the asset must be in a tangible form with intrinsic value.

A transfer for love and consideration, for example, is not considered a transfer for fair market value. Also, while relatives and family members legitimately can be paid for care they provide to the individual under an acceptable personal services contract, Medicaid presumes that services provided for free at the time were intended to be provided without compensation. Refer to the full discussion of personal services contracts later in this chapter at 304.01.05M.

Thus, a transfer to a relative for care provided for free in the past is a transfer of assets for less than fair market value. However, an individual can rebut this presumption with tangible evidence that is acceptable, such as a written repayment schedule agreed to at the time services were provided.

Valuable Consideration—Valuable consideration means that an individual receives in exchange for his or her right or interest in an asset some act, object, service, or other benefit which has a tangible and/or intrinsic value to the individual that is roughly equivalent to or greater than the value of the transferred asset.

Uncompensated Value—The uncompensated value is the difference between the fair market at the time of transfer(less any outstanding loans, mortgages, or other encumbrances on the asset) and the amount received for the asset.

Transfer Penalty Definitions (Continued)

Institutionalized Individual—An institutionalized individual is an individual who is:

- An inpatient in a nursing facility;
- An inpatient in a medical institution for who payment is based on a level of care provided in a nursing facility; or
- An inpatient in an ICF-MR facility

HCBS Individual—A participant in a long-term care alternative program. Although not institutionalized, this individual is considered to be receiving long-term care services. The eligibility criteria for the HCBS individual are the same as those for the institutionalized person, including application of transfer policy. .

Transfer of Asset Rules

Transfer of asset rules apply to the following:

- **Resources**

  Any real or personal property, annuity, liquid resource, or funds owned by the individual and his spouse that is given away, sold for less than fair market value, or used to purchase a promissory note, loan, mortgage, or life estate, waiving the right to receive any potential future resource that the individual might be entitled.

- **Income**

  Any earned or unearned income (including lump sum) of the individual and his or her spouse that is transferred to another individual in the month of receipt, waiving the right to receive any potential future income that the individual might be entitled.

304.01.05C EFFECTIVE DATE OF OBRA-93 TRANSFER POLICY

All transfers made on or after August 11, 1993, are treated under OBRA-93 rules with DRA amendments effective February 8, 2006. Transfers made before August 11, 1993, are treated under policy in effect prior to OBRA-93.

While this section applies to transfers made on or after August 11, 1993, penalties for transfers for less than fair market value under OBRA-93 cannot be applied to services provided before October 1, 1993. Apply pre-OBRA-1993 rules regarding transfers of assets to transfers made on or after August 11, 1993, and before October 1, 1993.

As indicated above, the effective date of all DRA changes is February 8, 2006. Assets disposed of on or after February 8, 2006, will be evaluated under OBRA-93 and any changes mandated by the DRA. The DRA changes are noted.

Individuals to Whom Transfer of Assets Applies

Apply these provisions when an institutionalized individual, HCBS waiver individual or the individual's spouse disposes of assets for less than fair market value on or after the look-back date explained below. For purposes of this section, assets transferred by a parent, guardian, court or administrative body, or anyone acting in place of or on behalf of or at the request or direction of the individual or spouse are considered to be transferred by the individual or spouse.

Verification and Documentation

In addition to the initial application, look for a transfer of assets at the time of review, when a transfer is reported, or when there is a request for a change to institutional or HCBS coverage. When there has been a transfer of assets during the look-back period, obtain the following documentation:

- A description of the asset transferred (the home, other real property, life estate, cash, lump sum, car, stocks, bank account, certificate of deposit, etc.).
- The name of the person who transferred the asset (client, spouse, legal representative).

Verification and Documentation (Continued)

- The name of the person(s) to whom the asset was transferred.
- The client's relationship to the individual to whom the asset was transferred.
- The countable value of the asset at the time of the transfer and the compensation (money or other benefit) received or expected to be received from the transferred asset.
- The date the asset was transferred.
- Whether the applicant was the sole owner of the asset at the time of the transfer; if not the name of any co-owners.
- If applicable, documentary evidence that the individual intended to dispose of an asset at fair market value or information from knowledgeable sources to support the value (if any) at which the asset was disposed.

304.01.05D LOOK BACK PERIOD

The Deficit Reduction Act of 2005 changed the look back period to 5 years (60 months) effective for institutional applications filed on or after February 8, 2006. The 60-month rule applies to any type of asset transferred including assets placed in a trust.

Transfers that took place during the 5-year look back period, but prior to February 8, 2006, will be evaluated using previous transfer of assets policy and the penalty period is calculated under the rules in effect at the time of the transfer.

Application of the DRA transfer rules is being phased in over the 60 month period starting February 8, 2006. Because the DRA implementation date will not change, the length of the look back period to evaluate transfers under DRA rules will increase each month by one month until it reaches 60 months in February 2011.

Under OBRA-93, the look-back period for transfers other than transfers to a trust is a date that is 36 months from the date the individual both is an institutionalized individual and has applied for Medicaid.

The following example illustrates this:

12/94 – enters nursing facility
02/95 – applies & 36 month look-back begins
11/94 – transfer occurs & penalty begins

The 36 month look-back period described above did not become fully effective until August 11, 1996 and was phased in over a 36 month period beginning August 11, 1993. Therefore, OBRA transfer rules are effective for transfers made on or after August 11, 1993. Any transfers actually made before that date are treated under the rules described in pre-OBRA-93 policy.

304.01.05E APPLYING THE TRANSFER PENALTY

Denial of coverage or services because assets were transferred for less than Fair Market Value is known as a transfer penalty. Under the DRA, transfer penalties are applied differently to institutionalized individuals and those applying for, or receiving, Home and Community Based Services.

The penalty period for an institutionalized applicant begins when the individual is receiving an institutional level of care for which he/she would be eligible if not for imposition of the transfer penalty. If the individual is otherwise eligible for Medicaid, he/she may receive Medicaid for all services except:

- Nursing facility services;
- Nursing facility services provided in an institution that is equivalent to that of nursing facility services;
- Home and Community Based Waiver Services

An application for Home and Community Based Services (HCBS) cannot trigger the start of a transfer penalty period. As indicated, a penalty can only start when an individual is receiving an institutional level of care for which he/she would be eligible if not for imposition of the transfer penalty. The transfer penalty does not allow an individual to enter into an HCBS waiver program; therefore, the start date for the penalty cannot be triggered and the individual remains ineligible as long as the transfer is within the 5-year lookback period.

If an individual or his/her spouse has a penalty as the result of a transfer, use the following guidelines to handle the imposition of the penalty:

- Nursing Home Assistance
    - Vendor payment (room and board) is denied or terminated for the duration of the penalty period;
    - Medicaid is approved for all other services.

Home and Community Based Services

- If Medicaid eligibility is dependent on participating in the waiver, the application is denied or the case is closed until the transfer is outside the 5-year look back period;
- Can be approved in a Medicare Savings Program (QMB, SLMB, QI) if all other criteria are met.

Examples

1. Jill entered a nursing home on January 10, 2008. She applied for nursing home Medicaid on August 12, 2008. During the interview, a $50,000.00 transfer of assets on January 5, 2006 was discovered. This transfer took place within the 5 year look back period; however, it was prior to DRA. The transfer penalty will begin the month of the transfer which January 2006. The penalty period will be determined by dividing $50,000.00 by $3,100.00. The penalty period is 16 months. The penalty expired prior to Jill asking for Medicaid coverage.

   HCBS- Pre-DRA, the same rules for calculating the penalty for nursing homes were used for waivers. So, in this case, waiver eligibility can be considered. If this transfer had occurred after February 8, 2006, Jill would have to wait a full 5 years before waiver eligibility could be considered or the transferred assets could be returned to Jill.

2. Tom transferred his home to his brother in September 2007. The home was valued at $78,200.00. This transfer occurred within the 5 year look back period but after the effective date of DRA. Tom has asked for nursing home Medicaid beginning September 2008.

   The penalty will begin the month that services are requested if eligible on all other criteria. The penalty period will be calculated by dividing $78,200.00 by $4,600.00. The penalty period will be 17 months. Tom can be approved for LTC Medicaid with a stop payment to the nursing home for 17 months.. If the brother returns the home property to Tom, the transfer penalty can be erased.

   HCBS—Since this transfer occurred after DRA, Tom cannot be eligible for waiver services until the transfer is outside the 5 year look-back period, unless the property is returned.

304.01.05F MULTIPLE PERIODS OF INSTITUTIONALIZATION AND MULTIPLE APPLICATIONS

When an individual has multiple periods of institutionalization or has made multiple applications for Medicaid (unless the application was withdrawn), the look-back date is based on a baseline date that is the first date upon which the individual has both applied for Medicaid and is institutionalized. Each individual has only one look-back date, regardless of the number of periods of institutionalization, applications for Medicaid (the exception is a withdrawn application), periods of eligibility or transfers of assets.

304.01.05G EFFECTIVE DATE OF PENALTY

Effective February 8, 2006, the date of the penalty will begin with the later of:

- The first day of a month during which assets have been transferred for less than fair market value; or

- The date on which the individual is eligible for medical assistance based on all factors of eligibility being met and is receiving institutional level of care services (based on an approved application for such services) that, were it not for the imposition of the penalty period would be covered by Medicaid.

  Recipients are prohibited from transferring resources after approval. For transfers discovered after approval, the penalty is imposed beginning with the month of the transfer, allowing for rebuttal and advance notice. An improper payment report will be prepared for any ineligible months before the penalty is imposed. If the penalty period has ended, the improper payment would cover all months of the penalty period.

For applications on or after 2-8-06, handled under DRA rules, the penalty will begin the month that Long Term Care services are requested if the individual is otherwise eligible for Medicaid. If an individual is already eligible for Long Term Care Services and a transfer of assets is discovered, the penalty will begin the month of the transfer.

Under the provisions of OBRA-93, the date of the penalty period is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this policy.

304.01.05H PENALTY PERIOD

The number of months of ineligibility for an institutionalized individual shall be equal to:

- The total, cumulative uncompensated value (UV) of all assets transferred by the individual (or individual's spouse) on or after the look back period

  divided by

- The average monthly cost to a private pay patient for nursing facility services in Mississippi. The average private rates are:

  - Effective 02/08/06 ongoing - $4,600.00
  - From 03/01/03 -- 02/07/06 - $3,100.00
  - From 04/01/99 -- 02/28/03 - $2,600.00
  - From 10/01/93 -- 03/31/99 - $2,000.00

304.01.05I DRA PROVISION - PARTIAL MONTH PENALTY

Under the DRA, when the amount of the transfer is less than the average monthly cost of nursing facility care, a penalty is imposed for less than a full month. This is called a partial month penalty.

Rounding down or otherwise disregarding any fractional part of an ineligibility period when determining the penalty period is not allowed effective 02/08/06. The average daily per diem of $151.00 is used in determining the partial month penalty period.

Example

An individual makes an uncompensated transfer of $30,534.00 in April 2006. He applies for Medicaid coverage for long-term care services in September 2008. The transfer falls within the 5 year look back period.

Therefore, the uncompensated transfer amount of $30,534.00 is divided by the average monthly rate of $4,600.00 and equals 6.64 months. The full 6 month penalty runs from September 1, 2008 (the month eligibility is requested) through February 28, 2009 with a partial month penalty calculated for March 2009. The penalty calculation is as follows:

Step 1: $30,534.00 uncompensated transfer amount divided by $4,600.00 average monthly private pay rate = 6.64 months in the penalty period

DRA Provision - Partial Month Penalty - Example (Continued)

Step 2: $4,600.00 average monthly private pay rate (x) 6 six full months penalty period = $27,600.00 penalty amount for six full months

Step 3: $30,534.00 uncompensated transfer amount (less) $27,600.00 penalty amount for 6 full months = $2,934.00 partial month penalty amount

Step 4: $2,934.00 partial month penalty amount (divided by) $151.00 daily rate (will be used for all transfers effective 2/8/2006) = 19.43 days or 19 days for partial month penalty

The month of March 2009 will have 19 days that a vendor payment will not be made to the nursing facility. Vendor payments will begin on day 20. Thus the total penalty period for the transfer of $30,534.00 will be September 1, 2008 through March 19, 2009.

HCBS and the Partial Month Penalty

If a transfer is discovered in an ongoing waiver case, the penalty period will be calculated the same as nursing home cases with the exception of the partial month. The penalty begins the month the transfer occurred; however, the "partial month' is extended to the end of the month for HCBS cases.

If the penalty period has not expired, the case will be closed and an improper payment report will be completed for the prior ineligible months. If the penalty period has expired, an improper payment will be completed for the transfer penalty period and the case will remain open. The client must be given the opportunity for rebuttal prior to preparing the improper payment report.

304.01.05J DETERMINING THE PENALTY WHEN PENALTY PERIODS OVERLAP

All countable transfers occurring during the look-back period are totaled and the penalty period determined by dividing the total UV by the average private pay rate. The first month of the transfer penalty period is the month in which the first countable transfer occurred.

Transfers that occur after a penalty period is in effect are added in full to the end of the penalty period currently in effect. There is no limit on the number of months a transfer penalty can be imposed. The penalty period is always determined by the total UV calculated during the look back period.

304.01.05K DETERMINING THE PENALTY WHEN PENALTY PERIODS DO NOT OVERLAP

When multiple transfers are made so that the penalty periods for each do not overlap, treat each transfer as a separate event with its own penalty period.

EXCEPTION: Consecutive transfers that occur on a regular basis must be calculated together. For example, an individual gave a relative $5,199.00 in April and $5,199.00 in May the two gifts are added together and divided by the average private pay rate.

NOTE: The penalty period for transfers occurring on or after February 8, 2006, and within the five year look-back period will begin the month that eligibility is requested or the first month eligibility is determined if the individual is not eligible in the month eligibility is requested.

304.01.05L TYPES OF TRANSFER OF ASSETS

The situations listed below are considered transfers of assets and may be subject to a penalty period for institutionalized and Home and Community Based individuals.

Treatment of Income as an Asset

Income, in addition to resources, is considered to be an asset for transfer (and trust) purposes. Thus, when an individual's income is given or assigned in some manner to another person, such a gift or assignment can be considered a transfer of assets for less than fair market value.

In determining whether income has been transferred, do not attempt to ascertain in detail the individual's spending habits during the look back period. Absent some reason to believe otherwise, assume that ordinary household income was legitimately spent on the normal costs of daily living.

However, you should attempt to determine whether the individual has transferred lump sum payments actually received in a month. such payments, while counted as income in the month received for eligibility purposes, are counted as resources in the following month if they were retained. Disposal of such lump sum payments before they can be counted as resources could constitute an uncompensated transfer of assets.

Also attempt to determine whether amounts of regularly scheduled income or lump sum payments, which the individual would otherwise have received, have been transferred. Normally, such a transfer 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 individual.

When a single lump sum is transferred (i.e., a stock dividend check is given to another person in the month in which it is received by the individual), the penalty period is calculated on the basis of the value of the lump sum payment.

When a stream of income, (i.e., income received in a regular basis, such as a pension) or the right to a stream of income is transferred, calculate the penalty period as you would for a lump sum. Using this method, a penalty period is imposed for each income payment.

Treatment of Income As An Asset (Continued)

When the transfer involves a right to income (as opposed to periodic transfer of income the individual owns) make a determination of the total amount of income expected to be transferred during the individual's life, based on an actuarial projection of the individual's life expectancy, and calculate the penalty on the basis of the projected total income.

Conveyance for Less than Fair Market Value

Giving away or conveying an asset for less than fair market value within the look back period for an institutionalized or HCBS individual may be considered a transfer of assets.

Waiving an Inheritance or Other Entitled Benefit

Refusal to accept an inheritance or refusal to take legal action to obtain benefits an individual is entitled to receive may be considered a transfer of assets.

Annuities When Expected Returns Are less than Cost of Annuity

Establishing or purchasing annuities in which anticipated payments based on life expectancy of the individual are less than the cost of the annuity. The policy on annuities is explained in detail on previous pages.

Irrevocable Burial Contracts Under Certain Circumstances

An irrevocable burial contract or similar device established by the funeral home/director is considered a transfer of assets if the cost to the individual or spouse exceeds the value of the merchandise and/or services. The specialist will obtain an itemized statement to assist in determining whether the costs are commensurate with the value of the merchandise and/or services.

Transfers by a Spouse

Transfers made by the Community Spouse (CS) will create a penalty for the Institutionalized Spouse (IS). Transfers by the CS **after** the IS has been determined eligible will also create a penalty for the IS.

Transfers by a Spouse (Continued)

If the CS becomes institutionalized and applies for Medicaid during the penalty period, the penalty must be apportioned between both spouses. However, if the IS has already served the penalty in full, it will not be applied a second time. If one member of the couple should leave the facility or die, the remaining portion of the penalty must be served by the remaining institutionalized spouse.

Transfers of Jointly-Held Assets

In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

Under this provision, merely placing another person's name on an account or asset as a joint owner might not constitute a transfer of assets subject, of course, to the specific circumstances of the situation. In such a situation, the individual may still possess ownership rights to the account or asset and thus have the right to withdraw all of the funds in the account or possess the asset at any time.

Thus, the account or asset is still considered to belong to the individual. However, actual withdrawal of funds from the account or removal of the asset by the other person removes the funds or property from the control of the individual and so constitutes a transfer of assets.

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 assist (e.g., the addition of another person's name requires that the person agree to the sale or disposal of the asset where no such agreement was necessary before), such placement constitutes a transfer of assets.

Use regular Medicaid rules to determine what portion of a jointly held asset is presumed to belong to an applicant or recipient. This portion is subject to a transfer penalty if it is withdrawn by a joint owner.

Personal Service Contracts

A personal service contract should be a written contract between the recipient/applicant and the personal services provider. The contract should be executed prior to the date any payments have been made to the provider. If payments have been made prior to the date of the contract these payments should be considered as transfers.

Once an individual begins receipt of Medicaid Long Term Care (LTC) services, the individual's personal and medical needs are considered to be met by the LTC provider. Payments to other individuals for services received after the individual enters LTC are considered an uncompensated transfer for Medicaid purposes.

The contract should be very specific as to the services to be provided and the payment to be paid for the services. Each service/duty should be listed with the number of hours for each service with the amount charged for each service. If the contract calls for a payment of a specific amount per hour, this amount should be reasonable. For example, nursing charges will not be allowed for non-nurses and CPA charges will not be allowed for persons who are not CPA's. Documentation of the services performed and the number of hours for each service should be submitted. All charges will be evaluated based on usual and customary charges for services in the community.

The contract must not provide for payment of compensation for future services. All payments should be made only as the services are actually rendered. Any payments made for future services should be considered as transfers. Contracts indicating a prior date but no payments have ever been made should be questioned as to why the payments for services were not made when the services were performed. This type of arrangement indicates services were provided for free. Services provided for free are not under obligation to be paid at a future unknown date.

Legal and/or Professional Fees Associated with Qualifying for Medicaid

Retaining an attorney in order to assist a family with the Medicaid application process is anyone's right. There may be instances where a family is in need of legal services to draw up various legal documents that are needed in association with the long term institutionalization of an elderly or disabled individual. However, many times these documents are either non-allowable, of no benefit to the applicant or are not required as part of the Medicaid application.

Legal and/or Professional Fees Associated with Qualifying for Medicaid (Continued)

The Division of Medicaid does not impose a limit on the amount of fees an attorney may charge a family; however, there is a limit on the legal fees associated with preparing documents in the spend-down process of an applicant's resources. The limit can also be applied to non-lawyers, but only those whose business it is to advise the elderly and disabled about Medicaid. If it cannot be determined that the person charging the fee has a business or represents a business that does Medicaid planning, the fee will be considered as a transfer.

The following instructions will address two (2) separate fees or contracts:

- **Professional Fees Associated with Filing a Medicaid Application**

  A capped fee of $2,000.00 is allowed for professional services incurred for assisting in the Medicaid application process. This maximum amount takes into consideration the estimated time of completing a Medicaid application, appearing with the individual for the in-person interview and assisting with the necessary documentation needed to apply. This fee also includes involvement with any appeal process that may be necessary.

  This capped fee is for expenses paid from the applicant's funds and does not attempt to set a maximum fee that can be charged to other family members that do not include the applicant or his/her spouse. When evaluating the spend-down of excess resources for an applicant, only $2,000.00 will be allowed from the applicant's resources. Amounts paid in excess of the capped fee will be treated as a transfer of resources in order to qualify for Medicaid.

- **Legal Fees Associated with Preparing a Trust**

  A copy of any trust agreement must be submitted for review along with the amount charged for preparing the trust. The attorney must explain how the trust benefits the Medicaid applicant or recipient in order for the Division of Medicaid to make a decision on whether the charge is allowable. It is only the legal fee that will be evaluated based on the benefit the trust provides. The terms of the trust itself will be evaluated using Medicaid's trust and transfer policy.

Legal Fees Associated with Preparing a Trust (Continued)

If Medicaid determines that the trust benefits the Medicaid applicant or recipient from a Medicaid perspective, a capped fee of $1,500.00 is allowed for preparing the trust document. Income Trust documents are subject to a lesser cap of $500.00 since the Division of Medicaid provides a model trust agreement for this provision. Fees paid from the applicant's money which are above the capped limit will be treated as a transfer of resources.

304.01.05M EXCEPTIONS TO TRANSFERS

Home Property

The transfer penalty will not apply to the transfer of home property by an institutionalized individual to the following family members of such individual:

- The individual's spouse or child under age 21 or a disabled or blind adult child (Disability must be established and age verified); **or**
- A sibling who is part owner of the home who lived in the home for one (1) year prior to the individual entering a nursing facility; **or**
- A child who lived in the home for two (2) years before the individual entered a nursing facility and provided care to the individual which permitted the individual to remain at home.

  Sufficient documentary information must be provided to make a determination that (1) the child resided in the home for the required length of time. This may include statements from knowledgeable individuals when other verification is not available. (2) Whether the child provided care which enabled the parent to remain at home. If the child was employed outside the home, the arrangements for care while the child was away must be determined.

Non-Home Property

The transfer penalty will not apply to the transfer of any type of non-home asset in the following situations:

- Assets transferred to the individual's spouse or to another for the sole benefit of the individual's spouse;
- Assets transferred from the individual's spouse to another for the sole benefit of the individual's spouse;
- Assets transferred to the individual's child under age 21 or a disabled or blind adult child. If the disabled adult child is not receiving a social security disability payment, a disability determination is required;
- Assets transferred to a Special Needs Trust established solely for the benefit of a disabled applicant less than 65 years of age.

EXCEPTIONS TO TRANSFERS (Continued)

In determining whether an asset was transferred for the sole benefit of a spouse, child, or disabled individual, 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 have been made for the sole benefit of the spouse, child, or disabled individual, since there is no way to establish, without a document, that only the specified individuals will benefit from the transfer. An individual shall not be ineligible for medical assistance if an acceptable rebuttal is submitted and a satisfactory showing is made to the Division of Medicaid that:

- The individual intended to dispose of the assets either at fair market value or for other valuable consideration;
- The assets were transferred exclusively for a purpose other than to qualify for medical assistance;
- All assets transferred for less than fair market value have been returned to the individual; or
- The Division of Medicaid determines that denial of eligibility would work an undue hardship on the individual.

Undue Hardship

Undue hardship exists when:

- Application of the transfer penalty would deprive the individual of medical care such that his/her health or his/her life would be endangered.
- Application of the transfer penalty would deprive the individual of food, clothing shelter, or other necessities of life and cause severe deprivation.
- The applicant or spouse or representative has exhausted all legal action to have the transferred assets that caused the penalty returned.

Undue Hardship Provision (Continued)

Undue hardship does not exist when:

- Application of the application of the transfer of assets provision merely causes the individual inconvenience or when such application might restrict his or her lifestyle but would not put him or her at risk of serious deprivation.

- The assets were transferred to community spouse and the community spouse refuses to cooperate in making the resource available to the institutional spouse.

- The resource was transferred to a person (spouse, child, or other person) who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless it is established that the transferred funds cannot be recovered even through exhaustive legal measures.

Each case situation must be reviewed individually to determine if undue hardship exists. Generally, this provision is limited to financially and medically needy individuals with no possible means of recovering the transferred assets..

Undue Hardship Waiver Requested by Facility

Effective February 8, 2006, an undue hardship waiver may be requested by the facility in which the person resides on behalf of the individual if the facility has the individual's consent, or their person representative's consent. The hardship waiver is for the recipient, not the hardship of the facility. The agency provides that, while an application for an undue hardship waiver is pending in the case of an individual, who is a resident of a nursing facility, payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed 30 days.

Exception for Transfers to Community Spouse or Third Party

Section 1924 of the Act sets forth the requirements for treatment of income and resources where there is an individual in a medical institution with a spouse still living in the community. This section of the Act provides for apportioning income and resources between the institutional spouse and the community spouse so that the community spouse does not become impoverished because the individual is in a medical institution.

Exception for Transfers to Community Spouse or Third Party (Continued)

The exceptions to the transfer of assets penalties regarding inter-spousal transfers and transfers to a third party for the sole benefit of a spouse apply even under the spousal impoverishment provisions. Thus, the institutional spouse can transfer unlimited assets to the community spouse or to a third party for the sole benefit of the community spouse.

When transfers between spouses are involved, the unlimited transfer exception should have little effect on the eligibility determination, primarily because resources belonging to both spouses are combined in determining eligibility for the institutionalized spouse. Thus, resources transferred to a community spouse are still considered available to the institutionalized spouse for eligibility purposes.

The exception for transfers to a third party for the sole benefit of the spouse may have greater impact on eligibility because resources may potentially be placed beyond the reach of either spouse and thus cannot be counted for eligibility purposes. However, for the exception to be applicable, the definition of what is for the sole benefit of the spouse must be fully met.

This definition is fairly restrictive, in that it requires that any transferred funds be spent for the benefit of the spouse within a time-frame actuarially commensurate with the spouse's life expectancy. If this requirement is not met, this exemption is void, and a transfer to a third party may then be subject to a transfer penalty.

304.01.05N TRANSFER OF ASSETS NOTIFICATION

The applicant/client will be notified via the appropriate DOM-322, Notice of Transfer of Assets, i.e., OBRA 93 or DRA, regarding countable transfers and the penalty period. The transfer and the penalty must be clearly indicated. The notice allow the client or representative time to present evidence to show that the transfer should not count. Evidence should include a written rebuttal plus any pertinent documentary evidence.

If no rebuttal is offered, the penalty will be applied and the appropriate adverse action notice. Individuals in nursing homes remain eligible for all other Medicaid services if the transfer penalty is the only factor of ineligibility; therefore, payment of nursing home services only will be denied or terminated. If the individual is ineligible on other factors as well as the transfer, the application or case must be denied or terminated. If Medicaid eligibility is dependent on participating in the HCBS waiver program, the application is denied or the case is closed until the transfer is outside the 5-year look back period; These individuals can be approved in a Medicare Savings Program (QMB, SLMB, QI) if all other criteria are met.

NOTE: Notice to the client via DOM-322 is required whenever a transfer is being charged. This is true even if the penalty period has expired and the action to be taken is an improper payment. DOM-322 must be issued prior to submitting an improper payment in order to allow the client the chance to rebut the transfer. All DOM-322s must be submitted for approval to the Bureau Director, Deputy prior to issuance.

304.01.05O REBUTTAL PROCESS

Written rebuttals along with the Regional Office decision regarding acceptability are to be submitted to the Bureau Director, Deputy, prior to issuing final notice to the client. The material submitted to State Office should include the rebuttal, a copy of DOM-322 issued to the client, and a summary of the circumstances surrounding the transfer. The Bureau Director, Deputy, will issue a memorandum to the Regional Office explaining the final decision on the transfer.

304.01.05P RETURN OF A TRANSFERRED RESOURCE

If a transferred resource is returned to, or if compensation is received by, the institutionalized individual, the UV is no longer an issue or is reduced as of the date of the return. The resource or compensation is evaluated according to normal resource rules in the month of return. Any portion of a transferred resource that is not returned continues to count as UV which means the penalty period must be re-evaluated.

304.01.05Q RECALCULATION OF A PENALTY PERIOD

A penalty period must be recalculated from the month a portion of the resource is returned or additional compensation is received.

Example: A transfer of $13,800.00 occurred in October 2008, resulting in a 3-month penalty period beginning with the month that LTC is requested or eligibility is determined. In January 2009, $9,200.00 is returned to the institutionalized individual. The penalty period is then recalculated using the UV of $4,600.00 transferred in October 2008. This results in a revised period of ineligibility for one (1) month beginning with the month that LTC is requested or eligibility is determined.

NOTE: If the resource is returned, normal resource rules apply in determining Medicaid eligibility.

304.01.04R TRANSFER PENALTY INVOLVING SSI MONTHS

The transfer penalty can be imposed during months that an individual receives SSI or is SSI eligible in a nursing home. Notices for SSI eligibles must not be sent verifying eligibility for nursing facility services until the possibility of any transfers have been developed.

Example: A Medicaid application is filed in July 2008 for an applicant who entered the nursing home in May 2008 as an SSI-eligible. SSI eligibility continued until July 31, 2008. A transfer, which occurred in May 2008, is discovered during the Medicaid application process and it results in a 6-month period of ineligibility. The penalty can be imposed for May 2008 through October 2008 even though the months of May 2008 through July 2008 are SSI months. This means no vendor payment will be authorized for the 6-month penalty period; however the individual is eligible for all other Medicaid services.

DOM-322 DRA
Revised 05-01-2010

Regional Office: _____

NOTICE OF TRANSFER OF ASSETS

_____ Case Name: _____

_____ Medicaid ID: _____

_____

Anyone applying for or receiving long term care services in a nursing home or Home and Community Based Waiver is prohibited from transferring assets at any time during the 60-month period (5 years) before applying for Medicaid and during the time Medicaid is received. If assets are transferred, a period of ineligibility shall be charged which is equal to the number of months required to deplete the total uncompensated value based on the total value of all transferred asset(s) divided by the average cost of monthly nursing home care to a private pay patient as determined by the Division of Medicaid. The period of ineligibility begins when the recipient asks for coverage or is otherwise eligible for nursing home Medicaid.

Nursing home recipients under a transfer penalty will receive all services except payment to the nursing home for room and board. Eligibility cannot be established for a Home and Community Based Waiver (HCBS) recipient during the transfer period; therefore, the transfer must be outside the 5 year look-back period. This transfer of assets provision applies to assets transferred on or after February 8, 2006, as specified in the Deficit Reduction Act of 2005. Assets can be returned in full and the transfer will be erased. Returned assets will be evaluated according to ongoing resource rules.

Listed below is specific information about assets transferred by the Medicaid applicant/recipient named above:

Resource(s)transferred: _____

_____

Uncompensated Value: _____

Period of Ineligibility for □ **Nursing Home Services** is _____months and _____ days.

Beginning: _____ Beginning and end dates are subject to change. You will be

Ending: _____ issued a revised DOM-322 if any dates change.

NOTICE OF TRANSFER OF ASSETS

☐ **HCBS Waiver Services** (application)

Beginning: _____ Eligibility cannot start until after the

Ending: _____ 60-month look back period.

☐ **HCBS Waiver Services** (transfer discovered after initial approval)

Beginning: _____

Ending: _____

If you wish to rebut the transfer charge, you must give us evidence that the individual intended to dispose of the resource(s) either at current market value or for other valuable consideration or that resource(s) were transferred exclusively for a purpose other than to qualify for Medicaid. You have ten days from the receipt of this notice to submit such evidence before final action is taken on the case. An undue hardship waiver may be requested by a client or the client's authorized representative. The facility in which the person resides may apply for a hardship waiver on behalf of the individual if the facility has the individual's consent, or their personal representative's consent. If you claim undue hardship, Medicaid will review on a case by case basis using established policy located in the Eligibility and Procedures Manual. The hardship waiver is not related to a hardship for the facility, but rather a hardship for the recipient. You have ten (10) days from the date of receipt of the notice to submit your rebuttal before action is taken on the case.

Medicaid Specialist: _____Date: _____

DOM-322 DRA NOTICE OF TRANSFER OF ASSETS INSTRUCTIONS

PURPOSE

The purpose of this form is to give notice to a nursing home or HCBS client that a period of ineligibility exists as a result of a transfer of assets on or after February 8, 2006. DOM-322 informs the client/representative that a 10-day period is allowed in which rebuttal evidence may be presented. This form does not replace the advance notice which must be issued if the rebuttal is not successful.

INSTRUCTIONS

The completed form must be submitted to the appropriate Bureau Director, Deputy, for approval prior to issuance to the client. . Prepare an original and 2 copies. The original is given or mailed to the client or representative and 1 copy is retained in the case record. The third copy is used as a tickler copy to hold for 12 days. Twelve (12) days allows mailing time. The client has 10 days from receipt of the notice to respond.

Enter the appropriate information pertaining to the transfer(s) being charged. List all specific resource(s) that were transferred. List the uncompensated value of the transferred resource(s). The uncompensated value is the difference between the fair market at the time of the transfer (less any outstanding loans, mortgages, or other encumbrances on the asset) and the amount received for the asset.

PERIOD OF INELIGIBILITY

Check the appropriate box—Nursing Home Services, HCBS Waiver Services (application) or HCBS Waiver Services(transfer discovered after initial approval).

The beginning date for nursing home services is the first day of the month in which the recipient asked for coverage/or the first day of the month in which eligibility can be established.

The beginning date for HCBS waiver services the first day of the month in which the asset was transferred.

The ending date for nursing home services is the last day that was computed when dividing by the average cost of monthly nursing home care. This date may reflect a partial month penalty.

PERIOD OF INELIGIBILITY (Continued)

The ending date for Community Based Waiver Services (application) is the last day of the month, 5 years after the transferred occurred. The transfer must be out of the 5 years look back period.

Example: Medicaid application date is 12-20-09.
The 5 year look back period is 12-1-04 through 12-31-09.
The transfer took place on 07-12-07.
The transfer was within the 5 year look back period.
The ending date would be 07-31-12. Any eligibility established after 07-31-12 would not include this transfer.

The ending date for Community Based Waiver Services (transfer discovered after initial approval) is the last day of the month that was computed when dividing by the average cost of monthly nursing home care. This date will not reflect a partial month penalty. If the calculation ends during the month, the penalty will extend to the last day of the month.

Example: Transfer took place on 08-10-2008.
Uncompensated value is $50,000.00
$50,000.00 divided by $4600 equals 10.86 or 10 months
$4600 times 10 months equals $46,000
$50,000 minus $46,000 equals $4,000
$4,000 divided by $151 equals 26 days

Since HCBS eligibility cannot start in the middle of the month, the penalty is a full 11 months.

The Medicaid Specialist must sign and date the form.