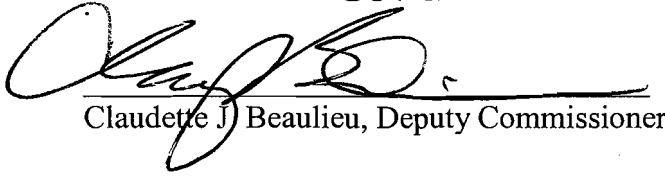




STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

UNIFORM POLICY MANUAL


Claudette J. Beaulieu, Deputy Commissioner

April 1, 2007
Effective Date

POLICY TRANSMITTAL NO.: UP-07-02

SUBJECT: Deficit Reduction Act of 2005 – Medicaid Long-Term Care Issues

This transmittal revises policy in accordance with changes made by the Deficit Reduction Act of 2005 (Public Law 109-171) regarding transfers of assets and their effect on eligibility for long-term care (LTC) services under the Medicaid program. Also included are other policy revisions being made pursuant to this federal law concerning the treatment of certain assets such as annuities, mortgage notes, interest in continuing care retirement communities (CCRC's), and home property in which the individual's equity is more than \$750,000.

Most of the changes affect transfers made or assets such as annuities purchased on or after February 8, 2006. Transfers made and annuities purchased before that date will continue to be evaluated as they have been previously.

Chapter 3028 of the Uniform Policy Manual (UPM) describes the effect of transfers of assets on eligibility for long-term care services under the Medicaid program, as they existed before the new law. Much of the policy contained in chapter 3028 is not changing. With minor revisions, 3028 is remaining as a chapter within the UPM because most of the transfers associated with upcoming applications will have been made prior to February 8, 2006. With respect to most transfers, Chapter 3028 will become obsolete on February 9, 2009. For transfers involving trusts and similar instruments, chapter 3028 will become obsolete on February 9, 2011.

We are adding a new chapter 3029 to implement the revised policy regarding transfers made on or after February 8, 2006. In some cases, workers may have to refer to both chapters 3028 and 3029, if an applicant has made transfers before and after the effective date of the new law. Many of the subject pages in chapter 3029 are the same as their corresponding subject pages in chapter 3028, because much of the policy is not changing, except where indicated below.

Here is a summary of the areas where changes are being made pursuant to the Deficit Reduction Act of 2005, followed by a more detailed explanation of the changes.

- Look-back period – from three to five years
- Beginning date of penalty period – from date of transfer to date otherwise eligible
- Undue hardship claim process – LTCF can file claim with resident's permission
- Treatment of annuities – the state becomes a beneficiary in LTC Medicaid cases
- Home equity limitation - \$750,000 limit for LTC Medicaid
- Treatment of interest in continuing care retirement communities (CCRC's)
- Treatment of promissory notes, loans and mortgages
- Treatment of life estates

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Look-Back Period

Policy for Transfers Made Prior to 2-8-06

Transfers (except for certain transfers involving trusts and similar instruments) made **prior to 2-8-06** are subject to DSS review if they occur **within three years** of an application for Medicaid to cover long-term care services (the look-back period). Example: Mr. Jones makes a transfer on 2-7-06. DSS would evaluate the transfer only if he applies for long-term care benefits under the Medicaid program before 2-8-09. The worker would use chapter 3028 to evaluate the transfer.

Policy for Transfers Made on or after 2-8-06

All transfers made **on or after 2-8-06** are subject to DSS review if they occur **within five years** of an application for Medicaid to cover long-term care services. Example: Mr. Jones makes a transfer on 2-8-06. If he applies before 2-9-11, DSS would have to evaluate the transfer, and use the new policy (chapter 3029).

Beginning Date of Penalty Period

Policy for Transfers Made Prior to 2-8-06

For someone making a transfer prior to 2-8-06, and applying for LTC Medicaid within three years of the transfer, the penalty period begins as of the first day of the month in which the transfer is made, and which does not occur during any other period of ineligibility. Example: Mr. Jones transfers \$100,000 on 2-7-06 and applies on 5-1-08. The penalty period would have begun on 2-1-06 and would have expired by the time of the application (based on the average cost of nursing home care as of 5-1-08). The worker would use UPM 3028.

Policy for Transfers Made on or after 2-8-06

For applicants, the penalty period for transfers made on or after 2-8-06 will generally begin as of the date on which the individual is eligible for Medicaid and would otherwise be eligible for payment of LTC services under the Medicaid program based on an approved application, and which does not occur during any other period of ineligibility. Example: Mr. Jones makes a transfer of \$100,000 on 2-8-06. He applies for LTC Medicaid on 2-5-11 and meets all other Medicaid eligibility requirements. There are no other transfers. The penalty period begins on 2-5-11 and its length is based on the transfer amount (\$100,000) divided by the average cost of nursing home care as of 2-5-11. The worker would use UPM 3029.

For those who are already receiving LTC Medicaid benefits and make an improper transfer on or after 2-8-06, the penalty period begins as of the first of the month in which the transfer is made, and which does not occur during any other period of ineligibility. Because of the ten-day notice requirements, we may have to initiate a recovery action to recoup Medicaid payments made on behalf of the recipient for services incurred in the month of the transfer. We may also need to initiate a recovery action when a transfer is not reported in a timely manner, and part or all of the penalty period has already passed.

Undue Hardship Claim Process

Even before the new law, there has been a process in which the applicant may claim that a denial of payment for LTC services would result in an undue hardship. If the claim is upheld, the department will grant full Medicaid benefits, including payment for LTC care.

This transmittal describes the undue hardship claim process in more detail. Time limits for the individual to file a claim, and for the department to respond, are given. A letter has been developed to notify the individual regarding the outcome of his or her claim of undue hardship, and to explain the individual's appeal rights. These clarifications apply to any undue hardship claim regardless of the date of the transfer associated with the claim. This policy will appear in both chapters 3028 and 3029.

For undue hardship claims associated with transfers occurring on or after February 8, 2006, a nursing home in which the individual is residing will be allowed to file such a claim on behalf of the individual, with the individual's or his or her authorized representative's permission. Follow UPM 3029.

Treatment of Annuities

Annuities are described in the Assets section (4000) in the UPM. They are evaluated both as assets to the extent that they are assignable or have not been annuitized, and as income to the extent that they generate an income stream to the beneficiary. Additionally, the right to receive income from an annuity is regarded as a counted asset, whether the annuity is or is not assignable, (i.e. the income stream is a counted asset). The purchase of an annuity may also be considered as a transfer of assets to the extent that funds that had previously been available to an individual may now be unavailable. We evaluate annuities in much the same way that we evaluate trusts.

Annuities purchased on or after February 8, 2006 will now be subject to other considerations. First, the department will automatically become a remainder beneficiary under the annuity or similar financial instrument by the provision of LTC Medicaid benefits to an individual. We must disclose this fact at the time of application or reapplication.

Second, the purchase of an annuity will automatically be considered to be a transfer of assets unless: the department is named as the remainder beneficiary in the first position for at least the total amount of Medicaid paid on behalf of the annuitant; or, the department is named as such a beneficiary in the second position after the community spouse or minor or disabled child, and is named in the first position if the spouse or representative of the child disposes of any such remainder for less than fair market value. In addition, the annuity must meet all the following criteria: it must be irrevocable and nonassignable; it must be actuarially sound; and it must provide for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments.

Certain types of annuities are not subject to the transfer of asset rules. Examples of such annuities are those described in certain subsections of sections 408 and 408A of the Internal Revenue Code of 1986, including simplified employee pensions and certain Roth IRAs.

Home Equity Limitation

Presently, there is no limit on the amount of equity an individual may have in his or her home property. If he or she permanently enters an LTCF, and there is no spouse or minor or disabled child in the home, the home continues to be excluded as an asset as long as the individual is making a bona fide effort to sell it.

Under the new law, an individual applying for LTC services under Medicaid is ineligible for payment of LTC services if his or her equity in the home property exceeds \$750,000. Please note that this provision affects only whether Medicaid will pay for LTC services – it does not affect actual Medicaid eligibility. Therefore, similar to an individual with a transfer of asset penalty, an individual with substantial home equity may qualify for Medicaid, but may not be entitled to receive Medicaid payment of LTC services. This provision does not apply if the individual's spouse, child under age 21, or disabled child is living in the home. The new law takes effect with LTC Medicaid applications filed on or after January 1, 2006. Individuals granted Medicaid based on applications filed prior to January 1, 2006 are not affected as long as they remain otherwise eligible. Those already granted Medicaid based on applications filed on or after January 1, 2006 may be affected at the time of their first redetermination.

Individuals may reduce their equity in home property by taking out a home equity loan or a reverse annuity mortgage. Such devices remain excluded as income. However, the Center for Medicare and Medicaid Services (CMS) has informed us that the proceeds of a loan or mortgage are counted assets, and that if an individual or his or her spouse improperly transfers the proceeds from a loan or mortgage, a penalty period should be imposed.

We may waive the home equity limitation if it would cause undue hardship, and for certain individuals with asset disregards resulting from long-term care insurance policies certified by the Connecticut Partnership for Long-Term Care.

Interest in Continuing Care Retirement Communities (CCRC's)

Presently, the entrance fee paid by a resident of a CCRC may be considered an asset under certain circumstances. This generally occurs when the resident leaves the CCRC and is entitled to a refund of part or all of the fee. There is nothing in the UPM that specifically addresses this type of asset, but it would be classified as an available asset under the general definition of something of value that an individual has the legal right, authority or power to use for his or her general or medical support.

The new law specifically addresses the treatment of entrance fees in a CCRC. The fees will generally be treated as they are now. The fees will not be considered assets if they convey an ownership interest in the CCRC.

Promissory Notes, Loans and Mortgages

Presently, promissory notes, loans, mortgages and similar financial instruments are considered assets to the extent that the owner can sell or otherwise obtain his or her equity. Monies derived from such assets are evaluated as income. The right to receive income is also an available asset.

Under the new law, we continue to evaluate a promissory note, loan, mortgage or similar financial instrument as an asset or as an income-producer. However, for transfer of asset purposes only, funds used to purchase a promissory note, loan, mortgage or similar financial instrument are considered assets that have been transferred for less than fair market value unless the financial instrument is bona fide (as explained in policy) and meets all of the following criteria: it has a repayment term that is actuarially sound; it provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments; and it prohibits the cancellation of the balance upon the death of the lender. If the note, loan, mortgage or similar financial instrument is not bona fide or does not meet all three criteria described above, the outstanding balance due as of the date the individual applies for LTC Medicaid is considered an asset transferred for less than fair market value.

Life Estates (Life Use)

Currently, life use is evaluated as an asset. It may or may not be counted, depending on whether the owner can sell it.

The new law describes how to treat funds an individual pays to purchase life use of another person's home. Under the new law, funds used to purchase life use of another person's home are considered assets transferred for less than fair market value unless the purchaser resides in the home for a period of at least one year after the date of the purchase.

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DISPOSITION: This Policy Transmittal should be retained for reference.

DISTRIBUTION: UPM list

RESPONSIBLE UNIT: Adult Support (860) 424-5250

Date Issued: 4-20-07

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Date: 4-1-07

Transmittal: UP-07-02

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Section:

Categorical Eligibility Requirements

Type:

POLICY

Chapter:

Medicaid Coverage Groups

Program:

FMA-CN

Subject:

HUSKY A for Long Term Care Facility Residents Under Special Income Level (T01)

2540.60 | C. Income and Asset Criteria (continued)

3. The home equity limitation described in Section 4030.20 applies to this coverage group.

**CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
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Date: 4-1-07

Transmittal: UP-07-02

2540.88

Section:
Categorical Eligibility Requirements

Type:
POLICY

Chapter:
Medicaid Coverage Groups

Program:
MAABD-CN

Subject:
Long Term Care Facility Residents Eligible Under Special Income Level (L01)

2540.88 A. Coverage Group Description

This group includes residents of long term care facilities (LTCF), who:

1. meet the categorical requirements of age, blindness or disability, and
2. reside in the LTCF for at least thirty (30) consecutive days; and
3. have income below a special income level.

B. Duration of Eligibility

Individuals qualify as categorically needy under this coverage group beginning with the first day of the thirty (30) continuous days of residence, for so long as the conditions above are met.

C. Income and Asset Criteria

1. The Department determines income eligibility under this coverage group by comparing the individual's gross income to the Special Categorically Needy Income Limit (CNIL), set at 300% of the maximum SSI amount for one person.
 - a. If the individual's gross income is less than the Special CNIL, he or she passes the income test.
 - b. If the individual's gross income equals or exceeds the Special CNIL, he or she does not qualify under this coverage group.
2. The Department uses the AABD asset limit to determine eligibility for this coverage group.
3. The home equity limitation described in Section 4030.20 applies to this coverage group.

**CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
UNIFORM POLICY MANUAL**

Date: 4-1-07

Transmittal: UP-07-02

2540.92

Section:

Categorical Eligibility Requirements

Type:

POLICY

Chapter:

Medical Coverage Groups

Program:

MAABD-CN

Subject:

Individuals Receiving Home and Community Based Services (W01)

2540.92 A. Coverage Group Description

This group includes individuals who:

1. would be eligible for MAABD if residing in a long term care facility (LTCF); and
2. qualify to receive home and community-based services under a waiver approved by the Centers for Medicare and Medicaid Services; and
3. would, without such services, require care in an LTCF.

B. Duration of Eligibility

Individuals qualify for Medicaid as categorically needy for as long as they meet the conditions above and receive home and community-based services under a waiver.

C. Income and Asset Criteria

1. Except as described in subparagraph 3 below, the Department determines income eligibility under this coverage group by comparing the individual's gross income to the Special Categorically Needy Income Limit (CNIL), set at 300% of the maximum SSI amount for one person. To qualify as categorically needy, the individual's gross income must be less than the special CNIL.
2. Except as described in subparagraph 3 below, the Department uses the AABD asset limit to determine eligibility.
3. Individuals who are eligible for Medicaid under the "Working Individuals with Disabilities" coverage group, and who also meet the non-financial eligibility criteria described in paragraph A to receive home and community-based services under the Personal Care Assistance waiver, are considered to meet the income and asset criteria of this coverage group (Cross Reference: 2540.85).
4. The home equity limitation described in Section 4030.20 applies to this coverage group.

**CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
UNIFORM POLICY MANUAL**

Date: 02-13-01

Transmittal: UP-01-04

2540.94

Section:
Categorical Eligibility Requirements

Type:
POLICY

Chapter:
Medicaid Coverage Groups

Program:
MAABD-CN

Subject:
Qualified Medicare Beneficiaries

2540.94 A. Coverage Group Description

1. This group includes individuals who:
 - a. are entitled to hospital insurance benefits under part A of Title XVIII of the Social Security Act; and
 - b. have income and assets equal to or less than the limits described in paragraph C and D.
2. A Qualified Medicare Beneficiary (QMB) may be eligible for full Medicaid benefits under another coverage group during the same period he or she is also eligible under the QMB coverage group.

B. Covered Benefits

An individual who qualifies for this coverage group may receive payment for:

1. Medicare Part A and B premiums; and
2. payment for coinsurance and deductible amounts for services covered under Medicare.

C. Duration of Eligibility

An individual qualifies for benefits under this coverage group starting the first day of the calendar month following the month in which an individual is determined eligible and continuing for every month thereafter in which the individual meets the criteria described in paragraph A.

D. Income Criteria

1. The Department uses AABD income criteria (Cross Reference: 5000), including deeming methodology, to determine eligibility for this coverage group except for the following:
 - a. the annual cost of living (COLA) percentage increase received by SSA and SSI recipients each January is disregarded when determining eligibility in the first three months of each calendar year;
 - b. for eligibility to exist income must be equal to or less than 100% percent of the Federal Poverty Level for the appropriate needs group size.

**CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
UNIFORM POLICY MANUAL**

Date: 4-1-07

Transmittal: UP-07-02

3028

Section:
 Technical Eligibility Requirements

Type:
 POLICY

Chapter:
 Transfer of Assets

Program: MA

Subject:

3028 This chapter describes the technical eligibility requirement in the Medicaid program pertaining to the transfer of an asset for less than fair market value, for transfers that occur prior to February 8, 2006.

The material contained in this chapter pertains only to the Medicaid program. Policy and procedures concerning transfers of assets in the cash and Food Stamp programs are contained elsewhere in this section, as are the Medicaid policy and procedures existing with respect to transfers of assets occurring on or after February 8, 2006.

