DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

JAN 2 3 2019

Graham Shaffer
Staff Attorney
Department of Social Services
55 Farmington Ave., 11th Floor
Hartford, CT 06105

Dear Mr. Shaffer:

We are responding to the letter written by Marc Shok, former director of Connecticut's Department of Social Services (DSS), dated November 3, 2016, to the Centers for Medicare & Medicaid Services (CMS). In the letter, Mr. Shok explained that Connecticut's Regulations Review Committee asked DSS to seek guidance from CMS on whether certain state regulations relating to asset transfers, which are not yet finalized but under which DSS has been operating as policy since 2007, are consistent with federal law. In subsequent communications with CMS, DSS staff raised an additional asset transfer issue not included in the original letter. We appreciate Connecticut's patience in awaiting our response. We address all of these issues below.

Community Spouse's Post-Eligibility Transfer of Assets

DSS's letter first identifies the proposed regulation that would codify section 3029.15(E) of the Connecticut Uniform Policy Manual (UPM), under "Post Eligibility Transfers Made By the Institutionalized Spouse." The UPM provision deems transfers made by a community spouse after the institutionalized spouse has established eligibility as having been made for a purpose other than to qualify for Medicaid, except where the transferred asset is the home or the proceeds of a home equity loan, reverse mortgage or similar instrument that reduces the institutionalized individual's or spouse's equity in his or her home.

DSS informs us that the Connecticut Elder Bar (the Elder Bar) believes that this UPM provision, which would permit a transfer penalty to be applied against an institutionalized spouse for a post-eligibility transfer made by the community spouse, is in conflict with the mandate of section 1924(c)(4) of the Act that the resources of a community spouse may not be deemed available to an institutionalized spouse after the latter has established Medicaid eligibility. The Elder Bar supports its argument with a 2000 letter from CMS's regional office in Boston,[1] while DSS notes that letters from CMS's central office in 2001 and 2003 express a different position,[2] and DSS asks for clarification on which CMS letter(s) to follow.

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[1] Letter from Ronald Preston, Associate Regional Administrator, Health Care Financing Administration, Division of Medicaid and State Operations, to Attorney Brian Barreira, April 5, 2000.

[2] Memorandum from Thomas E. Hamilton, Director, Disabled and Elderly Health Programs Group, Centers for Medicaid and State Operations, Health Care Financing Administration, U.S. Department of Health and Human

In the 2001 and 2003 letters, CMS changed the policy it articulated in the 2000 letter. While CMS had initially interpreted the prohibition in section 1924(c)(4) of the Act against the post-eligibility "deeming available" of a community spouse's resources to mean that the community spouse's resources cannot be considered in determining either the institutionalized spouse's financial eligibility or scope of coverage, we changed that view. We explained in the 2001 and 2003 letters that after further consideration, we concluded that the "deemed available" phrase in section 1924(c)(4) of the Act could be reasonably interpreted as either applying narrowly to the determination of an institutionalized spouse's resource eligibility at the point of a renewal of eligibility (in which case the institutionalized spouse can be penalized for a community spouse's post-eligibility transfers), or broadly to an institutionalized spouse's resource and coverage eligibility determinations (in which case the institutionalized spouse cannot be penalized for a community spouse's post-eligibility transfers). We further explained that states may choose which interpretation to apply.

Our interpretation of section 1924(c)(4), as described in the 2001 and 2003 letters, has not changed. Connecticut has the authority to interpret the "deemed available" phrase in section 1924(c)(4) of the Act to apply exclusively to the resource eligibility redeterminations of the institutionalized spouse, which would permit Connecticut to penalize the institutionalized spouse for a community spouse's post-eligibility transfers. Based on our review of section 3028.15(E) of the UPM and conversations with Connecticut state agency staff, Connecticut has adopted this interpretation of "deemed available."

The Start Date of Penalty Periods

The second issue raised in DSS's letter concerns the start date of a penalty period for a Medicaid applicant who is seeking coverage for long-term services and supports (LTSS) and has transferred assets for less than fair market value during the look-back period. Specifically, DSS reports that Connecticut's proposed regulation would establish the start date for a transfer-related penalty as "the date on which the individual is eligible for Medicaid under Connecticut's State Plan and would otherwise be eligible for Medicaid payment of the LTC services . . . based on an approved application for such care but for the application of the penalty period. . . ."

DSS explains in its letter that the Elder Bar objects to this language due to its adverse impact on individuals seeking "homecare" services." The Elder Bar is concerned that, due to delays it alleges are occurring in HCBS waiver application processing and the fact that the penalty does not begin until an individual's favorable eligibility determination for a 1915(c) waiver, this population is uniquely disadvantaged. DSS reports that the Elder Bar believes that, for HCBS waiver applicants, the penalty period should begin the month of application.

Services, to Associate Regional Administrator, Division of Medicaid and State Operations, Region VI-Dallas ("Policy Clarification – Interrelationship Between Transfer of Assets and Spousal Impoverishment (Your Memorandum Dated 5/24/01)"), Undated, and Letter from Thomas E. Hamilton, Director, Disabled and Elderly Health Programs Group, Centers for Medicaid and State Operations, Health Care Financing Administration, U.S. Department of Health and Human Services, to Attorney Dennis G. Mille, May 15, 2003.

CMS clarified the proper start date of a penalty period for an individual who is seeking HCBS through the eligibility group described at section 1902(a)(10)(A)(ii)(VI) of the Act (which is the only eligibility group to which a penalty against the provision of 1915(c) services applies). In State Medicaid Director Letter (SMDL) #18-004 ("Penalty period start date for certain HCBS waiver participants"), we explained that the penalty period start date for this eligibility group (implemented at 42 C.F.R. §435.217 of the regulations, and referred to as the "217 group") is the point at which a state has completed all of the following tasks: determined that the applicant meets the financial and nonfinancial requirements for Medicaid eligibility and the level-of-care criteria for a 1915(c) waiver; developed for the individual a person-centered service plan; and identified an available waiver slot for the individual's placement.

Connecticut should apply penalties against 217 group applicants consistent with the direction provided by SMDL #18-004. If Connecticut's regulation would permit the penalty period to begin running sooner than the point at which Connecticut has completed all of the tasks for a 217 group applicant described above, the regulation would be inconsistent with our guidance.

However, we remind Connecticut of the timeliness standards relating to Medicaid eligibility determinations described in 42 C.F.R. §435.912 of the regulations. This regulation does not provide states an exception to the timeliness standards for 217 group eligibility determinations.

Calculating the Penalty Period for Partial Returns

In addition to the two issues identified in DSS's letter, Connecticut state agency staff has raised with us during conversations pertaining to the letter Connecticut's policy on "partial returns." As most recently reported to us by Connecticut, the proposed regulation relating to partial returns reads, "If a portion of the transferred asset is returned to the individual, the *start date* of the penalty period is adjusted. The *ending date* of the penalty period as originally determined is not changed." (Emphasis provided.)

CMS has previously provided guidance to Connecticut on partial returns. In letters dated October 28, 2010, and December 16, 2010,[3] CMS explained to Connecticut, broadly speaking and among other things, that a state that adopts its option to recognize partial returns may not apply a policy that produces a penalty period that is not commensurate with the total amount of assets transferred after a partial return of assets is accounted for. We believe that the language of Connecticut's policy on partial returns may possibly produce a result that would be in conflict with the direction that we provided in the 2010 letters.

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[3] Letter from Richard McGreal, Associate Regional Administration, Division of Medicaid and Children's Health Operations, Boston Regional Office, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, to Michael P. Starkowski, Commissioner, Connecticut Department of Social Services, October 28, 2010, and Letter from Richard McGreal, Associate Regional Administration, Division of Medicaid and Children's Health Operations, Boston Regional Office, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, to Claudette Beaulieu, Deputy Commissioner, Connecticut Department of Social Services, dated December 16, 2010.

For example, assume that an institutionalized individual makes a $60,000 transfer for less than fair market value on December 31, 2018, and that the average monthly cost of nursing facility services in the state is $6,000. The individual applies for Medicaid on January 1, 2019, and is determined to meet all eligibility requirements as of that same day. Per section 1917(c)(1)(E)(i) of the Act, which dictates that the penalty period is the total value of all assets transferred for less than fair market value divided by the average monthly private cost of nursing facility services in the state, the penalty period is ten months and will run through October, 2019. Further assume that $42,000 of the transfer is returned to the individual on March 15, 2019, and that the individual disposes of the $42,000 in fair market value exchanges by March 31, 2019.

It is unclear to us, under the terms of Connecticut's proposed regulation, what the new start date of the penalty would be. Even if it were adjusted to begin on April 1, 2019 (to align with the date the individual again meets all eligibility requirements after disposing of the returned assets), so that the individual is eligible for coverage of his or her nursing facility services from January 1, 2019, through March 31, 2019, the individual will ultimately be subject to a seven-month penalty (April 2019 through October 2019) for an $18,000 transfer in a state in which the average monthly private cost of nursing facility care is $6,000 (as the *end* date of the original penalty may not change under Connecticut's proposed regulation). We believe this would effectively impose a penalty period that exceeds the duration of the penalty period described in section 1917(c)(1)(E)(i) of the Act.

We explained in our letter dated October 28, 2010, that Connecticut has alternatives to its partial return policy that would not pose conflicts with federal law. If Connecticut wants to maintain consideration of partial returns, it could reduce the penalty period from the back end. In the example above, Connecticut could roll back the penalty period by seven months from the October end date (seven months being equal to the percentage of the original penalty represented by the returned funds), which would mean the penalty period would expire at the end of March, 2019. The individual will have received a three-month penalty, from January through March, for the $18,000 transfer in January. This would make the penalty period appropriately commensurate with the amount ultimately transferred.

Thank you for contacting us about these matters. I appreciate your patience. If you have any questions or comments about this letter, please contact Gene Coffey at (410) 786-2234, or gene.coffey@cms.hhs.gov.

Sincerely,

/s/ for Stephanie Kaminsky

Stephanie Kaminsky
Director, Division of Medicaid Eligibility Policy.