TRANSFER OF ASSETS

F-400 OVERVIEW

For purposes of this section, assets include all income and resources of the individual and 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:

a. the individual or the individual's spouse;

b. 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; or

c. 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 to which an individual or spouse is entitled" includes assets to which the individual is entitled or would be entitled if action had not been taken to avoid receiving the asset.

The following are examples of actions which would cause income or resources not to be received:

a. irrevocably waiving pension income;

b. waiving the right to receive an inheritance;

c. not accepting or accessing injury settlements;

d. 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

e. refusal to take legal action to obtain a court ordered payment that is not being paid, such as child support or alimony.

Failure to cause assets to be received does not constitute a transfer of assets for less than fair market value in all instances. **Example:** the individual may not be able to afford to take the necessary action to obtain the asset, or the cost of obtaining the asset may be greater than the asset is worth, thus effectively rendering the asset worthless to the individual. Examine the specific circumstances of each case before making a decision whether an uncompensated asset transfer occurred.

Note: Not applicable to Medicare beneficiaries, public law and prior medical categories.

F-405 DEFINITIONS

Transfer of Assets – Assets (income/resources) which are given away, sold or disposed of for less than fair market value to obtain or retain Medicaid eligibility. This includes all income and resources to which the customer or spouse is entitled or would

be entitled if action had not been taken to avoid receiving the asset. **Note:** The home of an applicant/recipient (principal place of residence) can only be transferred in the specific instances outlined in 440.5 whether the home is excludable or not.

Institutionalized Individual - Any person who is residing in a medical facility, including SSI recipients, or persons who fall into any category considered institutionalized recipients, such as Home and Community Based Services Waiver (HCBW) customers.

Fair Market Value - The current market value of the asset **at the time of transfer**.

Compensation - All money, real or personal property, food, shelter, or services received by the applicant/recipient at or after the time of transfer in exchange for the asset. Items received prior to the transfer will be considered compensation only if they were provided pursuant to a binding contract (verbal or written) to provide such items in exchange for payment.

Personal Care Contract – a contract/agreement that provides health care monitoring, medical treatment, securing hospitalization, visitation, entertainment, travel/transportation, financial management, shopping, home help or other assistance with activities or daily living.

Home Care Contract – a contract/agreement which pays in advance for the applicant/recipient's expenses for their home or other real property, including but not limited to repairs, property maintenance, property taxes, homeowner's insurance, heat and utilities.

NOTE: Home Care and/or personal Care contracts/agreements may be between relatives or non-relatives. A relative is anyone related to the applicant/recipient by blood, marriage, or adoption.

Uncompensated Value - The Fair Market Value of the asset **at the time of transfer**, minus the amount of compensation received by the applicant/recipient or spouse in exchange for the asset.

Legal Representative - Parent of a minor child, power of attorney, legal guardian, or anyone legally authorized to execute a contract for the customer/spouse. **Note:** Assets transferred by anyone acting in place of, or on behalf of, or at the request or direction of the customer or spouse, are considered to be transferred by the customer or spouse.

Spouse – Person legally married to another under state law. In Nevada, a person is married until divorced.

Community Spouse – A spouse who is not living in a medical institution, nursing facility, or receiving HCBW services.

Penalty – Individuals who receive Home and Community Based Waiver (HCBW) services, or institutionalized individuals are denied coverage of certain Medicaid services during the transfer of asset penalty period. The individual remains eligible for Medicaid and can receive certain services not subject to the penalty. Eligibility codes C and D are used to indicate a penalty period.

F-410 GENERAL RULE

If an institutionalized individual, his/her spouse, or their legal representative has given away, sold or disposed of assets for less than fair market value, it is presumed the asset was disposed of for the purpose of becoming eligible for or to remain eligible for Medicaid.

F-410.1 Look-Back Period

a. Asset Transfers Prior to February 8, 2006

Asset transfers must be evaluated **during** the 36-month 'look-back' period beginning the month of application; OR if the individual is/was Medicaid eligible at the time he/she began receiving HCBW or long term care (LTC) services, the 36-month 'look-back' period begins with the month the HCBW or LTC Services began.

Asset transfers must also be evaluated **any time after** the individual begins receiving HCBW or LTC services or **any time after** the individual applies for Medicaid.

The 'look-back' period is extended to 60 months when there is a transfer of assets involving a trust. If, in the case of a revocable trust, a portion is disbursed to someone other than the grantor or for the benefit of the grantor, that portion is treated as a transfer of assets. If, in the case of an irrevocable trust, all or a portion of the trust cannot be disbursed to or on behalf of the individual, that portion is treated as a transfer of assets.

b. Asset Transfers On or After February 8, 2006

The Deficit Reduction Act (DRA) provides that for *any* transfer of assets made on or after February 8, 2006, the look-back period is *60 months* from the date the individual applied for Medicaid and was institutionalized or began receiving HCBW services.

Asset transfers must also be evaluated at **any time after** the individual begins receiving HCBW or LTC services.

F-415 TREATMENT OF INCOME AS ASSETS

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.

If income or the right to receive income has been transferred, a penalty period must be imposed. If the income is a single lump sum, the penalty period is calculated on the basis of the amount of the payment. If a stream of income or the right to such income is transferred, a determination of value will be made by the Chief of Eligibility and Payments and based on an actuarial projection of the individual's life expectancy.

F-415.1 Treatment of Jointly Owned Assets

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

When a transfer of assets situation is identified, individuals must be allowed an opportunity to rebut the presumption of ownership. Either individual can provide convincing evidence the assets transferred were the sole property of the other person.

The account resource balance will be presumed available to the individual unless the individual can successfully prove the funds are not his/hers. This portion will be considered a transfer of assets if withdrawn by the other individual or given away by the individual.

In the event of a divorce of an institutionalized applicant or recipient of Medicaid, a copy of the divorce decree and property settlement agreement must be provided to the case manager.

In the event that the court made an unequal disposition of the community property and failed to find a compelling reason set forth in writing for making such unequal disposition as required in state statute, this will be deemed to be a transfer of assets for less than fair market value to the extent of the unequal division. (NRS 125.150)

F-415.2 Treatment of Certain Kinds of Asset Transfers

Life Estates, Promissory Notes, Loans or Mortgages

a. Treatment of Life Estates Prior to April 1, 2006:

   In a transaction involving a life estate, a transfer of assets has occurred:

   1. Whenever the value of the transferred asset is greater than the value of the rights conferred (given) by the life estate.

b. Treatment of Life Estates and Promissory Notes, Loans or Mortgage Purchases on or after April 1, 2006:

   In a transaction involving a life estate, a transfer of assets has occurred:

   1. When the individual purchasing a life estate in another individual’s home has *not* actually resided in the home for a period of *at least* one year *after* the date of purchase.

   2. When payment exceeds the fair market value of the life estate.

   3. When an individual makes a gift or transfers interest in a life estate.

      Note: The amount of the transfer is the *entire* amount used to purchase the life estate. This amount is *not* reduced or prorated to reflect an individual’s residency for any time less than a year.

In a transaction involving a promissory note, loan, or mortgage, a transfer of assets has occurred unless *all* of the following criteria are met:

a. The repayment term is actuarially sound;

b. Payments are made in equal amounts during the term of the loan with no deferral of payments and no balloon payments; and

c. The cancellation of the balance of the note, loan, or mortgage upon the death of the lender is prohibited.

Note: If the above criteria are not met, the amount of the transfer is the value of the outstanding balance due as of the date of the individual's application for Medicaid coverage of LTC or HCBW services.

F-415.23 Personal Care and Home Care Contract Agreements

When assistance and/or services are provided to the applicant/recipient, regardless of whether it is by a relative or non-relative, compensation for past assistance and/or services will be considered a transfer for less than fair market value. If the transfer of assets decision is appealed or rebutted by the applicant/recipient or care provider, the fair market value of the assistance and/or services may be determined by consultation with area businesses which provide such services.

A contract that provides advanced payment for expenses, including, but not limited to, repairs, maintenance, property taxes, homeowner's insurance, heat and utilities for real property/homestead, or that provide for monitoring health care, securing hospitalization, medical treatment, visitation, entertainment, travel and/or transportation, financial management or shopping, etc., is considered a transfer of assets. Consider all payments for care and services which were made during the look-back period as transfer of assets. Contracts/agreements that include the provision of companionship are prohibited.

All Personal Care and Home Care contracts/agreements and payments made therein, regardless of whether between an applicant/recipient and a relative or an applicant/recipient and a non-relative, must be evaluated for transfer of assets.

Personal Care and Home Care contracts/agreements shall be considered a transfer for less than fair market value unless the agreement meets all of the following:

a. The services must be performed after a written legal contract/agreement has been executed between the applicant/recipient and the provider. The contract/agreement must be dated, and the signatures must be notarized. The services are not paid for until the services have been provided (there can be no advance payment for future expenses or services); and

b. At the time the services are received, the applicant/recipient cannot be residing in a nursing facility, adult foster care home (licensed or unlicensed), institution for mental diseases, inpatient hospital, intermediate care facility for individuals with intellectual disabilities, or be eligible for home and community-based waiver, home health or home help; and

c. At the time services are received, the services must have been recommended in writing and signed by the applicant/recipient's physician as necessary to prevent the transfer of the applicant/recipient to a residential care or nursing facility. Such services cannot include the provision of companionship; and

d. The contract/agreement must be signed by the applicant/recipient or legally authorized representative, such as an agent under a power of attorney, guardian, or conservator. If the agreement is signed by a representative, that representative cannot be the provider or beneficiary of the contract/agreement.

Assets transferred to another person in exchange for a contract/agreement related to personal services/assistance and/or payment for real property/homestead expenses after the date of application are considered available and countable assets until actually disposed of.

Field staff will forward the Personal Care or Home Care Agreement/Contract and itemized billing to the chief of Eligibility & Payments at Carson City Administrative Office, where DWSS will verify the contract/agreement by reviewing the written contract/agreement between the applicant/recipient and the provider which must show the type, frequency, and duration of such services being provided to the applicant/recipient and the amount of consideration (money or property) being received by the provider. Itemized billing for services not paid for in advance must accompany the contract/agreement verifying the type, frequency and duration of services provided and the type and amount of assets(s) being exchanged, including when such assets were exchanged. Once evaluated, a memo will be sent from the Chief of Eligibility & Payments to the field staff who will then determine the amount of penalty prior to processing the application.

F-420 ANNUITIES

An annuity is a contract between an individual and a commercial company in which the individual invests funds and, in return, is guaranteed fixed substantially equal installments for life or a specified number of years.

A determination must be made regarding the purpose of the annuity. The annuity must have an expected return commensurate (equal) with the life expectancy of the beneficiary to be deemed actuarially sound.

If the individual is not expected to live longer than the guarantee period of the annuity, the individual will not receive fair market value and is subject to a transfer of assets penalty.

a. Treatment of Annuities Purchased Prior to October 1, 2000.

An annuity purchased prior to October 1, 2000 is not an available resource if it is annuitized (yields monthly fixed, equal installments for a specified number of years, not to exceed the life expectancy of the customer, or for the life of the customer) and regular returns are being received by the annuitant. The funds received are income in the month received.

If the annuity purchased by the applicant/customer or his/her spouse has not been annuitized it shall be considered an available resource regardless of the irrevocable status.

b. Treatment of Annuities Purchased On or After October 1, 2000.

The purchase of an annuity shall be considered as a transfer of assets without fair consideration unless the following criteria are met:

1. The annuity is purchased from a life insurance company or other commercial company that sells annuities as part of its normal course of business; and

2. The annuity is annuitized for the applicant/customer or his/her spouse; and

3. The annuity is purchased on the life of the applicant/customer or his/her spouse; and

4. The annuity provides payments for a period not exceeding the annuitant's projected life.

Staff shall determine the maximum spousal need allowance of the community spouse, if applicable. If the monthly payment amount provided by the annuity to the community spouse exceeds the maximum spousal need allowance, the amount of the annuity which causes the monthly annuity payment to exceed the maximum spousal need allowance shall be considered a transfer without fair consideration in determining the institutionalized spouse's eligibility. This subsection applies only to the extent the transferred amount causes the community spouse resource allowance to exceed the maximum.

Staff shall determine if the applicant/customer is receiving substantially equal installments from the annuity for the period of the annuity. If the annuity is not paid in substantially equal installments, the original purchase price of the annuity shall be considered as a transfer without fair consideration.

If an annuity was purchased more than 36 months prior to the date of application, the penalty period for a transfer without fair consideration has expired. Any income received from the annuity shall be considered as income in the month received.

If an irrevocable annuity is purchased by a Medicaid applicant/customer, or their spouse, and the return or benefit from the annuity is transferred to a third party, a transfer of assets without fair consideration exists for the total amount of the annuity.

If a revocable annuity is purchased by a Medicaid applicant/customer, or their spouse, the total amount invested in the annuity is considered as a countable resource. Once it has been determined a transfer of assets without fair consideration exists, the penalty period shall be calculated as shown below.

An annuity purchased by the applicant/customer must name their spouse as the beneficiary, and if unmarried, Medicaid is the beneficiary, otherwise a transfer of assets without fair consideration exists for the total amount of the annuity.

c. Treatment of Annuities Purchased On or After February 8, 2006.

Application Requirements

Disclosure of interest in an annuity is required for Medicaid coverage for HCBW and long-term care services at application or redetermination. The individual is required to disclose any interest they, or their community spouse, may have in an annuity regardless if it is irrevocable or is treated as an asset.

If the individual, spouse, or representative refuses to disclose information related to any annuity, the case manager will deny or terminate eligibility for long-term care services or Home and Community Based Waiver (HCBW) services, as applicable.

Information regarding the income and/or resources related to an annuity must be collected and verified to establish Medicaid eligibility.

1. There is no option to withhold information about annuities.

2. If the individual fails to provide enough information about an annuity to allow a determination of Medicaid eligibility, the case manager will deny the application based on the individual's failure to cooperate.

3. When an unreported annuity is discovered *after* eligibility has been established *and* after payment for long-term care services has been made, terminate eligibility for long-term care services based on the applicant's failure to cooperate.

The state must be named as a remainder beneficiary in annuities in which the applicant or spouse is the annuitant.

The case manager will notify the issuer of any annuity disclosed of the state's right as a *preferred* remainder beneficiary.

The issuer is required to notify the state of any changes in disbursement of income or principal from the annuity.

The issuer may disclose information about the state's position as remainder beneficiary to others who have a remainder interest in the annuity.

d. Evaluation and Treatment of Certain *Transactions* Related to Annuities On or After February 8, 2006

Annuity-Related Transactions Other Than Purchases

Transactions that occur on or after February 8, 2006 may make an annuity, including one purchased *before* that date, subject to the DRA transfer of assets, if the transaction includes:

1. Any action taken by the individual that changes the course of payments, or

2. Any action taken by the individual that changes the treatment of the income, or principal.

For annuities purchased prior to February 8, 2006, routine changes and automatic events that do not require any action or decision after February 8, 2006 are not considered transactions that would subject the annuity to the DRA transfer of asset provisions include:

1. Notice of address change; or

2. Death or divorce of a remainder beneficiary, and other similar circumstance; or

3. Changes that 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. **Example:** if an annuity purchased in June 2001 included terms that require distribution to begin five years from the date of purchase, and payouts consequently begin, as scheduled, in June 2006, it would not be considered a transaction subject to the DRA transfer provision, since no action was required to initiate the change; or

4. Changes that are beyond the control of the individual, such as a change in law, change in the policies of the issuer, or a change in the terms based on other factors such as the issuer's economic conditions.

Requirement to Name the State as a Remainder Beneficiary on Annuities

The annuity shall be treated as a transfer of assets for less than fair market value unless the state is named as remainder beneficiary in the first position.

This applies unless there is:

1. A community spouse; and/or

2. A minor child or disabled child (the disabled child could be a minor or an adult); and

3. There is a community spouse or minor or disabled child and the state is named in the next position *after* (1) or (2); but

4. If a community spouse or minor or disabled child, or their representative disposed of any of the remainder of the annuity for less than fair market value, the state is named in the first position.

   As a remainder beneficiary the state may receive up to the total medical assistance, LTC, or HCBW services paid on behalf of an individual.

   The case manager notifies the issuer of the annuity of the state's right as the *preferred* remainder beneficiary, and requests verification the state is named as a remainder beneficiary in the correct position.

   The issuer is required to notify the state if and when there is a change in the amount of income or principal being withdrawn.

   If the state is *not* named as a remainder beneficiary in the correct position, the full purchase value of the annuity is considered a transfer for less than fair market value.

Annuities Purchased By or On Behalf of an Annuitant Who Applies for Medical Assistance

The purchase shall be treated as a transfer of assets for less than fair market value *unless* the annuity meets the following criteria:

1. The community spouse is the annuitant, and

2. The state is named in the proper position as a remainder beneficiary.

The purchase shall be treated as a countable resource *if* it meets one *or* both of the following:

1. The annuity can be cancelled or revoked; or

2. The annuity is assignable.

The purchase will *not* be treated as a transfer of assets *if* the annuity meets any of the following conditions:

Is either:

1. An individual retirement annuity (according to Section 408(b) of the Internal Revenue Code of 1986 (IRC)); or

2. A deemed Individual Retirement Account (IRA) under a qualified employer plan (according to Section 408(q) of the IRC).

Or

Is purchased with proceeds from one of the following:

1. A traditional IRA (IRC Section 408a); or

2. Accounts or trusts that are treated as traditional IRAs (IRC Section 408 §(c)); or

3. A simplified retirement account (IRC Section 408 §(p)); or

4. A simplified employee pension (IRC Section 408 §(k)); or

5. A Roth IRA (IRC Section 408A).

Or

Meets *all* the following requirements:

1. Is irrevocable and non-assignable;

2. Is actuarially sound;

3. Provides payments in equal amounts, with no deferred or balloon payments.

The burden of proof is upon the individual or their representative to verify if the annuity meets the provisions above. Absent proof, the full purchase value of the annuity is considered a transfer of assets.

Refer annuities which are irrevocable and non-assignable to the Chief of Eligibility and Payments to determine actuarial soundness.

Note: Even if an annuity is determined to meet the conditions above and the *purchase* is not treated as a transfer, if the annuity or the income stream from the annuity is transferred, except to a spouse or to another individual for the sole benefit of the spouse, child, or trust, that transfer may be subject to penalty.

Send all documents of the life estate, promissory note, loan, mortgage, and/or annuity to the Chief of Eligibility and Payments for review.

F-425 HOME AND COMMUNITY BASED WAIVER (HCBW) AND MILLER TRUST (QIT)

Section 1917 of the Social Security Act established that a Qualified Income Trust (QIT), also known as a Miller Trust*, may be used by individuals applying for or receiving Home and Community Based Waiver (HCBW) services to reduce the amount of countable income when determining eligibility for the HCBW program. Because a HCBW customer is not assessed a patient liability, the HCBW customer may not be able to spend all income deposited in the QIT monthly. No patient liability expense may cause income to accumulate in a QIT for a HCBW customer. HCBW customer with a QIT require regular accounting to verify proper payments of allowable expenses as outlined in 42 CFR 435.725 (i.e., personal needs allowance, spousal/family allowance and certain unreimbursed medical expenses) and income deposited into the QIT. If any accumulation occurs in the QIT, the HCBW customer must be evaluated for transfer of asset penalty.

***Note:** A QIT, or Miller Trust, helps an individual living in a long-term care or HCBW setting to potentially qualify for Medicaid if his or her income exceeds the allowable income limit.

F-430 RESOURCES

For the purposes of this section, the definition of resources is the same definition used by the (SSI) program, except that the home is not excluded for any institutionalized individuals.

F-435 PURSUING A POSSIBLE TRANSFER

If the individual follows the appropriate steps and provides a rebuttal to the presumption of transfer, but is unsuccessful in rebutting the presumption of transfer, the individual may request an undue hardship waiver if the request is made within twenty (20) days after the adverse decision of the Chief of Eligibility and Payments *or* the Hearing Officer on the presumption of transfer issue.

F-435.1 Transfer/Disposal of Asset Notification (Form 2601)

Send Form 2601-EE to applicant to inform the individual the Division presumes the asset was transferred to become/remain eligible for Medicaid LTC or HCBW Services. The amount of the uncompensated value is the amount of the transfer. Allow 20 days

for the individual to:

a. Rebut the presumption of transfer; **or**

b. Request an undue hardship.

The notice to the individual advises them of the undue hardship exceptions.

If the customer does not respond within the 20-day time limit, the case manager will assume he/she does not want to rebut the presumption of transfer or request an undue hardship waiver. The penalty period will remain imposed and HCBW benefits or long-term care benefits, as applicable, will not be paid by Medicaid during the penalty period.

If a rebuttal or undue hardship request is submitted, follow the appropriate steps.

F-435.2 Rebuttal

If the individual rebuts the presumption of the transfer, it is their responsibility to present convincing evidence responding specifically to each of the following listed points that the asset was transferred **exclusively** for some reason other than to become eligible or retain eligibility for Medicaid, LTC or HCBW services. The rebuttal must include:

a. A written statement from the customer/authorized representative and the other individual(s) involved in the transfer, stating the reason for the transfer;

b. Verification of the attempts to dispose of the asset at fair market value, if applicable;

c. Documentation fair market value was received if that is the contention or the reasons for accepting less than fair market value;

d. The customer's relationship, if any, to the person(s) to whom the resource was transferred;

e. The customer's plans for self-support after the transfer;

f. Any relevant documentation regarding the transfer such as legal documents, correspondence, statements from other individuals, receipts, etc.

Once a rebuttal and all the necessary information to substantiate the claim are received, the case manager must determine if the information specifically addresses points (a)

through (f) and as described on Form 2601. If the customer fails to address a point or points, advise the customer which point(s) must be addressed before a decision can be made.

Upon receipt of the information, send the rebuttal to the Chief of Eligibility and Payments requesting a decision on whether a transfer of assets occurred and include a Form 6009 with the following information:

a. The name and case number of the applicant/recipient;

b. The application date;

c. The date the customer began receiving HCBW of LTC Services;

d. A brief description of the circumstances of the transfer; and

e. Verification of the Fair Market Value of the asset **at the time of transfer**.

F-435.3 Undue Hardship

If undue hardship is claimed, the individual will be responsible for providing convincing evidence the penalty period would cause an undue hardship. The evidence must include:

a. A written statement from the customer/authorized representative, or facility staff person (upon consent of the individual or the individual's authorized representative) stating the reason they feel undue hardship applies;

b. Verification, if possible, there is no means, legal or otherwise, by which the customer is able to have the asset transferred back to his/her ownership or receive further compensation; and

c. The customer's relationship, if any, to the person(s) to whom the asset was transferred.

Denial of eligibility would cause an undue hardship against the individual when **all** of the following conditions exist:

a. The customer is otherwise eligible for Medicaid; **and**

b. The customer has insufficient funds to cover the cost of institutionalized care; **and**

c. The person(s) who has/have the asset(s) has refused to make the asset(s) available to the customer; **and**

d. The customer has exercised all reasonable efforts and all possible avenues to recover and/or access the assets by returning the assets to his/her ownership or to receive further compensation; **and**

e. Without Medicaid, the customer would be forced to go without life sustaining medical care as determined by an individual licensed to practice medicine in the State of Nevada.

Upon receipt of the information, send the hardship request to the Chief of Eligibility and Payments requesting a decision on whether undue hardship exists and include a Form 6009 with the following information:

a. The name and case number of the applicant/recipient;

b. The application date;

c. The date the customer began receiving LTC or HCBW Services; and

d. A brief description of the circumstances of the transfer and why it would be an undue hardship if the penalty were imposed.

A decision whether a transfer of assets occurred or an undue hardship waiver is granted will be made within 45 days from the date the Form 6009 and all pertinent information is received by the Chief of Eligibility and Payments, unless extenuating circumstances exist. An adverse determination may be appealed if received by the hearing officer within 90 days from the date of the transfer of assets or undue hardship decision.

If the individual's request for an undue hardship waiver is received timely, continue through to the decision-making process by the Chief of Eligibility and Payments.

F-435.4 Return of Assets

If all assets transferred for less than fair market value are returned to the individual, no penalty for transferring assets can be assessed. Full Medicaid eligibility must be restored for any months a penalty was assessed if the return of assets does not cause ineligibility for other reasons.

If counting the returned income/assets results in the individual being ineligible for some or all of the months of the penalty period (because of excess income/resources), do not restore full Medicaid for months that would now be ineligible due to the excess income/resource.

F-440 PENALTY PERIOD

F-440.1 Application of Penalties for Transfers Made Prior to February 8, 2006

The penalty begins the first day of the month in which the asset was transferred, provided that date does not occur during an existing penalty period.

For HCBW applicants/recipients:

a. The length of the penalty period is based solely on the value of the assets transferred and the average cost of private nursing care.

b. The length of the penalty period is calculated by dividing the value of the transferred asset (at the time of transfer) by the average cost of care (at the time of application).

For institutional applicants/recipients:

a. The length of the penalty period is based solely on the value of the assets transferred and the average cost of private nursing care.

b. The length of the penalty period is calculated by dividing the value of the transferred asset (at the time of transfer) by the average cost of care (at the time of application).

A new penalty period cannot begin until an existing penalty period has expired.

A penalty period runs continuously regardless of whether the individual remains eligible for HCBW services or if the institutionalized individual remains in or leaves the institution.

The penalty period can be shortened if:

a. Verification is received the asset has been returned to the customer.

b. The applicant/recipient receives additional compensation for the transferred asset. Verification of the additional compensation must be obtained by the case manager. The uncompensated value will be reduced by the amount of the additional compensation paid.

If the uncompensated value is reduced to a point that when dividing the remaining amount by the average cost of private nursing care only a partial month remains, the case may be eligible beginning with that partial month if all other eligibility criteria is met.

A penalty is not imposed when one amount or many amounts of transfer(s) in one month is less than the monthly cost of the nursing facility care.

A penalty is not imposed when a series of transfers, each less than the private nursing facility rate for a month, is made by an individual.

When a single asset is transferred or a number of assets are transferred during the same month, the penalty period is calculated using the total value of the asset(s) divided by the average monthly cost of nursing facility care.

When multiple transfers in separate months occur, use the following methods for calculating the penalty periods.

a. **Penalty Periods Overlap** – calculate the individual penalty periods and impose them sequentially.

Example: An individual transfers $20,000 in January, $20,000 in February and $20,000 in March, all of which are uncompensated. Calculate the individual penalty periods and impose them sequentially: $20,000/$4,583 (2004) equals a 4-month penalty. The penalty for the first transfer extends from January through April, the second extends May through August, and the third extends from September through December.

b. **Penalty Periods Do not Overlap** – when multiple transfers in multiple months occur where the penalty periods for each do not overlap, treat each transfer as a separate event with its own penalty period.

Example: An individual transfers $12,000 in January, $12,000 in May and $12,000 in October, all of which are uncompensated.

Using the current nursing facility cost of $4,583, calculate each transfer $10,000/$4,583 (2004) to determine each penalty period. In this example, the penalty periods for transfers are a 2-month period, respectively, the months of January through February, the months of May through June, and the months of October through November.

F-440.2 Application of Penalties for Transfers Made On or After February 8, 2006

The length of the penalty period is calculated by dividing the value of the transferred asset (at the time of transfer) by the average cost of care (at the time of application).

The period of ineligibility will *not* always be the first day of the month following the month in which the transfer occurred but:

a. The first day of the month following the month which assets have been transferred for less than fair market value; **or**

b. The date the individual would otherwise be eligible for HCBW or LTC services *whichever is later.*

Asset transfers are also evaluated *anytime after* the individual begins receiving nursing facility or HCBW services. Apply the transfer of assets penalty to the first month administratively possible allowing for adverse.

"Rounding down" or "disregarding" any fractional period of ineligibility is prohibited; therefore, calculate the percentage to continue the penalty into the next month.

Example: An applicant/recipient is eligible to receive Medicaid coverage for long-term care effective July, 2013. This individual made a transfer for less than market value of $20,000 in May, 2013. The penalty is calculated by dividing the $20,000 by $7,139 (state's average cost of care in 2013). The result is 2.80. The penalty would be imposed for July, 2013 through September, 2013, plus 25 days of October, 2013 (31 days times .80 equals 25 days.)

Any transfer of assets for less than market value must have a penalty imposed even if only for a *"partial month."* To determine the penalty period, case managers will divide the monthly cost of care by the number of days in the month the penalty is to be imposed, to establish a daily rate of care. The amount of the transfer is then divided by the daily rate to determine the total days for a fractional penalty period.

Example: An applicant/recipient is eligible to receive Medicaid coverage for long-term care effective July, 2013. In May, 2013, the individual made a transfer for less than fair market value of $2,000. The month of July has 31 days with a daily rate of cost of care at $230.29. This results in a penalty of 9 (8.68) days for July, 2013.

If an individual or the individual's spouse has made *"multiple transfers"* within the look-back period, regardless of whether the value exceeds the state's average cost of care, combine the values for a cumulative total and impose a penalty as if it were one transfer.

The penalty period cannot begin until the expiration of any existing penalty period.

Once a penalty period is imposed, it cannot be interrupted or temporarily suspended regardless if the individual remains in or leaves long-term care.

F-440.3 Exceptions

The Transfer of Assets policies shall *not* apply:

a. To medical assistance provided for services furnished prior to February 8, 2006;

b. To assets disposed of on or before February 8, 2006;

c. To trusts established prior to February 8, 2006; or

d. To transactions involving a partial month, multiple transfers, a life estate, or promissory note, loan or mortgage prior to April 1, 2006.

F-440.4 Penalty Period - Spouse Involvement

When a spouse transfers an asset resulting in a penalty period for the customer, in the following circumstances the penalty period must be apportioned between spouses:

a. The spouse is eligible for Medicaid as an institutionalized individual; and

b. Some portion of the penalty against the customer remains at the time the above condition is met.

The remaining penalty period existing for the customer will be divided in one-half and that one-half period of time will apply to the customer and the spouse.

If for some reason one spouse is no longer subject to a penalty, the remaining penalty period applicable to both spouses must be served by the remaining spouse.

F-440.5 Situations Under Which Transfer of Asset provisions DO NOT Apply (not all inclusive)

a. Assets which are **excluded at the time of the transfer**. **Exception**: The home of an institutionalized applicant/recipient (principal place of residence) can only be transferred in the specific instances outlined in section (e) below.

b. When the customer's name is removed from a joint bank account in accordance with joint banking policy.

c. Assets which have been divided **equally,** or by the legal portions owned, between legal owners.

d. When the customer provides verification they made a purchase(s) for themselves. If someone else made the purchase(s) for the customer, the Chief of Eligibility and Payments must make the final decision in accordance with the transfer procedures.

e. When the customer's home is transferred to:

1. The spouse of the applicant/recipient.

2. A child of the customer who is under 21, or over 21 and is blind or disabled.

3. A sibling of the applicant/recipient who has equity interest in the home **and** was residing in the home for at least one year immediately preceding the customer becoming institutionalized or receiving HCBW Services.

4. A son or daughter who does not meet "2" above, who resided in the home for at least two years immediately preceding the customer becoming institutionalized (including HCBW Services) **and** who (as determined by the state) provided care to the customer which permitted the customer to reside at home rather than in an institution or facility.

f. When the asset is transferred to the customer's spouse or to their child who is blind or disabled.

g. Assets placed in an **exempt trust** for a disabled individual or assets placed in a trust which are used to benefit the disabled individual **and** the trust purchases items and services for the disabled individual at fair market value. An exempt trust is a "special needs" or a "pooled" trust as described in subsection **Treatment of Trusts**.

If 3 or 4 above applies, the case manager supervisor must sign off on the case prior to the case being approved.

F-445 DECISION

Forward Form 6009 with all attached documents to the Chief of Eligibility and Payments for cases requiring a decision from the Chief of Eligibility and Payments. A memo will be issued to the district office notifying them of the decision. If the decision is that no transfer occurred, the case can be approved/continued if all other eligibility factors are met. If the decision is that a transfer took place, the memo will identify the penalty period to be applied.