I-1670 TRANSFER OF ASSETS FOR LESS THAN FAIR MARKET VALUE (FMV)

I-1671 GENERAL INFORMATION

An institutionalized individual who is applying or approved for long-term care (LTC) or home and community-based services (HCBS) waiver, or the spouse of the individual, that disposes of assets for less than fair market value (FMV) during or after the look-back period may not be eligible for payment of services. The look-back period for an institutionalized individual is the 60 months prior to applying for Medicaid.

Any income or resources transferred during or after the 60-month look-back period must be evaluated to determine if FMV was received in exchange for the asset. If FMV was not received in exchange for the asset, a period of ineligibility, known as a penalty period, must be served by the institutionalized individual. During the penalty period, Medicaid will not pay for the services provided in a nursing facility or by an HCBS waiver program.

Note:
Do not apply the transfer of assets rules to the Program of All-inclusive Care for the Elderly (PACE).

The transfer of an asset for less than FMV is presumed to be for the purpose of qualifying for Medicaid, unless the individual presents convincing evidence that the transfer was exclusively for some other purpose.

The individual shall be offered the opportunity to rebut the presumption that a transfer was made to reduce assets in order to qualify for Medicaid. Convincing evidence must be provided that proves that the transfer was done solely for a reason other than to qualify for Medicaid.

For every case in which a penalty period is determined, the individual shall be offered the opportunity to apply for an undue hardship exception. It is the responsibility of the individual to provide convincing evidence that imposing a penalty period would deprive the individual of medical care such that the individual's health or life would be endangered or of food, clothing, shelter, or other necessities of life.

All efforts to recover the transferred assets, or have the transferred asset returned, must be exhausted before undue hardship can be considered. In situations in which an individual alleges that assets were transferred without his/her consent, the individual is required to file a police report and pursue criminal charges against the accused. If Adult Protective Services (APS)/Elderly Protective Services (EPS) is investigating an allegation of exploitation or extortion of an individual's assets, a police report is not necessary. Refer to H-860 Undue Hardship And Undue Hardship Exception.

Note:
Refer to I-1660 Spousal Impoverishment Resource Provisions (LTC/HCBS), for transfers to a community spouse by an applicant/beneficiary who entered a facility on or after September 30, 1989.

I-1672 RESERVED

I-1673 WHAT IS A TRANSFER?

Transfers of asset ownership may occur through, but not limited to, any of the following types of transactions:

- Sale or purchase of personal/real property;
- Trade or exchange of one property for another; or
- Giving away property, cash, stocks, bonds, etc.

Obtain copies of available evidence of the alleged transaction. This includes items such as the bill of sale, act of donation, professional appraisals, bank statements, receipts for purchases, and/or signed statements from recipients of gifts.

When there is a transfer of assets made by the applicant or their spouse during or after the look-back period, if the information about the nature of the transfer is not available or the individual cannot provide documentation, obtain the individual's signed statement as to:

- The nature of the transfer (sold, given away, traded, exchanged for goods or services, etc.);

- The person who transferred the asset;
- The name of the person to whom the asset was transferred and the applicant or spouse's relationship to the person;
- The method of transfer;
- The date of the transfer;
- A description of the asset transferred (home, real property, cash lump sum, vehicles, stocks, bank accounts, etc.) and the value at the time of transfer;
- The amount of cash transferred or FMV of the property at the time of transfer;
- The compensation received or expected from the transferred asset; and
- Any remaining ownership interest the applicant/beneficiary or their spouse retained (e.g., a partial interest).

Document the decision concerning the validity of the transfer and the basis for it in the Medicaid case record.

Determine if the FMV was received in exchange for the transferred asset or if the transfer was made for some other purpose than to qualify for Medicaid. Value is based on criteria used in appraising the value for the purpose of determining Medicaid eligibility. For an asset to be considered transferred for FMV 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. For example, a transfer for love and consideration is not considered a transfer for fair market value.

- If the individual received FMV for the transferred asset or successfully rebuts the presumption, a penalty period does not apply.
- If the individual did not receive FMV for the transferred asset, determine if the transfer qualifies for exception.

- If the transferred asset qualifies for an exception, a penalty period does not apply.

- If no exceptions apply, compute the penalty period.

Refer to **1-1674 Exceptions to Application of Transfer of Asset Penalties.**

Assets to which an individual or spouse is entitled to includes assets that they would be or would have been entitled to if action had not been taken to avoid receiving the assets.

It is necessary to consider transfer of assets for less than FMV for any income or resources the individual or their spouse is entitled to but does not receive because of any action by:

- The applicant**/**beneficiary;

- The spouse of the applicant/beneficiary, where the spouse is acting in place of or on behalf of the applicant/beneficiary, except as allowed under Spousal Impoverishment provisions (Refer to I-1666, Spousal Impoverishment Resource Provisions);

- A person, including a court or administrative body, with legal authority to act on behalf of the applicant/beneficiary or their spouse, i.e. power of attorney, curator, or a parent of a minor child;

- A person, including a court or administrative body, acting at the direction of or upon the request of the individual, or their spouse; or

- The co-holder of an asset jointly held with the applicant/beneficiary.

Actions which would prevent income or resources to be received include, but are not limited to, the following:

- Irrevocably waiving all or part of federal, state, or private pensions or annuities;

- Giving away a lump sum payment, even the month of receipt;

- Diverting income received, e.g. insurance proceeds, settlements, etc. into a trust, or similar device not by a court order; and/or

- Renouncing an inheritance.

I-1673.1 Transfers of Assets

Applicants may declare transferred assets on the application or unreported transfers may be discovered during the application or renewal process. The following circumstances may indicate a transfer of assets occurred:

- Establishing a trust;

- The purchase of an annuity;

- Disposing of assets which could be received but are refused (e.g., refusing an inheritance);

- A pattern of unusual withdrawals or deposits prior to admission or application reported on financial statements;

- Tax assessor or clerk of courts records showing past ownership of real property by the applicant or their spouse;

- The owner of a life insurance policy irrevocably waives their rights to surrender the policy for cash, obtain a loan against the policy or to change the ownership of the policy without obtaining a funeral for fair market value. Contractual agreement and a list of funeral goods and services can be used to verify value of the funeral services and goods. (RS 37:862).

- Purchase of usufruct (life estate) interest;

  For the purposes of determining eligibility for Medicaid coverage, the terms “life estate” and “usufruct” have the same meaning.

  Some States allow life estates with powers, wherein the owner of the property creates a life estate for himself or herself, retaining the power to sell the property, with a remainder interest to someone else. Since the life estate

holder retains the power to sell the property, its value as a resource is its full equity value because nothing of value was transferred since the owner can terminate the life estate at any time and restore full ownership to himself or herself.

If an individual transfers real property but retains or reserves a life estate, the value of the remainder interest, not the life estate would be used in determining whether a transfer of assets have occurred and in calculating the period of ineligibility.

The purchase of a life estate interest in another individual's home may be a transfer of assets if the FMV was not received and the purchaser did not actually reside in the home for a continuous period of one year after the date of the purchase of the Life Estate/Usufruct.

If the applicant has not resided in the home for at least one year after purchase, the entire amount used to purchase the life estate is treated as a transfer of assets. The amount should not be reduced or prorated to reflect an applicant's residency for a period of less than a year.

If the applicant resided in the home for one year after the date of purchase, the value of the life estate interest purchased in another individual's home should be counted as a resource in determining Medicaid eligibility unless it can be excluded as the applicant's home.

Even if the applicant resided in the home for one year after the date of purchase, the purchase amount of the life estate interest cannot be greater than value of the life estate's interest. The difference between the purchase amount for a life estate interest and value of the life estate's interest should be treated as a transfer of assets.

The value of the Life Estate Interest must be determined to establish if fair market value was received.

To establish the value of the life estate interest, use the following steps:

1. Determine the current market (equity) value of the property to which the applicant/beneficiary purchased the Life Estate interest.

2. Refer to Z-1300 Usufruct and Remainder Interest Tables.

3. Select the figure for the age of the applicant at the last birthday.

4. Multiply the figure in the usufruct column by the current market (equity) value of the property.

5. The result is the Life Estate value.

6. Compare the life estate value to the purchase amount for the life estate interest.

7. If the amount paid for the life estate interest is greater than the life estate value, the difference is treated as a transfer for less than FMV.

- Transfer of income; and/or

  When income has been transferred as a lump sum (the money is transferred in the same month it was received), the penalty period is based on the amount of the lump sum payment.

  When income received on a regular basis, such as a pension is transferred, use the total amount of income expected to be received during the individual's lifetime based on an actuarial projection of the individual's life expectancy, and calculate the penalty on the basis of the projected total income transferred. Refer to Z-1200 Life Expectancy Tables.

- Purchasing a Loan, Promissory Note, Mortgage.

  Countable assets include funds used to purchase a promissory note, loan, or mortgage. Establishment of promissory notes, loans, or mortgages by the applicant or spouse is a transfer of assets unless all of the following criteria are met:

  - The repayment term must be actuarially sound;

  - Payments must be made in equal amounts during the term of the loan with no deferral of payments and no

balloon payments; and

- The promissory note, loan, or mortgage must prohibit the cancellation of the balance upon death of the lender.

Should the promissory note, loan, or mortgage not satisfy all of criteria, the amount of the asset transferred is the outstanding balance of the note, loan, or mortgage due as of the date of the individual's application for Medicaid.

The life expectancy chart at Z-1200 Life Expectancy Tables is used to determine if the repayment is actuarially sound.

Should the promissory note, loan, or mortgage contain all of the criteria, refer to I-1630 Need – SSI-Related Resources and I-1530 Need – SSI-Related Income.

I-1673.2 Valid Loan/Valid Debt Defined

A valid loan or valid debt is a legally binding agreement made in good faith and is enforceable under State law.

Verify by obtaining a copy of the valid loan or debt owned or owed by the applicant.

If the loan or debt was a verbal agreement, obtain a sworn written statement from both the borrower and the lender as to the nature of the loan, the amount, obligation for repayment, and other terms and conditions surrounding the alleged debt.

Obtain documentary evidence of payments made by or to the applicant according to the terms of the loan agreement.

Contracts which are no longer enforceable are not valid. For example, agreements whether oral or written have a prescriptive period depending on the type of contract. Once that limitation period passes, and no lawsuit was filed, the debt does not need to be paid by the borrower. The creditor relinquishes its right to file suit and collect a debt that it is owed after this time period has expired. Questions regarding the enforceability of a contract should be referred to the Policy unit.

I-1673.3 Actions Not Considered as Transfer of Assets for Less Than FMV

There are some circumstances where the transfer of assets provision does not apply. A transfer of assets has not occurred in the following situations:

- Using an asset to repay a valid debt or make a purchase;

  Note:
  Relatives and family members can legitimately be paid for care they provide; however, it is presumed that services provided for free at the time were intended to be provided without compensation. Therefore, any payment to a relative for care provided for free in the past is a transfer of assets for less than fair market value.

- Transfers of funds which do not result in a change of ownership (e.g., an authorized representative holding and managing funds for the sole benefit of an applicant/beneficiary or spouse as long as the funds are available to meet their needs);

- Removing an applicant/beneficiary's name from a joint account following successful rebuttal that the applicant/beneficiary is not owner of the resource; and

- Transactions, which render an asset inaccessible, but do not change the individual's degree of ownership of the asset. For example, an individual who jointly owns property with another individual can enter into an agreement with the joint owner not to sell the share without the joint owner’s consent.

- Transfer of an excluded asset with the exception of the home of an institutionalized individual.

  Note:
  Transfer of a disregarded asset, such as CSV of life insurance policies, is a transfer for less than FMV.

I-1673.10 Personal Care Agreement

A Personal Care Agreement (PCA) is a legally binding contract that allows an individual (care recipient) to pay another person (caregiver) to provide personal care services. Services may include, but are not limited to, assistance with Activities of Daily Living (ADL), such as

bathing, dressing, grooming, transferring, toileting, and eating. The PCA shall be considered a transfer for less than FMV unless all of the following mandatory provisions are met:

- The agreement provides for the provision of reasonable and necessary medical care or assistance, which is not otherwise covered by Medicare, Medicaid, or private insurance.

- The agreement must be in writing and properly executed prior to the service or assistance being provided. The agreement cannot be applied retroactively to pay for services or assistance that was provided prior to the agreement.

- The agreement must specify the type of service to be provided, the frequency for providing the service, the time to be spent providing the service or assistance, and the amount of compensation to be paid for the service.

- The agreement must provide for payment upon rendering of the services or assistance, or within 30 days thereafter.

- The agreement must be supported by evidence that services and payments were made in accordance with the agreement.

- The caregiver cannot be the spouse or parent of the applicant/beneficiary.

- The applicant/beneficiary or his/her legally authorized representative has the power to modify, revoke, or terminate the agreement.

A PCA that fails to contain all of the mandatory provisions is considered a transfer for less than FMV. Payments made under the written agreement that do not have the mandatory provisions will be considered as the amount transferred.

If a written agreement meets the mandatory requirements, it must be determined whether adequate compensation in the form of services or assistance was provided.

Adequate compensation shall be measured against the usual and customary charges for these services in the local area. If services or assistance require extraordinary skill, the provider or caregiver must possess the required skill, experience, or expertise. These services or assistance may be valued in accordance with similar services in the

community.

If payments are made for compensated services or assistance, but the payments exceed the usual and customary charges for the services or assistance, then the amount of the payment is a transfer without compensation.

The services and assistance must be provided within thirty days from the date of payment. Pre-payment for services or assistance not yet rendered, and that cannot be provided within 30 days, is a transfer without compensation.

The Personal Care Agreement ceases upon the death of the applicant/beneficiary or upon admission to a nursing facility.

Note:
Relatives and family members can legitimately be paid for care they provide; however, it is presumed that services provided for free at the time were intended to be provided without compensation. Therefore, any payment to a relative for care provided for free in the past is a transfer of assets for less than fair market value.

I-1674 EXCEPTIONS TO APPLICATION OF TRANSFER OF ASSET PENALTIES

1. The transferred asset is the individual's home and the title to the home is transferred to the individual's:
    - Spouse,
    - Child who is:
        - Under age 21, or
        - Meets the definition of Blindness or disability, as defined by SSI, at the time of the transfer. If there is no disability determination at the time of the transfer, obtain an MEDT decision. The age at onset of disability is not a factor. Refer to G-1600 Securing Disability Decisions for Non-MAGI Categories
    - Sibling who has:
        - An equity interest in the home, and
        - Been residing in the home for a period of at least one

year immediately before the date the individual admitted to nursing facility or HCBS waiver program. The applicant will need to provide verification (vehicle registration, mail received, etc.).

- Child who:
  - Is age 21 or over,
  - Is not blind or permanently and totally disabled,
  - Was residing in the home for at least two years immediately before the date the individual admitted to nursing facility or HCBS waiver program, and
  - Provided care to the individual allowing the individual to reside at home, rather than in an institution or facility.

    Note:
    To qualify for the exception, the applicant must provide:

    - A written statement from their physician indicating the applicant's medical/physical condition during the preceding two years was such that he/she required nursing facility level of care services, and the applicant's child resided in the home as the primary caregiver; and

    - Verification the child resided in the home for the entire two-year period (vehicle registration, mail received, etc.).

2. The assets transferred were other than the individual's home and were transferred:

   - To the individual's spouse, or to another for the sole benefit of the individual's spouse.

   - From the individual's spouse to another for the sole benefit of the individual's spouse.

   - To the individual's child, or to a trust established solely for the benefit of the individual's child, who is blind or disabled, as defined by SSI, at the time of the transfer. If there is no disability determination at the time of the transfer, obtain an MEDT decision. The age at onset of disability is not a factor.

- To a trust established for the sole benefit of an individual under 65 years of age who is disabled as defined by SSI.

  For the sole benefit of means to benefit one person only. A transfer is considered to be for the sole benefit of a spouse, blind, or disabled child, or 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.
  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.

  The transfer or trust 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.

3. The individual makes a satisfactory showing that he or she intended to dispose of the assets whether at fair market value or for other valuable consideration.

4. The individual establishes that the assets were transferred exclusively for a purpose other than to qualify for Medicaid.

5. All of the assets transferred for less than fair market value has been returned to the individual.

6. Imposition of a penalty would work an undue hardship.

I-1674.5 Annuities

For Medicaid eligibility purposes, an annuity is considered a legal instrument or device similar to a trust (Refer to I-1730, Trusts Established After August 11, 1993). 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.

Treatment of Annuities created January 1, 2003 thru February 7, 2006

An annuity containing a balloon payment will be considered an available resource. An annuity purchased by or for an individual using that individual's assets will be considered an available resource unless all of the following criteria are met. The annuity:

1. Is irrevocable;

2. Pays out principal and interest in equal monthly installments (no balloon payment) to the individual in sufficient amounts that the principal is paid out within the actuarial life expectancy of the institutionalized individual;

   Names the State of Louisiana, Louisiana Department of Health, or its successor agency as the primary and permanent residual beneficiary of funds remaining in the annuity, not to exceed any Medicaid funds expended on the individual during his/her lifetime; and

3. Is issued by an insurer or other body licensed and approved to do business in the jurisdiction in which the annuity is established.

Annuities which do not meet all of the above criteria must be amended to comply with these requirements. Annuities which do not provide for pay out of principal and interest in equal monthly installments, and for which documentation is received from the issuing company that the "pay out" arrangements cannot be changed, will be considered to meet the new requirements once amended to name the State of Louisiana, Louisiana Department of Health, or its successor agency as the primary and permanent residual beneficiary of funds remaining in the annuity, not to exceed any Medicaid funds expended on the individual during his/her lifetime.

Note:
The Louisiana Department of Insurance web site can be used to determine if a company is licensed and approved to do business in LA. The site is www.ldi.state.la.us.

Use Z-1200 Life Expectancy Tables to determine actuarial life expectancy of the annuitant when necessary.

Treatment of Annuities created on or after February 8, 2006

Effective February 8, 2006, all long term care applicants, including SSI beneficiaries, were required to disclose on their application and renewals for Medicaid assistance, a description of any interest the applicant or community spouse may have in an annuity. The disclosure is a condition for Medicaid coverage of long term care services, including nursing facility services and home and community based waiver services.

This disclosure requirement applies regardless of whether or not an annuity is irrevocable or is treated as an asset.

Note:
Application forms for long term care are required to include a statement that names the State as a remainder beneficiary on any annuity purchased on or after February 8, 2006 by virtue of the provision of medical assistance for institutional care.

Requirement to Name the State as Beneficiary

The requirement to name the State as a remainder beneficiary is not restricted to annuities purchased by or on behalf of an institutionalized individual who has applied for medical assistance for nursing facility or other long term care services. It applies to annuities purchased by an applicant or by a spouse, and to transactions made by the applicant or spouse.

An annuity must name the State 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 a minor or disabled child, the State may be named in the next position after those individuals.

If the State has been named beneficiary after a community spouse and or a 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, the State may then be named in the first position.

If the State is not named as a remainder beneficiary in the correct position, the purchase of the annuity will be considered a transfer for less than fair market value if it was obtained within the 60 month lookback period. The full purchase value of the annuity will be considered the amount transferred. If the annuity was purchased outside of the lookback period, the full Fair Market Value should be

counted as a resource.

For any annuity disclosed, Medicaid must also notify the issuer of the State's right as a preferred remainder beneficiary.

Medicaid may also require the issuer to notify it regarding any changes in disbursement of income or principal from the annuity.

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

When an unreported annuity is discovered after eligibility has been established and after payment for long-term care services has been made, verification of the unreported annuity shall be requested.

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.

Appropriate steps to terminate payment for long term care services will be taken, including appropriate notice to the individual of the adverse action.

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 the all of the annuity provisions that went into effect on February 8, 2006.

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, and
- Election to annuitize the contract and similar actions taken by the individual.

Routine changes and automatic events that do not require any action or decision after the effective date of the enactment are not

considered transactions that would subject the annuity to treatment under these provisions that went into effect on February 8, 2006.

Treatment of Annuities in Determining Eligibility

The following types of annuities are not treated as a transfer of assets if the annuity meets the following conditions (these conditions do not apply to an annuity owned or purchased by the community spouse):

a) The annuity is considered 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

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

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

(2) Certain accounts or trusts which are treated as IRAs (IRC Section 408 §(c)); or

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

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

c) The annuity meets all of the following requirements:

(1) The annuity is irrevocable and non-assignable; and

(2) The annuity is actuarially sound; and

(3) The annuity provides payments in approximately equal amounts, with no deferred or balloon payments.

Applicants or their responsible or authorized representative will be responsible for providing documentation from the financial institution for verifying qualifying IRS annuities. Absent such documentation, the purchase of the annuity will be considered a transfer for less than fair market value which is subject to penalty.

The full purchase value of the annuity will be considered the amount transferred.
Even if the purchase of an annuity is not treated as a transfer, if the annuity or income stream from the annuity is transferred, it may be subject to a penalty except when transferred:

- To or for the spouse's sole benefit;
- To their child who is under age 21 or blind or disabled; or
- To a trust established solely for the benefit of an individual under 65 years of age who is disabled.

Consideration of Income and Resources from an Annuity

Even when an annuity is not penalized as a transfer of resources, it must still be considered in determining eligibility, including spousal income and resources, and in the post eligibility calculation.

Count income or resources derived from an annuity in determining eligibility.

I-1675 UNCOMPENSATED VALUE

The uncompensated value of an asset is the difference between:

- FMV at the time of transfer (less any outstanding loans, mortgages, or other encumbrances on the resource); and
- The amount actually received for the asset.

The uncompensated value cannot exceed the amount that would have been counted if the asset had been retained.

To determine the uncompensated value, first determine the amount of compensation and the Fair Market Value.

Determining Compensation

Compensation is all money, real or personal property, food, shelter, or services received by the individual at or after the time of transfer in exchange for the asset.

Compensation includes items or services received by the individual prior to the transfer only if they were provided as a result of a binding contract between the parties involved. The contract must have been established at or before the transfer.

The contract must indicate that:

- The items are being provided in exchange for payment; and
- The transfer constitutes total or partial payment.

The value of the compensation is based on:

- The agreement;
- The expectation of the parties at the time of the transfer; and
- The form of compensation.

The value of compensation is the gross amount paid or agreed to be paid. The value is not reduced by expenses attributed to the sale.

Forms of Compensation

Forms of compensation are valued as follows:

- Cash is valued at the total amount paid or agreed to be paid.
- Real or personal property is valued at the fair market value at the time of transfer.
- Support and/or maintenance are valued based on actual current market value and the length of time it has been and/or is expected to be provided.
- Services are valued at the market value of such services based on:
    - The frequency and duration; or
    - The usual and customary charges, if purchased from an outside source in that community.

If the service is transportation for shopping, visits to the doctor, etc., the value may be based on the local taxi fare charges. If the services are to be provided for the life of the individual, the total value is determined by using the Life Expectancy Table to determine the total value. Refer to Z-1200 Life Expectancy Tables.

Multiply the yearly fair market value of the services by the figure in the "Average Years of Life Remaining" column, which corresponds to the age of the individual as of last birthday at the time the asset was transferred.

When compensation is made in the form of a service, the person who received the transferred asset must provide some verification such as:

- A written statement describing the service he or she agreed to perform; and
- The frequency and duration of such services.

If the services are to be provided on an as needed basis, the statement must include:

- The expectations as to the frequency of the services;
- A description of the agreement concerning compensation for services reached between the provider of the service; and
- The basis for that expectation.

Verification of Value of Real Property Transferred Within the Sixty Month Lookback Period

Verify the value in at least one of the following ways:

- By obtaining copies of the act of sale in the conveyance records, offer of sale, mortgage, judgement, or other documentary evidence dated less than one year from the date of transfer.
- By an appraisal that is dated less than one year from the date of the transfer.
- Obtain a FMV estimate from a knowledgeable third party if the real property did not sell on the open market (e.g., to a

relative or act of donation).

Note:
If the property was sold on the open market, this difference between the asking price and the sale price is not uncompensated value.

I-1676 EFFECT OF UNCOMPENSATED VALUE ON ELIGIBILITY
(Determining the Penalty)

There is no penalty for individuals other than LTC/HCBS applicants/beneficiaries who transfer countable assets or home property for less than FMV.

The uncompensated value of an asset which was transferred for the purpose of establishing Medicaid eligibility (individual did not rebut presumption or rebuttal was unsuccessful) will be used to restrict Medicaid coverage to an otherwise eligible institutionalized individual.

I-1676.1 Average Monthly Private Pay Rate for Nursing Facility Services

For applications received on or after November 1, 2007, the average monthly projected rate used as the divisor in determining a transfer of assets penalty period is $4,000.00 ($131.51 per day).

For applications received on or after March 1, 2018, the average monthly private pay rate used as the divisor in determining a transfer of assets penalty period is $5,000.00 ($164.38 per day).

For applications received on or after January 1, 2024 the average monthly private pay rate used as the divisor in determining a transfer of assets penalty period is $6,500.00 ($213.70 per day).

For applications received on or after September 1, 2024 the average monthly private pay rate used as the divisor in determining a transfer of assets penalty period is $7,200.00 ($236.71 per day).

When transferred assets are returned to a beneficiary, use the average monthly private pay rate divisor that was in place at the time that the transfer penalty was assessed when recalculating the penalty period.

I-1676.2 Reserved

I-1676.3 Transfers made on or after February 8, 2006

The look-back period begins with the look-back date and ends with the baseline date, which is the 60 months (five years) prior to applying for Medicaid. Explore uncompensated transfers occurring during the 60-month period before application for institutional coverage, and anytime thereafter.

Impose a partial month penalty period for transfers that are less than the States average monthly cost for private patients of a nursing facility. If a transfer results in a partial month penalty, the penalty must be served.

When transfers occurred in more than one month, multiple transfers may be combined to impose a single penalty period.

Look-Back Date

Penalties may be assessed for transfers that take place on or after the look-back date. The look-back period is the period that begins with the look-back date and ends with the baseline date. The baseline date is the first date as of which the individual is:

- Institutionalized; or
- Otherwise eligible for HCBS waiver based on an approved BHSF 142; and
- Found to meet all financial and non-financial criteria based on an application for medical assistance under the state plan.

Penalty Period Begin Date

For transfers that occurred on or before the effective date of Medicaid eligibility, the penalty period begins the date on which the individual would have been eligible for payment of nursing facility or HCBS waiver services, but for the imposition of the penalty. The applicant is informed of the penalty period as part of the written notice of decision.

For transfers which occurred after the effective date of Medicaid eligibility, penalties will not be served <u>in</u> retroactive periods. The

penalty period begins the first day of the month after the month in which assets were transferred and advance notice expires. Written notice of adverse action (issued at least 10 days before the adverse action takes effect) must be sent to the beneficiary or representative before a penalty period may be imposed.

Once a penalty period begins to run, it continues for the duration of the penalty period. The penalty period does not start and stop for reasons such as discharge from the nursing facility or waiver program.

Example:
An individual enters a nursing facility and a penalty period is imposed for six months. Three months into the penalty period, the individual discharges from the facility and returns to the community. Five months later the individual enters a nursing home, applies for Medicaid, and is found eligible. Medicaid will pay for their care as the penalty period has expired.

When a spouse transfers an asset that results in a penalty for the individual, divide the penalty between the spouses when:

- The spouse is eligible for Medicaid;
- A penalty could, under normal circumstances, be assessed against the spouse, i.e., the spouse is institutionalized; and
- Some portion of the penalty against the individual remains at the time the above conditions are met.

Example:
Mr. Smith enters a nursing facility and applies for Medicaid. Mrs. Smith transfers an asset that results in a 36-month penalty against Mr. Smith. Twelve months into the penalty period, Mrs. Smith enters a nursing facility and becomes eligible for Medicaid. The penalty period against Mr. Smith has 24 months to run. Because Mrs. Smith is now in a nursing facility, and a portion of the original penalty period remains, you must divide the remaining 24 months of penalty between Mr. and Mrs. Smith.

When one spouse is no longer subject to a penalty (e.g., the spouse no longer receives nursing facility services, or the spouse dies), the remaining penalty period applicable to both spouses must be served by the remaining spouse**.**

I-1677 RECEIPT OF ADDITIONAL COMPENSATION

If the applicant/beneficiary alleges that additional cash compensation (not part of the transfer agreement) has been received, obtain:

- The applicant/beneficiary statement giving the date, amount, and circumstances of the additional compensation; and
- The statement of the person paying the additional compensation; or
- Other documentary evidence.

Reduce the verified uncompensated value counted as of the date the additional compensation is received by the value of the additional compensation received. Recalculate the period of restricted coverage, if applicable.

I-1678 RETURN OF TRANSFERRED ASSETS

When the applicant/beneficiary alleges that an uncompensated transferred asset has been returned, obtain the following:

- Applicant/beneficiary/responsible person's written statement concerning:
  - the date and circumstances of return, and
  - what, if anything, was paid for the return of the asset, and
- Documentary evidence of the return, if available, or a statement from the person who returned the asset.

Do not continue to count the uncompensated value of a transferred asset if the original asset is returned.

Under pre-DRA, if all assets are returned to the individual, no penalty can be assessed. If a penalty has been assessed and payment for services denied, a return of the assets requires a retroactive adjustment back to the beginning of the penalty period.

Under post-DRA, this is no longer the case. Count all assets returned

to the individual as available in determining current eligibility.

If only a part of the asset or its equivalent value is returned, the penalty period end date is modified.

I-1679 REBUTTAL OF PRESUMED VALUE

All cases involving a transfer of assets with any amount of uncompensated value require that the applicant/beneficiary be offered an opportunity to rebut the presumption that the transfer was made to become Medicaid eligible or to qualify for LTC vendor payment.

Mail immediately, the BHSF Form 2-TR, Notification of Transfer of Resources Determination to the applicant/beneficiary/responsible person advising him of:

- The amount of the uncompensated value;
- The period for which he will be ineligible for LTC vendor payments and/or HCBS; and
- His right to rebut the presumed reason for transfer within seven (7) working days.

If the applicant/beneficiary/responsible person makes no effort to rebut within seven (7) working days after the notification form was mailed, assume that the presumption is valid and determine the impact on eligibility.

An applicant/beneficiary/responsible person who wishes to rebut the presumption is responsible for presenting convincing evidence that the transfer was exclusively for another purpose.

The presence of one or more of the following factors may indicate that the asset was transferred exclusively for a purpose other than to qualify for assistance:

- If after the transfer the individual experienced:
    - An unanticipated, drastic change in his health which resulted in a greatly increased need for medical care,
    - The unexpected loss of other assets which would have made him ineligible for assistance, or

- The unexpected loss of income which would have made him ineligible for assistance.

The transfer was made as a result of a court order or other legal commitment.

Request for Rebuttal

The applicant/beneficiary/responsible person shall be asked to provide:

- A written statement rebutting the presumption, although any oral statement should be accepted and documented in the case record; and

- Any relevant documentation (e.g., legal documents, realtor agreements, correspondence, statements from others involved in the transfer).

Statements must include at least the following information:

- Purpose for transferring the asset;

- Attempts, if any, to dispose of the asset at the Fair Market Value (FMV);

- Reasons for accepting less than the Fair Market Value (FMV) for the asset;

- Means of or plan for support after the transfer; and

- Relationship, if any, to the persons to whom the asset was transferred.

Decision on Rebuttal

Convincing evidence must be presented showing the specific purpose that the asset was transferred.

Consider all statements and documentation provided by the applicant/beneficiary.

If it is determined that the applicant/beneficiary had some other

reason for transferring the asset, but any expectation of establishing eligibility could reasonably be inferred to be a factor in the individual's decision to transfer the asset, the presumption that the transfer was exclusively for some other purpose is not successfully rebutted. The penalty period does apply.

If the applicant/beneficiary provides convincing evidence that the disposal was solely for some purpose other than to establish eligibility for Medicaid, the presumption is successfully rebutted. The penalty period does not apply.

Supervisory review and concurrence is required and shall be documented for all successful rebuttals.

If the supervisor is unable to reach a decision, refer a summary of pertinent facts to the Eligibility Program Operations in State Office for a decision.

Notification

Send notice of right to apply for an undue hardship exception. See H-860 Undue Hardship and Undue Hardship Exception. After the undue hardship notice expires, a final notice of decision may be sent.

Imposition of a penalty period for new applicants for Medicaid requires a denial notice. Send written notification of the decision to the applicant/beneficiary or responsible person.

At the time the penalty specified in the denial notice is exhausted, verify that assets are below the resource limit and that there has been no further transfer of resources for less than fair market value during the penalty period before vendor payment can be approved.

If a penalty period is imposed on an individual who is already eligible for Medicaid, the State must provide a 10-day adverse action notice.