Chapter 4C

NEW USC PROVISIONS INCORPORATING THE DEFICIT REDUCTION ACT OF 2005

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II. NEW USC PROVISIONS

A. Extension of Look Back

42 USC §1396p(c)(1)(B):

(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d) of this section or in the case of any other disposal of assets made on or after February 8, 2006, 60 months) before the date specified in clause (ii).

(ii) The date specified in this clause, with respect to—

(I) an institutionalized individual is the first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State plan, or

(II) a noninstitutionalized individual is the date on which the individual applies for medical assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value.

B. Start of Penalty Period

42 USC 1396p(c)(1)(D):

(i) In the case of a transfer of asset made before February 8, 2006, the date specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.

(ii) In the case of a transfer of asset made on or after February 8, 2006, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

C. Hardship Waivers

42 USC 1396p(c)(2)(D):

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that— . . .

(D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary.

The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the personal representative of the individual. While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.

D. Disclosure of Annuities

42 USC 1396p(e):

(e) Disclosure and treatment of annuities

(1) In order to meet the requirements of this section for purposes of section 1396a(a)(18) of this title, a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(1)(C)(i) of this section (relating to long-term care services) for an individual, the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.

(2) (A) In the case of disclosure concerning an annuity under subsection (c)(1)(F) of this section, the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State's remainder interest under such subsection.

(B) In the case of such an issuer receiving notice under subparagraph (A), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1). A State shall take such information into account in determining the amount of the State's obligations for medical assistance or in the individual's eligibility for such assistance.

(3) The Secretary may provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value.

(4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1).

E. Annuity Requirements

42 USC 1396p(c)(1)(F):

For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless—
(i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant under this subchapter; or
(ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

42 USC 1396p(c)(1)(G):

For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services under this subchapter unless—
(i) the annuity is—
(I) an annuity described in subsection (b) or (q) of section 408 of title 26; or
(II) purchased with proceeds from—
(aa) an account or trust described in subsection (a), (c), or (p) of section 408 of title 26;
(bb) a simplified employee pension (within the meaning of section 408(k) of title 26); or
(cc) a Roth IRA described in section 408A of title 26; or
(ii) the annuity—
(I) is irrevocable and nonassignable;
(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and
(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

F. Income-First Rule

42 USC 1396r-5(d)(6):

Application of "income first" rule to revision of community spouse resource allowance. For purposes of this subsection and subsections (c) and (e) of this section, a State must consider that all income of the institutionalized spouse that could be made available to a community spouse, in accordance with the calculation of the commu-

nity spouse monthly income allowance under this subsection, has been made available before the State allocates to the community spouse an amount of resources adequate to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse.

G. Substantial Home Equity

42 USC 1396p(f):

(f) Disqualification for long-term care assistance for individuals with substantial home equity

(1) (A) Notwithstanding any other provision of this subchapter, subject to subparagraphs (B) and (C) of this paragraph and paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the individual's home exceeds $500,000.

(B) A State may elect, without regard to the requirements of section 1396a(a)(1) of this title (relating to statewideness) and section 1396a(a)(10)(B) of this title (relating to comparability), to apply subparagraph (A) by substituting for "$500,000", an amount that exceeds such amount, but does not exceed $750,000.

(C) The dollar amounts specified in this paragraph shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

(2) Paragraph (1) shall not apply with respect to an individual if—

(A) the spouse of such individual, or

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title,

is lawfully residing in the individual's home.

(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

(4) The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.

H. CCRC Contracts

1. 42 USC 1396r(c)(5)

(5) Admissions policy

(A) *Admissions.* With respect to admissions practices, a nursing facility must—

(i) (I) not require individuals applying to reside or residing in the facility to waive their rights to benefits under this subchapter or subchapter XVIII of this chapter,

(II) subject to clause (v), not require oral or written assurance that such individuals are not eligible for, or will not apply for, benefits under this subchapter or subchapter XVIII of this chapter, and

(III) prominently display in the facility written information, and provide to such individuals oral and written information, about how to apply for and use such benefits and how to receive refunds for previous payments covered by such benefits;

(ii) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility; and

(iii) in the case of an individual who is entitled to medical assistance for nursing facility services, not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan under this subchapter, any gift, money, donation, or other consideration as a precondition of admitting (or expediting the admission of) the individual to the facility or as a requirement for the individual's continued stay in the facility.

(B) *Construction*

(i) No preemption of stricter standards Subparagraph (A) shall not be construed as preventing States or political subdivisions therein from prohibiting, under State or local law, the discrimination against individuals who are entitled to medical assistance under the State plan with respect to admissions practices of nursing facilities.

(ii) Contracts with legal representatives Subparagraph (A)(ii) shall not be construed as preventing a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care.

(iii) Charges for additional services requested Subparagraph (A)(iii) shall not be construed as preventing a facility from charging a resident, eligible for medical assistance under the State plan, for items or services the resident has requested and received and that are not specified in the State plan as included in the term "nursing facility services".

(iv) Bona fide contributions Subparagraph (A)(iii) shall not be construed as prohibiting a nursing facility from soliciting, accepting, or receiving a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the resident (or potential resident), but only to the extent that such contribution is not a condition of admission, expediting admission, or continued stay in the facility.

(v) Treatment of continuing care retirement communities admission contracts Notwithstanding subclause (II) of subparagraph (A)(i), subject to subsections (c) and (d) of section 1396r-5 of this title, contracts for admission to a State licensed, registered, certified, or equivalent continuing care retirement community or life care community, including services in a nursing facility that is part of such community, may require residents to spend on their care resources declared for the purposes of admission before applying for medical assistance.

2. 42 USC 1396p(g)

(g) Treatment of entrance fees of individuals residing in continuing care retirement communities

(1) *In general.* For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, the rules specified in paragraph (2) shall apply to individuals residing in continuing care retirement communities or life care communities that collect an entrance fee on admission from such individuals.

(2) *Treatment of entrance fee.* For purposes of this subsection, an individual's entrance fee in a continuing care retirement community or life care community shall be considered a resource available to the individual to the extent that—

(A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;

(B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

I. Additional Asset Transfer Rules

1. Partial Months of Ineligibility. 42 USC 1396p(c)(1)(E)(iv): "A State shall not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) with respect to the disposal of assets."

2. Combining Multiple Transfers. 42 USC 1396p(c)(1)(H):

Notwithstanding the preceding provisions of this paragraph, in the case of an individual (or individual's spouse) who makes multiple fractional transfers of assets in more than 1 month for less than fair market value on or after the applicable look-back date specified in subparagraph (B), a State may determine the period of ineligibility applicable to such individual under this paragraph by—

(i) treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months on or after the look-back date specified in subparagraph (B) as 1 transfer for purposes of clause (i) or (ii) (as the case may be) of subparagraph (E); and

(ii) beginning such period on the earliest date which would apply under subparagraph (D) to any of such transfers.

3. Notes, Loans, and Mortgages. 42 USC 1396(c)(1)(I):

For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage—

(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(iii) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individual's application for medical assistance for services described in subparagraph (C).

4. Life Estates. 42 USC 1396p(c)(1)(J):

(1) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

(A) the assets transferred were a home and title to the home was transferred to—

(i) the spouse of such individual;

(ii) a child of such individual who (I) is under age 21, or (II) (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title;

(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

(B) the assets—

(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,

(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,

(iii) were transferred to, or to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of, the individual's child described in subparagraph (A)(ii)(II), or

(iv) were transferred to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1382c(a)(3) of this title);

(C) a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that (i) the individual intended to dispose of the assets either

at fair market value, or for other valuable consideration, (ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or (iii) all assets transferred for less than fair market value have been returned to the individual; or

(D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary. The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the personal representative of the individual. While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.

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

(4) A State (including a State which has elected treatment under section 1396a(f) of this title) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection. In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the State plan.

(5) In this subsection, the term "resources" has the meaning given such term in section 1382b of this title, without regard to the exclusion described in subsection (a)(1) thereof.

J. State Long-Term Care Partnership Program

42 USC 1396p(b):

(b) Adjustment or recovery of medical assistance correctly paid under a State plan

(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

(A) In the case of an individual described in subsection (a)(1)(B) of this section, the State shall seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual.

(B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of—

(i) nursing facility services, home and community-based services, and related hospital and prescription drug services, or

(ii) at the option of the State, any items or services under the State plan.

(C) (i) In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual's estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.

(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii)) which provided for the disregard of any assets or resources—

(I) to the extent that payments are made under a long-term care insurance policy; or

(II) because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.

(iii) For purposes of this paragraph, the term "qualified State long-term care insurance partnership" means an ap-

proved State plan amendment under this subchapter that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if the following requirements are met:

(I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.

(II) The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of title 26) issued not earlier than the effective date of the State plan amendment.

(III) The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).

(IV) If the policy is sold to an individual who—

(aa) has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;

(bb) has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; and

(cc) has attained age 76 as of such date, the policy may (but is not required to) provide some level of inflation protection.

(V) The State Medicaid agency under section 1396a(a)(5) of this title provides information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

(VI) The issuer of the policy provides regular reports to the Secretary, in accordance with regulations of the Secretary, that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

(VII) The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership. In the case of a long-term care insurance policy which is exchanged for another such policy,

subclause (I) shall be applied based on the coverage of the first such policy that was exchanged. For purposes of this clause and paragraph (5), the term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

(iv) With respect to a State which had a State plan amendment approved as of May 14, 1993, such a State satisfies this clause for purposes of clause (ii) if the Secretary determines that the State plan amendment provides for consumer protection standards which are no less stringent than the consumer protection standards which applied under such State plan amendment as of December 31, 2005.

(v) The regulations of the Secretary required under clause (iii)(VI) shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. The Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the State involved.

(vi) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, State insurance commissioners, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access.

(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the individual's surviving spouse, if any, and only at a time—

(A) when he has no surviving child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title; and

(B) in the case of a lien on an individual's home under subsection (a)(1)(B) of this section, when—

(i) no sibling of the individual (who was residing in the individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), and

(ii) no son or daughter of the individual (who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution), is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution.

(3) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of this subsection (other than paragraph (1)(C)) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.

(4) For purposes of this subsection, the term "estate", with respect to a deceased individual—

(A) shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law; and

(B) may include, at the option of the State (and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies), any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(5) (A) For purposes of clause (iii)(III), the model regulations and the requirements of the model Act specified in this paragraph are:

(i) In the case of the model regulation, the following requirements:

(I) Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.

(II) Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

(III) Section 6C (relating to extension of benefits).

(IV) Section 6D (relating to continuation or conversion of coverage).
(V) Section 6E (relating to discontinuance and replacement of policies).
(VI) Section 7 (relating to unintentional lapse).
(VII) Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.
(VIII) Section 9 (relating to required disclosure of rating practices to consumer).
(IX) Section 11 (relating to prohibitions against post-claims underwriting).
(X) Section 12 (relating to minimum standards).
(XI) Section 14 (relating to application forms and replacement coverage).
(XII) Section 15 (relating to reporting requirements).
(XIII) Section 22 (relating to filing requirements for marketing).
(XIV) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.
(XV) Section 24 (relating to suitability).
(XVI) Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).
(XVII) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).
(XVIII) Section 29 (relating to standard format outline of coverage).
(XIX) Section 30 (relating to requirement to deliver shopper's guide).
(ii) In the case of the model Act, the following:
(I) Section 6C (relating to preexisting conditions).
(II) Section 6D (relating to prior hospitalization).
(III) The provisions of section 8 relating to contingent nonforfeiture benefits.
(IV) Section 6F (relating to right to return).
(V) Section 6G (relating to outline of coverage).
(VI) Section 6H (relating to requirements for certificates under group plans).
(VII) Section 6J (relating to policy summary).
(VIII) Section 6K (relating to monthly reports on accelerated death benefits).
(IX) Section 7 (relating to incontestability period).
(B) For purposes of this paragraph and paragraph (1)(C)—

(i) the terms "model regulation" and "model Act" mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000);

(ii) any provision of the model regulation or model Act listed under subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision; and

(iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that the State insurance commissioner for the State certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

(C) Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update, or other modification of a model regulation or model Act provision specified in subparagraph (A), or of any provision of such regulation or Act that is substantively related to a provision specified in such subparagraph, the Secretary shall review the changes made to the provision, determine whether incorporating such changes into the corresponding provision specified in such subparagraph would improve qualified State long-term care insurance partnerships, and if so, shall incorporate the changes into such provision.

APPENDIX A—CENTER FOR MEDICARE AND MEDICAID SERVICES DRA GUIDANCE

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

July 27, 2006 **SMDL #06-018**

Dear State Medicaid Director:

This is one of a series of letters that provides guidance on the implementation of the Deficit Reduction Act of 2005 (DRA) (Pub.L.109-171). This legislation makes a number of changes in the rules related to eligibility and benefits in the Medicaid program. This letter provides information for States regarding implementation of new rules related to the following DRA provisions:

- Sections 6011 and 6016, pertaining to transfers of assets for less than fair market value, including:
  - Extension of the look-back period to 60 months
  - Start date of the penalty period
  - Partial month transfers
  - Option to combine multiple transfers made in more than one month
  - Purchase of promissory notes, loans, or mortgages
  - Purchase of life estates
  - Undue hardship

- Section 6012, pertaining to treatment of annuities, including:
  - Disclosure of interest in an annuity
  - Requirement to name the State as a remainder beneficiary
  - Applications for coverage of long-term care services in section 1634 States
  - Consideration of income and resources from an annuity
  - Annuity-related transactions other than purchases
  - Requirement to name the State as a remainder beneficiary on annuities
  - Annuities purchased by or on behalf of an annuitant who applied for medical assistance

- Section 6013, pertaining to application of the "income first" rule under spousal impoverishment.

- Section 6014, pertaining to disqualification for long-term care coverage for individuals with substantial home equity.

- Section 6015, pertaining to the treatment of continuing care retirement community (CCRC) entrance fees.

These provisions are discussed in detail in a series of enclosures to this letter. The changes modify various portions of the Federal Medicaid statute related to the topics shown above. However, many provisions of the statute are not changed by the DRA. In implementing the DRA, States should note that unless specifically amended, existing law will govern the topics shown above, and prior policy guidance issued by the Centers for Medicare & Medicaid Services is applicable.

Effective Date

Most, but not all, of the changes made by the DRA are effective upon the date of enactment, February 8, 2006. Please see the individual enclosures for information about the effective dates of specific provisions.

If you have any questions, please contact Gale Arden, Director, Disabled & Elderly Health Programs Group at 410-786-6810 or by e-mail at Gale.Arden@cms.hhs.gov .

We look forward to working with you as you implement this legislation.

Sincerely,

/s/

Dennis G. Smith
Director

Enclosures

cc:

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Enclosure

Sections 6011 and 6016

New Medicaid Transfer of Asset Rules Under the Deficit Reduction Act of 2005

Centers For Medicare & Medicaid Services
Center for Medicaid and State Operations

July 27, 2006

Enclosure Highlights—Section 6011 and Section 6016

I. Extension of the Look-Back Period to 60 Months

II. Penalty Period

- A. Start Date of the Penalty Period
- B. Partial Month Transfers
- C. Option to Combine Multiple Transfers Made In More Than One Month

III. Purchase of Promissory Notes, Loans or Mortgages

IV. Purchase of Life Estates

V. Undue Hardship

- A. Establishment of Procedures
- B. Authority of Facility to Request Undue Hardship Waiver for Resident
- C. Bed Hold Payments

VI. Effective Dates

I. Extension of the Look-Back Period to 60 Months

Section 6011(a) of the Deficit Reduction Act (DRA); P.L. 109-171, amends section 1917(c)(1)(B)(i) of the Social Security Act (the Act). The amendment provides that for any transfer of assets made on or after the date of enactment of the DRA (February 8, 2006), the look-back period is 60 months.

II. Penalty Period

A. Start Date of the Penalty Period

Section 6011(b) of the DRA amends section 1917(c)(1)(D) of the Act to change the start date of the penalty period, which is the period during which an individual is ineligible for Medicaid payment for long term care services because of a transfer of assets for less than fair market value. Prior to the amendment, the penalty period began either in the month of transfer, or at State option, in the month following the month of transfer. Prior law resulted in some individuals being able to calculate the length of the penalty period that would result from an asset transfer and avoid the penalty by not applying for Medicaid coverage of institutional level care (or at State option, certain care provided to non-institutionalized individuals) until the expiration of that time period.

For transfers of assets made on or after February 8, 2006, the period of ineligibility will begin with the later of:

- The first day of a month during, or at State option the month after which, assets have been transferred for less than fair market value; or
- The date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level of care services (based on an approved application for such services) that, were it not for the imposition of the penalty period, would be covered by Medicaid.

The penalty period cannot begin until the expiration of any existing period of ineligibility. The penalty period will continue to run for the number of months determined by dividing the total value of assets transferred within the look-back period by the State's average monthly cost to a private patient of nursing facility services in the State, or at the option of the State, in the community in which the individual is institutionalized, as under present law. Once the penalty period is imposed, it will not be tolled (i.e., will not be interrupted or temporarily suspended), but will continue to run even if the individual subsequently stops receiving institutional level care.

States should be aware that imposition of a penalty period for new applicants for Medicaid requires a denial notice. 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. As well as complying with existing legal requirements (see regulations at 42 CFR 431 Subpart E), this notice must contain information about the undue hardship exception (see below).

B. Partial Month Transfers

Prior to enactment of the DRA, States had the option to impose penalty periods for transfers in a month that were less than the State's average monthly cost to a private patient of nursing facility services in the State, or to impose no penalty period for such "partial month" transfers. Additionally, some States elected not to impose a penalty for transfers made within a month that were under a certain threshold e.g., $500. In States that elected to impose no penalty period for such partial month transfers, individuals were able to transfer amounts less than the average monthly cost of nursing facility services in successive months, but never incur a penalty.

To address this, section 6016(a) of the DRA amended section 1917(c)(1)(E) of the Act, to add a new subsection (iv) that prohibits a State from rounding down or otherwise disregarding any fractional period of ineligibility. The result is that States are now required to impose penalty periods even in the case of smaller asset transfers, where the period of ineligibility would be less than a full month. In imposing penalties on such transfers, if the calculation of the penalty period produces a fractional amount, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the monthly nursing home rate used to calculate the penalty period.

C. Option to Combine Multiple Transfers Made In More Than One Month

While the DRA prohibits States from rounding down or disregarding fractional periods of ineligibility, it does give States the option to combine multiple transfers for less than fair market value in more than one month and impose a single period of ineligibility, rather than applying multiple penalty periods. This flexibility is the result of a new subsection (H), added to section 1917(c)(1) of the Act by section 6016(b) of the DRA. Under subsection (H), States may treat the total, cumulative value of all uncompensated transfers made within the look-back period as a single transfer and calculate a single period of ineligibility, which would begin on the earliest date applicable under section 1917(c)(1)(D). See Section II A. above.

For example, if an individual, or the individual's spouse, makes an uncompensated transfer of assets of $1,000 in each of the 60 months of the look-back period, the State would have two options. It may calculate a separate period of ineligibility for each month and impose the resulting periods of ineligibility separately. Or, exercising the option provided under subparagraph (H), the State may add the transfers together, arrive at a total amount of $60,000, divide that total by the average private payment for nursing facility care and impose one continuous period of ineligibility. In either case, the penalty period would start with the earliest date applicable under section 1917(c)(1)(D).

States must include information about whether they elect to combine multiple fractional transfers into a single transfer in their State Medicaid plans.

NOTE: It is important to understand that if a State elects to combine multiple fractional transfers into a single transfer for purposes of imposing a penalty period, the earliest date applicable under section 1917(c)(1)(D) is always the LATER of the start dates discussed in Section II A above.

III. Purchase of Promissory Notes, Loans, or Mortgages

Some States have experienced problems with individuals who have attempted to circumvent rules penalizing transfers of assets by obtaining promissory notes, loans, or mortgages containing a promise of repayment from transferees. Individuals would then present the note, loan or mortgage instruments at the time of their Medicaid application for long-term care services in order to establish that these transactions were actually loans, not gifts. In some cases, these were merely sham transactions, and repayment of the full amount transferred was neither expected nor enforced. Various techniques, such as balloon payments, in which token payments are made for most of the term of the loan with the balance due in a lump sum at the very end of the loan, and cancellation of the loan upon the death of the transferor, were used to ensure that the transferee would in fact retain most, if not all, of the funds.

In order to prevent improper use of promissory notes, loans or mortgages, section 6016(c) of the DRA amended section 1917(c)(1) of the Act by adding a new subparagraph (I) containing additional rules related to the purchase of these instruments. With respect to the transfer of assets, the term assets (see definition of "assets" at section 1917(e)(1) of the Act) includes funds used to purchase a promissory note, loan or mortgage 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 the death of the lender.

The actuarial standards to be applied are those determined by the Office of the Chief Actuary of the Social Security Administration (SSA). This table (called the Period Life Table, which can be found on SSA's Actuarial Publications Statistical Tables Web page under the heading "Life Table") may be accessed at http://www.ssa.gov/OACT/STATS/table4c6.html.

If the above criteria are not met, the purchase of the promissory note, loan or mortgage must be treated as a transfer of assets. In determining the amount of the asset transfer, the value of the note, loan or mortgage is the outstanding balance due as of the date of the individual's application for Medicaid coverage of services listed in section 1917(c)(1)(C) of the Act.

IV. Purchase of Life Estates

Another technique used by individuals in some States to avoid transfer of assets penalties was the purchase of a life estate interest in another individual's home. The individual purchasing the life interest in the home would allege that something of value, i.e., the life estate, had been received in exchange for the funds paid. However, in many cases, the purchaser never lived in the home nor derived any benefit from the life estate, and was in effect making a gift to the owner, who still retained the remainder interest. Since some States have elected to use more liberal resource methodologies and do not count life estate interests as resources, the value of the life estate was excluded in determining Medicaid eligibility. Thus, the acquisition of a life estate in the property of another would serve to transform countable resources (cash) into a non-countable resource (the life estate).

To deter the abuse of the life estate and transfer of assets rules, section 6016(d) of the DRA amended section 1917(c)(1) of the Act by adding a new subparagraph (J). This amendment provides that unless an individual purchasing a life estate in another individuals' home actually resides there for a period of at least one year after the date of purchase, the transaction should be treated as a transfer of assets. The amount of the transfer is the entire amount used to purchase the life estate. This amount should not be reduced or prorated to reflect an individuals' residency for a period of time less than a year.

States should note that the new rules pertaining to purchase of life estates add a criterion for evaluating whether a transfer of assets has occurred, but do not replace existing provisions of title XIX. Thus, States should still apply Medicaid resource eligibility and transfer of assets rules, even in cases where individuals purchasing life estates in the home of another individual do live there for at least one year. In determining the value of life estates, States should continue to follow Centers for Medicare & Medicaid Services (CMS) instructions at Section 3258.9 of the State Medicaid Manual. These instructions permit use of the life estate tables published by SSA for the Supplemental Security Income (SSI) program, which may be found in the Program Operations Manual System (POMS) at Section SI 01140.120.

If payment for a life estate exceeds the fair market value of the life estate as calculated in accordance with the POMS table, the difference between the amount paid and the fair market value should be treated as an asset transfer. In addition, if an individual makes a gift or transfer of a life estate interest, the value of the life estate, as calculated under the POMS life estate and remainder interest table, should be treated as a transfer of assets. Finally, unless a State has a provision for excluding the value of life estates in its approved State Medicaid plan, or the property in which the individual has purchased the life estate qualifies as the individual's exempt home, the value of the life estate should be counted as a resource in determining Medicaid eligibility.

The DRA provision pertaining to life estates does not apply to the retention or reservation of life estates by individuals transferring real property. In such cases, the value of the remainder interest, not the life estate, would be used in determining whether a transfer of assets has occurred and in calculating the period of ineligibility.

V. Undue Hardship

A. Establishment of Procedures

Section 6011(d) of the DRA requires that each State provide a hardship waiver process in accordance with section 1917(c)(2)(D) of the Act. Previously the State was required to establish procedures for determining undue hardship, but the criteria, notice, and appeal requirements were not specifically addressed in the statute.

Under the DRA, undue hardship exists when application of a transfer of assets penalty 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.

Further, the statute specifically requires that States provide the following:

- Notice to individuals that an undue hardship exception exists;
- A timely process for determining whether an undue hardship waiver will be granted; and
- A process, which the notice describes, under which an adverse determination can be appealed.

While these criteria and procedural requirements are listed in the statute for the first time, they are the same criteria and procedures that CMS has provided to States in the State Medicaid Manual at Section 3258.10(C)(5). Thus, States should already be applying these criteria to the determination of undue hardship. In addition, as long as they adhere to the DRA criteria, States still have considerable flexibility in deciding the circumstances under which they will not impose penalties under the transfer of assets provisions because of undue hardship.

States should note that in cases where application of the DRA provisions defining purchases of promissory notes, loans, mortgages, or life estates as transfers of assets would result in the imposition of a period of ineligibility (see sections III and IV above), the undue hardship rules apply.

States must include information about their implementation of the DRA undue hardship waiver requirements in their State Medicaid plans.

B. Authority of Facility to Request Undue Hardship Waiver for Resident

Section 6011(e)(1) of the DRA amends section 1917(c)(2)(D) of the Act by adding a new requirement that the procedures established by the State for determining undue hardship must permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of an individual who would be subject to a penalty period resulting from a transfer of assets. Before filing such an application, the facility must have the consent of the individual or the individual's personal representative. States may allow individuals authorized to act on behalf of the individual with respect to a Medicaid application to provide such consent to the facility. In addition to filing an undue hardship waiver application, the facility may present information on behalf of the individual to the State and may, with the specific written consent of the individual or the individual's personal representative, represent the individual throughout the appeals process.

C. Bed Hold Payments

Under the DRA (subsection 6011(e)(2)), States may, but are not required to, make bed hold payments to facilities on behalf of individuals for whom an undue hardship waiver application is pending, but not for more than 30 days. The application for an undue hardship waiver must meet the criteria specified in section 1917(c)(2)(D) of the Act, as described above. The State must include information about whether it will elect to make such payments in its State Medicaid plan.

VI. Effective Dates

The provisions of the DRA discussed above in sections I (Extension of the Look-Back Period to 60 Months) and II A (Penalty Period) are effective for transfers of assets made on or after the date of enactment, February 8, 2006.

The provisions of the DRA discussed above in sections II.B. and II.C. (Partial Months and Accumulation of Multiple Transfers Into One Penalty Period), III (Purchase of Promissory Notes, Loans, or Mortgages) and IV (Purchase of Life Estates) are effective for payments made under title XIX of the Act for calendar quarters beginning on April 1, 2006, and thereafter. These provisions do not apply to:

- Medicaid provided for services furnished before February 8, 2006;
- Disposal of assets made on or before February 8, 2006; or
- Trusts established on or before February 8, 2006.

The date by which States must implement the provisions discussed in sections II.B., II.C., III, and IV above may be extended if the Secretary of Health and Human Services determines that the State Medicaid plan requires State legislation in order for the plan to meet the additional requirements imposed by these amendments.

If your State requires such legislation, please submit a letter so stating to your CMS regional office. The letter should include the date the State will begin implementing the statutory provisions of the DRA relating to partial month transfers. For States with annual legislative sessions, this date must be no later than the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after February 8, 2006. For States with biannual legislative sessions, this date must also be no later than the first day of the first calendar quarter beginning after the close of the first regular session of the legislature that begins after February 8, 2006.

Enclosure

Section 6012

Changes in Medicaid Annuity Rules
Under the
Deficit Reduction Act of 2005

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

July 27, 2006

Enclosure Highlights—Section 6012

I. Application Requirements

A. Disclosure of Interest in an Annuity

B. Requirement to Name the State as a Remainder Beneficiary

C. Applications for Coverage of Long-Term Care Services in 1634 States

D. Consideration of Income and Resources from an Annuity

II. Evaluation and Treatment of Purchases of Annuities and Certain Transactions Related to Annuities on or after February 8, 2006

A. Annuity-Related Transactions Other than Purchases.

B. Requirement to Name the State as a Remainder Beneficiary on Annuities

C. Annuities Purchased by or on Behalf of an Annuitant Who Applied for Medical Assistance

III. Effective Date

The Deficit Reduction Act of 2005 (DRA), P.L. 109-171, adds new requirements to the Medicaid statute with respect to the treatment of annuities purchased on or after the date of enactment, February 8, 2006, as well as certain other transactions involving annuities that take place on or after the date of enactment. The DRA amends section 1917 of the Social Security Act (the Act) which pertains to Liens, Adjustments and Recoveries, and Transfers of Assets. The DRA adds new provisions to section 1917, which include:

- The requirement to disclose, in an application for long-term care services, information regarding any interest an applicant or community spouse may have in an annuity;
- The requirement to name the State as a remainder beneficiary in annuities in which the applicant or spouse is the annuitant; and
- Provisions for the treatment of the purchase of certain annuities as a transfer for less than fair market value.

I. Application Requirements

A. Disclosure of Interest in an Annuity

Section 6012(a) of the DRA adds a new section 1917(e) to the statute. Under the new section 1917(e)(1), all States, including those with "1634 agreements", are required to alter their applications for medical assistance for long-term care services, including applications for recertification, to include a disclosure and description of any interest the applicant or the community spouse may have in an annuity. This disclosure is a condition for Medicaid coverage of long-term care services described in section 1917(c)(1)(C)(i), which include:

- Nursing facility services;
- A level of care in any institution equivalent to that of nursing facility services; and
- Home and community-based services furnished under a waiver of section 1915 (c) or (d).

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

If the individual, spouse or representative refuses to disclose sufficient information related to any annuity the State must either:

- **Using the authority of new section 1917(e)(1) described above, deny or terminate coverage of long-term care services only; or**
- **Using existing Medicaid program authority, deny or terminate eligibility for Medicaid entirely based on the applicant's failure to cooperate**.

If the State wants to limit its action to denial of payment for long-term care services, it must still ensure that enough information regarding the income and/or resources related to an annuity has been collected and verified in order to establish Medicaid

eligibility under existing rules. The DRA does not provide applicants an option to withhold information about annuities that may impact the computation of resources or income. If the State cannot collect enough information about an annuity to allow the State to establish Medicaid eligibility, the State should deny eligibility entirely based on the applicant's failure to cooperate in accordance with the State's existing policies.

In cases where an unreported annuity is discovered after eligibility has been established and after payment for long-term care services has been made, the State should take appropriate steps to terminate payment for long-term care services as discussed above, including appropriate notice to the individual of adverse action. The State should also consider whether other steps should be taken including, if appropriate, possible civil and criminal charges, and potential recovery of benefits which were incorrectly paid.

B. Requirement to Name the State as a Remainder Beneficiary

Under new sections 1917(e)(1) and (2), all States must also include in the application for long-term care services, including the application for recertification, 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. The State must also notify the issuer of any annuity disclosed for purposes of section 1917(c)(1)(F) of the State's rights as a preferred remainder beneficiary.

- The State may require the issuer to notify it regarding any changes in disbursement of income or principal from the annuity; and
- 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.

C. Applications for Coverage of Long-Term Care Services in 1634 States

States that have entered into an agreement under section 1634 of the Social Security Act must ensure that any individual eligible for medical assistance under that agreement who wishes to receive coverage of long-term care services completes an application which includes the disclosure required under the new section 1917(e)(1) and the statement required under the new section 1917(e)(1) and (2). Failure to complete an application form that meets these requirements will not affect the individual's eligibility for Medicaid; however, the individual will not be eligible for coverage of long-term care services unless the appropriate form is completed and signed.

D. Consideration of Income and Resources from an Annuity

The State may take into consideration the income or resources derived from an annuity when determining eligibility for medical assistance or the extent of the State's obligations for such assistance. This means that even though an annuity is not penalized as a transfer for less than fair market value (see II. Evaluation and Treatment

of Purchases of Annuities and Certain Transactions On or After February 8, 2006 below for further information about treating the purchase of an annuity as a transfer of assets), it must still be considered in determining eligibility, including spousal income and resources, and in the post-eligibility calculation, as appropriate. In other words, even if an annuity is not subject to penalty under the provisions of the DRA, this does not mean that it is excluded as income or resource.

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

A. Annuity-Related Transactions Other than Purchases

Section 6012(d) specifies that the provisions of the DRA apply to transactions, including purchases, which occur on or after the date of enactment. In addition to purchases, certain transactions which occur on or after that date would make an annuity, including one purchased before that date, subject to the provisions of the DRA. Such transactions include any action taken by the individual that changes the course of payments to be made by the annuity or the treatment of the income or principal of the annuity. These actions include additions of principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract and similar actions taken by the individual on or after February 8, 2006. Such transactions result in all provisions of the DRA being applicable to the annuity.

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

For example, if an annuity purchased in June 2001 included terms which require distribution to begin five years from the date of purchase, and payouts consequently begin, as scheduled, in June 2006 this will not be considered a transaction subject to the DRA, since no action was required, post-enactment, to initiate the change. Lastly, changes which are beyond the control of the individual, such as a change in law, a change in the policies of the issuer, or a change in the terms based on other factors, such as the issuer's economic conditions, are not considered transactions that cause the annuity to be subject to the terms of the DRA.

B. Requirement to Name the State as a Remainder Beneficiary on Annuities

Section 6012(b) of the DRA adds a new section 1917(c)(1)(F) which provides that the purchase of an annuity shall be treated as a disposal of an asset for less than fair market value unless the State is named as a remainder beneficiary. Unlike the new section 1917(c)(1)(G) added by section 6012(c) of the DRA (discussed in detail below), section 1917(c)(1)(F) does not restrict application of its requirements only to an annuity purchased by or on behalf of an annuitant who has applied for medical assistance for nursing facility or other long term-care services. Therefore, we interpret section 1917(c)(1)(F) as applying to annuities purchased by an applicant or by a spouse, or to transactions made by the applicant or spouse.

Under the DRA an annuity must name the State as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the annuitant, unless there is a community spouse and/or a minor or disabled child. A child is considered disabled if he or she meets the definition of disability found at section 1614(a)(3) of the Act. If there is a community spouse and/or any minor or disabled child, the State may be named in the next position after those individuals. If the State has been named 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.

As a remainder beneficiary, the State may receive up to the total amount of medical assistance paid on behalf of the individual, including both long term care services and community services. Under the new section 1917(e) (see section I.B. above) the State must notify the issuer of the annuity of the State's right as the preferred remainder beneficiary. The State should require verification from the issuer that the State is named as a remainder beneficiary in the correct position. States should also require the issuer to notify the State if and when there is any 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 purchase of the annuity will be considered a transfer for less than fair market value. We interpret the statute to mean that the full purchase value of the annuity will be considered the amount transferred.

C. Annuities Purchased by or on Behalf of an Annuitant Who Applied for Medical Assistance

Section 6012(c) of the DRA amends section 1917(c)(1) by adding a new sub-paragraph (G) which provides that the purchase of an annuity on or after February 8, 2006, by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services, shall be treated as a transfer of assets for less than fair market value unless the annuity

meets certain criteria. Unlike the new section 1917(c)(1)(F) discussed above, this requirement does **not** apply to annuities for which the community spouse is the annuitant. **This requirement is in addition to those specified in 1917(c)(1)(F) pertaining to the State's position as a remainder beneficiary.** An annuity purchased by or on behalf of an annuitant who has applied for medical assistance will not be treated as a transfer of assets if the annuity meets any of the following conditions:

1. The annuity is considered either:
   - An individual retirement annuity (according to Sec. 408(b)) of the Internal Revenue Code of 1986 (IRC), or
   - A deemed Individual Retirement Account (IRA) under a qualified employer plan (according to Sec. 408(q) of the IRC).

OR

2. The annuity is purchased with proceeds from one of the following:
   - A traditional IRA (IRC Sec. 408a); or
   - Certain accounts or trusts which are treated as traditional IRAs (IRC Sec. 408 §(c)); or
   - A simplified retirement account (IRC Sec. 408 §(p)); or
   - A simplified employee pension (IRC Sec. 408 §(k)); or
   - A Roth IRA (IRC Sec. 408A).

OR

3. The annuity meets <u>all</u> of the following requirements:
   - The annuity is irrevocable and non-assignable; and
   - The annuity is actuarially sound; and
   - The annuity provides payments in approximately equal amounts, with no deferred or balloon payments.

To determine that an annuity is established under any of the various provisions of the Internal Revenue Code that are referenced in items 1. and 2. above, rely on verification from the financial institution, employer or employer association that issued the annuity. The burden of proof is on the institutionalized individual or his or her representative to produce this documentation. **Absent such documentation, the purchase of the annuity will be considered a transfer for less than fair market value which is subject to a penalty.** We interpret the statute to mean that the full purchase value of the annuity will be considered the amount transferred.

When evaluating whether or not an annuity meets the conditions listed in 3. above, use the methodology for determining actuarial soundness that is found in the State Medicaid Manual Chapter III, Section 3258.9 B. However, do not use the actuarial life expectancy tables published in that section. Instead, use the

current actuarial tables published by the Office of the Chief Actuary of the Social Security Administration. These tables may be accessed at http://www.ssa.gov/OACT/STATS/table4c6.html.

Note that even if an annuity is determined to meet the requirements 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 as described in 1917(c)(2)(B), that transfer may be subject to penalty.

III. Effective Date

These provisions apply to purchases of annuities, and certain transactions related to annuities, that occur on or after the date of enactment of the DRA, February 8, 2006. States must take all reasonable steps to implement these provisions as soon as practicable. States should consider if pending applications need to be supplemented to collect information regarding annuities, or if this information is already specifically collected to determine income and resources. States should also consider how to best notify applicants and recipients of the State's rights regarding annuities purchased after the date of enactment.

Enclosure

Section 6013

Application of the Spousal Impoverishment "Income-First" Rule Under the Deficit Reduction Act of 2005

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

July 27, 2006

Enclosure Highlights—Section 6013

I. Background

II. New Provision

III. Effective Date

I. Background

Section 6013 of the Deficit Reduction Act of 2005 (DRA); P.L. 105-171 amends section 1924 of the Social Security Act (the Act) to require all States to follow the "income-first" method in calculating revisions to the community spouse resource allowance (CSRA) under section 1924(d).

Section 1924(d) of the Act requires States to set a monthly maintenance needs allowance (MMNA) for community spouses of institutionalized individuals applying for Medicaid. If the community spouse's own income is less than the MMNA, income of the institutionalized spouse may be paid to the community spouse to make up the difference or "shortfall." The State must also protect (i.e., not count in determining the institutionalized spouse's resource eligibility) for the community spouse a certain amount of the couple's resources, known as the community spouse resource allowance (CSRA). Protecting resources as part of the CSRA makes them available for transfer to the community spouse without counting as resources in determining the institutionalized spouse's initial Medicaid eligibility.

In calculating the community spouse's income, any interest, dividend, or other income generated by resources that are part of the CSRA, is included to the extent made available to the community spouse (see section 1924(d)(1)(B) of the Act). However, under section 1924(e)(2)(C) of the Act, the CSRA may be increased if an increase is necessary to raise the community spouse's income to the MMNA.

Prior to enactment of the DRA, generally States could use one of two methods in determining whether to increase the CSRA in order to increase the community spouse's income. States using an "income-first" method assume that all income of the institutionalized spouse that could be made available to the community spouse to bring the spouse up to the MMNA will be made available. Only if there would still be a remaining income "shortfall" would the CSRA be increased to the amount necessary to make up for the "shortfall" in income. In other States, using a "resources first" method, the increased CSRA is calculated based on comparing the community spouse's income to the MMNA without assuming that any allocation of income from the institutionalized spouse will be made.

II. New Provision

The DRA makes use of the "income first" method mandatory for all States. Thus, all States are required to attribute or allocate the maximum available income of the institutionalized spouse to the community spouse before granting an increase in the CSRA under section 1924(e)(2)(C) of the Act.

In cases where a community spouse is seeking an increased CSRA on the basis that additional resources are needed to generate the monthly maintenance needs allowance (MMNA), States may now follow the following steps:

1. Determine the MMNA for the community spouse in the same manner that you currently use pursuant to sections 1924(d)(3), (4), and (5) of the Act;

2. Determine the community spouse's total gross monthly income, including income from income-producing assets retained by the community spouse;

3. Subtract the community spouse's total monthly gross income from the MMNA. If there is a deficit, this is the amount of the income "shortfall" for the community spouse;

4. Determine the institutionalized spouse's total gross monthly income. Deduct the personal needs allowance. Allocate sufficient income from the remainder of the institutionalized spouse's income to meet the "shortfall" amount for the community spouse.

5. If, after Step 4 above, there is still some "shortfall" remaining for the community spouse, determine the amount of increased resources needed to generate that amount of income for the community spouse. In making this calculation, States may use any reasonable method for determining the amount of resources necessary to generate adequate income, including adjusting the CSRA to the amount a person would have to invest in a single premium annuity to generate the needed income, attributing a rate of return based on a presumed available rate of interest, or other methods.

The above steps are offered for illustrative purposes, and do not preclude States from applying the income-first methodology in a different manner or sequence.

III. Effective Date

The effective date of this change is the date of enactment of DRA, February 8, 2006. However, this provision applies only to determinations of the CSRA made on or after the effective date, and only when the institutionalized spouse became institutionalized on or after the effective date. Couples who have had increased CSRAs calculated under a resources first methodology prior to the enactment of DRA will not be affected.

Enclosure

Section 6014

Disqualification for Long-Term Care Coverage for Individuals with Substantial Home Equity Under the Deficit Reduction Act of 2005

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

July 27, 2006

Enclosure Highlights—Section 6014

I. New Provision

II. Methodology

III. Limitations

IV. Increases in Limits

V. Undue Hardship

VI. Effective Date

I. New Provision

Section 6014 of the DRA amends section 1917 of the Social Security Act (the Act) to provide that in determining the eligibility of an individual to receive medical assistance payment for nursing facility services or other long-term care services, States must deny payment if the individual's equity interest in his or her home exceeds $500,000. States have the option to substitute an amount exceeding $500,000, but not in excess of $750,000. States that choose to use a higher amount than the $500,000 need not use the higher amount on a statewide basis. Also, States need not apply their higher amount to all eligibility groups.

For purposes of this provision, "other long-term care services" include:

- A level of care in any institution equivalent to nursing facility services;
- Home or community-based services furnished under a waiver under sections 1915(c) or (d) of the Act; and
- Services provided to a noninstitutionalized individual that are described in paragraph (7), (22), or (24) of section 1905(a) of the Act, and, if a State has elected to apply section 1917(c) to other long-term care services for which medical assistance is otherwise available under the State plan to individuals requiring long-term care, those services.

NOTE: This is not a change in the general rule that excludes a home of any value for purposes of determining eligibility for Medicaid. It applies only to medical assistance payment for nursing facility services, or other long-term care services as defined above.

II. Methodology

In determining the value of home equity, States should follow the basic policies of the Supplemental Security Income (SSI) program. The equity value of a resource is the current market value minus any encumbrance on it. Current market value is the going price of the home, or the amount for which it can reasonably be expected to sell on the open market in the particular geographic area involved. An encumbrance is a legally binding debt against the resource. This can be a mortgage, reverse mortgage, home equity loan, or other debt that is secured by the home. States should follow their existing policies to determine current market value. States should also apply their usual verification procedures if an encumbrance is alleged.

If the home is held in any form of shared ownership, e.g., joint tenancy, tenancy in common, or other arrangement, only the fractional interest of the applicant for medical assistance for nursing facility or other long-term care services should be considered. For example, if the home is owned in joint tenancy by an applicant and a sibling, one-half of the home's current market value should be used in calculating the equity value of the individual, unless the individual can rebut the presumption that he or she has equal ownership interest in the property.

III. Limitations

The limitations on home equity do not apply if the spouse of the individual, the individual's child under 21, or the individual's blind or disabled child is residing in the home. A child is considered disabled if he or she meets the definition of disability in section 1614(a)(3) of the Act. In Guam, Puerto Rico, and the Virgin Islands, instead of using the section 1614(a)(3) definition of disability, the child must be permanently and totally disabled (as defined for purposes of the State plan program under title XVI of the Social Security Act) for the exemption to apply.

IV. Increases in Limits

Beginning in the year 2011, the $500,000 and $750,000 limits on home equity will increase each year. The increase will be based on the percentage increase in the consumer price index for all urban consumers, rounded to the nearest $1,000. However, States will continue to have the option under the State plan to elect a home equity limit that is greater than $500,000 as adjusted by inflation, but that does not exceed $750,000, as adjusted by inflation.

V. Undue Hardship

In addition, the Secretary of Health and Human Services is directed to establish a process to waive the application of the home equity limit in the case of a demonstrated hardship. Pending publication of a process specific to the home equity limit, States may use their existing procedures for determining the existence of undue hardship as currently required under section 1917(c)(2)(D) (transfers of assets for less than fair market value), or newer procedures developed for transfer of assets undue hardship waivers under section 6011 of the DRA.

Effective Date

The changes made by this section apply to individuals who are determined eligible for medical assistance with respect to nursing facility services or other long-term care services based on applications filed on or after January 1, 2006.

Enclosure

Section 6015

Rules Pertaining to the Treatment of Continuing Care Retirement Community (CCRC) Entrance Fees Under the Deficit Reduction Act of 2005

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

July 27, 2006

Enclosure Highlights—Section 6015

I. General Discussion

II. Effective Date

I. General Discussion

This enclosure concerns provisions of the Deficit Reduction Act of 2005 (DRA); P.L. 109-171, applicable to cases where entrance fees have been paid to continuing care retirement communities (CCRCs), or life care communities. The changes modify portions of the Federal Medicaid statute, specifically section 1919(c)(5) of the Social Security Act (the Act) and section 1917 of the Act.

The Federal Medicaid statute does not define what constitutes a CCRC or life care community. However, as a general rule CCRCs or life care communities provide a range of living arrangements, from independent living through skilled nursing care. Regulation, licensing or certification of such facilities is a function of the States. Some CCRCs include Medicaid certified nursing facilities and others do not participate in Medicaid. In many cases, potential residents must provide extensive information about their finances, including their resources and income, before being accepted for admission. In addition, they frequently must pay substantial entrance fees and sign detailed contracts before moving to the community.

The amendments to section 1919(c)(5) of the Act provide that contracts for admission to a State licensed, registered, certified, or equivalent CCRC or life care community may require residents to spend on their care the resources that were declared by the resident for the purpose of admission to the CCRC prior to applying for Medicaid. However, the provisions of the entrance contract are subject to the rules relating to the prevention of impoverishment of a community spouse under subsections 1924(c) and (d) of the Act. Therefore, any contractual provision requiring the expenditure of resident entrance deposits must take into account the required allocation of resources or income to the community spouse before determining the amount of resources that a resident must spend on his or her own care.

In addition, the DRA and added a new subsection (G) to section 1917(c)(1) of the Act. The new subsection (G) defines when an entrance fee paid to a CCRC or life care community would be treated as a resource to an individual for purposes of determining Medicaid eligibility. The following three conditions must all be met in order for the entrance fee to be considered an available resource:

- The entrance fee can be used to pay for care under the terms of the entrance contract should other resources of the individual be insufficient; and
- The entrance fee (or remaining portion) is refundable when the individual dies or terminates the contract and leaves the CCRC or life care community; and
- The entrance fee does not confer an ownership interest in the community.

States should note that in order to meet the first condition listed above, it is not necessary for CCRCs or life care communities to provide a full, lump-sum refund of the entrance

fee to the resident. If portions of the fee can be refunded or applied to pay for care as required, this condition would be met.

Also, in order to meet the second condition listed above, it is not necessary for the resident to actually receive a refund of the entrance fee or deposit. This condition is met as long as the resident could receive a refund were the contract to be terminated, or if the resident dies.

II. Effective Date

The provisions related to entrance deposits made to CCRCs and life care communities became effective upon the date of enactment of the DRA, February 8, 2006.