RHODE ISLAND GOVERNMENT REGISTER

PUBLIC NOTICE OF PROPOSED RULEMAKING

AGENCY: Executive Office of Health and Human Services

DIVISION: Medicaid Policy Unit

RULE IDENTIFIER: Medicaid Code of Administrative Rules, Section #0384, ERLID #7765

REGULATION TITLE: "Resource Transfers"

RULEMAKING ACTION: Regular promulgation process

Direct Final: N/A

TYPE OF FILING: Repeal

TIMETABLE FOR ACTION ON THE PROPOSED RULE: Public comment will end on **Monday, October 29, 2018.**

SUMMARY OF PROPOSED RULE: The purpose of this rule is to set forth provisions related to determining Medicaid eligibility for long-term services and supports as it relates to an individual's transfer of assets for less than fair market value.

COMMENTS INVITED: All interested parties are invited to submit written or oral comments concerning the proposed regulations by **Monday, October 29, 2018** to the address listed below.

ADDRESSES FOR PUBLIC COMMENT SUBMISSIONS:
All written comments or objections should be sent to the Secretary of EOHHS, Eric J. Beane, c/o Elizabeth Shelov, Medicaid Policy Office, Rhode Island Executive Office of Health & Human Services
Mailing Address: Virks Building, Room 315, 3 West Road, Cranston, RI 02920
Email Address: Elizabeth.Shelov@ohhs.ri.gov

WHERE COMMENTS MAY BE INSPECTED: Mailing Address: Executive Office of Health & Human Services, Virks Building, Room 315, 3 West Road, Cranston, RI 02920

PUBLIC HEARING INFORMATION:
If a public hearing is requested, the place of the public hearing is accessible to individuals who are handicapped. If communication assistance (readers/ interpreters/captioners) is needed, or any other accommodation to ensure equal participation, please call (401) 462-6266 or RI Relay 711 at least three (3) business days prior to the meeting so arrangements can be made to provide such assistance at no cost to the person requesting.

ALTERNATIVE PUBLIC HEARING TEXT:
In accordance with R.I. Gen. Laws § 42-35-2.8, an oral hearing will be granted if requested by twenty-five (25) persons, by an agency or by an association having at least twenty-five (25) members. A request for an oral hearing must be made within ten (10) days of this notice.

FOR FUTHER INFORMATION CONTACT: Elizabeth Shelov, Interdepartmental Project Manager, Medicaid Policy Office, Rhode Island Executive Office of Health & Human Services, Virks Building, Room 315, 3 West Road, Cranston, RI 02920 or Elizabeth.Shelov@ohhs.ri.gov

SUPPLEMENTARY INFORMATION:
Regulatory Analysis Summary and Supporting Documentation:

Societal costs and benefits have not been calculated in this instance. To be in conformity with federal law, regulations, guidance and state law, the state has little discretion in promulgating this rule. For full regulatory analysis or supporting documentation see agency contact person above.

Authority for This Rulemaking: R.I. Gen. Laws Chapters 40-6 and 40-8; Title XIX of the Social Security Act

Regulatory Findings:
In the development of the proposed regulation, consideration was given to: (1) alternative approaches; (2) overlap or duplication with other statutory and regulatory provisions; and (3) significant economic impact on small business. No alternative approach, duplication, or overlap was identified based upon available information.

The Proposed Repeal:
These rules are proposed to be repealed and replaced, in part, by newly adopted regulations entitled, "Medicaid Long-Term Services and Supports: Financial Eligibility" (210-RICR-50-00-6).

STATE OF RHODE ISLAND

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES

PUBLIC NOTICE OF PROPOSED RULE-MAKING

Medicaid Code of Administrative Rules, Section #0384, "Resource Transfers"

The Secretary of the Executive Office of Health and Human Services (EOHHS) has under consideration the repeal of a Medicaid regulation entitled, **"Resource Transfers**" – Section #0384 of the Medicaid Code of Administrative Rules. These rules will be replaced in part by newly adopted regulations entitled, "Medicaid Long-Term Services and Supports: Financial Eligibility***"*** (210-RICR-50-00-6).

These regulations are being promulgated pursuant to the authority contained in R.I. Gen. Laws Chapter 40-8 (Medical Assistance); R.I. Gen. Laws Chapter 40-6 ("Public Assistance"); R.I. Gen. Laws Chapter 42-7.2; R.I. Gen. Laws Chapter 42-35; and Title XIX of the Social Security Act.

In accordance with R.I. Gen. Laws 42-35-2.8(c), an opportunity for a hearing will be granted if a request is received by twenty-five (25) persons, or by a governmental agency, or by an association having not less than twenty-five (25) members, within ten (10) days of this notice that is posted in accordance with R.I. Gen. Laws 42-35-2.8(a). A hearing must be open to the public, recorded, and held at least five (5) days before the end of the public comment period.

In the development of these proposed regulations, consideration was given to the following: (1) alternative approaches; (2) overlap or duplication with other statutory and regulatory provisions; and (3) significant economic impact on small businesses in Rhode Island. No alternative approach, duplication or overlap, or impact upon small businesses was identified based upon available information.

These proposed rules are accessible on the R.I. Secretary of State's website: http://www.sos.ri.gov/ProposedRules/, the EOHHS website: www.eohhs.ri.gov, or available in hard copy upon request (401 462-1575 or RI Relay, dial 711). Interested persons should submit data, views, or written comments by **Monday, October 29, 2018** to: Elizabeth Shelov, Medicaid Policy Office, RI Executive Office of Health & Human Services, Virks Building, 3 West Road, Room 315, Cranston, RI 02920 or Elizabeth.Shelov@ohhs.ri.gov.

The Executive Office of Health and Human Services does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief or handicap in acceptance for or provision of services or employment in its programs or activities.

The EOHHS in the Virks Building is accessible to persons with disabilities. If communication assistance (readers /interpreters /captioners) is needed, or any other accommodation to ensure equal participation, please notify the EOHHS at (401) 462-1575 (hearing/speech impaired, dial 711) at least three (3) business days prior to the event so arrangements can be made to provide such assistance at no cost to the person requesting.

Original signed by:

Eric J. Beane, Secretary
Signed this 21st day of September 2018

SEPTEMBER 2018: THESE RULES ARE PROPOSED TO BE REPEALED IN THEIR ENTIRETY:

~~**0384 Resource Transfers**~~

~~**0384.05 Legal Basis**~~
~~REV: April 2014~~

~~The Omnibus Budget Reconciliation Act (OBRA) of 1993 provides a penalty for institutionalized individuals who on or after 8/11/93, transfer or have transferred assets for less than fair market value.~~

~~Asset transfers, prior to February 8, 2006, are examined for potential penalty when the transfer took place within thirty six (36) months prior to or anytime after the date the individual was both institutionalized and applied for Medicaid. All asset transfers made on or after February 8, 2006 shall be subject to a look back period of sixty (60) months.~~

~~Under OBRA provisions, trusts and/or portions of trusts established on or after 8/11/93 are in some cases treated as a transfer of assets and subject to a penalty. Asset transfers involving a trust are examined for potential penalty when the transfer took place within sixty (60) months prior to or anytime after the date the individual was both institutionalized and applied for Medicaid. In the event that application of the transfer rules and the trust rules result in an individual being subject to a transfer penalty twice for actions involving the same resource, the trust rules supersede the transfer rules in determining eligibility. (See Medicaid Code of Administrative Rules (MCAR) Section 0382 for detailed information about Trusts.)~~

~~The Deficit Reduction Act of 2005 (DRA) provides a penalty for institutionalized individuals who on or after February 8, 2006, transfer or have transferred assets for less then fair market value.~~

~~All asset transfers made on or after February 8, 2006 are examined for potential penalty when the transfer took place within sixty (60) months prior to or anytime after the date the individual was both institutionalized and applied for Medical Assistance.~~

~~The penalty is a period of restricted Medicaid eligibility during which payment for Long Term Care Services is denied. Long Term Care Services include nursing facility services, Intermediate Care Facility Services for the Mentally Retarded (ICF-MR), administratively necessary days in a hospital, and home and community based waiver services.~~

~~The computation of the penalty period for transfers of assets made prior to February 8, 2006 and how the penalty is imposed for such transfers are determined as provided in Section 0384.20.~~

~~The computation of the penalty period for transfers of assets made on or after February 8, 2006 and how the penalty is imposed for such transfers are determined as provided in Section 0384.25.~~

~~The uncompensated transfer of resources which have been disregarded under the Qualified Long Term Care Insurance Partnership Program are treated as the uncompensated transfer of any other resource.~~

0384.10 Individuals Ineligible for Nursing Facility Payment

REV: April 2014

Unless exempt, transfers of assets (income and resources) made for less than fair market value by an institutionalized individual (or the community spouse - if made prior to the establishment of the applicant's Medicaid /LTC eligibility) are subject to a penalty if the transfer was made:

A. For transfers of assets made prior to February 8, 2006 within thirty six (36) months immediately prior to or any time after the date the individual was both institutionalized AND applied for Medicaid; or

B. For transfers of assets made on or after February 8, 2006, within sixty (60) months immediately prior to or anytime after the date the individual was both institutionalized AND applied for Medicaid; or

C. If the transfer involves a trust, within a sixty (60) month look back period immediately prior to or anytime after the date the individual was both institutionalized AND applied for Medicaid.

D. Since transfers involving a trust have for many years already been subject to a look back period of 60 months, their treatment is unaffected by Paragraph B. above. The look back period in Paragraph B, above, is effective for all other transfers made on or after February 8, 2006. As a result of this phase in, the look back periods, and those transfers which must be reported by applicants, are as follows:

For applications which are filed from February 8, 2011 and thereafter, the look back period is sixty (60) months immediately prior to or anytime after the date the individual was both institutionalized AND applied for Medicaid.

If the individual has multiple periods of institutionalization and/or applications, the look back period starts with the first date on which the individual was both institutionalized and applied for Medicaid.

The penalty is a period of ineligibility for payment of long term care services for an otherwise eligible individual.

For transfers of assets prior to February 8, 2006 see Section 0384.20 for the rules as to how the penalty period is calculated and how it is imposed.

For transfers of assets on or after February 8, 2006 see Section 0384.25 for the rules as to how the penalty period is calculated and how it is imposed.

0384.15 Resource Transfer Definitions

REV: April 2014

For purposes of evaluating transfers of assets, the following definitions apply:

1. **Assets** means:
   - All income and resources of the individual or the individual's spouse that would be countable in the determination of Medicaid eligibility for an SSI-related individual; and

- The home (and associated land) of an institutionalized individual.

This includes any income and resources to which the individual or his/her spouse is entitled but does not receive because of action taken by:

- The individual or his/her spouse;
- A person, including a court or administrative body, with legal authority to act in place of the individual or his/her spouse; or
- Any person, including any court or administrative body, acting at the direction or upon the request of the individual or his/her spouse.

2. **Compensation/Consideration** means:

All real and/or personal property (money, food, shelter, services, stocks, bonds, etc.) that is received by an applicant/recipient pursuant to a binding contract in exchange for an asset either prior to, at the time of, or after the transfer.

3. **Fair Market Value (FMV)** means:

The amount for which the property (real and personal) can be expected to sell on the open market in the geographic area involved and under existing economic conditions at the time of transfer.

4. **Institutionalized Individual** means:

An inpatient of a nursing facility, an inpatient of a medical institution for whom payment is based on a level of care provided in a nursing facility, an inpatient of an intermediate care facility for the mentally retarded (ICF-MR), and/or a home and community based waiver recipient.

5. **Sole Benefit** means:

A transfer is considered to be for the sole benefit of a spouse, blind or disabled child, or a blind or disabled individual, when the transfer is established using a written agreement that legally binds the parties and clearly expresses that the transfer is for the spouse, blind or disabled child, or blind or disabled individual only, and that no one else can benefit from the assets transferred. Without this agreement, a transfer cannot be determined to be for the sole benefit of the individual.

6. **Long Term Care Services** means:

Services provided to individuals in nursing facilities, ICF-MRs, as an inpatient in a medical institution for whom payment is based on a level of care provided in a nursing facility, and under home and community based waivers and administratively necessary days.

7. **Look Back Date** means:

The look back date is a date that is the appropriate number of months, as provided for in Section 0380.05, before an institutionalized individual has applied for Medicaid.

8. **Look Back Period** means:

The look back period is that period of time beginning with the look back date through the date an institutionalized individual has applied for Medicaid.

9. **Penalty Period** means:

The period of time during which payment for long term care services is denied. The number of months in a penalty period (P) is equal to the total uncompensated value (UV) of prohibited transfers made by the institutionalized individual (or spouse, if made prior to establishment of individual's Medicaid /LTC eligibility) during the thirty-six (36) or sixty (60) month period immediately prior to the date of institutionalization (or if later the date of Medicaid application) divided by the average monthly cost of a private patient in a nursing facility at the time of application. For transfers made on or after February 8, 2006, the penalty period begins from the date of transfer or the date that the individual would have otherwise been eligible, whichever is later.

$$P = UV/C$$

10. **Prohibited Transfer** means:

Transfer of an asset for less than fair market value by an individual (or spouse, if made prior to establishment of individual's Medicaid /LTC eligibility) which was made within thirty-six (36) months or sixty (60) months prior to or anytime after the date the individual was both institutionalized and applied for Medicaid.

11. **Transfer** means:

The conveyance of right, title, or interest in either real or personal property from one person to another by sale, gift, or other process; or the gift or assignment of income from one person to another. Disposal of a lump sum payment before it can be counted as a resource can be an example of a transfer of income.

Transfers made by an individual include transfers made by:

- The individual;
- His/her spouse;
- Any person, including a court or administrative body, with legal authority to act on behalf of the individual or his/her spouse; or
- Any person, including a court or administrative body, acting at the direction or upon the request of the individual or his/her spouse.

12. **Uncompensated Value** (UV) means:

The equity value (fair market value less any outstanding loans, mortgages or other encumbrances) minus the value of any compensation /consideration received by the applicant/recipient in exchange for the asset.

0384.20 Penalty Period for Payment of Long Term Care Services

REV: April 2014

The rules in this section, MCAR 0384.20, apply to transfers of assets which occurred prior to February 8, 2006.

The penalty for an otherwise eligible institutionalized individual who transfers assets for less than fair market value is a period of ineligibility for payment of long term care services.

A. The following provisions apply in determining the penalty period for a prohibited transfer:

1. **Start date of the penalty period.**

The penalty period begins on the first day of the month in which the transfer was made and runs continuously from the penalty date regardless of whether the individual remains in or leaves the institution (or waiver program). Thus, if an individual leaves the nursing facility, the penalty period nevertheless continues until the end of the calculated period.

2. **Calculation of the length of the penalty period**

To calculate the penalty period (P) for a prohibited transfer, divide the amount of the uncompensated value (UV) of the transfer by the average monthly cost (C) for private payment in a nursing facility.

$$P = UV/C$$

Currently, the average monthly cost for private payment in a nursing facility is $9,113 per month.

When more than one prohibited transfer occurs during the same month, the uncompensated values of all prohibited transfers made during the month are totaled, then divided by the average monthly private payment for an individual in a nursing facility.

Penalty periods are imposed for full months only; penalty periods of less than one month are not imposed.

There is no maximum length to the penalty period. However, no penalty is imposed for resources transferred prior to the look back period.

Multiple Transfers with Overlapping Penalty Periods

When assets have been transferred in amounts and/or frequency that make the calculated penalty periods overlap, a single penalty period is imposed. This penalty period begins on the first of the month in which the first prohibited transfer was made and is calculated as follows:

First, add the total of the uncompensated value of all assets transferred; then, divide the sum by the average private pay cost of nursing facility care. This produces a single penalty period that begins on the first day of the month in which the first transfer was made.

Multiple Transfers with No Overlapping Penalty Periods

When multiple prohibited transfers are made in such a way that penalty periods do not overlap, each transfer is treated as a separate event with its own penalty period. Each separate penalty period is calculated by dividing the total amount of the uncompensated value of the transfer by the average monthly nursing facility cost for a private patient.

Each separate penalty period begins on the first of the month in which transfer occurred.

B. **Transfers by the Spouse**

When a transfer by the spouse results in a penalty period for the institutionalized individual, and the spouse later becomes institutionalized and applies for Medicaid payment of long term care services, the penalty period remaining is apportioned equally between the spouses. If both spouses are institutionalized in the same month the period of ineligibility is divided equally between them. When one spouse is no longer subject to a penalty, any remaining penalty is then imposed on the remaining institutionalized individual.

C. **Transfers of Income**

When lump sum income is transferred (e.g., a stock dividend check is given to another person in the month in which it is received by the individual), a penalty period is calculated based on the value of the lump sum payment and the date transfer was made.

When a stream of income has been transferred, a penalty period is calculated for each income payment that is periodically transferred.

When the right to a stream of income is transferred, a penalty period is calculated based on the total amount of income expected to be transferred during the individual's lifetime, based on life-expectancy tables established by the Social Security Administration's Office of the Actuary.

0384.25 Partial Month Penalty

REV: April 2014

The rules in this MCAR Section, 0384.25, apply to transfers of assets which occur on or after February 8, 2006.

The penalty for an otherwise eligible institutionalized individual who transfers assets for less than fair market value is a period of ineligibility for payment of long term care services. The following provisions apply in determining the penalty period for a prohibited transfer:

A. The following provisions apply in determining the penalty period for a prohibited transfer:
Start Date of the penalty period:

The penalty period begins the later of:

a. The date on which an individual is eligible for Medicaid and would otherwise be receiving institutional level of care, described in MCAR Section 0384.10, based on an approved application for such care but for the application of the penalty period; or

b. The first day of the month during or after which the assets have been transferred for less than fair market value, and which does not occur during any other period of ineligibility based on a transfer of assets.

The provisions of (a) require that an application for Medicaid be filed.

0384.25.05 Calculation of Partial Month Penalty
REV: 03/2007

This Section, 0384.25.05, is applicable to calculations of penalty periods as of July 1, 2006.

When more than one prohibited transfer occurs during the look back period, the uncompensated values of all prohibited transfers made during the look back period are totaled.

To calculate the penalty period (P) for a prohibited transfer(s), divide the amount of the uncompensated value(s) (UV) of the transfer(s) by the average monthly cost (C) for private payment in a nursing facility. P+UV/C

In making these calculations, there is no "rounding down."

In making these calculations, partial month penalties are applied, if appropriate.

When calculating penalty periods, for transfers covered by this section, both the average monthly and daily rate of private nursing facility care will be utilized. The rate is set forth in section 0384.20.

There is no maximum length to the penalty period. However, no penalty is imposed for assets transferred prior to the look back date.

In order to assess a transfer penalty period, the uncompensated transfer amount is divided by the monthly rate, and the remainder is divided by the daily rate. Individuals are responsible for paying the cost of care until their penalty period expires. Medicaid begins paying for long term care expenses on the day the penalty period expires.

0384.35 Exceptions to Period of Ineligibility
REV: April 2014

A penalty period is not imposed when:

- The asset was transferred for fair market value;
- The transferred resource was the individual's home and title to the home was transferred to:
  - the individual's spouse;
  - a child of the individual who is under the age of 21, or is blind, or permanently and totally disabled (as evidenced by receipt of SSI or RSDI benefits, or as defined in MCAR Section 0352.15);

- a sibling of the individual who has an equity interest in the home and who resided in the home for at least one year immediately prior to the institutionalization of the individual;

- a son or daughter of the individual who:

  - was residing in the home for at least two years prior to the parent's institutionalization; and

  - can demonstrate that s/he provided care to the parent which prevented the parent from entering an institution for the two year period.

- The asset (other than a home, see above) was transferred to:

  - the spouse, or to another for the sole benefit of the spouse, or from the spouse to another for the sole benefit of the spouse;

  - the individual's child who is blind or permanently and totally disabled, or to another for the sole benefit of such child; or to a trust established for the sole benefit of such child;

  - a trust established for the sole benefit of an individual who is under the age of 65 and permanently and totally disabled (as defined in MCAR Section 0352.15);

- The individual can prove his/her intention was to receive fair market value or other valuable compensation/ consideration;

- The individual can prove the transfer was exclusively for some purpose other than to qualify for Medicaid;

- Denial of payment for long term care services would work an undue hardship;

- The asset is returned to the individual.

NOTE: Annuities that:

1. were obtained on or between February 8, 2006 and December 31, 2008 and

2. during that time, complied with EOHHS policy as it was promulgated in July 2006, by naming the state as a beneficiary of the remainder of the annuitant's annuity, and

3. were not subsequently changed to preclude the naming of the state as a beneficiary for the Medicaid expenses of the institutionalized and/or community spouse and

4. are documented by the issuer to be unable to be changed to comply with the requirement to name the state as a beneficiary for recovery of Medicaid up to the amount of Medicaid paid on behalf of the institutionalized spouse, based on the terms and conditions of the annuity contract, are deemed to meet the criteria listed above, that "The individual can prove his/her intention was to receive fair market value or other valuable compensation / consideration."

0384.40 Responsibilities

REV: April 2014

Field staff responsibilities pertaining to transfer of assets are the following:

FIRST

The agency representative is responsible to explain the policy on transferred assets and how it may affect eligibility for nursing facility payment, and assist the applicant in determining what documentation is relevant and how such documentation is generally obtained.

SECOND

Exceptions to the penalty period which involve transfer of an individual's home to his/her spouse, child under 21, or blind or disabled child are referred with relevant documentation to the casework supervisor for review.

All other exceptions should be referred to the Long Term Care Administrator or his designee, who will consult with the Legal Counsel as necessary.

Any and all documents relative to the transferred resource and its fair market value, such as bills of sale, deeds, purchasing agreements, and compensation received must be provided by the applicant as a part of the application process.

THIRD

Transfers of assets for less than FMV are presumed to be for the purpose of establishing eligibility for nursing facility payment. The applicant can rebut the presumption by making a satisfactory showing that the transfer was for some other purpose.

If the applicant/recipient wishes to rebut the presumption, the Medicaid agency representative shall explain that it is the applicant/recipient's responsibility to make a satisfactory showing that the assets were transferred exclusively (i.e., only) for some other reason. The information furnished by the applicant/ recipient should cover, but need not be limited to, the following factors:

- The purpose for transferring the asset;
- The attempts to dispose of the asset for FMV;
- The reasons for accepting less than FMV;
- The applicant/recipient's relationship, if any, to the person(s) to whom the asset was transferred.

The applicant/recipient should be assisted in obtaining information to rebut the presumption when necessary; however, the burden of proof rests with the applicant/recipient.

FOURTH

Once the LTC Administrator determines that an asset was transferred for less than fair market value and the resultant uncompensated value, the Medicaid agency representative will determine the period of ineligibility for nursing facility payment.

FIFTH

The Medicaid agency representative is responsible to inform the applicant of the outcome of the review conducted by LTC Administrator, and the period of ineligibility, if any. The individual must be notified of the decisions, and his/her right to appeal.

SIXTH
If the individual is either eligible for Medicaid or pending spenddown, but is determined to have a period of ineligibility for payment of LTC services due to the transfer, the penalty period information is recorded. Eligibility or pending spenddown status for Medicaid is approved, and the case is transferred to the appropriate Medicaid unit.

The responsibilities of the LTC Administrator are:

FIRST
Determine the fair market value (FMV) of the transferred asset based on the documentation forwarded by field staff.

SECOND
Determine the uncompensated value, if any, by subtracting the value of any compensation/ consideration received from the equity value.

THIRD
Evaluate the individual's rebuttal of the agency's presumption that resources were transferred in order to become eligible for nursing facility payments, and consult with the Office of Legal Services, as necessary.

FOURTH
Evaluate claims of undue hardship.

0384.45 Rebuttal of Presumption of Prohibited Transfers
REV: April 2014

An individual may rebut the Medicaid agency's presumption that assets were transferred in order to become eligible for nursing facility payments.

The presence of one or more factors may indicate that the asset was transferred exclusively for some purpose other than establishing eligibility for nursing facility payments.

These factors are:

- A traumatic onset (e.g., traffic accident) of disability or blindness after transfer of the resource

If the applicant/recipient states that after the transfer s(he) experienced a traumatic onset of disability which could not have been foreseen at the time of transfer, and which resulted in the inability to provide for his/her own support, consider the applicant's/recipient's age, medical history, and medical condition at the time of transfer as well as his/her financial situation. Was the applicant/recipient in good health at the time of the transfer and spending a minimal amount on medically related costs such as insurance, routine doctor visits, etc.? Did the applicant/recipient have sufficient income and/or resources to meet his/her medical needs, as well as basic living expenses, as they existed at the time of the transfer and as they could be foreseen over the next 36 months?

The applicant/recipient may submit whatever medical documentation s(he) wishes to substantiate his/her claim.

- Inability to dispose of the asset for fair market value

  The applicant/recipient must provide evidence of attempts to dispose of the asset for fair market value, as well as evidence to support the value at which the asset was disposed.

- Diagnosis of previously undetected disabling condition

- Unexpected loss of other resources (including deemed resources) which would have precluded Medicaid eligibility

- Unexpected loss of income (including deemed income) which would have precluded Medicaid eligibility

- Total countable resources that would have been below the resource limit at all times from the month of transfer through the present month even if the transferred resource had been retained

- Court-ordered transfer.

0384.45.05 Claims of Undue Hardship

REV: April 2014

A. **Standards for Granting an Undue Hardship Waiver**

A transfer penalty shall be waived if imposition of the penalty would cause the individual undue hardship. The entire penalty period or a portion of the penalty period shall be waived when:

1) Imposition of the penalty period would deprive the individual of medical care to the extent that his/her life or health would be endangered or would deprive the individual of food, shelter, clothing or other necessities of life; and

2) All appropriate attempts to retrieve the transferred asset have been exhausted; and

3) The nursing facility has notified the individual of its intent to initiate discharge or the agency providing essential services under a home and community based waiver has notified the individual of its intent to discontinue such services for reasons of non-payment; and

4) No less costly non-institutional alternative is available to meet the individual's needs.

Undue hardship does not exist when application of the transfer provisions merely causes inconvenience or restricts lifestyle but would not put him/her at risk of serious deprivation.

B. **Availability of Undue Hardship Waivers**

When eligibility for payment of long term care services has been denied due to imposition of a transfer of assets penalty, the Medicaid agency shall notify the applicant in writing that an undue hardship exception exists. The individual may claim undue hardship. The facility in which the institutionalized individual is residing may file an undue hardship waiver application on behalf of the individual if done with the consent of the individual or the personal representative of the individual.

C. **Process for Undue Hardship Waiver**

The individual and/or facility must submit a written request and any supporting documentation within 30 days of a denial from the Medicaid agency. A request for consideration of undue hardship does not limit the individual's right to appeal a denial of eligibility for reasons other than hardship.

Claims of undue hardship are forwarded to the Long Term Care Administrator or his/her designee for evaluation. The LTC Administrator or his/her designee may instruct the agency representative to obtain documentation from the individual which can include, but is not be limited to, the following:

- A statement from the attorney, if one was involved;
- Verification of medical insurance coverage and statements from medical providers relative to usage not covered by said insurance;
- A statement from the transferee relative to his/her financial position;
- Resource documents such as a deed, bank book, etc. to verify the existence and structure of the resource;
- If jointly held, a statement from the other owner(s) of the jointly held resource relative to the reason for and circumstances of the transfer.

The LTC Administrator or his/her designee, in consultation with the Office of Legal Services determines whether undue hardship applies.

Written notification of the Medicaid agency's decision regarding undue hardship, along with appeal rights, is provided to the individual within sixty (60) days of the Medicaid agency's receipt of the request.

0384.45.05.05 DRA Claims of Undue Hardship
REV: April 2014

The Medicaid agency may waive the penalty period if the transfer penalty being imposed is the direct result of an action taken on or after February 8, 2006 and before May 8, 2006, which would not have caused ineligibility prior to that date, but resulted in ineligibility because of the changes in policy due to the Federal Deficit Reduction Act, 42 U.S.C.1396p(e). The requestor must show that he/she (and his/her legal counsel, if applicable) was unaware of the provisions of the Deficit Reduction Act. The process shall follow 0384.45.05.

0384.50 – SSI Recipients

REV: April 2014

Resource transfers do not impact Medicaid or SSI eligibility determinations. Individuals may be eligible for Medicaid-only or SSI and Medicaid while at home or while in an institution, without regard to resource transfers.

However, once institutionalized, all Medicaid recipients are subject to the policies contained in this section regarding resource transfers.

The Social Security Administration (SSA) questions SSI recipients regarding transferred resources at the time of application and redetermination for SSI benefits. SSA maintains a record of those SSI recipients who have transferred resources which is transmitted to the Medicaid agency on a regular basis.

Prior to authorizing a vendor payment to a nursing facility, the Medicaid agency screens the list of alleged transferors to ascertain that the individual in question has not disclosed a resource transfer to SSA. In the event that this screening indicates that the applicant has transferred a resource, the case is referred for review and evaluation of the impact of the transfer on eligibility for nursing facility payment.