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TITLE 210 – EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 50 – MEDICAID LONG-TERM SERVICES AND SUPPORTS

SUBCHAPTER 00 – LONG-TERM SERVICES

PART 6 – Medicaid Long-Term Services and Supports: Financial Eligibility

6.1 Overview and Purpose

A. Financial eligibility for Medicaid LTSS is determined using a multi-faceted process that considers countable income and resources at the time of application, the allocation of joint spousal resources from the point the need for LTSS began, and financial transactions over a look-back period of up to five (5) years. The purpose of this process is not only to assess whether an applicant meets the applicable income and resources limits, but also to ensure that Federal requirements that both prohibit self-impoverishment and protect against spousal impoverishment are met.

B. The LTSS financial eligibility requirements differ somewhat depending on whether a person is a current Medicaid beneficiary or a new applicant. The method required by Federal Regulations for evaluating income and resources is linked to the applicable category of Medicaid coverage: modified adjusted gross income (MAGI) method for Affordable Care Act (ACA) expansion adults in Medicaid Affordable Care Coverage (MACC) category or the Supplemental Security Income (SSI) method for adults over age twenty-one (21) in the Integrated Health Care Coverage (IHCC) category.

6.2 Legal Authority

A. This Part is promulgated pursuant to the following Federal and State authorities:

1. Federal Law – Title XIX of the U.S. Social Security Act, 42 U.S.C. §§ 1396a, ~~Sections~~ 1902, 1903(i)(24),1905, 1917(b) through (d), 1924(d)03, 1905, 1915, 1919, 1929, 1934(a), and 1940.

2. Federal Regulations – 42 C.F.R. §§ 435.723(c)(2), 435.733(c)(2), 435.832(c)(2) and §§ 840-845 602, 441.180, 441.300 to 310, 441.350 to 365 and 42 C.F.R. §§ 430.25, 435.217, 440.180 and 460.92(b).

3. The Rhode Island Medicaid State Plan and the Title XIX, Section 1115 (a) Demonstration Waiver (11-W-00242/1), effective through December 31, 2018.

B. State Authority – R.I. Gen. Laws Chapters 40-6; 40-8; 40-8.3; 40-8.9, R.I. Gen. Laws §§ 40-8-15, and 42-7.2.

6.3 Definitions

A. For the purposes of this Part, the terms below are defined as follows:

1. “ACA expansion adult” means an adult between the ages of nineteen (19) and sixty-four (64) who is not eligible for or enrolled in Medicare or receiving SSI and qualifies for Medicaid coverage under the State Plan option established by the Federal Patient Protection and Affordable Care Act (ACA) of 2010 (42 U.S.C. § 18001).

2. “Annuity” means a purchased contract in which one (1) party (annuity issuer) agrees to pay the purchaser, or the person the purchaser designates (the payee or payees), a return on money deposited with the annuity issuer (either in the form of a single lump sum or several payments deposited over several months or years) according to the terms of the annuity contract.

3. “Authorized representative” means a person or entity whom an applicant or beneficiary designates to act responsibly on his or her behalf when applying for initial or continuing Medicaid eligibility and engaging with the agency on other ongoing communications. Such a designation requires the signed consent of the applicant or beneficiary, provided on paper or through any electronic signatures accepted by the State, unless conferred by court order or State law.

4. “Available resource” means that a person has the legal ability to access and use the resource(s) for support and maintenance. A resource is considered unavailable when there is a legal impediment that prevents the person from utilizing it for such purposes.

5. “Disqualifying transfer” means the divestment of an asset (liquid resource, prospective income, or real property) for less than fair market value or a fair market value than cannot be readily ascertained.

6. “Equity value” means the price an item can be reasonably expected to sell for on the local open market minus any encumbrances.

7. “Fair market value” or “FMV” means a certified appraisal or an amount equal to the price of the property or selling price of the asset on the open market in the locality that is readily ascertainable at the time of the transfer or contract for sale, or the application date if earlier.

8. “Financial responsibility unit” or “FRU” means the persons living with the applicant whose income and resources are considered available when determining financial eligibility.

9. “Guardian” means a person or institution appointed by a court in any state to act as a legal representative for another person, such as a minor or a person with disabilities.

10. “Medicaid eligibility group” means the total number of persons counted in a household – that is, the family size involved – when identifying the Federal Poverty Level (FPL) income level that applies when determining a person’s Medicaid eligibility.

11. “Ownership interest” means the Medicaid applicant holds sole or joint legal title to the residential property or is a party to a legal covenant establishing property ownership, such as identified in § 6.9 of this Part.

12. “Principal place of residence” means the residential property where the beneficiary, and/or in the instances specified, the spouse or a dependent child of such a person, lives the majority of the year (i.e., one hundred and eighty-three (183) days in the previous twelve (12) months).

13. “Real property” means land and generally whatever is erected, growing on, or affixed to land.

14. “Representative payee” means an individual, agency, or institution selected by a court or the Social Security Administration (SSA) to receive and manage benefits on behalf of another person.

15. “Trust” means property that is legally held or managed by a person or organization other than by its owners.

16. “Uncompensated value” or “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/beneficiary in exchange for the asset.

6.4 LTSS Determination of Income

A. In accordance with Medicaid institutional rules (Subchapter 05 Part 1 of this Chapter, Medicaid Long-Term Services and Supports: Institutionally Based LTSS), an applicant for Medicaid LTSS is both a financial responsibility unit (FRU) and a Medicaid eligibility unit of one (1) for the family size involved when determining financial eligibility once the joint resources of a couple have been allocated in the community spouse allocation of resources process in accordance with § 6.5 of this Part. There is also no spouse to spouse deeming of the income in the LTSS financial eligibility determination process.

B. The financial eligibility for current non-LTSS Medicaid beneficiaries is re-evaluated using the LTSS Rules with information previously provided to the State by the beneficiary. As additional information from the beneficiary may be

required, financial eligibility determination is not automatic unless the basis for coverage is receipt of SSI.

C. Medicaid LTSS is available to applicants and beneficiaries who have countable income that does not exceed the limits established for one (1) or more of the following eligibility pathways:

1. ACA expansion adults – Adults between the ages of nineteen (19) and sixty-four (64) with income up to one hundred thirty-eight percent (138%) of the FPL, including the five percent (5%) disregard, using the MAGI method as set forth in Part 30-00-5 of this Title, Medicaid MAGI Financial Eligibility Determinations and Verification. The LTSS applicant is treated as a family of one (1) for LTSS eligibility purposes, irrespective of whether he or she resides with a non-LTSS spouse and receives services at home, in a health institution or a community-based service setting.

2. Elders and adults with disabilities (EAD), including:

   a. SSI-eligible Medicaid beneficiaries;

   b. Adults between the ages of nineteen (19) and sixty-four (64). Medicare eligible or enrolled with countable income up to three hundred percent (300%) of the SSI rate using the method set forth in § 40-00-3.2 of this Title; and

   c. Elders sixty-five (65) and older. Countable income up to three hundred percent (300%) of the SSI rate based on the SSI method in § 40-00-3.2 of this Title.

3. LTSS medically needy adults – Adults with countable income above three hundred percent (300%) of the SSI rate up to the average private pay rate for the applicable institutional level of care may be eligible as medically needy if they meet the requirements set forth in Part 2 of this Subchapter, Medicaid Long-Term Services and Supports: Medically Needy Eligibility Pathway. For these purposes, the average monthly private pay rate for the institutional level of care is as set forth in § 2.6 of this Subchapter and is included in summary of resources limits in § 40-00-3.1.7(A)(7)(d) of this Title. Except as provided herein, countable income is determined based on the SSI method in § 40-00-3.2 of this Title.

D. The provisions in § 6.11 of this Part govern the treatment of income from trusts for applicants and beneficiaries of Medicaid LTSS.

E. Financial eligibility for Medicaid LTSS is determined at the time of initial application and annual renewal. Applicants and beneficiaries are required to report changes to EOHHS about income and resources that may affect eligibility within ten (10) days of the date the change occurs. Failure to make a timely

report is treated as non-cooperation and may result in the termination of Medicaid LTSS eligibility unless good cause for non-reporting exists.

F. Distributions from long-term care insurance policies that are used to pay for long-term services and supports are not treated as income for the purposes of determining Medicaid LTSS eligibility. For these distributions to be exempt, the policy must be issued by an appropriately licensed and certified entity or under the auspices of a Qualified Long-Term Care Insurance Partnership (QLTCIP) program in this State or another State.

6.5 LTSS Determination of Countable Resources

A. The State has established a four thousand dollar ($4,000.00) resource limit for Medicaid LTSS eligibility for family size of one – that is, a single individual – except for ACA expansion adults as indicated § 6.5.1 below. These resource limits are used to determine financial eligibility only and are not protected or reserved for any purpose related to Medicaid LTSS access or coverage. Therefore, the State treats countable resources within these limits to be available to the applicant or beneficiary as indicated in § 40-00-3 of this Title.

B. The process for determining countable resources for LTSS purposes requires evaluating total assets at the time of application as well as a look-back period of five (5) years prior to the application date. The purpose of this five (5) year look-back period is to assess whether an applicant has transferred an asset (that is, resource or income) for less than or an unascertainable fair market value and to ensure that the resources available to the applicant/beneficiary do not exceed any limits that apply. As indicated below, resource limits do not apply to applicants seeking LTSS through the eligibility pathway for ACA expansion adults.

6.5.1 Resources and ACA Expansion Adults

A. The Centers for Medicare and Medicaid Services (CMS), the Federal agency that oversees the Medicaid program, has issued guidance stating the ACA expansion adults seeking Medicaid LTSS are exempt from the provisions in Title XIX requiring States to establish resource limits for eligibility that are no more restrictive than those that apply for SSI recipients. As indicated in Part 8 of this Subchapter, Medicaid Long-Term Services and Supports (LTSS) Post-Eligibility Treatment of Income (PETI), the provisions in Title XIX related to the post-eligibility treatment also do not apply.

B. CMS has determined that ACA expansion adults are subject to Federal requirements related to the transfer of assets (i.e., liquid resources and real property) to prevent the divestiture of resources to gain access to Medicaid LTSS and ensure that a share of the applicant's resources are protected for a spouse and dependents. Therefore, the only provisions set forth in this section that apply to ACA expansion LTSS applicants are in §§ 6.6 to 6.12 of this Part.

6.5.2 Community Spouse Resource Allocation (CSRA) Process

A. The Community Spouse Resource Allocation (CSRA) is one of several mechanisms established by the U.S. Congress to ensure that the costs of LTSS care do not impoverish the spouse and/or dependents of the person who is receiving LTSS. Toward this end, a CSRA assessment considers the couple's total resources beginning when LTSS began and allocates certain amounts, within the limits established by Federal regulation, to both the LTSS recipient and his or her spouse. Hereinafter, the non-LTSS spouse is the person in a couple who is not receiving or applying for LTSS. Once the CSRA is completed, the amount allocated to the spouse is considered protected and is unavailable to pay for the Medicaid LTSS beneficiary's cost of care.

B. On and after the point in which one begins to receive LTSS on a continuous basis and/or applies for Medicaid LTSS, a CSRA assessment of combined resources is conducted to determine the amount allocated to the non-LTSS or "community" spouse. For the purposes of this Part, the point of continuous LTSS (formerly referred to as the point of continuous institutionalization) is:

1. Health institution – The first (1st) day of the month in which the LTSS applicant or beneficiary has begun to receive or is determined to have a need for services in a health institution that is expected to last for thirty (30) consecutive days or longer going forward.

2. Home or community-based services – The first (1st) day of the month that State or its contractual agent, or an appropriately qualified health care provider determines, based on an assessment as defined in § 5.4 of this Subchapter, that a person who has submitted a completed application for Medicaid LTSS requires or is receiving at least monthly one (1) or more of the Medicaid LTSS covered services identified in Subchapter 10 Part 1 of this Chapter, Medicaid Long-Term Services and Supports: Home and Community-Based Services (HCBS).

C. The CSRA assessment is optional for LTSS recipients in health institutions before applying for Medicaid and mandatory for all couples at the time of application without regard to the type of Medicaid LTSS they are seeking – that is, in health institution, at home, or in a community-based setting (HCBS).

1. Optional, preliminary CSRA for LTSS in health institutions -- At the beginning of a continuous period of LTSS in a health institution, either spouse, or a representative acting on behalf of either spouse, may request a preliminary CSRA assessment. The optional CSRA assessment serves only as a snapshot of the couple's joint resources at the point in time in which it is completed. A CSRA is performed again, at the time of application, in most instances.

a. Purpose. The optional assessment calculates the total value of the couple's combined countable resources, owned either jointly or separately, as of the date on which continuous LTSS in the health institution began. The purpose of this assessment is to provide the couple with the information necessary for their financial planning in anticipation of Medicaid eligibility.

b. Requirements. An application for Medicaid is not required in conjunction with the optional assessment. Accordingly, information for this CSRA is not verified. The State bases the assessment on information provided through attestations and any documents that may be submitted in conjunction with the request for the CSRA. A letter is sent to the person requesting the CSRA assessment by the State indicating the outcome.

c. Limits. Due to federal requirements, the optional CSRA is not available for persons receiving long-term care in a HCBS setting until they have applied for Medicaid LTSS. The CSRA for a Medicaid applicant seeking HCBS is never retrospective, as an applicant must be receiving at least one Medicaid-covered LTSS service to qualify for eligibility.

2. Mandatory CSRA – In conjunction with the application for Medicaid, all countable resources owned by either spouse, jointly or separately, are pooled together as of either the date continuous LTSS began if in a health institution, or the date Medicaid LTSS eligibility will begin if not receiving LTSS or seeking HCBS coverage. Before the eligibility determination is made for the LTSS spouse, resources are allocated to the non-LTSS spouse up to the maximum allowed under Community Spouse Resource Standard set forth in § 40-00-3.1.7(A)(7)(d) of this Title. This standard is set by the Federal government and changes annually on July 1 every year.

D. To determine the allocation of the resources for the LTSS spouse, the CSRA calculation includes the following steps:

1. Total countable resources – The countable resources of the couple are totaled. A resource is only included in the CSRA calculation if it is countable for eligibility purposes using the SSI method, as indicated in § 40-00-3.5 *et seq.* of this Title or as specified in § 6.5.3 of this Part below.

2. Determination of Community Resource Allowance – The allocation of community resources for each spouse is determined by dividing the total countable resources for the couple by two (2).~~Once countable resources for the couple are totaled, the amount is divided by two and one half (2 ½) is allocated to each spouse.~~ If necessary, the amounts are adjusted to ensure the non-LTSS spouse is allocated no less than the minimum but

no more than the maximum allowed under the Community Spouse Resource Standard in § 40-00-3.1.7(A)(7)(d) of this Title unless directed by a court order or fair hearing decision. Any amount exceeding the minimum or the maximum that may be allocated to the non-LTSS spouse as an allowance is considered available to the Medicaid LTSS applicant in the eligibility determination, regardless of which spouse owns the excess amount.

3. Medicaid LTSS resource eligibility – The amount of any excess resources after this calculation is compared to four thousand dollars ($4,000.00), the Medicaid LTSS resource eligibility limit for one (1) person. If the amount is equal to or below this limit, the LTSS spouse applying for Medicaid LTSS is resource-eligible; if the remaining resources exceed the eligibility standard, Medicaid LTSS eligibility is denied. Resource reduction is an option when resources exceed the limit, in accordance with § 6.5.2(D)(6) of this Part.

4. Notice – The State provides timely and adequate notice of the results of the CSRA assessment that includes the right to appeal the manner and/or the amount of the assessment.

5. Allocation adjustment – If income of the non-LTSS spouse is below the minimum monthly maintenance of needs allowance, as determined in Part 8 of this Subchapter ~~of this Chapter~~, Medicaid Long-Term Services and Supports (LTSS) Post-Eligibility Treatment of Income (PETI), during the post-eligibility treatment of income process, additional joint resources may be allocated from the LTSS applicant/beneficiary to his or her spouse to make up the difference.

6. Spousal transfers – An LTSS beneficiary has ninety (90) days from the date of the eligibility determination to transfer any resources necessary into the non-LTSS spouse’s name. After the initial ninety (90) day period is over, the State counts all resources that remain in the LTSS applicant/beneficiary's name in determining Medicaid LTSS eligibility. The State may extend the ninety (90) day period if any of the following conditions exist:

    a. Legal action. A court is involved in assigning the couple’s property through support actions;

    b. Appeal pending. An appeal of the CSRA has been filed and a decision has not been rendered; or

    c. Change in competency. The condition of the LTSS beneficiary requires the appointment of a conservator or guardian to act on his or her behalf.

7. Annual increases – The maximum amount of resources available under the Community Spouse Resource Standard for a non-LTSS spouse is increased every year by the Federal government. No notice is required in conjunction with this adjustment unless the eligibility of the LTSS beneficiary is adversely affected.

E. In instances in which the total countable resources of a couple are increased as the result of the sale or divestiture of an excluded resource, the assets are allocated equally to each spouse unless otherwise noted in the sales or divestiture agreement.

F. Under Rhode Island law, the rights to spousal support are automatically assigned to the State upon application for and receipt of Medicaid. Accordingly, the CSRA process differs somewhat when spouses are estranged or the non-LTSS spouse refuses to make all or a portion of a couple's joint resources available, as follows:

1. Estrangement – "Estrangement" means a breakdown to the point that the spouses would not be living together if one (1) was not receiving LTSS, whether in a health institution or the home and community-based setting. If the LTSS applicant is estranged from the non-LTSS spouse, eligibility is not denied due to excess resources or failure to cooperate if the applicant is able to demonstrate any of the following forms of hardship:

   a. Information unavailable. The LTSS applicant cannot obtain required information about the non-LTSS spouse's resources after exploring all legal means.

   b. Resources unavailable. The LTSS applicant is unable to access the estranged non-LTSS spouse's resources after exploring all legal means, even though the non-LTSS spouse's resources are sufficient in amount to cause a determination of ineligibility.

2. Spousal refusal – If the couple is not estranged and the non-LTSS spouse refuses to make resources available, eligibility is not denied on the basis of either the excess resources that are unavailable as a result of such refusal, or non-cooperation, as long as the LTSS applicant or beneficiary provides appropriate documentation of spousal refusal.

3. State recovery – Once eligibility has been determined, the State is authorized to pursue and recover from the non-LTSS spouse any of the couple's joint resources that were unavailable due to spousal refusal to the extent required to reimburse the State for the cost of Medicaid provided to the spouse receiving Medicaid LTSS.

6.5.3 LTSS-Specific Factors Considered in the Treatment of Resources

A. The provisions governing the evaluation and treatment of countable resources and the types of resources and related exclusions that apply when using the SSI

method are set forth in §§ 40-00-3.5.3 through 3.5.5 of this Title unless otherwise noted in this Part.

B. LTSS-specific factors related to the treatment of resources include:

1. Home exclusion – The applicant's primary residence and associated land are excluded if it has an equity value at or below the equity limit established in § 40-00-3.1.7(A)(7)(e) of this Title. The provisions governing applicability of the home exclusion are set forth in § 40-00-3.5.5(A)(1)(a) of this Title. A person who owns a primary residence with equity value in excess of the limit may request a hardship exemption in accordance with the criteria established in § 6.12 of this Part. Home exclusion is applicable under the provisions of § 5.3(B)(2)(e) of this Part.

2. Intent to return – The home exclusion applies when the LTSS applicant or beneficiary, the non-LTSS spouse and/or a dependent resides in the home or, when receiving LTSS outside of the home in a health institution or community-based setting, the LTSS applicant or beneficiary has an intent to return to the home as a primary residence. The following specific provisions also apply with respect to the intent to return:

a. One (1) established residence. The intent to return only applies to the one (1) home that has been established as the principal place of residence at the time of application for Medicaid LTSS. The exclusion does not apply to a home in which residency was not established at the time Medicaid LTSS began, even if the person expresses an intent to return to that home.

b. Duration. The initial expression of the intent to return is not maintained indefinitely. At the time of application and with each subsequent eligibility renewal, the LTSS applicant/beneficiary or an authorized representative must provide a written expression of the intent to return for the home exclusion to apply.

c. Contrary acts. If the applicant or beneficiary acts in a manner that is inconsistent with the intent to return by attempting to transfer or sell ownership in the primary residence, the home exclusion may be withdrawn. The home is then treated as a countable resource. Timely and adequate notice by the State is provided prior to withdrawal of the exclusion.

d. Diminished capacity. If the State finds that the capacity of an applicant or beneficiary to express a clear expression of the intent to return is diminished, an authorized representative may submit a sworn affidavit of the intent to return on behalf of the applicant/beneficiary. Evidence of diminished capacity is required,

such as a legal judgment of incompetence or a documentation of a medical or mental health condition.

e. Residence of spouse or dependents. The entire value of a home is excluded, regardless of its equity value and without the need of an expression of the intent to return, if any of the following relatives of the LTSS applicant/beneficiary residing in a health institution is living in the property:

(1) A spouse;

(2) A child who is younger than twenty-one (21) years old or who is blind or permanently and totally disabled;

(3) A sibling who has a legal interest in the home and who was living there for a period of at least one (1) year immediately before the applicant's or beneficiary's admission to the medical institution;

(4) A son or daughter who was living in the home and shows, to the State's satisfaction, that he or she served as the primary caregiver for the LTSS applicant/beneficiary for a period of at least two (2) years immediately before admission to the health institution; or

(5) A dependent relative has any kind of medical, financial, or other dependency on the LTSS applicant/beneficiary, including a child, stepchild, or grandchild; a parent, stepparent, or grandparent; an aunt, uncle, niece, or nephew; a brother, sister, stepbrother, or stepsister; a half-brother or half-sister; a cousin; or an in-law.

3. Life estate – A life estate conveys the property of one (1) party (the life estate holder) for life and to a second (2nd) party (remainderman) when the life estate expires. The holder of the life estate agreement is entitled to all the income produced by the property unless the life estate specifies otherwise. The agreement that creates a life estate is a will, a deed or some other legal instrument. The following factors determine whether a life estate is treated as an excluded resource:

a. Value of the life estate. The physical property has one value and the life estate has another, separate value. The value of the life estate is based on the equity value of the property and the age of the life estate holder. The value is determined as follows:

(1) Equity value. Determined by subtracting any encumbrances from the FMV of the real property (home).

(2) Age of holder. Age of the estate holder rounded to the nearest year.

(3) Life estate and remainder tables. These tables provide the value of a life estate and of a remainderman at any given age. The equity value of the real property is multiplied by the appropriate age figure from the tables. The State uses the life estate and remainder tables published by the U.S. Social Security Administration for the SSI program located in the Program Operations Manual System (POMS) at Section SI 01140.120.

b. Excluded resource. The equity value of a life estate is an excluded resource if the provisions set forth in § 6.5.3(B)(1) of this Part are met with respect to:

(1) Rhode Island residence -- The home is located in the State;

(2) Equity value limit – The equity value of the life estate is at or below the limit set in § 40-00-3.1.7(A)(7)(e) of this Title; and

(3) Principal place of residence – The home is established as the principal place of residence; and there is an intent to return to the home as specified in § 6.3(B)(2) of this Part.

(4) Use of property – The life estate holder may use the property as a home or sell his or her ownership interest or may rent the property. If the life estate was purchased on or after July 1, 2006, the applicant or beneficiary must have resided in the home for a period of at least one (1) year for the home exclusion to apply.

(5) Salability – If a life estate cannot be sold, then it is an unavailable resource and is excluded on that basis in accordance with the provisions in § 6.5.4 of this Part.

c. Disqualifying transfer. The establishment of a life estate may be considered a disqualifying transfer which results in a penalty period as set forth in § 6.9 of this Part.

4. Qualified long-term care insurance partnership – Rhode Island has established a Qualified Long-Term Care Insurance Partnership (QLTCIP) program. The QLTCIP operates as follows:

a. Resource disregard. A Medicaid applicant's resources are disregarded in an amount equal to the benefits paid by their QLTCIP policy as of the time of their application for Medicaid, and

b. Estate recovery relief. The total amount paid by the QLTCIP policy at the time of death is disregarded in the determination of the amount to be recovered from a beneficiary's estate. This amount may be above the total amount disregarded at the time eligibility is determined if there are continuing QLTCIP policy payments after Medicaid eligibility is established, and the beneficiary gains assets that exceed total resources protected at the time of eligibility.

c. Basis for the disregard. Long-term care insurance benefits that count toward the disregard include:

(1) Benefits paid as direct reimbursement of LTSS expenses;

(2) Benefits for LTSS paid to or on behalf of the beneficiary on a per diem, or other periodic basis, while the beneficiary is receiving LTSS services.

d. Application of the disregard. It is not required that benefits available under a Partnership policy be fully exhausted before the disregard of resources can be applied. The use of a qualified partnership policy cannot be used to reduce the length of a penalty period resulting from a disqualifying transfer or a denial of Medicaid LTSS when an applicant's equity interest in home property exceeds the limits set forth in § 40-00-3.1.7(A)(7)(e) of this Title.

e. Policies issue in other states. The State recognizes the validity of Partnership policies issued in other States. However, the State is not bound to accept the terms of these policies if they require that resource disregards or other financial exceptions be applied in a manner that exceeds or is inconsistent with the provisions set forth herein.

5. Other forms of LTSS insurance – The State provides a resource disregard for the payments of other forms of long-term care insurance issued by licensed/certified long-term care providers that meet national standards for actuarial soundness. Benefits from these insurance plans must be paid as a direct reimbursement for LTSS expenses provided to the Medicaid beneficiary. Estate recovery relief for payments disregarded is not available at the time of death if the insurance is not issued under the QLTCIP.

6. Trusts – The provisions in § 6.11 of this Part govern the treatment of resources from trusts for applicants and beneficiaries of Medicaid LTSS.

7. Retirement funds – The treatment of retirement funds, including individual retirement accounts (IRAs), of the LTSS applicant for determining countable income and resources is as set forth in § 40-00-3.5.5(A)(2)(g) of this Title.

a. The Coronavirus Aid, Relief, and Economic Security Act (CARES) enabled any taxpayer with a Required Minimum Distribution (RMD) due in 2020 from a defined-contribution retirement plan, including a 401(k) or 403(b) plan, or an IRA, to skip those RMDs in 2020. This includes anyone who turned age seventy and one half (70 ½) in 2019 and would have had to take the first RMD by April 1, 2020. This waiver does not apply to defined-benefit plans. In addition to the rollover opportunity, an IRA owner or beneficiary who had already received a distribution from an IRA of an amount that would have been an RMD in 2020 could repay the distribution to the IRA by August 31, 2020. This repayment is not subject to the one (1) rollover per twelve (12) month period limitation and the restriction on rollovers for inherited IRAs.

b. For the purposes of determining the allocation of joint resources in accordance with § 6.5.2 of this Part above, a couple is treated as if they were living together when evaluating the availability and attribution of retirement funds irrespective of whether the LTSS applicant or beneficiary is residing in a health institution. The transfer of asset provisions set forth in §§ 6.6 to 6.12 of this Part apply if any funds withdrawn are divested for less than fair market value, or converted into another resource that is not actuarially sound or does not otherwise meet the criteria for an allowable transfer set forth therein.

6.5.4 Availability of Resources

A. As a condition of eligibility for Medicaid LTSS under Federal law, an applicant or beneficiary must liquidate all available resources unless there is a specific exemption set.

B. When a person is legally entitled to a resource, the State considers it to be available on the application date or the date the resource is acquired, whichever is later. If a person so entitled cannot competently represent his or her interests, the resource is treated as available from the period beginning six (6) months after the date of application or the date the resource is acquired, whichever is later, in the following circumstances:

1. No legal representative – The applicant/beneficiary requires assistance to obtain the resource and has no guardian or conservator and an authorized representative (which may include a provider) is making a good-faith effort to secure the appointment of a competent guardian or conservator; or

2. Inaccessible trustee – The sole trustee of a Medicaid Qualifying Trust as defined in § 6.11 of this Part is incapacitated or unavailable and the applicant/beneficiary or an authorized representative is making a good-

faith effort to contact the missing trustee or to secure the appointment of a competent trustee to act as the sole trustee.

C. A resource is unavailable when the applicant or beneficiary has no legal access. The State does not count an unavailable resource when determining Medicaid eligibility, but only for the period in which there is no legal access. Unavailable resources include, but are not limited to:

1. Real Property – Real property may be considered unavailable when the ownership of it is the subject of legal proceedings such as probate or and divorce suits); and

2. Life insurance – The cash-surrender value of life-insurance policies is treated as unavailable when the policy has been assigned to the issuing company for adjustment.

3. Jointly owned financial instruments and holdings – The value of such financial instruments and holdings (stocks, bonds, CDs, etc.) is considered unavailable for both CSRA and the determination of financial eligibility when a sworn statement is provided indicating the applicant or beneficiary:

   a. Bonds jointly held. Is the named co-owner and does not have possession of the paper bond or the electronic transaction authority required to redeem the bond and the other co-owner will not redeem the bond, cannot be located, or refuses to provide the bond or transaction authority;

   b. Stocks and similar holdings and investment accounts. Is prohibited from selling the asset at its current value without the authorization of a co-owner and the co-owner cannot be located or refuses to provide such authorization.

6.5.5 Resource Reduction

A. An applicant who is denied eligibility due to excess resources – that is, resources above the set limit allowed for financial eligibility – may become eligible for Medicaid LTSS through resource reduction. To become eligible using this process, an applicant must provide evidence that he or she paid an allowable health expenses that equals or exceeds the amount of excess resources.

B. When using the resource reduction process, the Medicaid eligibility date is the date the applicant pays health expenses (medical bills) that reduce his or her total resources to the allowable limit. The following conditions apply:

1. Time-period – The resource reduction must occur in no more than thirty-five (35) days from the date on the eligibility denial notice, unless the applicant proves that he or she did not receive the notice in a timely

manner. After the resource reduction time-period expires, a person must reapply for Medicaid LTSS.

2. Transfer of assets – An applicant must comply with the transfer of asset provisions set forth in § 6.6 of this Part below. A disqualifying transfer of assets is not accepted for resource reduction purposes in any circumstances.

3. No State payment – The State does not pay or otherwise reimburse any portion of the health expenses used for resource reduction.

4. Limits – To be used for resource reduction, the health expense must have been incurred in or after the ninety (90) day period prior to the first (1st) day of the month the application was filed. If the applicant were eligible – that is, were not denied due to excess resources – this is same three (3) month period in which Medicaid LTSS retroactive coverage would be available if all applicable requirements were met.

4. Single use – The total amount or any portion of a health expense that is used for resource reduction must not be used for any other purpose in the determination of financial eligibility, including to meet an LTSS medically needy spenddown, or the post-eligibility treatment of income.

5. Adjustments – If a beneficiary submits an allowable health expense bill with a date that precedes the date eligibility is established through the resource reduction process, the State readjusts the date of eligibility if all the requirements set forth herein are met.

6.6 Transfer of Assets

A. The Federal Deficit Reduction Act (DRA) of 2005 (42 U.S.C. § 1305) governs the treatment of assets in the Medicaid LTSS eligibility determination process. The law presumes transfers of assets for undiscernible or less than fair market value (FMV) prior to or at the time of applying for Medicaid LTSS coverage are transactions made for the principal purpose of gaining or maintaining eligibility. The DRA requires the States to treat all but a narrow range of these transactions as disqualifying transfers that result in a "penalty" period during which a person is ineligible for Medicaid LTSS coverage. For the purposes of this section:

1. Assets – Includes all income and resources of an LTSS applicant and his or her spouse that is countable in the determination of Medicaid eligibility using the SSI method and the home (and associated land) when a person is seeking or receiving Medicaid LTSS.

2. Transfer – The conveyance of right, title, or interest in an asset from one person to another person or entity, the disclaiming, assignment or divestment of an income producing resource or other source of income, or

disposal of a lump sum before it is treated as a countable resource or income.

B. The State reviews asset transfers made by an LTSS applicant/beneficiary and/or the non-LTSS spouse in the five (5) year look back period prior to the first (1st) day of the month in which an application is filed. In determining whether a transfer is disqualifying, the State considers the date, amount of the asset, who is making the transfer, and the instrument used, as well FMV of the transaction, if discernable, as set forth below.

1. Allowed transfers – The DRA identifies the following transfers that are permissible in most circumstances and therefore exempt from a penalty period:

a. Family transfers. Transfers from and between certain family members.

(1) Spouse – A transfer made to a spouse or to someone else if solely for the spouse's benefit;

(2) Child – A transfer made to a dependent child under age nineteen (19); or child of any age who is blind or living with a disability, including the establishment of a trust to or for the sole benefit of such a child; or to an adult child nineteen (19) years of age or older who lived in the home with and provided care to the LTSS applicant/beneficiary for two (2) years prior to the date of application if the home care prevented or delayed the need for Medicaid LTSS;

(3) Sibling – A transfer made to a sibling with an equity interest in the home who lived with the LTSS applicant/beneficiary for at least one (1) year before the date of application.

b. Fair market value. Transfers of assets for fair market value are allowed.

c. Financial transfers. Transfers of assets using certain financial instruments such as Medicaid compliant annuities, loans of various kinds, and specific types of trust are not considered disqualifying transfers when they meet the requirements for allowed transfers set forth in §§ 6.7 to 6.11 of this Part.

d. Prevent hardship. Assets for less than FMV or no discernable FMV may be allowed if the applicant/beneficiary can provide proof that the imposition of the penalty will pose a hardship as defined in § 6.12 of this Part.

e. Other purposes. The applicant/beneficiary can prove to the State's satisfaction that the transfer of assets was not made to gain or retain eligibility for Medicaid LTSS. See § 6.6.2 of this Part pertaining to rebuttal process.

f. Asset return. The asset transferred for less than FMV is returned to the person who made the transfer.

2. Disqualifying transfers –Under current State and Federal law, a transfer is considered disqualifying on its face unless allowed under § 6.6(B)(1) of this Part if it was made on or after February 8, 2006, within the sixty (60) month look-back period before an application is filed or on or after the date of application, and is a transfer for less than fair market value. Fair market value is customarily based on a certified appraisal or the amount equal to the last or average selling or purchase price on the open market on the date and in the location of the transfer transaction. A transfer is treated as disqualifying if the State cannot discern the FMV, and the transaction is between private parties, involves a promise to provide future payments or services, and there is no valid contract or agreement that is legally and reasonably enforceable by the applicant, beneficiary or non-LTSS spouse. The range of disqualifying transfers includes, but is not limited to:

   a. Gifts. A gift is considered a transfer of an asset for less than FMV and is subject to a penalty period unless the provisions set forth in § 6.6(B)(1) of this Part on family transfers apply.

   b. Sale or divesture. Selling or conveying an asset for less than FMV is a disqualifying transfer and is subject to a penalty. Divesting an ownership interest in an asset is also a disqualifying transfer even if it involves only the removal or change of a person's name on a title or other ownership document and no money or goods of value are sold or exchanged. This includes the sale or divesture of real property such as a house, land, or vehicle as well as a business or service in which the Medicaid LTSS applicant or beneficiary and/or the non-LTSS spouse in some instances has an ownership interest. The State determines the FMV of a good or service sold or divested as the average sale or purchase price at the time of the transfer of ownership interest.

   c. Purchases and loans. The use of certain financial instruments to purchase or loan resources or transform them into an income stream is considered a disqualifying transfer for less than FMV unless the criteria indicated in §§ 6.7 to 6.11 of this Part. The range of disqualifying transfers in this category includes, but is not limited to, the purchase of an annuity that is not actuarily sound or a mortgage that over-values a property; acquiring a debt that reduces the value of an asset such as a home equity loan; and certain

buying and lending practices, including entering into contracts for future goods and service, that encumber an asset, lower its FMV, or transform it from an available to unavailable resource.

d. Trusts. The establishment of a trust for the benefit of someone other than the applicant, non-LTSS spouse, a dependent child or person with special needs is a disqualifying transfer in accordance with the provisions in § 6.11 of this Part.

e. Refusing or transferring an inheritance or income stream. The State considers the refusal or transfer of lump sum resources or an income stream available to a Medicaid LTSS applicant through a trust, will or any other such source to be a disqualifying transfer. The penalty period in such cases in based on the total amount of the inheritance or income stream when establishing the penalty period without regard to its availability to the Medicaid LTSS applicant regardless of the source of the funds.

C. If there is a disagreement over the State's determination of FMV or the State is unable to discern the FMV by customary means, the onus is on the parties involved in the transaction to enter into a legally enforceable contract in which all agree to a certified appraisal of the transfer's fair market value by an appropriately qualified independent third (3rd) party. Depending on the nature of the goods or services transferred, the range of independent third (3rd) party appraisers includes, but is not limited to, a licensed or certified real estate, financial services, or insurance broker, home health or other service provider, public or private auditor, public accountant, actuary, or attorney.

D. Any transfer that involves a promise to provide future payments or services is considered a disqualifying transfer of assets for less than fair market value if the State is unable to discern the FMV or if the transaction is not embodied in a valid contract that is legally and reasonably enforceable by the applicant, member, or spouse.

E. The treatment of income or resources resulting from both allowable and disqualifying transfers is considered in the financial eligibility determination process. For disqualifying transfers, increases in the countable income and resources of the otherwise eligible LTSS recipient resulting from the transfer, or any subsequent transactions, may affect access to other non-LTSS forms of Medicaid during the penalty period or Medicaid LTSS eligibility once the penalty period expires. Redetermination of financial eligibility before Medicaid LTSS coverage begins may be required.

F. When conducting the initial financial eligibility determination for Medicaid LTSS, and at the time of annual renewal, the State examines the value of assets on the first (1st) and last day of each month to identify transfers that may be disqualifying and subject to a penalty. An automated asset verification system is used along

with city property assessments, tax rolls and financial and legal documents during this review and verification process.

G. A Medicaid LTSS beneficiary is required to report changes in assets in the interim between renewals within ten (10) days from the date the change occurs. Timely determinations of financial eligibility require that applicants provide all information and documentation requested at the time of application and during the period of review in accordance with the requirements set forth in Part 4 of this Subchapter, Medicaid Long-Term Services and Supports Application and Renewal Process.

6.6.1 Penalty Periods

A. The State establishes a penalty for disqualifying transfers made during the look-back period. The penalty is a period of Medicaid LTSS ineligibility. During the penalty period, the State does not pay for LTSS provided in a health institution such as a nursing facility, or at home, or in a community setting, including community residences for people with intellectual/developmental disabilities, and shared living and assisted living residences.

B. The look-back period and date a penalty period begins is a function of when a person applied for and began receiving Medicaid LTSS before or after implementation of the Federal DRA – and several other factors as follows:

1. Pre-DRA before February 8, 2006 – For persons who applied for or began receiving Medicaid LTSS before this date, the look-back period extends back in time from the date of initial application for thirty-six (36) months. The penalty period begins on either the date of the disqualifying transfer or the first (1st) day of the month the person applied for Medicaid LTSS, whichever occurs later, and runs continuously even if long-term care services cease on an interim or permanent basis.

2. Post-DRA on or after February 8, 2006 – For persons who apply for and begin receiving Medicaid LTSS on or after this date, the penalty period begins on the date the State determines a person to be "otherwise eligible" for Medicaid or the date of the disqualifying transfer, whichever occurs later. Under the DRA, the term "otherwise eligible" means that Medicaid LTSS is being denied during a penalty period as a direct result of a disqualifying transfer. An applicant who does not meet any of the other requirements (general, financial, functional/clinical, etc.) for Medicaid LTSS eligibility must be denied on that basis and, therefore, is not considered otherwise eligible.

   a. Requirements. To be determined otherwise eligible, the applicant/beneficiary must be receiving LTSS in a health institution, or at least one (1) Medicaid LTSS covered service at home or in a community-based setting monthly, such as assisted living; and

have applied for Medicaid LTSS and met all other eligibility requirements for Medicaid LTSS identified in Part 1 of this Subchapter, Medicaid Long-Term Services and Supports Overview and Eligibility Pathways, including having income within the allowable limits for Medicaid LTSS set forth in § 6.4(C) of this Part and resources at or below the four thousand dollar ($4,000.00) limit.

b. Otherwise eligible date. The date a person is determined otherwise eligible is the effective date of the State's denial of Medicaid LTSS eligibility. The date the denial takes effect is generally the first (1st) day of the month the application was filed.

c. Choice During a penalty period, a person who has been determined otherwise eligible may qualify for non-LTSS Medicaid, if he or she meets the requirements for coverage as an ACA expansion adult under Part 30-00-1 of this Title, Medicaid Affordable Care Coverage Groups Overview and Eligibility Pathways, a low-income adult with disabilities or an elder under Part 40-05-1 of this Title, Medicaid for Elders and Adults with Disabilities: Community Medicaid, or the provisions governing LTSS medically needy eligibility set forth in Part 2 of this Subchapter, Medicaid Long-Term Services and Supports: Medically Needy Eligibility Pathway. To qualify for Medicaid as LTSS medically needy, otherwise eligible status is required. To attain this status, a person must have countable income at or below the penalty divisor and incurred or paid sufficient allowable expenses by the first day of the month to spenddown excess income to the medically needy income limit in accordance with requirements set forth in Part 2 of this Subchapter, Medicaid Long-Term Services and Supports: Medically Needy Eligibility Pathway. The penalty divisor is set by the State and is always the same as the average monthly private pay rate for the type of institutional care the person is seeking, as set forth in § 2.6 of this Subchapter.

d. Limits. To maintain non-LTSS Medicaid coverage during a penalty period, a beneficiary must meet the income and resource limits for the applicable eligibility category as of the first moment of the month and report any changes in financial or clinical/functional eligibility within ten (10) days from the date the change occurs. As the financial eligibility requirements and treatment of LTSS expenses during a penalty period vary across these coverage categories, eligibility for non-LTSS Medicaid coverage is not automatic and may not be advantageous if third-party health coverage is available.

C. Pre-DRA. The State determines the penalty period for disqualifying transfers made before February 8, 2006 as follows:

1. Determine the equity value of all assets transferred in the thirty-six (36) months before the applicant applied for Medicaid, other than those transferred to or by a trust.

2. Determine the equity value of all assets transferred into or by a trust in the sixty (60) months before the applicant applied for Medicaid.

3. Divide the total equity value of the transferred assets by the average monthly cost of nursing services at the time of application to determine the number of months of penalty. Drop any fraction remaining, so the result is in whole months.

D. Post DRA. The State determines the penalty period for disqualifying transfers made on or after February 8, 2006 as follows:

1. Total uncompensated value – The total uncompensated value (UV) is the amount of the transfer for less than fair market value. The UV is calculated by adding the disqualifying transfers made by the Medicaid applicant/beneficiary and/or the non-LTSS spouse during the applicable look-back period if the transfer occurs prior to a determination of eligibility, or the application date if the transfer happens after eligibility is determined.

2. Penalty divisor – The UV of the disqualifying transfers is divided by the average daily/monthly cost of LTSS at the applicable institutional level of care in Rhode Island, at the average private pay rate, indicated in § 40-00-3.1.7(A)(7)(d) of this Title. The amount of the private rate is adjusted annually and is based on a variety of national public and private sources that publish the average monthly/daily costs for LTSS in a nursing facility, hospital, or intermediate care facility for persons with intellectual/developmental disabilities by state using Medicare and Medicaid payment data.

E. The State determines the penalty period of ineligibility in special circumstances as follows:

1. Transfer patterns – If the State detects a pattern of uncompensated transfers over a period of months that when totaled equal or exceed the resource limit, the State presumes these have been made to gain Medicaid LTSS eligibility and treats the amount in total as a disqualifying transfer, unless provided a reasonable rebuttable in accordance with § 6.6.2 of this Part.

2. Spousal eligibility – If the non-LTSS spouse becomes eligible for Medicaid LTSS after the penalty period is established, the State divides the period of ineligibility in half and applies one-half (1/2) of the penalty period to

each spouse. If one (1) spouse dies before the penalty period is completed, the remaining period of ineligibility applies to the surviving spouse.

3. Multiple disqualifying transfers – The treatment of multiple disqualifying differs depending on the year the transfer occurred and whether there is overlap:

   a. Pre-DRA – Transfers before February 8, 2006. When more than one (1) disqualifying transfer is made prior to this date, the State treats each transfer separately and sets the start date for the penalty on the first (1st) day of the month when each transfer was made. If the penalty periods for the transfers would overlap, the start date for the penalty is the first (1st) day of the month that the first disqualifying transfer was made.

   b. Post-DRA – On or after February 8, 2006. When multiple disqualifying transfers are made on or after this date, and within the five (5) year look-back period, the State considers the total UV of all the transfers when determining the penalty period. The penalty start date is the date the applicant or beneficiary is otherwise eligible or, in the event there is overlap, the first (1st) day of the month of the first (1st) transfer, whichever is later.

4. Penalty period of less than one month – If the penalty period of ineligibility is determined to be less than one (1) month, the State imposes a partial-month penalty and does not round down or disregard any fractional period of ineligibility. The date the penalty period begins is the date the person is otherwise eligible for Medicaid LTSS or the first (1st) day of the month during or after the disqualifying transfer. If a penalty period is in effect on that date, the penalty period is extended by the appropriate number of days.

5. Lump-sum income – When there is a disqualifying transfer of income in a lump sum, the State calculates the penalty period on the lump-sum value.

6. Stream of income – The State calculates the penalty for each income payment that is periodically transferred.

F. In instances in which disqualifying asset is returned in its entirety, the transfer penalty is expunged as of the first moment of the first day of the month after the return. When an asset transferred for less than FMV is returned in full in the same month, a period of ineligibility does not apply and the disqualifying transfer is treated as if it never occurred. If an asset transferred for less than FMV is returned in a subsequent month, the uncompensated value of the asset is recomputed to determine whether any period of ineligibility applies through the

month of the return or subsequent months based on the adjusted uncompensated value.

G. During the penalty period, the Medicaid LTSS coverage is unavailable for Medicaid LTSS provided in a health institution as specified under Subchapter 05 Part 1 of this Chapter, Medicaid Long-Term Services and Supports: Institutionally Based LTSS, and in the home or community-based setting as set forth in Subchapter 10 Part 1 of this Chapter, Medicaid Long-Term Services and Supports: Home and Community-Based Services (HCBS). All non-LTSS Medicaid State Plan and waiver services are available to a person subject to the penalty if otherwise eligible and enrolled in one of the coverage groups identified in Chapters 30 or 40 of this Title.

H. The EOHHS reserves the discretion to refer to the appropriate State and/or Federal authorities any applicant who has transferred assets in a manner that indicates an attempt has or is being made to fraudulently gain Medicaid LTSS eligibility.

6.6.2 Rebuttal of Disqualifying Transfer Determination

A. The State presumes that disqualifying transfers of assets during the look-back period were made to gain or retain eligibility for Medicaid LTSS. The State has established a process that provides an opportunity to rebut this presumption. The burden of proof is on the LTSS applicant/beneficiary to prove that the assets were not transferred to meet eligibility requirements.

B. There are certain factors the State takes into consideration when evaluating whether there is credible evidence that a disqualifying transfer was made for a reason other than to obtain Medicaid eligibility:

1. Unexpected need for LTSS – Transfers made before the applicant or beneficiary was diagnosed with a previously undetected disabling condition or experiences a sudden traumatic injury from an accident.

2. Financial calamity – Transfers made to cover unexpected loss of income or resources, including any deemed available from another person, necessary to meet financial obligations or prevent imminent risk to health and/or safety.

3. No impact on eligibility – Total countable resources would have been at or below the resource limit at all times from the month of disqualifying transfer through the present month even if the asset had been retained.

4. Court-ordered – Transfers made to satisfy a court-order, including any required to cover familiar support obligations or satisfy liens or debts.

C. The person making the rebuttal, whether the applicant or beneficiary or an authorized representative making the rebuttal on his or her behalf, must provide a written statement that includes:

1. Reasons for the transfer – An explanation of why the asset was transferred and the relationship of the LTSS applicant's/beneficiary to the person who received the transfer.

2. Value of the asset – Information establishing the fair market value and the equity value of the asset transferred and from an appropriately qualified independent, third (3rd) party appraiser when the FMV is disputed or cannot be discerned.

3. Proof of effort – Verification of an attempt to dispose of the asset for a fair market value and an explanation of why the transfer ultimately occurred for less than this amount.

4. Compensation terms – The terms of an agreement, contract, or other expectation established at the time of the transfer indicating that the applicant or beneficiary received or will receive compensation for the fair market value of the transfer. Compensation may be made in cash or other tender, real or personal property, food, shelter, or services received by an owner in exchange for an asset. (See § 6.10 of this Part for personal service/care contract provisions.)

5. Self-support – An explanation of how the applicant or beneficiary planned for self-support after the asset was transferred.

D. Initiating a rebuttal does not restrict the right of the applicant, beneficiary, or an authorized representative thereof from requesting a hardship exemption in accordance with § 6.12 of this Part or making an appeal for a hearing pursuant to Part 10-05-2 of the Title.

6.7 Asset Transfers Involving Annuities

A. An annuity is a contract reflecting payment to an insurance company, bank, charitable organization, or other registered or licensed entity; it may also be a private contract between two (2) parties. This section provides the criteria for determining whether annuity is treated as disqualifying transfer resulting in a period of ineligibility for Medicaid LTSS. Irrespective of whether the establishment of the annuity is considered a disqualifying transfer, the provisions pertaining to whether any income derived is counted or excluded for eligibility purposes is located in § 40-00-3.5.5(A)(2)(a) of this Title are applied.

B. Annuities established pre-DRA- Before February 8, 2006:

1. Disqualifying transfer – The annuity was purchased before February 8, 2006, and the expected return on the annuity is not commensurate with a

reasonable estimate of life expectancy, also referred to as "actuarially sound."

2. Allowed transfer – When an annuity purchased before February 8, 2006, is "actuarially sound," then it is not considered a transfer of assets for less than fair market value. The annuitant has just converted the resources to income.

C. To determine whether the annuity is "actuarially sound," the State uses the life expectancy tables compiled from information 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.

D. The average number of years of expected life remaining for the annuitant must coincide with the life of the annuity. If the annuitant is not reasonably expected to live as long as or longer than the guarantee period of the annuity, the annuitant will not receive fair market value for the annuity based on the projected return. In that case, the annuity is not actuarially sound and a disqualifying transfer has occurred. The penalty is assessed based on the disqualifying transfer at the time the annuity was purchased or the date the annuity became available as a countable resource, whichever is later.

E. Post-DRA – Annuities established on or after February 8, 2006.

1. Disqualifying transfer – Purchase of a Medicaid non-compliant annuity on or after February 8, 2006, by an LTSS applicant or beneficiary as the annuitant. An annuity is considered non-compliant if purchased at less than FMV or has no readily ascertainable FMV;

2. Allowed transfer – Purchase of a Medicaid compliant annuity. A Medicaid compliant annuity must meet one (1) of the first two (2) conditions and the third (3rd) condition described below when purchased for the applicant or beneficiary:

a. The annuity is an annuity described in subsection (b) or (q) of § 408 of the United States Internal Revenue Code of 1986 (26 U.S.C. § 408); or

b. The annuity is purchased with proceeds from:

(1) An account or trust described in subsection (a), (c), or (p) of § 408 of the United States Internal Revenue Code of 1986 (26 U.S.C. § 408); or

(2) A simplified employee pension (within the meaning of § 408(k) of the United States Internal Revenue Code of 1986) (26 U.S.C. § 408); or

(3) A Roth IRA described in § 408A of the United States Internal Revenue Code of 1986 (26 U.S.C. § 408); and

c. The annuity must be:

(1) Irrevocable and non-assignable;

(2) Actuarially sound, as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration; and provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made; and

(3) Have the State of Rhode Island named as the remainder beneficiary for at least the total amount of Medicaid paid on behalf of the annuitant or the annuitant's spouse, if either is currently receiving Medicaid LTSS. Rhode Island may be named as either:

(AA) The remainder beneficiary in the first (1st) position, or

(BB) The remainder beneficiary in the second (2nd) position, after the community spouse, minor child or disabled child, and in the first (1st) position if the spouse or a representative of the child does not dispose of the remainder for less than fair market value.

F. Annuities purchased by a non-LTSS spouse:

1. Disqualifying transfer – Purchase of an annuity on or after February 8, 2006, by the non-LTSS spouse of a Medicaid LTSS applicant or beneficiary in which the spouse is the annuitant.

2. Allowed transfer – The annuity has the State of Rhode Island named as the remainder beneficiary for at least the total amount of Medicaid paid on behalf of the annuitant or the annuitant's spouse, if either is currently receiving Medicaid LTSS. The State may be named as either:

a. The remainder beneficiary in the first (1st) position; or

b. The remainder beneficiary in the second (2nd) position, after the community spouse, minor child or disabled child, and in the first (1st) position if the spouse or a representative of the child does not dispose of the remainder for less than fair market value.

6.8 Asset Transfers Involving Loans – Promissory Notes, Mortgages and Commercial and Informal Lending Instruments

A. Loans are financial instruments that allow an applicant or beneficiary to lend an asset to another person for a set period in exchange for fixed payments. § 40-00-3.5.5 of this Title contains the provisions for evaluating each of these instruments and the treatment of principal and interest when determining income and resource eligibility.

B. The use of loans to borrow or lend assets during the Medicaid LTSS application look-back period, or on or after the date eligibility is established, is evaluated to determine whether a disqualifying transfer exists. Treatment is as follows:

1. Disqualifying transfer – The use of loan to transfer assets on or after February 8, 2006 may be a disqualifying if the transaction is for less than fair market value and in amount that cannot be reasonably paid back within the expected life-time of the applicant or beneficiary or the non-LTSS spouse. Commercial and informal loans that do not meet the criteria set forth in § 40-00-3.5.5(A)(2)(d) of this Title are treated as gifts and, therefore, as disqualifying transfers excepted as provided herein under § 6.6(B) of this Part. Mortgages made for less than fair market value are disqualifying transfers for Medicaid LTSS eligibility purposes. The penalty period for disqualifying transfers made using a loan is the total uncompensated value of the transfer including principal and interest amortized over the repayment period.

2. Allowed transfer – Use of one of these financial instruments is considered an exempt transfer when the loan agreement states the total amount of the debt, including principal and interest amortized over the life of the loan, and:

   a. Actuarily sound. The repayment terms are actuarially sound, as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration;

   b. Equal payments. The debt payments are made in equal amounts during the full term of the loan, with no deferral or balloon payments of principal or interest;

   c. Limits. The cancellation of the balance upon the death of the lender is prohibited.

3. Prepayment – Early payment of a debt incurred as an allowed asset transfer under subsection (§ 6.8(B)(2) of this Part) is subject to review by the State for a disqualifying transfer if it is the result of making higher, multiple, or unequal payments of principal and/or interest or otherwise violates the criteria therein. Unequal payments are only permitted when

they are required under the terms of commercial loan that has variable interest rates.

6.9 Asset Transfers Involving Life Estates

A. Life estate means a legal arrangement entitling the owner of the life estate (sometimes referred to as the "life tenant") to possess, rent, and otherwise profit from real or personal property during their lifetime. The amount of a life estate that is countable depends on when it was established, whether the applicant(s) have the legal right to sell the home, and the portion of the proceeds of the sale, if allowed, that are available.

B. For all Medicaid LTSS applications and renewals after January 1, 2006, the establishment of a life estate for a home is treated as a transfer of assets.

1. Disqualifying transfer – A life estate may be a disqualifying transfer in the following instances:

    a. Applicant/beneficiary owns the property – When an applicant or beneficiary has an ownership interest in a home and establishes the life estate on his or her own behalf, the remainder interest is a disqualifying transfer. The remainder interest is the equity value of the property minus the value of the life estate as determined in accordance with § 6.3(B)(3) of this Part.

    b. Applicant/beneficiary purchases property – When an applicant/beneficiary purchases a life estate in the home of another person, and the payment made exceeds the FMV of the life estate, the difference between the amount paid and the FMV is treated as a disqualifying transfer. This transfer is disqualifying even if the applicant/beneficiary lives in the home of the life estate for one (1) year or more.

    c. Applicant/beneficiary gifts the property – In instances in which the applicant/beneficiary makes a gift or transfer of a life estate interest, the value of the life estate, as calculated under § 6.3(B)(3) of this Part, is considered a disqualifying transfer of assets.

2. Allowed transfer – When an applicant or beneficiary establishes a life estate for fair market value, the purchase price is an allowed transfer if he or she resides in the home for at least one (1) year after the life estate is established. If the home held in the life estate is not excluded in accordance with the provisions set forth in §§ 6.3(B)(1) and (2) of this Part, the value of the life estate is counted as a resource in determining Medicaid LTSS eligibility.

C. A home held in a life estate may be excluded as a resource for Medicaid LTSS eligibility determination, providing the provisions of § 6.3(B)(3) of this Part have been met.

6.9.1 Life Estate with Enhanced Powers

A. A deed containing a life estate with enhanced powers is also known as an "enhanced life estate deed" or a "Ladybird deed." An enhanced life estate deed permits a person to reserve the rights to sell, convey, mortgage, revoke, amend, and otherwise dispose of the property while alive. Upon the life estate holder's death, the life estate passes to a remainderman, without the need for probate. The deed specifies who will become the owner of the property upon death.

B. On or after July 1, 2014, an applicant or beneficiary who holds a life estate with enhanced powers that serves as a primary residence is ineligible for Medicaid LTSS, unless or until the applicant/beneficiary:

1. Conveyance of the remainder interest – Exercises the retained power to convey all outstanding remainder interest to him or herself.

2. Basis of the transfer – Uses a warranty deed or quitclaim deed created, executed, and recorded to transfer the remainder interest.

3. Ownership – Holds the real estate, free and simple with no encumbrances.

C. Upon assuming ownership of the remainder interest, a determination of whether the home exclusion applies is made in accordance with § 6.3 of this Part if the applicant or beneficiary is otherwise eligible.

D. An applicant or beneficiary who has a reserved a life estate with enhanced powers with retained rights to revoke, amend, or re-designate the remainderman by a deed created, executed, and recorded prior to July 1, 2014 is not denied Medicaid eligibility based on that deed, regardless of whether the remainderman designated is a person or persons, a trust, or other entity.

6.10 Asset Transfer Involving Personal Service/Caregiver Contracts

A. A personal service or caregiver contract is a formal written agreement between an applicant or beneficiary and an individual service/care provider. Under the terms of the contract, the service/care provider agrees to provide personal and/or managerial services in exchange for compensation paid by applicant or beneficiary who receives the services over a set period of time. Typically, the caregiver is, but is not required to be, an adult family member or friend of the applicant and the services covered range from home chores (such as housecleaning, grocery shopping, laundry, shoveling and like) to assisting with personal care needs (transportation to medical appointments, aiding in dressing and grooming, and so forth).

B. Personal service/caregiver contracts are not a countable resource for Medicaid LTSS purposes. The purchase price – the amount to be paid over the life of the contract – is a treated as a transfer of assets under the DRA. Accordingly, the State is required to determine whether a personal service/caregiver contract is a transaction made for less than FMV that constitutes a disqualifying transfer. The State makes this determination as follows:

1. Disqualifying transfer – A personal service/care contract is a disqualifying transfer if the payments are for services performed before the date of the transaction. A lump sum payment for services provided in the past is, therefore, a transfer for less than FMV. A contract for requires payment at the time the services/care are rendered is a disqualifying transfer if the services/care are covered by Medicaid or another third (3rd) party payer ~~payor~~, or for a person other than a non-LTSS spouse, dependent child, or dependent with disabilities that has no alternative form of coverage. In addition, a contract that requires payment upfront at the time of the transaction for service/care to be provided at some point in the future is treated as a disqualifying transfer unless proof is provided that the services/care will not be covered by Medicaid or another third (3rd) party at the time they are rendered. All contracts based on the promise of services performed in the future are treated as disqualifying transfers if FMV cannot be discerned in accordance with § 6.6.1(H) of this Part.

2. Allowed transfer – A personal service/caregiver contract is an allowed transfer if the agreement is in writing, the payment is for services/care provided prospectively (after the contract is executed) and at the time they are performed, and the compensation for services/care provided is reasonable -- commensurate with the wage scale or customary fees that would be paid typically to a third (3rd) party performing for the same services/care in the State. Also, the services/care to paid for under the contract must not be covered by Medicaid or another third (3rd) party payer. To ensure there is no overlapping coverage, the contract must specify the types of services/care to be provided, the location, and how often, as well as a start and end date, the form and frequency of compensation, the terms for altering the contract and the signatures of the parties involved. An agreement that include these elements may be treated as a disqualifying transfer if the State determines the payments are being used for purposes other than those specified in the contract or made to persons or entities other than the persons or entities identified as the service/care provider(s) under the contract.

6.11 Treatment of Trusts and the Transfer of Assets

A. A trust is an arrangement in which a person, known as the “grantor” transfers property to a trustee with the intention that it be held, managed, or administered by the trustee for the benefit of the grantor or certain designated beneficiaries. The term "trust" also includes any legal instrument or a device similar to a trust.

The grantor (or grantor beneficiary) establishes or creates the trust upon signature.

B. The “property” transferred to the trust takes on the form of a fund and may be comprised of any type of a resource including liquid, non-liquid, and real property as well as income producing goods, services and businesses. Trusts and portions of trusts may be treated as available income, available resources, or as a transfer of assets for less than fair market value.

C. For the purposes of this Part, the term “Medicaid LTSS applicant” refers to both a person seeking initial eligibility and current beneficiary so as to distinguish between a trust beneficiary. When a trust includes the assets of multiple persons, only the portion of trust that is attributable to the Medicaid LTSS applicant is considered in the eligibility process.

D. The factors that affect the treatment of a trust in the Medicaid LTSS financial eligibility process are as follows:

1. Legally valid – A trust must be valid under Rhode Island law.

2. Date established – Under Federal law, trusts established prior to August 11, 1993 are treated differently than those established after that date. In addition, income and resources generated from trusts created before implementation of the DRA in 2005 may be treated differently.

3. Types of trusts – Treatment of a trust varies depending on whether it is:

a. Living trust versus testamentary trust.

(1) A living trust or an *inter-vivos* trust – Set up during a person's lifetime and becomes effective when it is created. The State reviews Medicaid living trusts to determine whether and to what extent the instrument affects a person’s LTSS financial eligibility.

(2) Testamentary trust – Generally established within a will and does not become effective until after the death of the “testator” who established the trust. A testamentary trust takes effect after the testator’s death. Testamentary trusts are not treated as trusts for Medicaid eligibility purposes and therefore are exempt from the provisions in this section.

b. Revocable versus irrevocable under Rhode Island law.

(1) Revocable trusts – The grantor who established the trust retains ownership and control of the property in the trust and can change the terms, including the trustees and grantor beneficiaries.

(2) Irrevocable trusts – The grantor who created the trust gives ownership and control of the property in the trust to one or more other persons known as "trustees." The grantor is thus unable to enact changes in the trust.

4. Principal versus earnings and interest – In general:

   a. Principal. The trust principal is the property placed in trust by the grantor that the trustee holds, subject to the rights of the trust beneficiary, plus any trust earnings paid into the trust and left to accumulate the month following the month of a distribution.

   b. Earnings or interest. Trust earnings/interest are amounts of income derived from trust principal, such as interest, dividends, royalties, or rents. These amounts are unearned income to the trust beneficiary if he or she is legally able to use them for personal support and maintenance.

5. Medicaid eligibility category – Available income and resources from a trust are counted only once during the determination of eligibility for Medicaid health coverage. Accordingly, the State does not reconsider available income and/or resources from a trust that was included in the determination of financial eligibility for SSI.

6.11.1 Qualifying Trusts – Established Prior to August 11, 1993

A. A trust, or similar legal device, is called a Medicaid qualifying trust (MQT) when the following conditions have been met:

   1. Date – The trust was established prior to August 11, 1993;

   2. Grantor – Established by the Medicaid LTSS applicant or someone acting on the applicant's behalf including the applicant's spouse, or a legal guardian or authorized representative;

   3. Source – The source of the trust is either funds owned by the grantor or funds the grantor is entitled to use;

   4. Type of trust – The trust is a living trust that was not established by a last will and testament;

   5. Trust beneficiary – The trust names the Medicaid LTSS applicant to be the trust beneficiary of all or part the trust and the discretionary or required payments or distributions from the trust;

   6. Distribution – Trustee discretion. The terms of distribution under the trust give one (1) or more trustees the discretion to distribute payments to the trust beneficiary and set limits on the discretion of the trustee(s) therein;

7. Use limits – There may be requirements in the trust related to the distribution of trust principal and interest/earnings but there are no limits on their “use”; and

8. Exceptions – Any trust or trust decree established prior to April 7, 1986 when solely for the benefit of person with an intellectual/development disability who resides in an intermediate care facility for persons with intellectual/developmental disabilities (CF/I-D).

9. Purpose – The trust was created for a purpose other than to qualify for Medicaid.

B. In the determination of Medicaid LTSS financial eligibility and in the post-eligibility treatment of income, the State determines the maximum amount that could be distributed from an MQT and then the amount of countable income and resources as follows:

1. Maximum distribution amount – The maximum amount of income and principal from an MQT is the total amount trustees are permitted to distribute to the trust beneficiary when exercising full discretion under the terms of the trust.

2. Available countable amount – The terms of the trust that specify the available income (interest/earnings) and resources (principal) determine the amount counted as available, regardless of whether any distributions are being made. For LTSS eligibility:

    a. Countable resource. The trust principal (including accumulated income) available to the trust beneficiary is a countable resource.

    b. Countable income – If the terms of the trust explicitly limit the amount of trust principal that is available on an annual (or specified less frequent) basis, the principal is countable income beginning the month it becomes available.

    c. Countable income or resource. Trust principal and earnings/interest available for daily living expenses (food, clothing or shelter), including items not typically considered to be essential to daily living, are countable and treated according to their source under the terms of the trust. If paid from trust principal, the payment is treated as resource; if paid from trust interest/earnings, the payment is treated as income.

3. Non-countable – Interest/earnings and principal available only to pay providers meeting non-basic needs are considered unavailable to the LTSS applicant when determining eligibility.

4. Health care specific – Trusts established for health care payments are considered to be a third (3rd) party resource. Principal and interest/earnings are not counted if the terms of the trust specify that they are available only for making health care-related payments.

C. In both the determination of LTSS financial eligibility and the post-eligibility treatment of income a revocable trust established before August 11, 1993 is treated as follows:

1. Countable resources and income – The trust principal and earnings/interest are treated as countable resources and income, respectively.

2. Home and adjoining land – The fair market value of a primary residence or former primary residence of an LTSS applicant or spouse in a revocable trust does not qualify for the exclusions set forth in § 6.3(D)(3) of this Part and is treated as a countable resource.

6.11.2 Non-Qualifying Trusts – Established on or After August 11, 1993

A. The requirements for evaluating non-MQT differ when determining Medicaid LTSS eligibility. A trust other than a MQT is subject to the provisions of this Part when the following conditions are met:

1. Date – The trust was established on or after August 11, 1993;

2. Grantor – Established by the Medicaid LTSS applicant, or a grantor on the applicant's behalf including a spouse, or a legal guardian or authorized representative;

3. Source – The source of the trust is either funds owned by the grantor or funds the grantor is entitled to use;

4. Type of trust – The trust is a living trust that was not established by a last will and testament;

5. Trust beneficiary – The trust names the Medicaid LTSS applicant to be the trust beneficiary and, as such, to receive distributions from the trust;

6. Distribution – The terms of the trust establishing the purposes and/or circumstances for which distributions of principal and earnings/interest may be made dictate treatment rather than the discretion of the trustee(s) therein;

7. Use limits – Restrictions on the timing of distributions or how the funds may be used are not a factor; and

8. Exceptions -- Any trust or trust decree established prior to April 7, 1986 when solely for the benefit of person with an intellectual/development disability who resides in an ICF/I-DD.

9. Purpose – The reason the trust was created is not considered.

B. Whether such a trust is revocable or irrevocable affects how it is treated for Medicaid LTSS financial eligibility. A revocable trust is a trust under Rhode Island law that can be revoked by the grantor. A trust that authorizes a court of appropriate jurisdiction to modify or terminate all or some of its terms is revocable for the purposes of this section because the grantor can petition the court to act. Similarly, a trust referred to as "irrevocable" is treated as revocable if it requires a trustee to terminate or modify distributions when the beneficiary takes a specific action such as leaving a nursing home, marrying or divorcing, or moving out of State.

1. Revocable trusts – The State treats revocable trusts as follows:

a. Countable resource – The principal of the trust is treated as a countable resource. The primary residence or former primary residence of a Medicaid LTSS applicant held in a revocable trust established on or after December 1, 2000 is a countable resource and is therefore exempt from the home exclusion, regardless of the intent to remain, as set forth in § 6.5.3(B)(1) of this Part;

b. Countable income – Payment distributions made from the trust to or for the benefit of the trust beneficiary are counted as available income;

c. Transfer of assets – Any other distributions made from the trust within sixty (60) months immediately prior to or any time after the trust beneficiary applied for Medicaid LTSS are considered to be disqualifying transfers and are subject to a penalty as set forth in § 6.6.1 of this Part.

2. Irrevocable trusts – Irrevocable trusts are treated as follows:

a. Countable income. Any payment distributions from trust principal or earnings/interest made to or for the benefit of the trust beneficiary are counted as income;

b. Countable resource. Any portions of the principal that could be paid to or for the benefit of trust beneficiary for a circumstance or purpose allowed under the terms of the trust are treated as a countable resource. The primary residence or former primary residence of a trust beneficiary held in an irrevocable trust established on or after December 1, 2000 is not subject to the intent to return exclusion;

c. Distributions from countable resource trusts. The distributions of income or principal under the trust which could have been made to or for the benefit of the trust beneficiary, but are instead made to someone else and not for the benefit of the trust beneficiary, are considered disqualifying transfers as of the date of the distributions and are subject to a penalty pursuant to § 6.6 of this Part if the those distributions were made within the sixty (60) months immediately prior to or at any time after the month the trust beneficiary both is receiving long-term care and has applied for Medicaid LTSS.

d. Disqualifying transfers into non-countable irrevocable trusts – Portions of the trust which cannot under any circumstances be paid to or for the trust beneficiary are treated as disqualifying transfers as of the date the asset was transferred and are subject to a penalty pursuant to § 6.6 of this Part if the asset was transferred into the trust resource within sixty (60) months immediately prior to or any time after the month in which the trust beneficiary was both receiving long-term care and has applied for Medicaid LTSS.

C. Any time there is a disqualifying transfer related to a non-MQT, the date of the transfer is the date the trust was established or, if later, the date payment to the trust beneficiary foreclosed. The uncompensated value of the disqualifying transfer can be no less that its value on the date of transfer.

D. When funds are added to a trust, the additional funds are considered to be a disqualifying transfer, effective on the date the funds were added to that portion of the trust.

6.11.3 Special and Supplemental Needs Trusts

A. Certain trusts established on behalf of a Medicaid applicant or beneficiary are treated differently due to their purpose or manner in which they were established.

B. Special needs and pooled trusts. These trusts are established for persons who meet certain age and disability requirements. Assets placed in the trust are exempt from the provisions related to disqualifying transfers when the conditions specified below have been met.

1. Special needs trust – A special needs trust has the following characteristics:

a. Date. Established on or after August 10, 1993;

b. Grantor. Established by or on the behalf of the Medicaid LTSS applicant by a parent, grandparent, legal guardian or other third party with the legal authority to act with respect to the person’s assets, or a court.

c. Source. The source of the trust is the assets owned by an LTSS applicant/beneficiary under age sixty-five (65) who has been determined to have a disability. The trust may also contain assets owned by other persons;

d. Trust beneficiary. The trust beneficiary named is a Medicaid LTSS applicant or beneficiary who meets the disability criteria established by the U.S. Social Security Administration for SSI or Social Security Disability Insurance (SSDI).

e. Distribution. Terms of the trust. Upon death of the beneficiary, any amounts remaining in the trust are paid to the State of Rhode Island up to the amount paid on behalf of the beneficiary by the Medicaid program unless amounts are owed to other States, in which case, payments are made proportionally to each State if there are insufficient funds to pay all States which provided Medicaid in full. The trust remains exempt from the transfer of asset provisions set forth herein once the trust beneficiary turns age sixty-five (65) providing there are no changes in trust prior to the date the trust beneficiary attains this age. The exemption does not apply to assets added to the trust once the beneficiary turns sixty-five (65).

f. Purpose. The reason the trust is created is solely for the benefit of a trust beneficiary with a disability.

2. Pooled trusts – A pooled trust established for a person with a disability under § 1917 of the Social Security Act is also exempt from the provisions related to disqualifying transfers. A pooled trust for a particular applicant/beneficiary is a subaccount within a master trust in which the assets of multiple persons are combined – the pooled part – for investment and management purposes only. A pooled trust has the following characteristics:

   a. Date. Established on or after August 10, 1993.

   b. Grantor. Created and managed by a non-profit organization which maintains a separate account within a master trust that contains the assets and provisions specific to each beneficiary. Accounts in the trust are established for a person with a disability by or on the behalf of an applicant or beneficiary by a parent, grandparent, legal guardian or other third party with the legal authority to act with respect to the person's assets, or a court.

   c. Source. The source of the trust is the assets owned by an LTSS applicant/beneficiary who has been determined to have a disability. The trust may also contain assets owned by other persons.

d. Trust beneficiary. The trust beneficiary named is of any age and is a Medicaid LTSS applicant/ or beneficiary who meets the disability criteria established by the U.S. Social Security Administration for SSI or Social Security Disability Insurance (SSDI).

e. Distribution. Terms of the trust. Upon death of the beneficiary, the beneficiary's account may retain some portion of the balance, not to exceed fifteen thousand dollars ($15,000.00), subsequent to making payment to the State of Rhode Island of any funds in the account remaining up to the amount paid on behalf of the beneficiary by the Medicaid program. In instances in which more than one (1) State has provided Medicaid, payments are made proportionally to each State if there are insufficient funds to pay all Sstates which provided Medicaid in full.

g. Purpose. The reason the trust is created is solely for the benefit of a trust beneficiary with a disability.

C. Assets owned by others may be used to establish both testamentary and living trusts. In instances in which the grantor uses assets owned by someone other than the Medicaid LTSS applicant, and the Medicaid LTSS applicant's access to those assets is dictated solely by the terms of the trust, then the trust is evaluated in accordance with this Part.

D. In general, the terms of the trust determine the portions of principal and interest that are treated as income and resources. Terms of a trust related to the discretion of trustees and the extent to which funds must be distributed to meet the trust beneficiary's basic needs – that is, for food, shelter, clothing, health maintenance and the like – determine whether trust income and resources are counted for Medicaid LTSS eligibility purposes:

1. Countable income and resources – Trust principal and earnings/interest are countable resources and income when the terms of the trust require the trustee to pay or to make available the funds necessary to meet the trust beneficiary's basic needs. Both are also countable when the terms of the trust allow the beneficiary to withdraw trust principal and earnings/interest for basic needs. Principal is counted as resource and earnings/interest are treated as a countable income.

2. Countable income only – Trust principal and earnings/interests are countable income, but not a countable resource, when the terms of the trust allow the trustee to use trust principal or earnings/interests to pay for the basic needs of the beneficiary, and the trustee makes either available to cover those needs.

3. Countable income then resource – In the following circumstances, a trust treats income and resources as unavailable. For Medicaid financial

eligibility purposes, any distributions made to the trust beneficiary in these circumstances are treated as countable income in the period of intended use, and countable resources thereafter:

a. Prohibited distributions. The terms of the trust prohibit the trustee from making either trust principal or earnings/interest available for the trust beneficiary's basic needs and Medicaid is covering the costs of those needs; or

b. Trustee discretion. The terms of the trust provide the trustee with the discretion to make distributions to cover the trust beneficiary's basic needs, but the trustee does not make either principal or earnings/interest available for those basic needs and they are covered by Medicaid.

6.12 Hardship Exemption

A. The State has established a process in which applicants and beneficiaries may seek hardship exemption of certain Medicaid LTSS financial eligibility requirements.

B. To qualify for an exemption, the Medicaid LTSS applicant or beneficiary must show that complying with the requirement poses an undue hardship. The criteria for determining undue hardship vary as follows:

1. Jointly owned real property – The State may exclude otherwise countable real property, including a former primary residence, when it is jointly owned and the sale of the property by an applicant or beneficiary would cause the other owner(s) to lose housing. For this purpose, loss of housing is considered undue hardship if the property serves as the principal place of residence for one (1) (or more) of the other owners, its sale would result in loss of that residence, and no other alternative and appropriate housing is readily available for the displaced other owner. If such undue hardship ceases to exist, the property becomes a countable resource.

2. Excess equity in a home – The State may waive denial of the home exclusion due to excess equity value in the principal place of residence if undue hardship exists. The applicant or beneficiary must provide evidence that ineligibility for Medicaid LTSS based on denial of the home exclusion:

   a. Risk to personal health or safety. The loss of Medicaid LTSS prevents access to or the continuation of services and supports necessary to ensure the health and safety of the applicant or beneficiary is not in jeopardy;

b. Deprivation. Evidence must be provided that without Medicaid LTSS the applicant or beneficiary would be deprived of food, shelter, clothing, or other necessities required to sustain personal health and safety;

c. Prospective termination. The current LTSS provider has notified the applicant or beneficiary of the intent to initiate a discharge or cease providing services and supports; or prospective LTSS providers are unwilling to start services due to the lack of Medicaid coverage;

d. No alternative. There is not an affordable option to Medicaid LTSS coverage available that meets the needs of the applicant/beneficiary; and

e. Intent to live or return. The applicant or beneficiary lives in the home or intends to return to the home as required pursuant to § 6.3(B) of this Part.

3. Transfer penalty – An applicant or beneficiary may request a hardship exemption of the penalty period of Medicaid LTSS eligibility. Undue hardship exists when the applicant or beneficiary provides proof that:

a. Risk to personal health or safety. The loss of Medicaid LTSS prevents access to or the continuation of services and supports necessary to ensure the health and safety of the applicant or beneficiary is not in jeopardy;

b. Recovery fails. All available strategies for recovering the asset(s) conveyed in a disqualifying transfer have been exhausted without success;

c. Prospective termination. The current LTSS provider has notified the applicant or beneficiary of the intent to initiate a discharge or cease providing services and supports; or prospective LTSS providers are unwilling to start services due to the lack of Medicaid coverage;

d. No alternative. There is not an affordable option to Medicaid LTSS coverage available that meets the needs of the applicant or beneficiary.

e. Limited other resources. The applicant or beneficiary must have minimal remaining available resources after the CSRA is completed, if appropriate, as indicated in § 6.5.2 of this Part. For this purpose, the remaining resources must be less than the monthly statewide average cost of nursing facility services to a private pay-resident, excluding the value of:

(1) The primary residence, but only if the home exclusion in § 6.5.3(B) of this Part applies;

(2) Household goods.

(3) A vehicle required by the applicant or member for transportation.

(4) Funds for burial of four thousand dollars ($4,000.00) or less.

f. Public Health Emergency Exemption. The State will temporarily allow nursing facility residents to claim a hardship exemption for penalty periods that would otherwise be imposed due to transferring up to ten thousand dollars ($10,000.00) during the PHE.

~~f.~~g. No hardship. Hardship will not be found if:

(1) The disqualifying transfer was made to a person who was handling the financial affairs of the applicant or beneficiary or to the spouse or children of such a person, unless proof is provided that the payments were used to pay for LTSS;

(2) There is no satisfactory evidence showing that the applicant or beneficiary intended to dispose of the asset either at fair market value or for other valuable consideration equal to the fair market value. Attempts to sell the asset for fair market value must verified through an independent source;

(3) The criteria for rebutting the determination of a disqualifying asset pursuant to § 6.6.2 of this Part are not met;

(4) Documentation is provided indicating that the person who made the disqualifying transfer has returned the assets subject to the penalty period of ineligibility.

C. When claiming undue hardship, the applicant or beneficiary or an authorized person acting on his or her behalf must submit a written request and any supporting documentation including a statement from an attorney, if one was involved; proof of medical costs, and a statement from the trustee and/or transferee, if appropriate.