TABLE OF CONTENTS

These rules (4400s) were repealed effective 1/1/2014 and replaced with Health Benefits Eligibility & Enrollment (HBEE).

Spenddown, Patient Share, and Resource Transfer

4400 Spenddown, Patient Share, and Resource Transfer (08/01/2003, 02-11)

The following spenddown, patient share and transfer of resources provisions apply to individuals requesting SSI-related and ANFC-related Medicaid depending on their living arrangement (rules 4410-4412). They are calculated using an accounting period of either one or six months, depending on the type of Medicaid services requested (rules 4420-4422).

When a Medicaid groups total countable income or resources exceed the applicable income or resource standard for eligibility after allocations are made, and exclusions and disregards are applied, a person requesting Medicaid may use spenddown provisions to attain financial eligibility (rules 4430-4454).

The department requires individuals requesting long-term care to apply their available income to the cost of their care through payment of a patient share (rules 4460-4463.3).

The department considers whether individuals otherwise eligible for long-term care, including waiver and hospice services, have transferred resources that should be subject to penalty period before eligibility begins. The rules at 4470 apply to transfer of resources after July 1, 2002 and the rules at 4471 apply to transfers before July 2, 2002.

Living Arrangements

4410 Living Arrangements (08/01/2003, 02-11)

The length of the accounting period used to compute spenddown requirements and patient share payments depends on the living arrangement of the person requesting Medicaid. For the purposes of Medicaid eligibility, a person may be in a community or long-term care living arrangement.

Community Living Arrangement

4411 Community Living Arrangement (08/01/2003, 02-11)

Community living arrangements include any residence, such as a house, apartment, residential care facility, boarding house, rooming house. Persons requesting Medicaid coverage of long-term care services, including waiver and hospice services, are not considered to be in a community living arrangement.

In a community living arrangement, the person requesting Medicaid obtains and pays for basic maintenance items, such as food, shelter, clothing, personal needs, separately from medical care. The person requesting Medicaid may live alone, as a member of a family, or with non-relatives.

Long-Term Care Living Arrangement

4412 Long-Term Care Living Arrangement (08/01/2003, 02-11)

Persons requesting Medicaid coverage of long-term care, including waiver and hospice services, are considered to be in a long-term care living arrangement. Medicaid eligibility and patient share payments are determined according to long-term care rules for persons living in an institution or receiving waiver or hospice services.

Institutional living arrangements include nursing facilities, rehabilitation centers, and intermediate care facilities for the mentally retarded.

Individuals receiving waiver services are considered to be in a long-term care living arrangement. Individuals receiving Medicaid waiver services would be eligible for Medicaid if they lived in an institution and need enhanced residential care, home-and-community-based care, traumatic brain injury services, developmental disability services, or children's mental health services to live in the community.

Individuals receiving hospice services are considered to be in a long-term care living arrangement. Individuals receiving Medicaid hospice services are terminally ill and would be eligible for Medicaid if they live in an institution and need additional interdisciplinary medical care and support services to enable them and their families to maintain personal involvement and quality of life in their choice of care setting and site of death.

Accounting Periods

4420 Accounting Periods (08/01/2003, 02-11)

Accounting period means the one-month or six-month span of time the department uses to budget the income of a person requesting Medicaid.

Six-Month Spend-down Period

4421 Six-Month Spend-down Period (08/01/2003, 02-11)

The department uses a six-month accounting period to determine spenddown requirements for persons in a community living arrangement.

The six-month period begins with the first month for which Medicaid coverage is requested, usually the month of application. If Medicaid coverage is requested for expenses incurred during any one or more of the three months preceding the month of application, the six-month period begins with the earliest of these three months in which expenses were incurred and the applicant met all other eligibility requirements.

To determine the amount of income a person must spend down, the department shall make reasonable estimates of future income, subject to review and adjustment if the applicant's circumstances change during the remainder of the six-month period.

One-Month Patient-Share Period

4422 One-Month Patient-Share Period (08/01/2003, 02-11)

The department uses a one-month accounting period to determine spenddown requirements and patient share payment amounts for persons in waiver, hospice, or institutional living arrangements.

A one-month accounting period begins with the first calendar month during which the person lives in long-term care for any part of the month, applies for Medicaid coverage for that month, and meets the general and categorical requirements for Medicaid eligibility.

A one-month accounting period ends with the last calendar month during which the person lives in long-term care for any part of the month and passes all other Medicaid eligibility tests.

Spenddown of Excess Resources and Income

4430 Spenddown of Excess Resources and Income (08/01/2003, 02-11)

Individuals who pass all nonfinancial eligibility tests may qualify for Medicaid coverage by spending down the income or resources in excess of applicable maximums. The department specifies the income and resource maximums for each eligibility category in the benefit program descriptions found at rule 4202 and rule 4310, as well as in the Medicaid procedures manual.

Spending down is the process by which a Medicaid group incurs allowable expenses to be deducted from its income or spends resources to meet financial eligibility requirements, according to the rules in 4430-4434 and 4440-4454.

Spending Down Excess Resources

4431 Spending Down Excess Resources (08/01/2003, 02-11)

A resource spenddown is the amount a Medicaid group must spend to reduce its excess resources to the resource standard applicable to the appropriate Medicaid coverage category. The department determines that a person requesting Medicaid with excess resources has passed the resource test upon proof that the excess resources are no longer held as a resource and have actually been spent or given away. A person with excess resources requesting long-term care services, including waiver and hospice services, is subject to the transfer of resource provisions specified in rule 4470.

Medicaid may be granted for the month of application if the resource test is passed at any point in the month and all other eligibility criteria are met. A Medicaid group's resources may rise above the resource maximum, for example, due to interest added to bank accounts or failure to use the full monthly income amount protected for maintenance expenses during the month it is received. The recipient may maintain Medicaid eligibility for any month in which the Medicaid groups resources exceed the resource maximum by taking any action that reduces the excess amount, including giving the excess to the department to repay department expenditures on the individuals care. As long as resources are reduced to the resource maximum before the end of the month during which resources exceed the limit, Medicaid coverage continues without interruption.

In addition, when a third party who handles any resources of a member of the Medicaid group is unaware of a resource or its value, the department will provide uninterrupted Medicaid coverage as long as the excess amount is paid to the department as a recovery of Medicaid payments. Excess resources reimbursed to the department in these situations will not result in ineligibility.

Individuals seeking long-term care coverage may be subject to a transfer penalty if they spend or give away excess resources within the penalty period specified in rule 4474 and its subsections.

Retroactive Coverage

4432 Retroactive Coverage (08/01/2003, 02-11)

One or more of the following actions may be taken to reduce excess resources in order to qualify for Medicaid up to three months prior to the month of application as long as all other eligibility test are passed:

A. Individuals may set up a burial fund that meets the requirements specified in rule 4243 for an excluded resource.

B. If the Medicaid groups countable income is less than the applicable PIL, they may spend resources on maintenance expenses, such as housing, food, clothing and fuel, up to a maximum per month of the difference between their countable income and the applicable PIL.

C. Individuals may spend money on covered or noncovered medical expenses.

Spending Down Excess Income

4433 Spending Down Excess Income (08/01/2003, 02-11)

An income spenddown is the amount of qualifying medical expenses a Medicaid group must incur to reduce its income to the maximum applicable to their Medicaid coverage category. The department determines that a person requesting Medicaid with excess income has passed the income test upon proof that the Medicaid group has paid or incurred medical expenses (rules 4440-4454) at least equal to the difference between its countable income and the applicable income maximum for the accounting period.

Allowable Uses of Excess Income

4434 Allowable Uses of Excess Income (08/01/2003, 02-11)

The medical expenses of the financial responsibility group, whether they are paid or incurred but not paid, may be used for individuals requesting Medicaid to meet the spenddown requirement (see rule 4281.5 and 4350-4363.1).

Medical Expense Spenddown

4440 Medical Expense Spenddown (09/01/2005, 05-19)

The amount of a Medicaid groups spenddown is the amount by which their countable income or resources exceed the applicable standard for the accounting period.

An individual with income greater than the protected income level (PIL) may spend the excess down to the PIL on medical expenses following the methodology specified below to receive community Medicaid as part of the medically needy coverage group. An individual with income greater than the institutional income standard (IIS) may spend the excess income down to the PIL on medical expenses following the methodology specified below to receive long-term care Medicaid as part of the medically needy coverage group.

The spenddown methodology is the same for all living arrangements, except that a one-month accounting period applies to long-term care living arrangements and a six-month accounting period applies to those in the community living arrangement.

Eligibility Date

4441 Eligibility Date (09/01/2005, 05-19)

Medicaid groups with excess income meet the spenddown requirement on the first day within the accounting period that their deductible medical expenses meet or exceed the spenddown requirement. Sometimes this allows for retroactive coverage as specified in rule 4122.

A. Eligibility becomes effective on the first day of the month when a spenddown requirement is met using health insurance and noncovered medical expenses.

B. Eligibility becomes effective later than the first day of the month when a spenddown requirement is met using covered medical expenses.

C. Special eligibility dates apply, as set forth in rule 4452.4 for Medicaid groups who meet their spenddown requirement using noncovered assistive community care services (ACCS).

Medicaid groups remain responsible for medical expenses incurred before the date of eligibility.

When they receive services from more than one provider on the day that coverage begins, Medicaid groups must decide which services they will be responsible for paying and which ones Medicaid will cover. Medicaid pays for covered services on the first day that the groups expenses exceed the amount of the groups spenddown. Medicaid continues until the end of the accounting period, unless the Medicaid groups situation or protected income level changes.

Deduction Sequence

4442 Deduction Sequence (08/01/2003, 02-11)

Eligible medical expenses are deducted from countable income in the following order:

A. Health insurance expenses (rule 4451).

B. Noncovered medical expenses (rules 4452-4452.4).

C. Covered medical expenses (rules 4453 and 4454) that exceed limitations on amount, duration, or scope of services covered (rules 7201-7608).

D. Covered medical expenses (rules 4453 and 4454) that do not exceed limitations on amount, duration or scope of services covered and are incurred by the financial responsibility group. These must be deducted in chronological order of the date the service was received beginning with the oldest expense.

Time Frames for Deductions

4443 Time Frames for Deductions (08/01/2003, 02-11)

Deductible expenses include medical expenses incurred by the financial responsibility group:

A. during the current accounting period, whether paid or unpaid;

B. before the current period and paid in the current period, or

C. before the current period, remaining unpaid, and for which continuing liability can be established.

In addition, deductible expenses include medical expenses paid during the current accounting period by a state or local program other than those that receive Medicaid funding.

Medical expenses incurred before or during the accounting period and paid for by a bona fide loan may be deducted if the expense has not been previously used to meet a spenddown requirement and the financial responsibility group establishes continuing liability for the loan and documents that all or part of the principal amount of the loan remains outstanding at any time during the accounting period. A bona fide loan means an obligation, documented from its outset by a written contract and a specified repayment schedule. Only the amount of the principal outstanding during the accounting period, including payments made on the principal during the accounting period, may be deducted.

4443.1 Predictable Expenses (08/01/2003, 02-11)

In general, an expense is incurred on the date liability for the expense begins. Only four types of predictable medical expenses may be deducted before they are incurred, if it can be reasonably assumed that the expense will continue during the accounting period:

A. health insurance premiums (rule 4451);

B. medically necessary over-the-counter drugs and supplies (rule 4452.1);

C. ongoing, noncovered personal care services (rule 4452.3); and

D. assistive community care services provided to residents in a level III residential care home either not enrolled as a Medicaid provider or with admission agreements specifying the residents financial status as private pay (rule 4452.4).

4443.2 Prior Medical Expenses (08/01/2003, 02-11)

Continuing liability for unpaid medical expenses or a loan used to pay medical expenses incurred before the current accounting period will be established when any of the following conditions is met. The liability was incurred:

A. within six months of the date of application or the first day of the accounting period, whichever is later.

B. more than six months before the date of application or the first day of the accounting period, whichever is later, and there is a bill for the liability dated within 90 days of that date.

C. more than six months before the date of application or the first day of the accounting period, whichever is later, and the service provider or lender has confirmed that the unpaid liability has not been forgiven and is not expected to be forgiven at any time within the current accounting period.

Allowable Medical Expenses

4450 Allowable Medical Expenses (08/01/2003, 02-11)

The following deductions apply to spenddowns when excess income exceeds the applicable income maximum. Medical expenses that are the current liability of the Medicaid group and for which no third party is legally liable may be deducted from total excess income or resources for the accounting period. No medical expense may be used more than once to meet a spenddown requirement. A medical expense may be used to spend down either income or resources. If only a portion of a medical expense is used to meet the spenddown requirement for a given accounting period, that portion of the medical bill that was not used and remains a current liability may be applied toward a spenddown requirement in a future accounting period. Upon receiving coverage, the Medicaid group remains directly responsible to providers for expenses incurred before the spenddown was met.

Health Insurance Expenses

4451 Health Insurance Expenses (08/01/2003, 02-11)

Health insurance means insurance to meet costs of medical care and services, such as Medicare Part B, and similar group or individual policies. Premiums for the following types of insurance are not deductible:

A. Income protection or similar insurance plans designed to replace or supplement income lost due to sickness or accident; or

B. Automobile or other liability insurance, although these may include medical benefits for the insured or his family.

Health insurance expense also includes any enrollment fees, deductibles or coinsurance imposed by Medicare or other health insurance not subject to payment by a third party (such as another insurance policy).

This deduction is allowed for premium payments by a member of financial responsibility group if it can be reasonably assumed that coverage will continue during the accounting period. Coverage and premium or other expense amounts must be verified.

Expenses Not Covered by Medicaid

4452 Expenses Not Covered by Medicaid (08/01/2003, 02-11)

A deduction from excess income is allowed for necessary medical and remedial expenses recognized by state law but not covered by Medicaid in the absence of an exception for Medicaid coverage under rule 7104. In determining whether a medical expense meets these criteria, the commissioner may require an individual Medicaid group to submit medical or other related information to verify that the service or item for which the expense was incurred was medically necessary and was a medical or remedial expense. The patients physician shall verify medical necessity with a written statement or prescription specifying the need, quantity, and time period covered. These medical expenses, when not covered by Medicaid, include but are not limited to expenses for the services and items listed below:

A. over-the-counter drugs and supplies (rule 4452.1);

B. transportation (rule 4452.2);

C. personal care services for recipients age 21 and older (rule 4452.3);

D. assistive community care services provided to residents in a level III residential care homes either not enrolled as a Medicaid provider or with admission agreements specifying the residents financial status as private pay (rule 4452.4);

E. dental services in excess of the allowable annual maximum; and

F. private duty nursing services for recipients age 21 and older.

Any medical bills, including those incurred during a period of Medicaid eligibility, that are the current liability of the Medicaid group and have not been used to meet a previous spenddown requirement may be deducted from excess income. Generally, the Medicaid group is required to present a bill or receipt to verify that medical expenses have been incurred or paid. Special requirements for certain medical expenses are specified in rules 4452.1– 4452.4.

4452.1 Over-the-Counter Drugs and Supplies (08/01/2003, 02-11)

Either a standard deduction or actual costs, if greater, may be used to deduct noncovered over-the-counter drugs and supplies from excess income.

A. Documentation

Documentation verifying medical necessity is not required when the department determines that an over-the-counter drug or supply is a common remedy for the medical condition of a member of the Medicaid group and the usage is within the maximum amount for common over-the-counter drugs and supplies. Documentation verifying medical necessity may be required whenever one or both of the following two situations apply: when the drug or supply is not a common remedy for the medical condition or when the reported usage exceeds the maximum amount.

B. Amount Deductible

Instead of actual expenses, a reasonable estimate of ongoing expenses for over-the-counter drugs and supplies may be applied prospectively to the six-month accounting period. Reasonable estimates of unit sizes, costs and maximums for common over-the counter drugs and supplies used to meet the spenddown requirement are found in the Medicaid procedures manual. If the Medicaid group uses the expense to meet

INTERPRETIVE MEMO

[X] Medicaid Spend Down Rule Interpretation **[ ] Medicaid Spend Down Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4452.2 Date of this Memo 09/26/2012 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

Mileage reimbursement rates are the rates established by the U.S. General Services Administration. The rates fluctuate periodically. It is important to refer to the federal website in order to determine the current rate. The website is: www.gsa.gov/mileage

the spenddown requirement, they shall not be eligible to receive Medicaid coverage during that accounting period for the same expenses.

4452.2 Transportation (08/01/2003, 02-11)

Noncovered commercial and private transportation costs may be deducted from excess income.

The actual cost of commercial transportation, verified by receipt, may be deducted.

Either a standard deduction or actual costs, if greater, may be used for deducting the cost of private transportation. These costs may be deducted from excess income without verification of medical necessity, provided that:

A. the transportation was essential to secure the medical service; and

B. the Medicaid group was responsible for the cost and was charged an agreed-upon fee or purchased fuel to use a family-owned vehicle or other non-commercial vehicle.

The process set forth in Medicaid procedures shall determine the deductible expense for private transportation.

4452.3 Personal Care Services (08/01/2003, 02-11)

The department will allow a deduction for noncovered personal care services provided in an individuals own home or in a level IV residential care home when they are medically necessary in relation to an individuals medical condition.

A. Deductible Personal Care Services

Deductible personal care services include those personal care services described in rule 7406.2 and assistance with managing money. They also include general supervision of physical and mental well-being where a physician states such care is required due to a specific diagnosis, such as Alzheimers disease or dementia or like debilitating diseases or injuries. Room and board is not a personal care service.

B. Qualified Service Providers

Services may be deducted when performed by a home health agency or other provider identified by the physician as qualified to provide the service with the following exceptions. When the service provider is living in the home, deductions may not be based on payments for personal care services provided to an individual:

1. under age 21 by the individuals parent, stepparent, or legal guardian, unless the individual is 18, 19, or 20 years old and payment for personal care services is made from and does not exceed the individuals own income or assets;

2. by the individuals spouse;

3. by the individuals sibling, child, or grandchild when the person providing the services is under age 18; or

4. by a parent of the individuals minor child.

C. Documentation

To document the need for personal care services, the physician must submit:

1. a plan of care (form 288B);
2. a list of the personal care services required;
3. a statement that the services are necessary in relation to a particular medical condition; and
4. a statement that the level of care provided by the particular level IV residential care home is appropriate or, if the individual is not living in a level IV residential care home and the services are not provided by a home health agency, that the provider is qualified to provide the service.

Upon the initial submission of a plan of care (form 288B), it is assumed that the individual will continue to need the personal care services for the entire six-month period, unless the plan of care has specified a date by which the individuals need for services is expected to change.

A new plan shall be submitted:

- whenever the service provider changes, unless the service is performed by a home health agency; and
- whenever the need for services in relation to the individuals condition is expected to change, according to the current plan of care.

In addition, a new plan shall be submitted:

- once every six months, when the physician has not specified an ongoing need for personal care services in the current plan; or
- once every two years, when the physician has specified an ongoing need for personal care services in the current plan.

D. Amount Deductible

Either a standard deduction or actual costs, if greater, may be used for deducting personal care services from excess income. Expenses that have not been incurred yet may be deducted if they are predictable and meet the requirements in rule 4443.1. Expenses also may be deducted if they have actually been incurred by the Medicaid group and are not subject to payment by Medicaid or any other third party.

The standard monthly deduction for personal care services shall be deducted for each full or partial calendar month in the accounting period during which the plan of care documents the need for services. The actual documented costs of personal care services may be deducted if they exceed the monthly standard deduction. Deductions may be made for anticipated need through the end of the accounting period.

All changes to these standards that result in lower standard deductions will be made via the Administrative Procedures Act.

4452.4 Assistive Community Care Services (08/01/2003, 02-11)

A. Deductible Assistive Community Care Services

The department will allow a deduction for noncovered assistive community care services provided to individuals residing in a licensed level III residential care home. In addition,

these individuals may deduct medically necessary personal care services included under the list at rule 7406.2 but not part of the list at rule 7411.4.

B. Qualified Service Providers

Qualified service providers include all level III residential care homes licensed by the Vermont Department of Disabilities, Aging, and Independent Living.

When a resident becomes eligible for Medicaid by projecting the cost of ACCS across part of the six-month accounting period, the residential care home may agree to function as a Medicaid provider for ACCS with respect to that resident for the remainder of the accounting period. In these cases, the provider may bill for ACCS services no sooner than the ACCS coverage date given to the resident and the provider in a notice from the department.

When a privately paying resident becomes eligible for Medicaid after having met a spenddown requirement by projecting the cost of ACCS across the entire six-month spenddown period, the home shall not function as a Medicaid provider of ACCS with respect to that resident during that the period when the resident is meeting the spenddown requirement.

C. Documentation

Documentation verifying medical necessity is not required for assistive community care services. If an individual claims a deduction for medically necessary personal care services included under the list at rule 7406.2 but not part of the list at rule 7411.4, the physician must submit:

1. a plan of care (form 288B);
2. a list of the personal care services required;
3. a statement that the services are necessary in relation to a particular medical condition; and
4. a statement that the level of care provided by the particular level III residential care home is appropriate and that the provider is qualified to provide the service.

Upon the initial submission of a plan of care (form 288B), it is assumed that the individual will continue to need the personal care services for the entire six-month period, unless the plan of care has specified a date by which the individuals need for services is expected to change.

Beneficiaries with approved personal care services deductions must submit new plans at the frequencies specified in rule 4452.3.

D. Amount Deductible

The deduction for assistive community care services (ACCS) may be used for the entire accounting period or part of it. Whether the standard daily or monthly deduction is used depends on the size of the spenddown requirement. The actual documented costs of ACCS may be deducted if they exceed the monthly standard deduction. Deductions may be made for anticipated need through the end of the accounting period. All changes to these standards that result in lower standard deductions will be made via the Administrative Procedures Act.

1. If the Medicaid groups excess income and resources after deduction of all expenses for which Medicaid coverage is not available equal or exceed the deduction for ACCS for the entire accounting period, for the purposes of meeting a spenddown requirement, ACCS are projected and deducted as if they were not Medicaid-covered services for the entire accounting period. Medicaid eligibility for services other than ACCS becomes effective on the day the spenddown requirement is met. Expenses for which Medicaid coverage is not available are:

Expenses Not Covered by Medicaid

a. medical expenses excluded from coverage listed at rule 4451 through rule 4452.4;

b. covered medical expenses incurred prior to the accounting period, not used to meet a previous spenddown requirement, and remaining unpaid; and

c. covered medical expenses incurred and paid during the current accounting period.

2. If the Medicaid groups excess income and resources after deduction of all expenses for which Medicaid coverage is not available are less than the deduction for ACCS for the entire accounting period, ACCS expenses are not projected. Instead, they are deducted as covered expenses on a daily basis. In this case, Medicaid eligibility for all covered services other than ACCS becomes effective the first day of the accounting period. Medicaid coverage for ACCS begins later. It starts the day cumulative daily ACCS deductions exceed the groups remaining excess income and resources. The Medicaid group is not responsible for payment of a portion of the ACCS expense on the first day of ACCS eligibility.

In addition, the amount of the deduction for any services included under the list at rule 7406.2 but not part of the list at rule 7411.4 documented as medically necessary by the plan of care shall be determined based on the number of hours times minimum wage, or actual costs, if greater.

Covered Medical Services

4453 Covered Medical Services (08/01/2003, 02-11)

Covered medical expense means any medical service that Medicaid would pay for if the person were an eligible Medicaid recipient (see rule 7201–7608).

Deductions are not limited to the Medicaid reimbursement for the service. The Medicaid group member's actual cost paid or incurred must be allowed. A standard deduction may be taken for assistive community care services, rule 7411.4, as specified in Medicaid procedures.

Third-Party Coverage

4454 Third-Party Coverage (08/01/2003, 02-11)

No deduction is allowed if the medical expense is subject to payment by a third party such as health insurance, worker's compensation, liability award, or other benefit program unless the third party is a state or local program other than Medicaid.

When a third party is liable for all or some medical expenses, only the portion owed by those requesting Medicaid may be deducted from their applied income. The department is required to take reasonable measures to determine the legal liability of third parties to pay for incurred expenses. Estimates of payment by the third party may be used if actual third party liability cannot be ascertained within the period for determining Medicaid eligibility. The department cannot delay an eligibility determination simply because actual third party liability cannot be ascertained or payment by the third party has not been received.

If an applicant or recipient is pursuing a liability award but liability has not yet been established, a deduction should be allowed. Eligibility must be based on the departments estimate of the amount the applicant owes for the bill. The Coordination of Benefits (COB) Unit in the Office of Vermont Health Access should be notified of the pending potential liability award when the applicant is found eligible for Medicaid.

Patient Share Payment for Long-Term Care

4460 Patient Share Payment for Long-Term Care (09/01/2005, 05-19)

Once the department determines individuals are eligible for long-term care, including waiver and hospice services, it computes how much of their income must be paid to the long-term care provider each month for the cost of care (patient share). A patient share is computed for an individual in a medical institution or who qualifies for home-based waiver services as part of the special income group (rule 4202.3(b)) or as medically needy (rule 4203). The department determines the patient share amount at initial eligibility, eligibility redeterminations, and when changes in circumstances occur.

An individuals patient share is determined by computing the maximum patient share and deducting allowable expenses. Rules 4461-4461.2 describe how the department determines the maximum patient share. Rules 4462-4462.5 describe allowable deductions from the patient share. The actual patient share equals the lesser of either the balance of a patients income remaining after computing the patient share or the cost of care remaining after the third party payment.

In cases in which allowable deductions exceed the individual's income, the patient share payment is reduced by the deductions, sometimes resulting in no patient share obligation. When monthly income and medical expenses are stable, the patient share amount remains constant. When income or allowable deductions fluctuate, the patient share payment usually varies.

Individuals owe their patient share by the last day of the month in which they receive the income. Payment is made either to the facility in which they resided or the highest paid provider of long-term care waiver services. The department may adjust patient share payments to long-term care providers when a patient transitions from one living arrangement to another, as specified in rules 4463-4463.3.

When monthly income and medical expenses are stable, the patient share payment remains constant. When deductions fluctuate, the patient share payment is likely to vary. When allowable deductions exceed the individual's income, the patient share payment is zero for as many months needed to exhaust the medical expenses against the patients available income. The month when the remaining medical expense deductions no longer exceed the patient's income, the balance is the patient share payment for that month.

Long-Term Care Residence Period

4461 Long-Term Care Residence Period (10/07/2005, 05-25)

The department assesses a patient share obligation in the month of admission to long-term care as long as the individual is expected to remain in long-term care for at least 30 consecutive days. If long-term care is expected to be needed for fewer than 30 consecutive days, the department does not assess any patient share. Instead, the department covers these services through community Medicaid or VHAP Managed Care, if the individual meets those eligibility rules.

A. Beginning of long-term care residence period in a general hospital setting

The long-term care residence period in a general hospital setting begins with the first day that the utilization review committee finds acute hospital care is no longer medically necessary and skilled nursing care is medically necessary.

B. Beginning of long-term care residence period in other long-term care settings

The long-term care residence period in long-term care settings, other than a general hospital, begins with the first day that the utilization review committee finds medical need for long-term care or the date of admission, whatever is later.

C. Ending of long-term care residence period

A long-term care residence period ends with the earliest of the date of death; the date of discharge from a long-term care living arrangement (see rule 4412); or the last day medical need for long-term care is established by utilization review committee.

A long-term care residence period is not ended by a leave of absence from the current setting (see rule 7604.1). A long-term care residence period also continues despite transfer from either:

A. one long-term care setting to another long-term care setting;

B. a general hospital setting (where skilled nursing care has been continuously authorized while awaiting transfer) to another long-term care setting; or

C. a long-term care setting to a general hospital setting followed by return to the long-term care setting without an intervening residence period in a community living arrangement (see rule 4411).

4461.1 Percentage of Month in Long-Term Care (10/07/2005, 05-25)

Determine the percentage of the month individuals were in long-term care using the appropriate table below.

Percentage of Month in Long-Term Care: all months except February

Day of the month admitted tolong-term care	Percentage of month inlong-term care	Day of the month admitted tolong-term care	Percentage of month inlong-term care	Day of the month admitted tolong-term care	Percentage of month inlong-term care
1	100%	11	67%	21	33%
2	97%	12	63%	22	30%
3	93%	13	60%	23	27%

Long-Term Care Residence Period

Day of the month admitted tolong-term care	Percentage of month inlong-term care	Day of the month admitted tolong-term care	Percentage of month inlong-term care	Day of the month admitted tolong-term care	Percentage of month inlong-term care
4	90%	14	57%	24	23%
5	87%	15	53%	25	20%
6	83%	16	50%	26	17%
7	80%	17	47%	27	13%
8	77%	18	43%	28	10%
9	73%	19	40%	29	7%
10	70%	20	37%	30-31	3%

Percentage of Month in Long-Term care: February

Day of the month admitted tolong-term care	Percentage of month inlong-term care	Day of the month admitted tolong-term care	Percentage of month inlong-term care	Day of the month admitted tolong-term care	Percentage of month inlong-term care
1	100%	11	64%	21	29%
2	96%	12	61%	22	25%
3	93%	13	57%	23	21%
4	89%	14	54%	24	18%
5	86%	15	50%	25	14%
6	82%	16	46%	26	11%
7	79%	17	43%	27	7%
8	75%	18	39%	28	4%
9	71%	19	36%	29	0%
10	68%	20	32%		

4461.2 Determining Maximum Patient Share (10/07/2005, 05-25)

To determine the maximum patient share, the department considers the individuals gross income less allowable deductions as specified in rule 4462. This is the most that a long-term care recipient is obliged to pay toward the cost of long-term care. If an individual was in long-term care for less than a full month, multiply the maximum patient share by the applicable percentage in the table in rule 4461.1.

Deductions from Patient Share

4462 Deductions from Patient Share (09/01/2005, 05-19)

A. When determining the patient share amount, the department deducts the following from gross income:

1. SSI/AABD, AABD only and Reach Up benefit payments still being received when the person first enters long-term care;

2. SSI/AABD payments intended to be used to maintain the community residence of persons temporarily (not to exceed 3 months) in institutions;

3. Austrian Reparation Payments;

4. German Reparation Payments;

5. Japanese and Aleutian Restitution Payments;

6. Payments from the Agent Orange Settlement Funds; and

7. Radiation Exposure Compensation.

8. VA payments for aid and attendance paid to a veteran residing in a nursing home or to the veterans surviving spouse residing in a nursing home.

B. Then the department deducts the following items from the individual's patient share specified in the subsections below in the following order:

1. a personal needs allowance or community maintenance allowance (rule 4462.1);

2. home upkeep expenses, if applicable (rule 4462.2);

3. allocations to community spouse or maintenance needs of family members living in the community, if applicable (rule 4462.3); and

4. reasonable medical expenses incurred, if applicable (rules 4440-4453). For the purposes of this subsection, "reasonable medical expenses" do not include long-term care services received during penalty periods for long-term care Medicaid.

Unpaid patient share obligations may not be used to reduce a current patient share obligation.

4462.1 Personal Needs Allowance and Community Maintenance Allowance (09/01/2005, 05-19)

The department deducts a reasonable amount for clothing and other personal needs of the individual from monthly income. For institutionalized individuals, the department applies a standard personal needs deduction. For individuals receiving waiver or hospice services, the department applies a standard community maintenance deduction. Unlike the institutionalized individual, whose room and board are covered by Medicaid, persons in the waiver and hospice living arrangements have higher allowances to provide a reasonable amount for food, shelter, and clothing to meet their personal needs.

INTERPRETIVE MEMO

[X] Medicaid Spend Down Rule Interpretation **[ ] Medicaid Spend Down Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4462.4 **Date of this Memo** 06/29/2009 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

"Assisted living" is considered a community setting and not a medical institution or nursing facility because assisted living does not include 24 hour care, has privacy, a lockable door, and is a homelike setting.

An institutionalized spouse is permitted to allocate income and resources to a community spouse when the community spouse resides in assisted living.

Deductions from Patient Share

4462.2 Home Upkeep Deduction (02/01/2007, 06-46)

The department deducts expenses from the monthly income of an individual receiving long-term care services in a nursing facility or receiving enhanced residential care (ERC) services to help maintain their owned or rented home in the community. This deduction is allowed for three months, renewable for up to an additional three months. It is available for each separate admission to long-term care, as long as the criteria listed below are met. The home upkeep standard deduction equals three-fourths of the SSI/AABD payment level for a single individual living in the community.

A. The department grants the deduction when the Medicaid group has income equal to or greater than the standard home upkeep deduction and the Medicaid group has income greater than the personal needs allowance (PNA). Individuals who have less income than the standard home upkeep deduction may deduct an amount for home upkeep equal to the difference between the individuals income and the personal needs allowance.

B. This deduction may be applied at any point during the institutionalization as long as all criteria for the deduction are met:

1. no one resides in the long-term care beneficiarys home and receives an allocation as a community spouse or other eligible family member; and

2. the beneficiary submits a doctor's statement before each three-month deduction period, stating that the beneficiary is expected to be discharged from the institution within three months and to return home immediately after discharge.

C. If the situation changes during this period, the Medicaid group's eligibility for the home upkeep deduction must be redetermined. The department will deny or end the deduction when:

1. the home is sold or rented,

2. rented quarters are given up, or

3. the individuals health requires the long-term care admission period to last longer than six months.

4462.3 Allocation to Family Members (10/07/2005, 05-25)

The department allows individuals to allocate their income to certain family members as described in the following subsections.

4462.4 Allocation to Community Spouse (10/07/2005, 05-25)

The department may deduct a community spouse income allocation for the needs of spouses living in the community (community spouse) from the incomes of individuals receiving long-term care, including waiver and hospice services, (institutionalized spouse). The term community spouse applies to the spouse of an individual receiving long-term care services, even if the community spouse is also receiving waiver or hospice services. When one spouse in a nursing facility and the other is receiving waiver services, the waiver spouse may receive an allocation. When both spouses are receiving waiver services, either may allocate to the other.

Deductions from Patient Share

Institutionalized spouses may allocate less than the full amount to their community spouse or may allocate nothing. The allocation is reduced by the gross income, if any, of the community spouse. Community spouses, as well as institutionalized spouses, have a right to request a fair hearing on the amount of the income allocation.

The standard community spouse income allocation equals 150 percent of the federal poverty level for two. The actual community spouse income allocation equals the standard community spouse allocation plus any amount by which actual shelter expenses exceed the standard allocation, up to the maximum. The maximum community spouse income allocation equals a maximum provided by the federal government each year by November 1.

The department applies the following presumptions to ownership of income when determining the community spouse allocation, unless an institutionalized spouse establishes by a preponderance of the evidence that the ownership interests in income are other than as follows:

A. income paid in the name of the spouse is considered available only to the named spouse;

B. income paid in the name of both spouses is considered available in equal shares to each;

C. income paid in the name of either spouse and any other person is considered available to that spouse is proportion to his or her ownership interest;

D. income paid in the name of both spouses and any other person is considered available to each spouse in an amount of one-half of the joint interest.

4462.5 Allocation to Other Family Members (08/01/2003, 02-11)

The department allows a deduction for the following family members, unless the members countable resources exceed $12,000:

A. any child under age 18; and

B. any dependent children, parents, or siblings of either spouse, as specified below.

For the purposes of this subsection, the department considers individuals dependents if they meet each of the following three criteria:

A. they have been or will be a member of the household of the beneficiary for at least one year;

B. more than one half of their total support is provided by the beneficiary; and

C. they have gross annual income below $2500 or are a child of the beneficiary under age 19 or under age 24 and a full-time student during any five months of the tax year.

When family members live with the community spouse of a person living in a nursing facility, the deduction equals the maintenance income standard reduced by the gross income of each family member and dividing by three. The resulting amount is the maximum allocation that may be made to each family member.

When family members do not live with the community spouse of the person living in a nursing facility, the deduction equals the applicable protected income level for the number of family members living in the same household as the family member, reduced by the gross income, if any, of the family members in the household.

Deductions from Patient Share

The department may require the family members described above to apply for SSI, AABD or Reach Up, as long as this would not disadvantage them financially.

Transfer Between Nursing Facilities

4463 Transfer Between Nursing Facilities (02/01/2007, 06-46)

Individuals receiving long-term care sometimes move from one facility to another, such as from one nursing home to another or from a nursing home to a hospital and back to the same or another nursing home. Patient share payments must be paid toward the cost of the individuals care from income received by the individual during each month of a continuous period of receiving long-term care Medicaid services.

As a general rule, the provider giving long-term care services to the individual on the last day of the preceding month sends the individual a bill for the patients share of the cost for that month. Payment is made to the nursing facility if the individual was receiving long-term care in a nursing facility on the last day of the preceding month. Payment is made to the highest paid provider of waiver services if the individual is active on a waiver program on the last day of the preceding month. Exceptions to this rule are specified in the subsections below.

If payment of a patient share results in a credit to the provider then the provider sends the excess to the Office of Vermont Health Access.

4463.1 Hospital Admission From Nursing Facility (02/01/2007, 06-46)

Long-term care Medicaid recipients who are hospitalized remain long-term care recipients and their patient share amount is not redetermined. The department allocates payment of the patient share to the providers as follows:

A. For acute care: the patient share is paid directly to the Office of Vermont Health Access when the recipient is hospitalized and receiving acute hospital care on the last day of the month preceding the month in which income is received. Failure to pay the patient share may result in closure of long-term care Medicaid eligibility.

B. For long-term care: the patient share is paid to the hospital when the recipient is hospitalized and receiving long-term care services in the hospital on the last day of the month preceding the month in which income is received.

4463.2 Transfer from Waiver Services to Nursing Facility (08/01/2003, 02-11)

A. For respite services: the department does not adjust patient share payment when a long-term care recipient of waiver services enters a nursing facility for respite services. The patient share is paid to the highest paid provider of waiver services, even if the individual is in a nursing home on the last day of the month and receiving respite services.

B. For other services: The department adjusts the patient share amount when a long-term care recipient of waiver services enters a nursing facility for services other than respite and has been in the nursing facility for a full calendar month. The patient share is paid to the nursing facility since the individual was receiving long-term care in a nursing facility on the last day of the month.

Transfer Between Nursing Facilities

4463.3 Discharge from Nursing Facility to Waiver Services (08/01/2003, 02-11)

The department adjusts the patient share amount when individuals are in a nursing facility for more than one full calendar month and discharged to waiver services. After the patient share payment is redetermined using the community maintenance allowance, the first months patient share is paid to the nursing facility because the individual resided in the facility on the last day of the previous month. Thereafter it is paid to the highest paid provider of waiver services.

4463.4 Discharge from Long-Term Care (08/01/2003, 02-11)

The department excludes all income long-term care recipients receive during the month of discharge from long-term care and any month after discharge when long-term care Medicaid recipients leave a long-term care living arrangement (rule 4412). Long-term care providers must refund patient share payments made by long-term care Medicaid recipients when they pay their patient share from income received in the month of their discharge.

4463.5 Termination of Eligibility for Long-Term Care (08/01/2003, 02-11)

Long-term care Medicaid recipients become fully responsible for the total cost of any care they receive after the effective date of the decision when they remain institutionalized after a medical review team decision that they no longer need skilled nursing or intermediate care, or they become ineligible for other reasons. Recipients usually must pay in advance for such care as a private patient. They incur no patient share obligation for the calendar month that the review decision takes effect.

The long-term care providers must credit payment toward the cost of private care furnished after the effective date of the decision to end Medicaid long-term care coverage when long-term care Medicaid recipients have already paid their patient share to the institution during the calendar month the review decision takes effect.

4463.6 Patient Share in the Month of Death (08/01/2003, 02-11)

The department counts income received during the calendar month of the death of a long-term care Medicaid recipient and applies it to the cost of their care received during the prior month. For example, if a long-term care Medicaid recipient dies on June 26, the patient share payment from income received during June is due for care provided in May. If a long-term care Medicaid recipient dies on July l, the patient share payment from any income received during July is due for care provided in June.

INTERPRETIVE MEMO

[X] Medicaid Spend Down Rule Interpretation **[ ] Medicaid Spend Down Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4470 Date of this Memo 12/21/2009 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

UPDATE:

At the request of the Centers for Medicare and Medicaid Services, we have reviewed our regulations and policies on pooled trusts to assure they meet Federal statutory requirements. In order to bring our policy into compliance with Federal statutory requirements, the following clarification is being issued:

The purpose of this interpretive memorandum is to clarify Medicaid regulations with respect to the application of the resource exclusion rules and application of the transfer of assets penalty provisions on pooled trusts established by individuals age 65 and older.

Background

A pooled trust is a trust that can be established for a disabled individual under the authority of §1917(d)(4)(C) of the Social Security Act (the Act). A trust that meets the requirements of this section of the statute is exempt from being treated under the normal Medicaid trust rules in §1917(d) of the Act. A pooled trust is run by a non-profit organization. The trust (or more accurately, a sub-account within the trust) is established for each individual beneficiary. All the beneficiary sub-accounts are pooled for investment and management purposes. Upon the death of the disabled individual, the balance remaining in the account is paid back to the State Medicaid agency in an amount equal to the medical assistance paid on behalf of the beneficiary. The statute also allows the trust to retain some portion of the balance remaining after the death of the beneficiary.

4470 Transfer Rule Intrepretation

A pooled trust established by an individual age 65 and older is not exempt from the transfer of assets provisions.

Although a pooled trust may be established for beneficiaries of any age, funds placed in a pooled trust established for an individual age 65 or older may be subject to penalty as a transfer of assets for less than fair market value. When a person places funds in a trust, the person gives up ownership of those funds. Since the individual generally does not receive anything of comparable value in return, placing funds in a trust is usually a transfer for less than fair market value. The federal statute does provide an exception to imposing a transfer penalty for funds that are placed in a trust established for a disabled individual. However, only trusts established for a disabled individual age 64 or younger are exempt from application of the transfer of assets penalty provisions (see §1917(c)(2)(B)(iv) of the Act).

Income or Resource Transfer and Long-Term Care Coverage

4470 Income or Resource Transfer and Long-Term Care Coverage (09/01/2005, 05-19)

The department shall determine whether transfers of income or resources made by applicants and recipients requesting Medicaid coverage of long-term care expenses, or by any member of their financial responsibility group, are allowable transfers under the rules set forth in this section. This section applies to applicants and recipients in a medical institution or who qualify for home-based waiver services as part of the special income group (rule 4202.3(b)) or as medically needy (rule 4203). This section also applies to the spouses of applicants and recipients in a medical institution or who qualify for home-based waiver services as part of the special income group (rule 4202.3(b)) or as medically needy (rule 4203). If the department determines that such transfers are not allowable, the person requesting long-term care coverage shall not be eligible for such coverage until a penalty period has expired. The beginning and duration of the penalty period shall be based upon the date and value of the disallowed transfers.

The department shall make this determination concerning transfers occurring before the individual requests coverage of long-term care services, including waiver and hospice services, as part of its determination of initial eligibility for such coverage. Once the department has determined that a transfer is disallowed and has established a penalty period, that transfer is not reconsidered unless the department obtains new information about the transfer. If the department discovers that the individual has made additional transfers after the initial determination, the department shall also determine whether these are allowable, whether the dates of transfer are before or after the initial determination, and establish penalty periods as required. After the month in which an individual is determined eligible for long-term care Medicaid, no resources of the community spouse shall be determined available to the institutionalized spouse.

Rule 4471 sets forth a definition of transfers.

Rules 4472 and 4473 specify the criteria for allowable transfers, to which no penalty period applies, effective for all initial long-term care Medicaid eligibility determinations and redeterminations. No other transfers are allowable.

Definition of Transfer

4471 Definition of Transfer (09/01/2005, 05-19)

A transfer of income or resources, for the purposes of this section, means any action taken by a member of the financial responsibility group (see rules 4201(d); and 4221) or by any other person with lawful access to the income or resources (see rule 4473.5) that disposes of the member's income or resources. The date of the transfer is the date this action was taken. It also applies to certain income and resources to which the member is entitled but does not have access because of an action taken by:

A. a member of the financial responsibility group entitled to the income or resources;

B. a person, including a court or administrative body, with legal authority to act in place of or on behalf of the member or the member's spouse, entitled to the income or resources; or

C. a person, including a court or administrative body, acting at the direction or upon the request of the member or the member's spouse, entitled to the income or resources.

Transfers for Fair Market Value

4472 Transfers for Fair Market Value (08/01/2003, 02-11)

No penalty period is applied to income or resources transferred for fair market value.

Fair market value means an amount equal to the price of an item on the open market in the individuals locality at the time of a transfer, or contract for sale, if earlier. The department determines whether an individual received fair market value for a transfer of income or resources by determining the difference, if any, between the fair market value of any asset reduced by any applicable deductions at the time of the transfer and the amount received for the asset.

Any of the following deductions may be used to reduce fair market value:

A. the amount of any legally enforceable liens or debts against the transferred income or resource at the time of transfer that reduced the transferors equity in the income or resource;

B. the reasonable and necessary costs of making the sale or transfer;

C. the value of income or resources received in exchange for the transferred income or resources;

D. the value of income or resources returned to the individual; and

E. the following verified payments or in-kind support given to or on behalf of the individual as compensation for receipt of the income or resources by the person who received the income or resources:

1. personal services;

2. payments for medical care;

3. funeral expenses of the individual's deceased spouse;

4. taxes, mortgage payments, property insurance, or normal repairs on the transferred property; or

5. support and maintenance (e.g., food, clothing, incidentals, fuel and utilities) provided in the individual's own home or in the home of the person who received the income or resource.

4472.1 Receipt of Fair Market Value (02/01/2007, 06-46)

If the value of a transferred resource is scheduled for receipt after the date of transfer, the department considers it a transfer for fair market value only if the individual or spouse can expect to receive the full fair market value of the resource within the expected lifetime of the individual or spouse. Expected lifetime is determined by the department as specified in subsections (A) and (B) below.

A. Expected lifetime of the institutionalized individual will be measured at the time of the transfer as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration) (http://socialsecurity.gov/OACT/STATS/table4c6.html) and set forth in the Medicaid procedures manual.

B. Expected lifetime of the spouse will be measured at the time of the transfer as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration) (http://socialsecurity.gov/OACT/STATS/table4c6.html) and set forth in the Medicaid procedures manual.

Transfers for Fair Market Value

Pursuant to the authority granted in Vermont Act 71 § 303(7)(2005), the department is developing alternate actuarial tables that will be consistent with federal law and adopted by rule.

INTERPRETIVE MEMO

[X] Medicaid Spend Down Rule Interpretation **[ ] Medicaid Spend Down Procedure Interpretation**

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Reference 4473.1 C Date of this Memo 12/21/2009 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

UPDATE:

At the request of the Centers for Medicare and Medicaid Services, we have reviewed our regulations and policies on pooled trusts to assure they meet Federal statutory requirements. In order to bring our policy into compliance with Federal statutory requirements, the following clarification is being issued:

The purpose of this interpretive memorandum is to clarify Medicaid regulations with respect to the application of the resource exclusion rules and application of the transfer of assets penalty provisions on pooled trusts established by individuals age 65 and older.

Background

A pooled trust is a trust that can be established for a disabled individual under the authority of §1917(d)(4)(C) of the Social Security Act (the Act). A trust that meets the requirements of this section of the statute is exempt from being treated under the normal Medicaid trust rules in §1917(d) of the Act. A pooled trust is run by a non-profit organization. The trust (or more accurately, a sub-account within the trust) is established for each individual beneficiary. All the beneficiary sub-accounts are pooled for investment and management purposes. Upon the death of the disabled individual, the balance remaining in the account is paid back to the State Medicaid agency in an amount equal to the medical assistance paid on behalf of the beneficiary. The statute also allows the trust to retain some portion of the balance remaining after the death of the beneficiary.

4473.1 Transfer Rule Intrepretation

A pooled trust established by an individual age 65 and older is not exempt from the transfer of assets provisions.

Although a pooled trust may be established for beneficiaries of any age, funds placed in a pooled trust established for an individual age 65 or older may be subject to penalty as a transfer of assets for less than fair market value. When a person places funds in a trust, the person gives up ownership of those funds. Since the individual generally does not receive anything of comparable value in return, placing funds in a trust is usually a transfer for less than fair market value. The federal statute does provide an exception to imposing a transfer penalty for funds that are placed in a trust established for a disabled individual. However, only trusts established for a disabled individual age 64 or younger are exempt from application of the transfer of assets penalty provisions (see §1917(c)(2)(B)(iv) of the Act).

4473 Transfers for Less than Fair Market Value (02/01/2007, 06-46)

The department does not impose a penalty period for transfers made by members of the financial responsibility group for less than fair market value that meet one or more of the following criteria.

A.

1. The income or resource was transferred before February 8, 2006 and was not in a trust, and the date of the transfer was more than 36 calendar months prior to the first month in which the applicant or recipient both requests Medicaid coverage of long-term care expenses and meets all other requirements for Medicaid eligibility.

2. The income or resource was transferred on or after February 8, 2006 and the date of the transfer was more than 60 calendar months prior to the first month in which the applicant or recipient both requests Medicaid coverage of long-term care expenses and meets all other requirements for Medicaid eligibility.

B. The transferred income or resources have been returned to the individual or otherwise remain available to the individual or another member of the financial responsibility group.

C. The action that constituted the transfer was the removal of a member's name from a joint account in a financial institution, and the member has demonstrated, to the department's satisfaction, that the funds in the account accumulated from the income and resources of another owner who is not a member of the financial responsibility group.

D. The member has documented to the department's satisfaction convincing evidence that the resources were transferred exclusively for a purpose other than to become or remain eligible for long-term care. A signed statement by the individual is not, by itself, convincing evidence. Examples of convincing evidence are documents showing that:

1. the transfer was not within the individual's control (e.g., was ordered by a court);

2. the individual could not have anticipated long-term care eligibility on the date of transfer (e.g., the individual became disabled due to a traumatic accident after the date of transfer); or

3. a diagnosis of a previously undetected disabling condition leading to long-term care eligibility was made after the date of transfer.

E. The transfer meets the criteria specified in rules 4473.1-4473.2 for transfers involving trusts, transfers of homes, and transfers for the benefit of certain family members.

F. The individual intended to dispose of the income or resources either at fair market value, or for other valuable consideration.

G. The member transferred excluded income or resources. Penalties are imposed for the transfer of any asset considered by the social security administrations supplemental security income program to be countable or excluded income or resources. For example, transfer of the home or of the proceeds of a loan are both subject to penalty.

4473.1 Allowable Transfers of Trusts for Less than Fair Market Value (10/07/2005, 05-25)

The department does not impose a penalty period for transfers involving trusts that meet one or more of the following criteria.

INTERPRETIVE MEMO

[X] Medicaid Spend Down Rule Interpretation **[ ] Medicaid Spend Down Procedure Interpretation**

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UPDATE:

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Background

A pooled trust is a trust that can be established for a disabled individual under the authority of §1917(d)(4)(C) of the Social Security Act (the Act). A trust that meets the requirements of this section of the statute is exempt from being treated under the normal Medicaid trust rules in §1917(d) of the Act. A pooled trust is run by a non-profit organization. The trust (or more accurately, a sub-account within the trust) is established for each individual beneficiary. All the beneficiary sub-accounts are pooled for investment and management purposes. Upon the death of the disabled individual, the balance remaining in the account is paid back to the State Medicaid agency in an amount equal to the medical assistance paid on behalf of the beneficiary. The statute also allows the trust to retain some portion of the balance remaining after the death of the beneficiary.

4473.1 Transfer Rule Intrepretation

A pooled trust established by an individual age 65 and older is not exempt from the transfer of assets provisions.

Although a pooled trust may be established for beneficiaries of any age, funds placed in a pooled trust established for an individual age 65 or older may be subject to penalty as a transfer of assets for less than fair market value. When a person places funds in a trust, the person gives up ownership of those funds. Since the individual generally does not receive anything of comparable value in return, placing funds in a trust is usually a transfer for less than fair market value. The federal statute does provide an exception to imposing a transfer penalty for funds that are placed in a trust established for a disabled individual. However, only trusts established for a disabled individual age 64 or younger are exempt from application of the transfer of assets penalty provisions (see §1917(c)(2)(B)(iv) of the Act).

A. The income or resources were transferred to an irrevocable trust that does not under any circumstances allow disbursements to or for the benefit of the individual, and the date of the transfer was more than 60 calendar months prior to the first month in which the applicant or recipient requests Medicaid coverage of long-term care expenses.

B. The action that constituted the transfer was the establishment of a trust solely for the benefit of a person under age 65 who is blind or permanently and totally disabled, specified at rule 4245.2(f).

C. The action that constituted the transfer was the establishment of a pooled trust, specified at rule 4245.2(f).

D. The action that constituted the transfer was the establishment of a revocable trust. Payments from the trust to anyone other than the individual are considered a transfer for less than fair market value and are subject to penalty unless the payments are for the benefit of the individual.

4473.2 Transfers of Homes to Family Members (02/01/2007, 06-46)

The department does not impose a penalty period for transfer of a home that meets the definition at rule 4241.1, provided that title was transferred by a member of the financial responsibility group to one or more of the following persons:

A. the member's spouse;

B. the member's child who was under age 21 on the date of the transfer;

C. the members son or daughter who is blind or permanently and totally disabled, regardless of age;

D. the brother or sister of the member requesting coverage of long-term care expenses, when the brother or sister had an equity interest in the home on the date of the transfer and was residing in the home continuously for at least one year immediately prior to the date the person began to receive long-term care services, including waiver and hospice services; or

E. the son or daughter of the member requesting coverage of long-term care expenses, provided that the son or daughter was residing in the home continuously for at least two years immediately prior to the date the parent began to receive long-term care services, including waiver and hospice services and provided care to the parent during part or all of this period that allowed the parent to postpone receipt of long-term care services, including waiver and hospice services.

The department also does not impose a penalty period for the purchase of a life estate interest in another individuals home when it is the purchasers residence and the purchaser resides in the home for a period of at least one year after the purchase.

4473.3 Other Transfers to Family Members (02/01/2007, 06-46)

The department does not impose a penalty period for transfers that meet any of the following criteria.

A. The transfer was for the sole benefit of the individual requesting coverage for long-term care services, including waiver and hospice services.

B. The income or resource was transferred by an institutionalized spouse to the community spouse before the initial determination of the institutionalized spouse's eligibility for long-term care coverage. This also applies to a transfer made to a third party for the sole benefit of the community spouse.

C. The income or resource was transferred to a members son or daughter who is blind or permanently and totally disabled or to a trust for the sole benefit of a members son or daughter who is blind or permanently and totally disabled, regardless of age.

4473.4 Transfers Involving Annuities (02/01/2007, 06-46)

Annuities purchased by the institutionalized individual or community spouse on or after February 8, 2006 must name Vermont Medicaid as the first remainder beneficiary up to the amount of long-term care and community service Medicaid payments made by the state on behalf of the institutionalized individual. In cases where a minor or disabled child, or a community spouse is named as a beneficiary ahead of the state, Vermont Medicaid must be named as the secondary beneficiary. If Vermont Medicaid is not named as a remainder beneficiary in the correct position, the purchase of the annuity will be considered a transfer for less than fair market value. When Vermont Medicaid is a beneficiary of an annuity, issuers of annuities are required to notify Vermont Medicaid of any changes in the disbursement of income or principal from the annuity as well as any changes to the States position as remainder beneficiary.

A. Allowable Transfers

The department does not impose a penalty for the purchase of an annuity when it meets one or more of the four alternatives described below. To determine that an annuity is established under any of the various provisions of the Internal Revenue Code that are referenced in items 3 and 4 below, the department relies on verification from the financial institution, employer or employer association that issued the annuity. The burden of proof is on the individual to produce this documentation. Absent such documentation, the department will consider the purchase of the annuity a transfer for less than fair market value which is subject to a penalty.

1. The annuity meets the provisions of rule 4244 or 4252.1.

2. The annuity is purchased by the institutionalized spouse and:

   a. is irrevocableand nonassignable;

   b. provides for payments to applicants or their spouses in equal intervals and equal amountswith no deferral and no balloon payments made; and

   c. is actuarially sound because it does not exceed the life expectancy of the applicants or their spouses, as determined by the department using the actuarial publications of the Office of the Chief Actuary of the Social Security Administration) (http://socialsecurity.gov/OACT/STATS/table4c6.html) and set forth in the Medicaid procedures manual and returns to the beneficiary at least the amount used to establish the contract and any additional payments plus earnings, as specified in the contract.

3. The annuity is purchased by the institutionalized spouse and considered either:

   a. an individual retirement annuity (according to Sec. 408(b)) of the Internal Revenue Code of 1986 (IRC), or

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

4. The annuity is purchasedby the institutionalized spouse with proceeds fromone of the following:

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

b. certain accounts or trusts which are treated as traditional IRAs (IRC Sec. 408 §(c)); or

c. a simplified retirement account (IRC Sec. 408 §(p)); or

d. a simplified employee pension (IRC Sec. 408 §(k)); or

e. a Roth IRA (IRC Sec. 408A).

B. Impermisible Transfers

Annuities that do not meet the criteria in rule 4473.4 A shall be assessed a transfer penalty based on their fair market value. The fair market value equals the amount of money used to establish the annuity and any additional amounts used to fund the annuity, plus any earnings and minus any early withdrawals and surrender fees.

4473.5 Jointly Held Income or Resources (02/01/2007, 06-46)

A. Transfers after January 1, 1994

For joint ownerships established after January 1, 1994, the portion of jointly held assets subject to penalty is evaluated by the department based on the specific circumstances of the situation. The department presumes individuals own the value of the resource using rules in rule 4250 and its subsections. Individuals may rebut the presumption of ownership by establishing to the departments satisfaction that the amount withdrawn was, in fact, the sole property of and contributed to the account by the other person, and thus did not belong to the individual. In the case of accounts in financial institutions (rule 4233.1), for example, the portion subject to transfer penalty is the amount withdrawn by a joint owner. In the case of life estates, for example, individuals may transfer their home and retain a life estate without being subject to penalty if they have retained the right to sell the property. In this situation their ownership interest has not been reduced or eliminated.

B. Transfers before January 1, 1994

For joint ownerships established before January 1, 1994, the date of the transfer is the date the other person became a joint owner. The value of the transfer equals the amount that the resource available to the individual or the individuals spouse was reduced in value.

4473.6 Income-Producing Notes and Contracts (02/01/2007, 06-46)

Promissory notes or similar income-producing resources (contracts) shall be assessed a transfer penalty based on their fair market value unless they:

Transfers for Less than Fair Market Value

A. have a repayment term that is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration (http://socialsecurity.gov/OACT/STATS/table4c6.html) and specified in the Medicaid procedures manual;

B. provide for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

C. prohibit the cancellation of the balance upon the death of the lender.

Fair market value equals the amount of money used to establish the contract and any additional payments used to fund it, plus any earnings and minus any payments already received as of the date of the Medicaid long-term care application.

INTERPRETIVE MEMO

[X] Medicaid Spend Down Rule Interpretation **[ ] Medicaid Spend Down Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4474.1 B2 Date of this Memo 12/18/2009 Page 1 of 1
This Memo: [ ] is New [X] Replaces one dated 08/01/2009

The meaning of "otherwise eligible for long-term care Medicaid"

This interpretive memo explains when individuals who have made transfers subject to penalty are otherwise eligible for long-term care Medicaid.

Individuals are considered "otherwise" eligible for long-term care Medicaid as of the earliest date they pass all eligibility criteria in the sequence listed below. They must also meet each of these criteria in any month for which they request retroactive Medicaid.

A. Clinical Criteria— rule 4201 G

B. Citizenship and Identity Criteria — rule 4216 and 4170

C. Category — rule 4210 — 4215, 4300

D. Residency — rule 4217

E. Living Arrangement — rule 4218

F. Resources — rule 4230 — 4260

G. Income — rule 4270 (for anyone with gross income above the institutional income standard, see explanation below)

Individuals whose Income exceeds the Institutional Income Standard (IIS)

When an individual's income exceeds the Institutional Income Standard (IIS), the individual must spend down to the applicable Protected Income Level (PIL) in the month of application or the next month. Individuals with a penalty are subject to the penalty period start date the date the spenddown is met.

If the spenddown is not met in the month of application or the next month, the individual is denied Long-Term Care Medicaid. Then, the department determines whether the person is eligible for community Medicaid. If so, it assesses a 6-month spenddown.

Examples:

A. Individual applies in June and requests retroactive coverage as of April. Individual meets all eligibility criteria but the gross countable income exceeds the IIS and has transfers that will result in a 38 day penalty. The spenddown period is April – September. The applicant meets their spenddown on April 23rd. April 23rd is the date the individual is considered to be otherwise eligible. Their penalty period would be April 23rd – May 30th.

B. Same case, but no retroactive coverage requested. The spenddown is met June 23. June 23 is the date the individual is considered to be otherwise eligible. The penalty period is June 23 – July 30.

Penalty Period for Disallowed Transfers

4474 Penalty Period for Disallowed Transfers (02/01/2007, 06-46)

If a transfer is disallowed, the department imposes a penalty period of restricted Medicaid coverage to an otherwise eligible individual. During this period, no Medicaid payments are made for long-term care services, including waiver and hospice services. Medicaid payments are made for all other covered services provided to the recipient during the period of restricted coverage.

4474.1 Penalty Date (02/01/2007, 06-46)

The penalty date is the beginning date of each penalty period imposed for a disallowed transfer.

A. For applications filed before February 1, 2007, the period of restricted coverage begins the first day of the month following the date the asset was transferred if that does not occur in any other period of restricted coverage.

B. For applications filed after February 1, 2007 the period of restricted coverage is dependent upon the date of the transfer.

1. When the transfer occurred before February 8, 2006 and not in any other period of restricted coverage, the penalty date starts on the first day of the month following the date the asset was transferred.

2. When the transfer occurred on or after February 8, 2006 and not in any other period of restricted coverage, the penalty date starts on the first day in which the individual would have been otherwise eligible for long-term care Medicaid.

Penalty periods for transfers occurring in different months run consecutively rather than concurrently, in the order in which the transfers occurred. If, after establishing a penalty period for disallowed transfers, the department determines that additional disallowed transfers were made in a subsequent month but before the end of the first penalty period, the department shall designate the first day following the end of the first penalty period as the penalty date for the subsequent penalty period.

4474.2 Penalty Period (02/01/2007, 06-46)

For transfers that occurred before July 1, 2002, the number of months in a penalty period shall be equal to the total value of all disallowed transfers made during a given calendar month divided by the average monthly cost to a private patient of nursing facility services as of the date of application. When a fraction of a month results, the months are rounded down to the nearest whole number.

For transfers that occurred on or after July 1, 2002, the number of days in a penalty period shall be equal to the total value of all disallowed transfers made during a given calendar month divided by the average daily cost to a private patient of nursing facility services in the state as of the date of application or the date of discovery, if the department discovered additional disallowed transfers after the initial determination of eligibility for long-term care coverage.

Penalty periods for transfers in different calendar months shall be consecutive and established in the order in which the disallowed transfers occurred.

A penalty period runs continuously from the first date of the penalty period, even if the individual stops receiving long-term care services, including waiver and hospice services.

INTERPRETIVE MEMO

[X] Medicaid Spend Down Rule Interpretation **[ ] Medicaid Spend Down Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4474 **Date of this Memo** 08/01/2009 **Page** 1 of 1

This Memo: [ ] is New [X] Replaces one dated 07/06/2009

The meaning of "otherwise eligible for long-term care Medicaid"

This interpretive memo explains when individuals who have made transfers subject to penalty are otherwise eligible for long-term care Medicaid.

Individuals are considered "otherwise" eligible for long-term care Medicaid as of the earliest date they pass all eligibility criteria in the sequence listed below. They must also meet each of these criteria in any month for which they request retroactive Medicaid.

A. Citizenship an identity criteria — rule 4170

B. Category — rule 4210 — 4215, 4300

C. Residency — rule 4217

D. Living Arrangement — rule 4218

E. Resources — rule 4230 — 4260

F. Income — rule 4270 (for those with income above the institutional income standard, see explanation below)

Individuals whose Income exceeds the Institutional Income Standard (IIS)

When an individual's income exceeds the Institutional Income Standard (IIS), the individual must spend down to the applicable Protected Income Level (PIL) in the month of application or the next month. Individuals with a penalty are subject to the penalty period start date the date the spenddown is met.

If the spenddown is not met in the month of application or the next month, the individual is denied Long-Term Care Medicaid. Then, the department determines whether the person is eligible for community Medicaid. If so, it assesses a 6-month spenddown.

Examples:

A. Individual applies in June and requests retroactive coverage as of April. Individual meets all eligibility criteria but the gross countable income exceeds the IIS and has transfers that will result in a 38 day penalty. The spenddown period is April – September. The applicant meets their spenddown on April 23rd. April 23rd is the date the individual is considered to be otherwise eligible. Their penalty period would be April 23rd – May 30th.

B. Same case, but no retroactive coverage requested. The spenddown is met June 23. June 23 is the date the individual is considered to be otherwise eligible. The penalty period is June 23 – July 30.

Penalty Period for Disallowed Transfers

4474.3 Penalty when Both Spouses Request Long-Term Care Coverage (08/01/2003, 02-11)

The department applies the following rules to the assignment of penalty periods when both members of a couple are requesting or receiving Medicaid coverage of long-term care services, including waiver and hospice services.

A. For spouses determined otherwise eligible for Medicaid payment of long-term care services at the same time, the department divides the value of the disallowed transfer by two to determine the number of days of restricted coverage for each member of the couple.

B. If the penalty period established for one member of the couple has not yet expired when the other member of the couple requests and is determined otherwise eligible for Medicaid payment of long-term care services, the number of days remaining in the penalty period shall be divided by two to determine the number of days of restricted coverage for each member of the couple.

C. When the member of the couple for whom a penalty period has been established dies, the days remaining in that members penalty period shall not be reassigned to the members spouse, if the spouse requests and is determined otherwise eligible for Medicaid payment of long-term care services.

D. When the department establishes a penalty period for a disallowed transfer by the second member of the couple to request and be determined otherwise eligible for Medicaid payment of long-term care services, the department assigns that penalty period to the spouse who made the transfer, provided that it was made after the determination of disallowed transfers for the first spouse.

4474.4 Undue Hardship (02/01/2007, 06-46)

The department does not establish a penalty period resulting from an improper transfer when it determines that restricted coverage will result in an undue hardship. Undue hardship is considered only in cases where the department has first determined that a transfer has been made for less than fair market value and that no transfer exception applies (rules 4473-4473.4).

For the purposes of this section the term individual refers to the long-term care applicant or recipient as well as a long-term care service provider. Providers may file a request for undue hardship on behalf of the individual with the consent of the individual or the personal representative of the individual.

A. Definition of undue hardship

Undue hardship means depriving the individual: of medical care such that the individuals health or life would be endangered; or of food, clothing, shelter, or other necessities of life such that would be at risk of serious deprivation. Undue hardship does not exist when the application of a transfer penalty merely causes an individual or individuals family member(s) inconvenience or restricts their lifestyle. Undue hardship does not exist when the individual transferred the assets to the community spouse and the community spouse has countable or excluded resources in excess of the community spouse resource allocation standard.

B. Process for reviewing undue hardship requests

The department shall inform the individual of the right to request an undue hardship exception through written notice of a penalty period of ineligibility for Medicaid payment of long-term care services because of an impermissible asset transfer. The notice shall specify the factual and legal basis for the imposition of the penalty, and shall explain

how the individual may request a hardship exception. Individuals may receive an undue hardship exception to the transfer of assets penalty if they can show that the penalty will cause an undue hardship to them. Undue hardship shall be established when the individual demonstrates by a preponderance of the evidence that denial of Medicaid payment for long-term care services will cause actual and not merely possible undue hardship. The departments decision may waive all or a portion of the penalty period.

Individuals subject to a transfer penalty may request an undue hardship within 20 days of notification of the transfer penalty by providing documentation supporting the request to the department. Once the department determines that it has received complete documentation, the department shall inform the individual within 10 business days of the undue hardship decision and of the right to request a fair hearing. The department may extend these periods if the department determines that extenuating circumstances require additional time. If no request for undue hardship is received within 20 days after notification of the transfer penalty, or if the request is denied, the department shall issue an eligibility determination specifying the applicable penalty period. If the individual is a recipient, the notice shall include the date of Medicaid long-term care termination and include the right to request a fair hearing and continuing benefits.

When undue hardship requests are made for the first time at the time of requesting a fair hearing, individuals challenging the penalty period must raise all claims and submit all evidence permitting consideration of undue hardship at least 10 business days in advance of the fair hearing. Undue hardship shall be referred to the department for consideration and the department shall inform the Human Services Board of its decision on undue hardship within 10 business days of receipt.

Undue hardship requests also may be filed at any time during the penalty period if new circumstances leading to undue hardship arise during the duration of a transfer penalty period. If granted, the undue hardship request shall be prospective from the date of the request.

The department shall have no obligation to pay for long-term care services during the penalty period unless it grants an undue hardship exception or the beneficiary prevails at the fair hearing.

C. Undue Hardship Reasons

In determining the existence of “undue hardship”, the department shall consider all circumstances involving the transfer and the situation of the individual. Undue hardship is established when one or more of the following circumstances, or any other comparable reasons, exist.

1. Whether imposition of the transfer penalty would result in the immediate family qualifying for Supplemental Security Income; Reach Up; Aid for the Aged, Blind or Disabled; General Assistance; 3SquaresVTs; or another public assistance program requiring a comparable showing of financial need.

2. Whether funds can be made available for long-term care only if assets such as a family farm or other family business are sold, and the assets are the primary source of income for the individual’s spouse, parents, children or siblings.

3. Whether a power of attorney (POA) or guardian transferred the asset, and the POA or guardian was not acting in the best interest of the individual when the transfer was made as determined by the department or a court, or the transfer forms the basis for a report to the Department of Disabilities, Aging and Independent Living for investigation of abuse, neglect or exploitation.

Penalty Period for Disallowed Transfers

4. Whether the individual was deprived of an asset by fraud or misrepresentation. Such claims must be documented by official police reports or civil or criminal action against the alleged perpetrator or substantiated by the Department of Disabilities, Aging and Independent Living (DAIL) or by a sworn statement to the department attesting to the fact that the claim was reported to the police or DAIL.

5. Whether the individual cannot recover the assets due to loss, destruction, theft, or other similar circumstances.

6.

   a. When the transfer is to a person the department presumes the recipient of the transferred resource could make arrangements for the individuals care and the care of dependent family members up to the value of the transfer unless the evidence submitted indicates that there is no reasonable way that the person can make any of these arrangements. The facts and verification required to determine if the recipient of the transferred resource can make other arrangements to pay or provide the care of the individual, or to provide for the needs of financially dependent family members may include the following, if applicable:

      i. A copy of the tax return for the preceding calendar year;

      ii. All earnings pay stubs for the past 12 months;

      iii. All bank books, stocks, bonds, certificates, life insurance policies (e.g. bank books must include those before and after receipt of the transferred resource); and

      iv. All documents associated with the proceeds of the transferred resource which will show the value of any purchase of new resources from the sale proceeds of the transferred property.

      When the transfer is made to a relative who is a minor, a family member with financial responsibility for the minor must be asked to provide the required facts and verification.

   b. If the individual rebuts the presumption and shows there is no reasonable way that the recipient of the transferred resource can make arrangements for the individuals care and the care of dependent family members up to the value of the transfer, the department will consider whether the individual has exhausted all reasonable efforts to meet his or her needs from other available sources. This includes whether the individual has exhausted all reasonable efforts to obtain return of the assets transferred, and demonstrated that efforts to obtain return of the asset or adequate compensation would probably not succeed. The department will take into consideration all excluded and countable assets above the protected resource standard and income above the monthly maintenance needs allowance. Burial funds and the individuals principal place of residence will continue to be excluded.