(5) NOTE: Unpaid patient-share obligations may not be used to reduce a current patient share obligation.

(c) Personal-needs allowance and community-maintenance allowance. A reasonable amount for clothing and other personal needs of an individual is deducted from their monthly income, as follows:

(1) For an individual receiving Medicaid coverage of long-term care services and supports in an institutional setting, a standard personal needs deduction (PNA) is applied.

(2) For an individual receiving Medicaid coverage of long-term care services and supports in a home and community-based setting, a standard community maintenance deduction (CMA) is applied. (NOTE: Unlike the individual in the institutional setting whose room and board is covered by Medicaid, an individual receiving long-term care services and supports in a home and community-based setting has a higher deduction to provide a reasonable amount for food, shelter, and clothing to meet their personal needs.)

(d) Home-upkeep deduction

(1) Expenses from the monthly income of an individual receiving Medicaid coverage of long-term care services and supports in an institution or receiving enhanced residential care (ERC) services in a residential care home are deducted to help maintain their owned or rented home in the community. This deduction is allowed for six 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 is three-fourths of the SSI/AABD payment level for a single individual living in the community.

(2) The home-upkeep deduction is granted when the individual has income equal to or greater than the standard home-upkeep deduction and greater than their PNA. An individual who has less income than the standard home-upkeep deduction may deduct an amount for home upkeep equal to the difference between the individual's income and the PNA.

(i) The home-upkeep deduction may be applied at any point during the individual's institutionalization or receipt of ERC services, as the case may be, as long as both of the following criteria for the deduction are met:

(A) No one resides in the individual's home and receives an allocation as a community spouse or other eligible family member; and

(B) The individual submits a doctor's statement before the six-month deduction period, stating that the individual is expected to be discharged from the institution or ERC setting within six months and to return home immediately after discharge.

(ii) If the situation changes during the period the individual is receiving the home-upkeep deduction, the individual's eligibility for the deduction is redetermined. The deduction is denied or ended when:

(A) The individual's home is sold or rented;

(B) The rented quarters of the individual are given up; or

(C) The individual's health requires the long-term care admission period to last longer than six months.

(e) Allocations to family members

(1) In general. An individual is allowed to allocate their income to certain family members as described in this paragraph.

(i) Allocation to community spouse

(A) If an individual receiving Medicaid coverage of long-term care services and supports (the institutionalized spouse) has a spouse living in the community (the community spouse), an allocation may be deducted from the institutionalized spouse's income for the needs of the community spouse. The term "community spouse" applies to the spouse of the institutionalized spouse even if the community spouse is also receiving Medicaid coverage of long-term care services and supports in a home and community-based setting. When one spouse is receiving Medicaid coverage of long-term care services and supports in an institutional setting and the other is receiving Medicaid coverage of long-term care services and supports in a home and community-based setting, the spouse receiving home and community-based services and supports may receive an allocation. When both spouses are receiving home and community-based services and supports, either may allocate to the other.

(B) "Assisted living" is considered a community setting and not an institutional setting provided that assisted living does not include 24-hour care, has privacy, a lockable door, and is a homelike setting. If the spouse of an institutionalized spouse is living in an assisted living setting, they are considered a community spouse for purposes of the community spouse income allocation.

(C) An institutionalized spouse may allocate less than the full amount of the allocation to their community spouse or may allocate nothing. The allocation is reduced by the gross income, if any, of the community spouse. A community spouse, as well as an institutionalized spouse, has a right to request a fair hearing on the amount of the allocation.

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

(E) The presumptions set forth below are applied to the ownership interests in income when determining a community spouse's community spouse income allocation unless the institutionalized spouse establishes by a preponderance of the evidence that the ownership interests are other than as presumed.

(I) Income paid in the name of one spouse is presumed available only to the named spouse.

(II) Income paid in the name of both spouses is presumed available in equal shares to each spouse.

(III) Income paid in the name of either spouse and any other person is presumed available to that spouse in proportion to their ownership interest.

(IV) Income paid in the name of both spouses and any other person is presumed available to each spouse in an amount of one-half of the joint interest.

(ii) Allocation to other family members

(A) A deduction from the individual's income is allowed for the maintenance needs of certain other family members. If the individual has no community spouse living in the home, the countable resources of any such family member cannot exceed the community spouse resource allocation (CSRA) minimum.[2] If the individual has a community spouse living in the home, there is no limit on the amount of countable resources of any such family member.

For purposes of this deduction, a family member must be:

(I) A child of either the individual or the individual's spouse under age 18; or

(II) A dependent child, parent, or sibling of either the individual or the individual's spouse. For the purposes of this subparagraph, a family member is considered dependent if they meet each of the following three criteria:

(i) They have been or will be a member of the household of the individual or their spouse for at least one year;

(ii) More than one half of their total support is provided by the individual or the individual's spouse; and

(iii) They have gross annual income below $2,500 or are a child of the individual (or spouse) under age 19 or under age 24 and a full-time student during any five months of the tax year.

(B) *Deduction for family members living with the community spouse*. When family members live with the community spouse of the individual receiving Medicaid coverage of long-term care services and supports, the deduction equals the maintenance income standard reduced by the gross income of each family member and divided by three. The resulting amount is the maximum allocation that may be made to each family member.

(C) *Deduction for family members not living with the community spouse*. When family members do not live with the community spouse of the individual receiving Medicaid coverage of long-term care services and supports, the deduction equals the applicable PIL for the number of family members living in the same household, reduced by the gross income, if any, of the family members in the household.

(D) The family members described above may be required to apply for SSI, AABD or Reach Up, as long as this would not disadvantage them financially.

24.05 Transfer between settings (01/15/2017, GCR 16-097)

(a) In general. An individual receiving long-term care sometimes moves from one setting to another, such as from one nursing facility to another or from a nursing facility to a hospital and back to the same or another nursing facility. The patient share must be paid toward the cost of the individual's care from income received by the individual during each month of a continuous period of receiving Medicaid coverage of long-term care services and supports. As a general rule, the provider giving long-term care services and supports to the individual on the last day of the preceding month sends the individual a bill for the individual's share of the cost for that

[2] For the current CSRA minimum, see Vermont's Eligibility Standards for Healthcare Programs on the Department of Vermont Health Access website.

month. Payment is made to an institution if the individual was receiving Medicaid coverage of long-term care services and supports in the institution on the last day of the preceding month. Payment is made to the highest-paid provider of long-term care services and supports if the individual was receiving Medicaid coverage of long-term care services and supports in a home and community-based setting on the last day of the preceding month. If payment of a patient share results in a credit to the provider, then the provider sends the excess to AHS. Exceptions to this rule are specified in the paragraphs below.

(b) Hospital admission from nursing facility. An individual receiving Medicaid coverage of long-term care services and supports who is hospitalized continues to receive Medicaid coverage of long-term care services and supports, and their patient share amount is not redetermined. Payment of the patient share is allocated to the providers as follows:

(1) Acute care. The patient share is paid directly to AHS when the individual 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 the individual's eligibility for Medicaid coverage of long-term care services and supports.

(2) Long-term care. The patient share is paid to the hospital when the individual is hospitalized and receiving Medicaid coverage of long-term care services and supports in the hospital on the last day of the month preceding the month in which income is received.

(c) Transfer from home and community-based setting to nursing facility

(1) Respite services. The patient share amount is not adjusted when an individual receiving Medicaid coverage of long-term care services and supports in a home and community-based setting enters an institution for respite services. The patient share is paid to the highest-paid provider of the long-term care services and supports, even if the individual is in an institution on the last day of the month.

(2) Other services. AHS adjusts the patient share amount when an individual receiving Medicaid coverage of long-term care services and supports in a home and community-based setting enters an institution for services other than respite services and has been in the institution for a full calendar month. The patient share is paid to the institution since the individual was receiving Medicaid coverage of long-term care services and supports in an institution on the last day of the month.

(d) Discharge from nursing facility to home and community-based setting. The patient share amount is adjusted when an individual is in an institution for more than one full calendar month and discharged to a home and community-based setting. After the patient-share amount is redetermined using the community maintenance allowance (see § 24.04(c)), the first month's patient share is paid to the institution because the individual resided in the institution on the last day of the previous month. Thereafter, the patient share it is paid to the highest paid provider.

(e) Discharge from long-term care. All income an individual receiving Medicaid coverage of long-term care services and supports receives during the month they are discharged from long-term care and any month after discharge when the individual leaves a long-term care living arrangement (see § 30.01) is excluded. A long-term care provider must refund any patient-share payment made by an individual when the individual pays their patient share from income received in the month of their discharge.

(f) Termination of eligibility for long-term care. An individual receiving Medicaid coverage of long-term care services and supports becomes fully responsible for the total cost of any care they receive 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. The individual's responsibility begins after the effective date of the review team's decision. An individual usually must pay in advance for such care as a privately-paying patient. They incur no patient share obligation for the calendar month that the review team's decision takes effect. A long-term care provider must credit payment toward the cost of private care furnished after the effective date of the review team's decision to end Medicaid coverage of long-term care services and supports when an individual receiving Medicaid coverage of long-term care services and supports has already paid their patient share to the provider during the calendar month the review team's decision takes effect.

(g) Patient share in the month of death. Income received during the calendar month of the death of an individual receiving Medicaid coverage of long-term care services and supports is counted and applied to the cost of the care the individual received during the prior month. For example, if the individual dies on June 26th, the patient-share payment from income they received during June is due for care provided in May. If the individual dies on July 1st, the patient-share payment from income they received during July is due for care provided in June.

25.00 Income or resource transfers and eligibility for Medicaid coverage of long-term care services and supports (01/01/2024, GCR 23-085)

25.01 In general (01/15/2017, GCR 16-097)

(a) AHS determines whether transfers of income or resources made by an individual requesting Medicaid coverage of long-term care services and supports are allowable transfers under the rules set forth in this section.

(1) This section applies to an individual:

(i) Who is requesting Medicaid coverage of long-term care services and supports in a medical institution under MABD or MCA.

(ii) Who is requesting Medicaid coverage of long-term care services and supports in a home and community-based setting under MCA.

(iii) Who is requesting Medicaid coverage of long-term care services and supports in a home and community-based setting under MABD and is in a special income coverage group under § 8.05(k)) or is medically needy (§ 8.06).

(2) This section also applies to the spouse of an individual described in (1) above.

If AHS determines that a transfer is not allowable, the individual requesting Medicaid coverage of long-term care services and supports will not be eligible for such coverage until a penalty period has expired. The start date of the penalty period is based on when the individual would, but for the disallowed transfer, be otherwise eligible for Medicaid coverage of long-term care services and supports, as explained in more detail in this section. The duration of the penalty period is based on the value of the disallowed transfer.

(b) AHS makes determinations concerning transfers occurring before the individual requests Medicaid coverage of

(3) Application requirements. To request an undue hardship exception, the individual must submit documentation supporting their claim of undue hardship.

(4) Standard of proof. Undue hardship is established when the individual demonstrates by a preponderance of the evidence that denial of Medicaid coverage of long-term care services and supports will cause actual and not merely possible undue hardship.

(5) Nature of available relief. If the individual establishes undue hardship, AHS may waive all or a portion of the penalty period.

(6) Notice of decision on request. A notice of decision on the undue hardship exception request will be issued within 10 business days of receipt of all information determined by AHS as needed to evaluate the request. The notice will be in writing and will inform the individual of the right to request a fair hearing to appeal the decision.

(7) Notice of decision on eligibility for Medicaid coverage of long-term care services and supports. If no request for an undue hardship exception is received within 20 days after notification of the transfer penalty, or if the request is denied, an eligibility determination will be issued specifying the applicable penalty period. If the individual is receiving Medicaid coverage of long-term care services and supports, the notice will include the date the Medicaid coverage terminates and the right to request a fair hearing and continuing benefits.

(8) Exception: Request made within request for fair hearing. When an individual makes a request for an undue hardship exception for the first time at the same time they are requesting a fair hearing, the individual must raise all claims and submit all evidence permitting consideration of the undue hardship exception at least 10 business days in advance of the fair hearing. The undue hardship request must then be referred to AHS for consideration. AHS will then inform the fair hearings entity of its decision on the request within 10 business days of receiving it.

(9) Exception: Request made during penalty period on the basis of changed circumstances. A request for an undue hardship exception may be filed at any time during a penalty period if new circumstances leading to undue hardship arise during the duration of the penalty period. If granted, the request will be prospective from the date of the request.

(10) Limitation on obligation to pay for long-term care services and supports during penalty period. The state has no obligation to pay for cost of an individual's long-term care services and supports during the individual's penalty period unless an undue hardship exception has been granted or the individual prevails at a fair hearing.

(11) Extension of time period. The time periods specified in this paragraph (e) may be extended if AHS determines that extenuating circumstances require additional time.

26.00 [Reserved]

27.00 [Reserved]

Special Rules for Medicaid Coverage of Long-Term Care Services and Supports – Eligibility and Post Eligibility