

# Enclosure

Sections 6011 and 6016

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

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

July 27, 2006

**Enclosure Highlights—Section 6011 and Section 6016**

- I. Extension of the Look-Back Period to 60 Months
- II. Penalty Period
  - A. Start Date of the Penalty Period
  - B. Partial Month Transfers
  - C. Option to Combine Multiple Transfers Made In More Than One Month
- III. Purchase of Promissory Notes, Loans or Mortgages
- IV. Purchase of Life Estates
- V. Undue Hardship
  - A. Establishment of Procedures
  - B. Authority of Facility to Request Undue Hardship Waiver for Resident
  - C. Bed Hold Payments
- VI. Effective Dates

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

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

## **II. II. Penalty Period**

### **A. Start Date of the Penalty Period**

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

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

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

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

States should be aware that imposition of a penalty period for new applicants for Medicaid requires a denial notice. If a penalty period is imposed on an individual who is already eligible for Medicaid, the State must provide a 10-day adverse action notice. As well as complying with existing legal requirements (see regulations at 42 CFR 431 Subpart E), this notice must contain information about the undue hardship exception (see below).

### **B. Partial Month Transfers**

Prior to enactment of the DRA, States had the option to impose penalty periods for transfers in a month that were less than the State's average monthly cost to a private patient of nursing

facility services in the State, or to impose no penalty period for such “partial month” transfers. Additionally, some States elected not to impose a penalty for transfers made within a month that were under a certain threshold e.g., \$500. In States that elected to impose no penalty period for such partial month transfers, individuals were able to transfer amounts less than the average monthly cost of nursing facility services in successive months, but never incur a penalty.

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

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

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

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

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

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

### **III. Purchase of Promissory Notes, Loans, or Mortgages**

Some States have experienced problems with individuals who have attempted to circumvent rules penalizing transfers of assets by obtaining promissory notes, loans, or mortgages containing a promise of repayment from transferees. Individuals would then present the note, loan or mortgage instruments at the time of their Medicaid application for long-term care services in order to establish that these transactions were actually loans, not gifts. In some

cases, these were merely sham transactions, and repayment of the full amount transferred was neither expected nor enforced. Various techniques, such as balloon payments, in which token payments are made for most of the term of the loan with the balance due in a lump sum at the very end of the loan, and cancellation of the loan upon the death of the transferor, were used to ensure that the transferee would in fact retain most, if not all, of the funds.

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

- The repayment term must be actuarially sound;
- Payments must be made in equal amounts during the term of the loan with no deferral of payments and no balloon payments; and
- The promissory note, loan or mortgage must prohibit the cancellation of the balance upon the death of the lender.

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

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

#### **IV. Purchase of Life Estates**

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

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

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

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

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

## **V. Undue Hardship**

### **A. Establishment of Procedures**

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

Under the DRA, undue hardship exists when application of a transfer of assets penalty would deprive the individual----

- of medical care such that the individual's health or life would be endangered; or
- of food, clothing, shelter, or other necessities of life.

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

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

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

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

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

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

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

#### **C. Bed Hold Payments**

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

### **VII. VI. Effective Dates**

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

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

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

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

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

# Enclosure

Section 6012

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

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

July 27, 2006

## **Enclosure Highlights—Section 6012**

### **I. Application Requirements**

- A. Disclosure of Interest in an Annuity
- B. Requirement to Name the State as a Remainder Beneficiary
- C. Applications for Coverage of Long-Term Care Services in 1634 States
- D. Consideration of Income and Resources from an Annuity

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

- A. Annuity-Related Transactions Other than Purchases.
- B. Requirement to Name the State as a Remainder Beneficiary on Annuities
- C. Annuities Purchased by or on Behalf of an Annuitant Who Applied for Medical Assistance

### **III. Effective Date**

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

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

## I. Application Requirements

### A. Disclosure of Interest in an Annuity

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

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

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

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

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

If the State wants to limit its action to denial of payment for long-term care services, it must still ensure that enough information regarding the income and/or resources related to an annuity has been collected and verified in order to establish Medicaid eligibility under existing rules. The DRA does not provide applicants an option to withhold information about annuities that may impact the computation of resources or income. If the State cannot collect enough information about an annuity to allow the

State to establish Medicaid eligibility, the State should deny eligibility entirely based on the applicant's failure to cooperate in accordance with the State's existing policies.

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

#### B. Requirement to Name the State as a Remainder Beneficiary

Under new sections 1917(e)(1) and (2), all States must also include in the application for long-term care services, including the application for recertification, a statement that names the State as a remainder beneficiary on any annuity purchased on or after February 8, 2006 by virtue of the provision of medical assistance for institutional care. The State must also notify the issuer of any annuity disclosed for purposes of section 1917(c)(1)(F) of the State's rights as a preferred remainder beneficiary.

- The State may require the issuer to notify it regarding any changes in disbursement of income or principal from the annuity; and
- The issuer of an annuity may disclose information about the State's position as remainder beneficiary to others who have a remainder interest in the annuity.

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

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

#### D. Consideration of Income and Resources from an Annuity

The State may take into consideration the income or resources derived from an annuity when determining eligibility for medical assistance or the extent of the State's obligations for such assistance. This means that even though an annuity is not penalized as a transfer for less than fair market value (see II. Evaluation and Treatment of Purchases of Annuities and Certain Transactions On or After February 8, 2006 below for further information about treating the purchase of an annuity as a transfer of assets), it must still be considered in determining eligibility, including spousal income and resources, and in the post-eligibility calculation, as appropriate. In other words, even if an annuity is not subject to penalty under the provisions of the DRA, this does not mean that it is excluded as income or resource.

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

### **A. Annuity-Related Transactions Other than Purchases**

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

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

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

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

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

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

As a remainder beneficiary, the State may receive up to the total amount of medical assistance paid on behalf of the individual, including both long term care services and community services. Under the new section 1917(e) (see section I.B. above) the State must notify the issuer of the annuity of the State's right as the preferred remainder beneficiary. The State should require verification from the issuer that the State is named as a remainder beneficiary in the correct position. States should also require the issuer to notify the State if and when there is any change in the amount of income or principal being withdrawn.

**If the State is not named as a remainder beneficiary in the correct position, the purchase of the annuity will be considered a transfer for less than fair market value.** We interpret the statute to mean that the full purchase value of the annuity will be considered the amount transferred.

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

Section 6012(c) of the DRA amends section 1917(c)(1) by adding a new subparagraph (G) which provides that the purchase of an annuity on or after February 8, 2006, by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services, shall be treated as a transfer of assets for less than fair market value unless the annuity meets certain criteria. Unlike the new section 1917(c)(1)(F) discussed above, this requirement does **not** apply to annuities for which the community spouse is the annuitant. **This requirement is in addition to those specified in 1917(c)(1)(F) pertaining to the State's position as a remainder beneficiary.** An annuity purchased by or on behalf of an annuitant who has applied for medical assistance will not be treated as a transfer of assets if the annuity meets any of the following conditions:

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

OR

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

OR

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

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

When evaluating whether or not an annuity meets the conditions listed in 3. above, use the methodology for determining actuarial soundness that is found in the State Medicaid Manual Chapter III, Section 3258.9 B. However, do not use the actuarial life expectancy tables published in that section. Instead, use the *current* actuarial tables published by the Office of the Chief Actuary of the Social Security Administration. These tables may be accessed at <http://www.ssa.gov/OACT/STATS/table4c6.html>.

Note that even if an annuity is determined to meet the requirements above, and the *purchase* is not treated as a transfer, if the annuity or the income stream from the annuity is transferred, except to a spouse or to another individual for the sole benefit of the spouse, child or trust as described in 1917(c)(2)(B), that transfer may be subject to penalty.

### III. Effective Date

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

notify applicants and recipients of the State's rights regarding annuities purchased after the date of enactment.

# Enclosure

Section 6013

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

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

July 27, 2006

## **Enclosure Highlights—Section 6013**

I. Background

II. New Provision

III. Effective Date

## **I. Background**

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

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

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

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

## **II. New Provision**

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

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

1. Determine the MMNA for the community spouse in the same manner that you currently use pursuant to sections 1924(d)(3), (4), and (5) of the Act;
2. Determine the community spouse's total gross monthly income, including income from income-producing assets retained by the community spouse;
3. Subtract the community spouse's total monthly gross income from the MMNA. If there is a deficit, this is the amount of the income "shortfall" for the community spouse;

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

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

### **III. Effective Date**

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

# Enclosure

Section 6014

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

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

July 27, 2006

## **Enclosure Highlights—Section 6014**

I. New Provision

II. Methodology

III. Limitations

IV. Increases in Limits

V. Undue Hardship

VI. Effective Date

## **I. New Provision**

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

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

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

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

## **II. Methodology**

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

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

## **III. Limitations**

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

program under title XVI of the Social Security Act) for the exemption to apply.

#### **IV. Increases in Limits**

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

#### **V. Undue Hardship**

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

#### **Effective Date**

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

# Enclosure

## Section 6015

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

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

July 27, 2006

## **Enclosure Highlights—Section 6015**

I. General Discussion

II. Effective Date

## **I. General Discussion**

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

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

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

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

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

States should note that in order to meet the first condition listed above, it is not necessary for CCRCs or life care communities to provide a full, lump-sum refund of the entrance fee to the resident. If portions of the fee can be refunded or applied to pay for care as required, this condition would be met.

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

## **II. Effective Date**

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