# NURSING FACILITY SERVICES

## 17.10 ASSETS

A nursing care client must meet the asset test for his eligibility coverage group. The asset level for those eligible by having income equal to or less than 300% of the monthly SSI payment for an individual is the same as for an SSI-Related Medicaid eligible. Certain individuals who meet the gross income test but are ineligible for Medicaid due to being over the allowable asset limit, may be eligible for the LTCIP Asset Disregard. When both spouses are institutionalized and apply for nursing facility services, the SSI-Related Medicaid asset limit for a couple is used to determine eligibility. An asset assessment is not completed when both spouses are institutionalized. See Chapter 11 for the asset limit of the appropriate coverage group.

Once the Worker determines the value of the assets, an Asset Assessment, described in item A below, is completed when an institutionalized person has a spouse in the community.

NOTE: Once Medicaid eligibility is established, the assets of the community spouse are not counted for the institutionalized spouse. In addition, when assets such as the home and attributed assets legally transferred to the community spouse are subsequently transferred by him, no penalty is applied to the institutionalized spouse.

A. ASSET ASSESSMENTS

NOTE: A legally married individual and his spouse, although separated, are treated as a couple for the Asset Assessment, regardless of the length of the separation.

When determining eligibility for nursing facility services for an individual, institutionalized on or after 9/30/89, and who has a community spouse, the Worker must complete an assessment of the couple's combined countable assets. The assessment is completed, when requested by the client or his representative, prior to application, or at application, if not previously completed. It is completed as of the first continuous period of institutionalization and is completed one time only. The first continuous period of institutionalization is the date the client first enters the nursing facility and remains for at least 30 days or is reasonably expected to remain for 30 days at the time the individual enters the facility. The spousal limits in effect at the time the assessment is completed are used.

NOTE: When a Medicaid recipient in a MAGI coverage group applies for payment of nursing facility services, an Asset Assessment is not required. However, if the client is later determined disabled by SSA an asset assessment is completed with information using the date the client first entered the nursing facility.

## NURSING FACILITY SERVICES

**NOTE:** An Asset Assessment is completed when an institutionalized individual transfers to a nursing facility in WV, even if one was previously completed in the former state of residence.

The assessment is completed on form IM-NL-AC-1 or in RAPIDS. See the RAPIDS User Guide. The purpose of the Asset Assessment is to allow the spouse of an institutionalized individual to retain a reasonable portion of the couple's assets and to prevent the impoverishment of the community spouse.

When requested, the Worker must advise the individual(s) of the documentation required for the assessment. Verification of ownership and the FMV must be provided. When it is not provided, the assessment is not completed.

The Worker documents the total value of all non-excluded assets.

Nursing facilities are required to advise all new admissions and their families that an Asset Assessment is available upon request from the local office.

**NOTE:** The accessible pension of a community spouse counts in the Asset Assessment, minus any penalty for early withdrawal.

**EXAMPLE:** An institutionalized individual's wife has a $75,000 pension through her employer from which she can withdraw without incurring a penalty. The pension is counted in the Asset Assessment as an available resource to the couple.

**EXAMPLE:** An institutionalized individual's husband has a $100,000 pension through his employer from which he can withdraw but incurs a ten percent early withdrawal penalty. The pension of $100,000, minus the early withdrawal penalty of $10,000, is counted in the Asset Assessment as an available resource of $90,000 to the couple.

The agency has developed a statement concerning the availability of asset assessments. Nursing facilities provide this "Patient's Bill of Rights" as part of their admission package. See Appendix C.

1. Calculation Of The Spouses' Shares

   The spouses' shares are computed as follows:

   Step 1: Determine the FMV of the couple's combined countable assets, as of the beginning of the first continuous period of institutionalization.

## NURSING FACILITY SERVICES

Step 2: Compare the amount from Step 1 to $23,844. If the Step 1 amount is equal to or less than $23,844, all assets are attributed to the community spouse. If not, go to Step 3.

Step 3: Divide the Step 1 amount by 2 and compare to $23,844. If one-half of the Step 1 amount is equal to or less than $23,448, the community spouse is attributed $23,844 and the remainder belongs to the institutionalized spouse. If not, go to Step 4.

Step 4: When one-half of the Step 1 amount is greater than $23,844, one-half of the total assets (Step 1 amount) is attributed to the community spouse, not to exceed $119,220.

Step 5: The amount not attributed to the community spouse is attributed to the institutionalized spouse.

Certain individuals who meet the gross income test but are ineligible for Medicaid due to being over the allowable asset limit, may be eligible for the LTCIP Asset Disregard.

If an application for nursing facility services is not made when the assessment is completed, the spouse retains the amount attributed to him at the assessment, regardless of the couple's combined assets at the time of application.

2. Notification Requirements

When the assessment is complete, the Worker must provide each member of the couple with a copy of the RAPIDS asset assessment or the IM-NL-AC-1. A copy of the IM-NL-AC-1 is retained in the case record. See item 7 below for the RAPIDS asset assessment.

The Worker must also notify the community spouse using form ES-NL-D or RAPIDS form AEL3 that the assessment may not be appealed until a Medicaid application is made.

3. Revisions To The Asset Assessment

The Asset Assessment may be revised when the client, his spouse, the Hearings Officer or the Worker determine, with supporting documentation, that the initial determination was incorrect or based on incorrect information.

## NURSING FACILITY SERVICES

4. Additional Asset Exclusions For Institutionalized Spouses

Certain individuals who meet the gross income test but are ineligible for Medicaid due to being over the allowable asset limit, may be eligible for the LTCIP Asset Disregard.

The institutionalized individual is not ineligible for Medicaid due to the assets determined above, if he lacks the ability to or is legally prevented from assigning the assets which would otherwise make him ineligible. In addition, certain asset-related denials of LTC Services are subject to Waiver due to the Undue Hardship Provision. See Chapter 11 for the definition of undue hardship.

5. Transfers Of Assets To The Community Spouse

Once initial eligibility has been established, assets that were not counted for the institutionalized spouse must be legally transferred to the community spouse. Assets cannot merely be attributed to the community spouse, but must actually be transferred to the community spouse, if they are to be excluded in determining continuing Medicaid eligibility of the institutionalized spouse. Assets legally transferred to the community spouse based on the Asset Assessment are not treated as uncompensated transfers of resources.

To exclude assets attributed to the community spouse, the institutionalized spouse must indicate his intent to transfer the assets to the community spouse, and the transfer must take place within 90 days, unless a longer period is required to take the action.

**NOTE:** Once Medicaid eligibility is established, the assets of the community spouse based on the Asset Assessment are not counted for the institutionalized spouse. In addition, when assets such as the home and attributed assets legally transferred to the community spouse are subsequently transferred by him, no penalty is applied to the institutionalized spouse.

6. Additional Asset(s) Received/Obtained

When the institutionalized spouse obtains an additional asset(s) after the community spouse's share has been calculated and initial Medicaid eligibility is established, the additional asset(s) is excluded when one of the following conditions exist:

- The new asset(s), combined with the other assets the institutionalized spouse intends to retain, does not exceed the asset limit for one person; and/or

## NURSING FACILITY SERVICES

- The institutionalized spouse intends to transfer the new asset(s) to the community spouse who has assets below the previously determined spousal amount. To exclude the additional asset(s), the institutionalized spouse or his representative must promptly report receipt of the new asset(s) and provide the Worker with a written statement that he intends to transfer the new asset(s) to the community spouse within 90 days.

- The Qualified LTCIP Policy has paid benefits to or on behalf of the institutionalized spouse that equal or exceed the amount of the newly acquired countable asset.

The assets of the community spouse may still not exceed the amount determined in the previous Asset Assessment. This criteria would come into play when another asset of equal or greater value than the additional one(s) is no longer owned.

7. RAPIDS System Entry

When an asset assessment is completed, the Worker must enter the results in RAPIDS. See the RAPIDS User Guide for instructions.

**NOTE:** Prior to RAPIDS conversion, asset assessments were entered in the SAS system and may be viewed in that system. No SAS entries were made after 12/19/97.

B. TRANSFER OF RESOURCES

Four policies dealing with the transfer of assets and/or income are addressed in this Chapter. The current policy is detailed below. The others are contained in Appendix A. They are:

- Transfers made on or before June 30, 1988

- Transfers made after June 30, 1988

- Transfers made on or after July 1, 1988 when application for Medicaid eligibility for nursing facility services, ICF/MR Services or the HCB Waiver is made

- Transfers made on or after 8/11/93

The following policy is used for transfers of resources made on or after 2/8/06.

## NURSING FACILITY SERVICES

1. Definitions

For purposes of this item (item B.), the following definitions apply.

- Fair Market Value (FMV): An estimate of the value of a resource, if sold at the prevailing price at the time it was actually transferred.

  For a resource to be considered transferred for FMV, or to be considered transferred for valuable consideration, the compensation received for the resource must be in a tangible form, with intrinsic value. A transfer for love and consideration, for example, is not considered a transfer for FMV. Also, while relatives and friends legitimately can be paid for care they provide to the individual, it is presumed that services provided for free, at the time, were intended to be provided without compensation. Therefore, a transfer to a relative for care provided in the past normally is not a transfer of assets for FMV. However, an individual may rebut this presumption. See Transfers for Payment of Personal Care Services.

- For the Sole Benefit Of: A transfer is considered to be for the sole benefit of a spouse, disabled child, or a disabled individual under age 65, if the transfer is arranged in such a way that no individual, except the spouse, child or individual, can benefit from the transferred asset(s) in any way, either at the time of the transfer, or at any time in the future, except as provided below. The agreement must be in writing.

  Similarly, a trust is considered to be established for the sole benefit of one of these individuals if the trust benefits no one but the individual, either at the time of the establishment of the trust, or any time in the future, except as provided below. However, the trust may provide for reasonable compensation for a trustee to manage the trust, as well as for reasonable costs associated with investing or otherwise managing the funds or property in the trust. In defining reasonable compensation, consider the amount of time and effort involved in managing a trust of the size involved, as well as the prevailing rate of compensation, if any, for managing a trust of similar size and complexity.

  If a beneficiary is named to receive the funds remaining in a trust upon the individual's death, the transfer is considered made for the sole benefit of the individual if the Department is named as the

## NURSING FACILITY SERVICES

primary beneficiary for up to the amount paid for services to the individual. The designated beneficiary receives any remaining amount.

- Institutionalized Individual: An individual who is an inpatient in a nursing facility, or who is an inpatient in a medical institution, and for whom payment is made for a level of care provided in a nursing facility, or who is a Home and Community-Based waiver participant. For purposes of this section, a medical institution includes an ICF/MR.

- Look-Back Date: The look-back date is the earliest date for which a penalty for transferring resources for less than FMV can be applied. Penalties can only be applied for transfers which take place based on the appropriate look-back date.

  When an individual applies for Medicaid more than once (e.g., he applies and is denied due to excess assets and applies again later), the look-back date is based on the first date on which the individual had both applied for Medicaid and been institutionalized.

- Resources: For purposes of this item (item B.), resources includes all income and assets of the individual and of his spouse that are counted for SSI-Related Medicaid purposes. This includes some income or assets which the individual or the spouse is entitled to, but does not receive, because of any action or inaction by

  - The individual or his spouse;

  - A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or

  - Any person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

  Resources to which an individual or spouse is entitled includes resources to which the individual is actually entitled, or would be entitled if action had not been taken to avoid receiving the resources.

## NURSING FACILITY SERVICES

Examples of actions which cause income or assets not to be received are:

- Irrevocably waiving pension income
- Waiving an inheritance
- Not accepting or accessing injury settlements
- Settlements which are diverted by the defendant into a trust or similar device to be held for the benefit of the plaintiff
- Refusal to take legal action to obtain a court-ordered payment that is not being paid, such as child support or alimony

2. Effective Date

This policy does not apply to assets disposed of before February 8, 2006; and applies to payments made for institutional care on or after March 1, 2009. See Appendix A for transfers and payments prior to these dates.

3. Look-Back Period

The length of time for which the Worker looks back for any resource transfers is the same whether or not a trust fund was involved.

a. Trust Amounts Treated As Uncompensated Transfers

The look-back period is 60 months for amounts in revocable or irrevocable trusts that are considered transferred. The time period begins the month the client is both institutionalized and has applied for Medicaid. See Chapter 11.

b. Other Transfers

The look-back period is 60 months for transfers on or after 2/8/06. The time period begins the month the client is both institutionalized and has applied for Medicaid. See Appendix A for transfers prior to 2/8/06.

4. Permissible Transfers

The following transfers do not result in a penalty for transferring resources

## NURSING FACILITY SERVICES

a. Transfer of the Home

When the client transfers his home as follows, no penalty is applied:

- To the client's spouse
- To the client's minor child (under age 21)
- To the client's disabled child. The SSA definition of disability is used. Therefore, any person medically approved for or receiving disability-based RSDI and/or disability-based SSI meets the definition, as well as persons who are determined disabled by MRT. If no disability determination has been made, the case must be submitted for a MRT decision.
- To the client's sibling who has an equity interest in the home and who resided in the home for at least one year immediately prior to the client's institutionalization.
- To the client's child(ren) who was residing in the home for at least two years immediately prior to the client's institutionalization and who provided care to the individual which allowed him to remain at home rather than being institutionalized.

b. Transfer from the Economic Stimulus Tax Rebate for 2007

When the client transfers funds from this Rebate for less than fair market value during the 3-month exclusion period, there is no transfer penalty.

**EXAMPLE:** A client receives his 2007 $600 Rebate in August 2010. Transfers can occur through October 2010 without penalty.

c. Transfers from American Recovery and Reinvestment Act of 2009 (ARRA) One-Time Payments and Tax Credits/Refunds

American Recovery and Reinvestment Act of 2009 (ARRA) One Time Payments and Tax Credits/Refunds are excluded as transfers as follows:

- The one-time $250 payment issued to recipients of RSDI, SSI, Railroad Retirement and VA disability pensions and compensation is excluded as an asset for 9 months following

## NURSING FACILITY SERVICES

- the month of receipt. No penalty is imposed for amounts transferred during the 9-month exclusion period. After that time, transfers may result in a penalty.

- Tax credits/refunds paid under Section 1001 and Section 2202 of ARRA 2009 are excluded for 2 months following the month of receipt. No penalty is imposed for amounts transferred during the 2-month exclusion period. After that time, transfers may result in a penalty.

d. Transfer of Federal Refunds or Advance Payments

Federal tax refunds and advance payments received January 1, 2010 through December 31, 2012 are excluded as assets for 12 months following the month of receipt. No penalty is imposed for amounts transferred during the 12-month exclusion period. After that time, transfers may result in a penalty.

e. Other Transfers

When the client transfers resources other than his home, as follows, no penalty is applied:

- To the client's spouse or to another person for the sole benefit of the client's spouse not to exceed the amount determined attributable to the community spouse during the Asset Assessment.

- From the client's spouse to another person for the sole benefit of the client's spouse not to exceed the amount determined attributable to the community spouse during the Asset Assessment.

- To the client's disabled child. See definition of disabled above in item a.

**NOTE:** All transfers to another person for the sole benefit of the client’s spouse or to the client’s disabled child must be accomplished by a written instrument of transfer, such as a trust, which legally binds the parties to a specific course of action and specifies the conditions under which the transfer was made, and names those who benefit from the transfer.

## NURSING FACILITY SERVICES

f. Transfer to a Trust

When the client or his spouse transfers resources to a trust that is excluded from consideration as an asset, no penalty is applied. See Chapter 11.

**NOTE:** Federal tax refunds and advance payments received January 1, 2010 through December 31, 2012 are excluded as assets for 12 months following the month of receipt of the payment. Federal tax refunds and advance payments that are placed in trusts during the exclusion period are excluded as assets.

g. Transferred Resources Returned

When the client reports assets transferred for less than FMV have been returned to the client, the Worker must verify this information. Any return of assets must be to the client or his representative rather than to another individual on his behalf or paid directly to the long-term-care facility. When substantiated, the Worker must recalculate the penalty period.

When all such assets have been returned to the client, no penalty is applied. If a penalty has already been applied, a retroactive adjustment back to the beginning of the penalty period is required.

If part of such assets are returned, the penalty period is adjusted accordingly, from the later months of the penalty period rather than the earlier months, and is not applied to months of the penalty period that have expired.

h. Client Intended Fair Market Return or Other Valuable Consideration

When the client or his spouse can demonstrate that he intended to dispose of the resource for FMV or for other valuable consideration, no penalty is applied.

i. Transfer Was Not to Qualify for Medicaid

When a transfer of resources was exclusively for a purpose other than to qualify for Medicaid, no penalty is applied.

## NURSING FACILITY SERVICES

**NOTE:** A transfer is assumed to be for the purpose of qualifying for Long-Term Services. The burden of proof is the individual's to prove otherwise. The Worker and Supervisor can make this decision.

**EXAMPLE:** Mrs. R. has a stroke and enters the nursing home on 10/15/09. Her daughter's home was in foreclosure and the mother transferred $5,000 to her on 9/19/09 to prevent foreclosure. The Worker verifies the situation with the foreclosure notice dated 9/4/09 and the mother's withdrawal and check to the daughter on 9/19/09 for the exact amount of the foreclosure of $5,000. The Worker and Supervisor determine Mrs. R. did not transfer money to qualify for Medicaid.

**EXAMPLE:** Mr. G., a widowed man, has failing health and transfers $25,000 to each of his children before he enters the nursing home. The children are not disabled. The transfer is assumed to be for the purpose of qualifying for Medicaid.

j. Denial Would Result in Undue Hardship

An undue hardship may exist when a denial of payment for LTC Services is due to one or more of the following asset policies, (1) excessive home equity, (2) transfer to a non-permissible trust, and/or (3) a transfer of asset penalty and results in depriving the individual of medical care to the extent that the individual's health or life would be endangered, or his food, clothing, shelter or other necessities of life are at severe risk.

When the Worker determines the individual is *otherwise* eligible for LTC Services but for one or more of the asset policies listed above to which an undue hardship provision applies, he is given at the time of the eligibility decision the DFA-FH-1 and the DFA-NL-UH-1 which provides him the opportunity to request a Waiver of the denial due to undue hardship. The individual, his representative or a nursing facility staff member with the client's permission, can apply for this Waiver.

The DFA-UH-5 must be attached to the DFA-NL-UH-1. The DFA-UH-5 is the application that must be completed and returned to the Worker within 13 days of notice of the eligibility decision. Upon receipt, the Worker immediately forwards it via mail, electronic mail or fax to the DFA Policy Unit for distribution to the Undue Hardship Waiver Committee. The DFA-UH-5 must include a signature of the individual for whom the Waiver is filed when the LTC facility is

## NURSING FACILITY SERVICES

completing the Request. It must include an explanation of any efforts made to resolve the asset issue that resulted in the LTC Services denial. Documentation that supports these attempts must be attached. Details regarding the individual's undue hardship must be explained. If the DFA-UH-5 is not returned complete and timely, no additional notice occurs and the negative eligibility decision and any penalty applied remains.

An individual that resides in a facility and requests an Undue Hardship Waiver is eligible for payment of up to 30 bed-hold days from the date the DFA-UH-5 is received by the DFA Policy Unit through when a decision is made by the Committee. The Committee has 60 days to make a decision concerning the Waiver request. Denial of payment of LTC Services due to excessive home equity is not subject to payment of bed-hold days. If the Request is not appropriate for the Committee, it is returned to the local office that made the eligibility decision. The individual is notified of the Committee's decision via form DFA-NL-UH-2. The Committee forwards the DFA-NL-UH-2 to the individual, with a copy to the Supervisor and Worker. The decision of the Committee to deny the Request can be overturned by a State Hearings Officer, therefore a DFA-FH-1 is sent. The local office must notify the DFA Economic Services Policy Unit when a Hearing Request regarding the Committee's decision is received. The Regional Attorney is also advised. A member of the Committee will be available, via telephone to participate in a Fair Hearing regarding the denial of the DFA-UH-5, but not to discuss the ineligibility for LTC Services for reasons other than those related to excessive home equity, trust, and/or transfer issues.

k. Transfer of Resources Previously Disregarded by the Long-Term-Care Insurance Partnership (LTCIP) Asset Disregard

If an aged, blind or disabled individual whose income is equal to or less than 300% of the SSI payment for 1 transfers an asset that was previously disregarded by the LTCIP Asset Disregard, the transfer is not subject to a transfer penalty since the asset was previously disregarded.

Should the individual obtain an additional countable asset that causes him to exceed the allowable asset amount he must verify additional payments made to him or on his behalf by the LTCIP

## NURSING FACILITY SERVICES

Policy in addition to the amount of payments that were previously used to disregard the assets that were transferred. Additionally, the amount of the individual's estate that was protected from Estate Recovery is reduced by the same amount as the value of the asset that was transferred.

NOTE: Questions about the Estate Recovery process must be referred to the current contract agency. Information about this agency is in Appendix I.

additional payments made to him or on his behalf by the LTCIP Policy in addition to the amount of payments that were previously used to disregard the assets that were transferred.
Additionally, the amount of the individual's estate that was protected from Estate Recovery is reduced by the same amount as the value of the asset that was transferred.

NOTE: Questions about the Estate Recovery process must be referred to the current contract agency. Information about this agency is in Appendix I.

EXAMPLE: Mr. Smalley is in a nursing facility and applies for Medicaid November 1, 2010. Mr. Smalley's income is less than 300% of the SSI payment for 1 but he has $12,000 in individual assets consisting of $5,000 in an accessible money market and $5,000 in stocks. He verifies ownership of a $100,000 Qualified LTICP Policy issued after July 1, 2010, the date WV implemented the LTCIP, and insurance payments in the amount of $10,000 paid to the nursing home after July 1, 2010. The Worker disregards his money market and stocks and Medicaid eligibility is effective November 1, 2010.

At redetermination, Mrs. Smalley reports transferring the stock to their son. The transfer is not subject to a penalty since the asset was previously disregarded. However, since insurance payments verified as paid by the LTCIP Policy on behalf of Mr. Smalley were applied to disregard the value of the stock, and resulted in Mr. Smalley being eligible and receiving Medicaid, these same insurance payments cannot be used again to disregard other assets. Should Mr. Smalley's money market increase in value or he acquires additional countable assets, he must verify additional payments by the insurance company before any other assets can be disregarded.

## NURSING FACILITY SERVICES

Mr. Smalley's amount of assets that were protected at estate recovery is also reduced from $10,000 to $5,000 since the previously disregarded stock was transferred to his son.

5. Transfers Which Are Not Permissible

All transfers not specifically excluded from the application of a penalty result in application of a penalty. This also applies to jointly owned resources. The jointly-owned resource, or the affected portion of it, is considered transferred by the client when any action is taken, either by the client or any other person, that reduces or eliminates the client's ownership or control of the resource.

6. Transfers Related to a Life Estate

a. Transfer with Retention of a Life Estate

A transfer of property with the retention of a life estate interest is treated as an uncompensated transfer.

To determine if a penalty is assessed and the length of the penalty, the Worker must compute the value of the transferred asset and of the life estate, then calculate the difference between the two.

Step 1: To determine the value of the transferred asset, subtract any loans, mortgages or other encumbrances from the CMV of the transferred asset.

Step 2: Determine the age of the life estate holder as of his last birthday and the life estate factor for that age found in Appendix A of Chapter 11. Multiply the CMV of the transferred asset by the life estate factor. This is the value of the life estate.

Step 3: Subtract the Step 2 amount from the Step 1 amount. The result is the uncompensated value of the transfer.

Step 4: Divide the Step 3 amount by the State's average, monthly nursing facility private pay rate of $6,359. The result is the length of the penalty.

**NOTE:** A life estate may be excluded as a home, if the individual intends to return to it.

The value of a life estate interest is considered a transfer of resources when it is transferred or given as a gift.

## NURSING FACILITY SERVICES

b. Purchase of a Life Estate

The purchase a life estate interest in another individual's home is treated as an uncompensated transfer, unless the individual who purchased the life estate interest resides in the home for at least 1 year after the purchase. The amount of the transfer is the entire amount used to purchase the life estate.

See Section 11.4, to determine the value of the life estate.

7. Transfer To Purchase An Annuity

See Section 11.4,B for annuities as an asset.

a. Annuity-Related Transfers

**NOTE:** This requirement does not apply to revocable or assignable annuities since these can be cancelled and funds used to purchase the annuity can be refunded.

(1) Institutional Spouse is Annuitant

Establishment of an annuity is treated as a transfer of resources, unless the annuity meets the following criteria:

- The individual disclosed to the State any interest the individual or his spouse has in any annuity;
- The State is named as the remainder beneficiary, or as the second remainder beneficiary after a community spouse or minor or disabled adult child, for an amount at least equal to the amount of Medicaid benefits provided when the annuity is purchased by an applicant/recipient or spouse;
- The annuity was purchased by or on behalf of the individual and one of the following applies.
  - The annuity is considered either:
    - An individual retirement annuity (according to Section 408 (b) of the Internal Revenue Code of 1986 (IRC); or

## NURSING FACILITY SERVICES

- A deemed Individual Retirement Account (IRA) under a qualified employer plan (according to Section 408§ of the IRC).

OR

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

OR

- 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.

(2) Community Spouse Is Annuitant

Establishment of an annuity is treated as a transfer of resources, unless the annuity meets the following criteria:

## NURSING FACILITY SERVICES

- The individual disclosed to the State any interest the individual or his spouse has in any annuity;

- The State is named as the remainder beneficiary, or as the second remainder beneficiary after a community spouse or minor or disabled adult child, for an amount at least equal to the amount of Medicaid benefits provided when the annuity is purchased by an applicant or spouse;

If the annuity does not meet all stated requirements above, the full purchase value is considered the amount of the transfer.

**NOTE:** Endowment Life Insurance Policies are considered balloon annuities and subject to a transfer penalty.

In order for an annuity to be actuarially sound, the average number of years of expected life remaining for the individual who benefits from the annuity must coincide with the life of the annuity. If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive FMV. The annuity is not, then, actuarially sound and a transfer of resources for less than FMV has taken place.

**NOTE:** For annuities purchased prior to 2/8/06, use Periodic Life Tables found in Appendix E. The penalty is considered to have occurred at the time the annuity was purchased prior to 2/8/06. Only the amount that is not actuarially sound is treated as an uncompensated transfer.

**NOTE:** Period Life Tables in Appendix G of this chapter are used for annuities purchased on or after 2/8/06.

**EXAMPLE:** A 65-year-old man purchases a $10,000 irrevocable, non-assignable annuity on 7/28/08 which is to be paid over 10 years in equal payment amounts and names the State of WV as the second remainder beneficiary after his disabled son. His life expectancy, according to Appendix G, is 16.05 years. The annuity is irrevocable, non-assignable, actuarially sound, provides equal payment amounts and the state is named as a secondary remainder beneficiary. No transfer of resources has taken place.

**EXAMPLE:** An 80-year-old man purchases a $10,000 annuity on January 1, 2006 to be paid over 10 years. According to Appendix E, his life expectancy is only 6.98 years. Therefore, the amount

## NURSING FACILITY SERVICES

which will be paid out by the annuity for 3.02 years is considered an uncompensated transfer of resources that occurred at the time the annuity was purchased on January 1, 2006.

**EXAMPLE:** A 60-year old woman purchases an annuity on 3/13/07 which is to be paid over 10 years with a balloon payment in the 10th year. The annuity names the State as the remainder beneficiary and is considered an uncompensated transfer of resources since it does not provide for equal monthly payments.

**EXAMPLE:** A 65-year old woman retired from a company on 12/31/07 with an annuity that was purchased by the employer as part of her bona fide retirement plan. The annuity is not considered an uncompensated transfer of resources since it was purchased on her behalf as part of her bona fide retirement plan.

b. Annuity-Related Transactions Other Than Purchases

(1) Transactions Subject to Penalty

Certain annuity-related transactions, which occur on or after March 1, 2009, are subject to a transfer penalty. These transactions include any action taken by the

## NURSING FACILITY SERVICES

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 but are not limited to,

- Additions of principal,
- Elective withdrawals,
- Requests to change the distribution of the annuity,
- Elections to annuitize the contract and other similar transactions.

When these transactions occur a transfer penalty is applied.

(2) Transactions Not Subject to Penalty

Annuities purchased prior to March 1, 2009 which experience routine events and automatic changes that do not require any action or decision by the individual after March 1, 2009 are not subject to a transfer penalty. Routine changes include notification of an address change, death or divorce of a remainder beneficiary and other similar circumstances. Automatic changes are based on the terms of annuity which existed prior to March 1, 2009, and which do not require a decision, election or action by the individual to take affect. Changes beyond the individual's control, 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 condition, are not considered transactions that result in imposition of a transfer penalty.

**NOTE:** Annuities and annuity-related transactions that are not subject to a penalty are still subject to applicable income and/or asset policies.

## NURSING FACILITY SERVICES

**NOTE:** Multiple penalties can be applied to the same annuity under certain circumstances.

**EXAMPLE:** A 60-year old woman served a six month penalty period because the annuity did not provide equal monthly payments. She became eligible for LTC services payments, but 3 months later she made an elective withdrawal from the annuity. Another transfer of resources occurred and a penalty is applied.

8. Transfer to Pay For Personal Care Services

a. Non-permissible Transfer of Resources for Payment of Personal Care Services

Personal care services provided to an individual by a relative or friend are presumed to have been provided for free, at the time rendered, when a Personal Care Contract (PCC) did not exist. Therefore, a transfer of resources from an individual to a relative or friend for payment of personal care services is an uncompensated transfer without Fair Market Value (FMV) received for the transferred resource and subject to a penalty, unless the services were provided in accordance with item (b) below. See Section 17.10,B,1 regarding FMV.

b. Permissible Transfer of Resources for Payment of Personal Care Services

A transfer of resources by an individual to a relative or friend to pay for personal care services rendered may be a permissible transfer if the personal care services were performed through an eligible PCC, personal care agreement or personal service contract. The PCC must meet all the following criteria:

(1) Requirements Regarding the Contract

- A Personal Care Contract exists between the individual or his representative and the caregiver. See Section 11.1 for the definition of a PCC; and

- The duration of the PCC is actuarially sound.

## NURSING FACILITY SERVICES

- The terms of the PCC are in writing between the individual or his authorized representative and the caregiver; and

- The PCC is reviewed by the Worker for compliance;

- The terms of the Contract include:

  - A detailed description of the services provided to the individual in the home; and

  - The frequency and duration of the services provided. The services must be measurable and verifiable and the compensation to the caregiver paid at a reasonable amount of consideration, i.e., money or property. Payment must be clearly defined either as a set amount or an amount to be determined by an agreed-upon hourly rate that will be multiplied by the hours worked; and

    **NOTE:** Reasonable payment is determined by comparing compensation paid by home-care agencies or other independent caregivers for similar services in the same locale at the specific time period for which services were provided.

  - Services expected of the caregiver, if any, during any period the individual may reside in an assisted living, skilled nursing, or other type of medical or nursing care facility on a temporary basis between stays at home.

(2) Requirements Regarding the Provision of Services

- Services paid from transferred resources must be rendered after the written agreement was executed between the individual and the caregiver; and

## NURSING FACILITY SERVICES

- A PCC may be in place at the time of the individual's stay in a nursing facility or a similar placement; however, it is assumed, unless proven otherwise, that personal care services during this time are provided by staff rather than the caregiver named in the PCC; and

- At the time of the receipt of the services, the services must have been recommended in writing and signed by the individual's physician as necessary to prevent the transfer of the individual to residential care or nursing facility care. Such services may not include the mere providing of companionship.

(3) Requirements Regarding the Transfer

- The transfer to the relative or friend acting as caregiver must have taken place at the time the personal care services were rendered; and

- The transfer cannot be for services projected to occur in the future, but must be paid for at the time rendered; and

- FMV must be received by the caregiver in the form of payment for personal care services provided to him. The Worker must determine if reasonable payment for personal care services occurred.

**NOTE:** Reasonable payment is determined by comparing compensation paid by home-care agencies or other independent caregivers for similar services in the same locale at the specific time period for which services were rendered.

If the amount transferred to pay for personal care services is above FMV, the amount transferred in excess of FMV is subject to a transfer penalty.

**EXAMPLE:** Mr. Shore applies for Medicaid. He transferred $5,000 to his granddaughter to pay for personal care services provided to him for the last 5

## NURSING FACILITY SERVICES

months. The Worker reviews the PCC and contacts a community agency representative who indicates the payments made were similar to the rate paid by agencies at the same time period in the same locale. Since the payment was reasonable and the PCC meets all the criteria required in Section 17.10,B,1,b, the $5,000 was a permissible transfer of resources for payment of personal care services and no penalty is applied.

Other examples related to a transfer of resources for payment for personal care services are listed below.

**EXAMPLE:** Since June, 2009, Mr. Johnson had a PCC in place that meets all the Department's requirements. On April 1, 2010, he is admitted to a Long Term Care facility with all personal care services provided. Any transfer of resources to pay for personal care services rendered after April 1, 2010 would be subject to a transfer penalty.

**EXAMPLE:** Mrs. Landers has a compliant Personal Care Agreement with payments stipulated to occur at the end of the month after personal care services are rendered. On February 27, 2010, Mrs. Landers transferred $3,000 to her daughter for payment for services at $1,000 per month for January through March 2010. Since payment for March is for projected services, $1,000 of the payment is subject to a transfer penalty.

**EXAMPLE:** Mrs. Higginbotham has a compliant PCC in place but is admitted to a Long Term Care facility on a temporary basis for special treatment. The PCC remains in place; however, from the date of her admission, since personal care services are provided by the facility staff, only transportation to the facility is a service for which she can pay her caregiver if transportation is included in the terms of her PCC.

## NURSING FACILITY SERVICES

9. Transfer To Purchase A Promissory Note, Loan Or Mortgage

Any purchase of a note, or any loan or mortgage is treated as an uncompensated transfer unless all of the following criteria are met:

- The repayment terms must be actuarially sound, based on the Period Life Table found in Appendix G; and

- Payments must include the institutionalized spouse/individual in equal amounts during the term of the loan, with no payment deferrals or balloon payments; and

- The note, loan or mortgage must prohibit cancellation of the debt upon the death of the lender.

If all of the criteria listed above are not met, the loan is treated as a transfer of resources. The amount of the transfer is the entire outstanding balance due on the loan as of the month of application for Medicaid long-term care services.

See Section 11.4 to determine if the loan, mortgage / land sale contract or promissory note is an asset.

10. Treatment Of The Transfer Of A Stream Of Income Or The Right To A Stream Of Income

When the client fails to take action necessary to receive income or transfers the right to receive income to someone else for less than CMV, the transfer of resources penalty is applied. The Worker must:

Step 1: Verify the amount of potential annual income.

Step 2: Using the client's age as of his last birthday, determine the Remainder Interest Value in Appendix B.

## NURSING FACILITY SERVICES

Step 3: Multiply the Step 2 amount by the Step 1 amount to determine the uncompensated value.

Step 4: The result from Step 3 is divided by the average monthly nursing facility private pay rate of $6,359 to determine the penalty period.

**NOTE:** A partial month's penalty is imposed for the transfer of an individual or single income payment that is less than the monthly nursing facility private pay rate. See Transfer Penalty Section below for instructions about how to determine and apply partial month penalties.

11. Treatment Of Jointly Owned Resources

Jointly owned resources include resources held by an individual in common with at least one other person by joint tenancy, tenancy in common, joint ownership or any similar arrangement. Such a resource is considered to be transferred by the individual when any action is taken, either by the individual or any other person, that reduces or eliminates the individual's ownership or control of the asset.

Under this policy, merely placing another person's name on an account or resource as a joint owner might not constitute a transfer of resources, depending upon the specific circumstances involved. In such a situation, the client may still possess ownership rights to the account or resource and, thus, have the right to withdraw all of the funds at any time. The account, then, still belongs to the client. However, actual withdrawal of funds from the account, or removal of all or part of the resource by another person, removes the funds or property from the control of the client, and, thus, is a transfer of resources. In addition, if placing another person's name on the account or resource actually limits the client's right to sell or otherwise dispose of it, the addition of the name constitutes a transfer of resources.

If either the client or the other person proves that the funds withdrawn were the sole property of the other person, the withdrawal does not result in a penalty.

12. Transfer Penalty

The transfer of resources penalty is ineligibility for:

- Nursing facility services; and

## NURSING FACILITY SERVICES

- A level of care in any institution, equivalent to that of nursing facility services.

The client may remain eligible for Medicaid, but only services not subject to a penalty are paid. This includes individuals in a nursing facility with income below 300% of the SSI level and who are otherwise Medicaid eligible. This does not apply to ADW Waiver.

The penalty is applied as follows.

a. Start of the Penalty

The beginning date of each penalty period imposed for any uncompensated transfer of resources is the later of:

- The date on which the individual is eligible for and is receiving an institutional level of care services that would be covered by Medicaid if not for the imposition of the penalty period;

OR

- The first day of the month after the month in which assets were transferred and advance notice expires, when the individual receives Long Term Care Medicaid;

AND

- Which does not occur during any other period of ineligibility due to a transfer of resources penalty.

(1) Penalty for Transfers During the Look-Back Period

When resources have been transferred at singular or multiple periods during the look-back period, add together the value of all resources transferred, and divide by the average cost to a private-pay patient of nursing facility services. This produces a single penalty period which begins on the earliest date that would otherwise apply, if the transfer had been made in a single lump sum.

**EXAMPLE:** An individual enters the nursing facility and applies for Medicaid in July 2014. The individual transferred $50,000 in April 2010. Based on the average

## NURSING FACILITY SERVICES

private pay nursing facility rate of $6,359 a month, the penalty is 7 whole months, beginning July 2014 when the individual was otherwise eligible for and receiving an institutional level of care that would have been covered by Medicaid, if not for the imposed penalty. A partial month's penalty of $5,468 is imposed for February 2015. The individual is required to pay this amount to the nursing facility, in addition to the calculated monthly contribution. See item b below.

**EXAMPLE:** Same situation as above but during the penalty period the Worker discovers an additional, undisclosed transfer that occurred during the look-back period. The penalty period is recalculated to include the undisclosed transfer of resources.

**EXAMPLE:** An individual enters a nursing facility in January 2014 and applies for Medicaid in September 2014 with a request for backdated coverage to August 2014. The individual transferred $19,000 in January 2013, $19,000 in February 2013 and $19,000 in March 2013. The Worker must calculate the penalty period by adding the transfers together. The total of $57,000 is divided by the nursing facility cost of $6,359. The penalty period is 8 whole months, beginning in August 2014, because the individual requested backdated coverage to August 2014, and was otherwise eligible for and receiving institutional level of care that would have been covered by Medicaid, if not for the imposed penalty. A partial month's penalty for April 2015 of $6,105 is also imposed. The individual is required to pay this to the nursing facility, in addition to his calculated monthly contribution. See item b below for partial month penalties.

**EXAMPLE:** Same situation as above but after the penalty period ends and the client is receiving Medicaid the Worker discovers an undisclosed transfer occurred during the look-back period. A penalty is assessed and advance notice of an additional transfer penalty is sent to the individual.

## NURSING FACILITY SERVICES

(2) Transfers During a Penalty Period

When an individual is in a penalty period and transfers additional resources during the penalty, a new penalty period begins as soon as the previous penalty ends.

**EXAMPLE:** An individual transfers $70,000 and is serving a 11-month penalty beginning July 2013 through May 2014 with a partial month's penalty of $644 for June 2014. In October 2011, the individual receives an inheritance of $6,500 which he gives to a nephew. There is an assessed penalty of 1 whole month and a partial month's penalty of $130. The new penalty begins July 2014.

**EXAMPLE:** An individual approved for and receiving institutional level of care services receives an inheritance of $100,000 in 2014 and gives the money to his grandson. Advance notice of the transfer penalty is sent in November and the penalty period begins December 1, 2014.

All penalties for resources transferred on or after March 1, 2009 run consecutively.

b. Length of Penalty

The penalty period lasts for the number of whole and/or partial months determined by the following calculation:

Total amount transferred during the look-back period divided by the State's average, monthly nursing facility private pay rate of $211.95/day or $6,359/month.

When the amount of the transfer is less than the average monthly private pay cost of nursing facility care, the agency imposes a penalty for less than a full month. The partial month's penalty is converted to a dollar amount and added to the individual's calculated contribution to his cost of nursing facility care for his first month of eligibility.

The partial month's penalty is determined as follows:

## NURSING FACILITY SERVICES

Step 1: The total amount transferred is divided by the State's average monthly nursing facility private pay rate of $6,359.

Step 2: Multiple the number of whole months from Step 1 by the average private pay rate of 6,359.

Step 3: Subtract the amount in Step 2 from the total amount of all transfers. The remainder is the amount which is added to the individual's calculated contribution.

**EXAMPLE:** An individual makes an uncompensated transfer of $24,534 in the month of application for Medicaid coverage of nursing facility services.

| | | |
|---|---|---|
| Step 1: | $24,534 | Uncompensated transfer amount |
| | ÷ 6,359 | State's average monthly nursing facility private pay rate |
| | 3.8 | Number of months for penalty period |
| Step 2: | $ 6,359 | State's average monthly nursing facility private pay rate |
| | x 3 | Whole months in penalty period |
| | $19,077 | |
| Step 3: | $24,534 | Total uncompensated transfer amount |
| | - 19,077 | Amount for 3 whole months in penalty period |
| | $ 5,457 | Partial month's penalty amount |

If the individual applies in July and is otherwise eligible, the penalty period runs for 3 full months from July through September, with a partial month's penalty calculated for November of $5,457. The October partial month's penalty amount of $5,457 is added to the calculated October contribution for his cost of care. If the individual had a $500 monthly contribution, he is required to pay $5,957 for the cost of care in October.

**NOTE:** The penalty or extra payment is only applied in the last / partial month of the penalty period.

The penalty runs continuously from the first day of the penalty period, whether or not the client leaves the institution.

## NURSING FACILITY SERVICES

There is no maximum or minimum number of months a penalty may be applied.

c. Who is Affected by the Penalty

The institutionalized client is affected by any transfer described above when he or his spouse or any entity acting on their behalf or at their direction transfers an asset.

When the three following conditions are met, any remaining penalty period is divided equally between the institutionalized person and spouse:

- The spouse transferred resources which resulted in ineligibility for the institutionalized client, and

- The spouse either is eligible for or applies for Medicaid and is, then, an institutionalized individual, and

- Some portion of the penalty against the original institutionalized spouse remains when the above conditions are met.

A recording in each affected case must specifically explain the division of the penalty period.

**EXAMPLE 1:** Mr. A enters a nursing care facility and applies for Medicaid. Mrs. A transfers a resource that results in a 36-month penalty against Mr. A. Twelve months into the penalty period, Mrs. A enters a nursing care facility and becomes eligible for Medicaid. The penalty period against Mr. A still has 24 months to run.

Because Mrs. A is now in a nursing care facility, and a portion of the original penalty period remains, the remaining 24 months of the penalty must be divided equally between Mr. and Mrs. A.

**EXAMPLE 2:** Mr. J is in a nursing facility and applies for Medicaid. Two months before his application he transferred resources to become eligible for Medicaid and a 10-month penalty begins. Two months into the penalty, Mrs. J refuses an inheritance left to both of them because she is afraid it will adversely affect his future eligibility for nursing care coverage. The next month, Mrs. J becomes eligible for HCB waiver services. The Worker inquires

## NURSING FACILITY SERVICES

about resource transfers and is told about the refusal of the inheritance. This is a transfer of resources. A penalty period is determined to be 12 months. Mr. J continues to serve his 10-month penalty. The other penalty period begins the month after the 10-month period ends. His second penalty lasts 6 months (½ of the 12-month period for his wife's transfer of their resource). Mrs. J receives a 6-month penalty period which begins the month she is otherwise eligible to receive an institutional level of care.

If the penalty period is not equally divisible, the extra month in the penalty period is assigned to the spouse who actually transferred the resource.

When the penalty period is divided between spouses, the total penalty period applied to both spouses must not exceed the total penalty which remained at the time the penalty was divided.

When, for any reason, one spouse is no longer subject to a penalty, such as, when the spouse no longer receives nursing facility services, or dies, the penalty period which was remaining for both spouses must be served by the remaining spouse.

a. Application of the Penalty

The only penalty for transferring resources is total ineligibility for nursing facility, ICF/MR and Home and Community Based Waiver care. The client is approved, if otherwise eligible, for any other applicable Medicaid coverage group.

C. HOMESTEAD PROPERTY EXCLUSION

A nursing facility resident is entitled to an exclusion of their homestead as a countable asset as long as he has intent to return to his homestead when/if discharged. It is not necessary that the client be medically able to return home to apply the exclusion. It is totally based on the client's intended actions not whether he has the ability. The property to which the person intends to return must be the principal place of residence in which he resided before he went into the nursing home. See Chapter 11.1 for the definition of Principal Place of Residence. If the client's homestead is a multi-unit dwelling, such as an apartment building, the entire property is excluded, not just the portion of the value which corresponds to the portion of the property in which he actually lived. When the client does not have intent to return due to domestic abuse, see Chapter 11.4.

The homestead property need not be in West Virginia. The homestead exclusion applies, regardless of the state in which it is located. The client's expressed

## NURSING FACILITY SERVICES

intent to return to the homestead property does not necessarily affect his West Virginia residency. See Chapter 8 for residency details.

When the client's spouse or dependent relative resides in the primary residence, the homestead property remains excluded, regardless of the client's intent to return. For purposes of the homestead exclusion only, a dependent relative is one who is dependent financially, medically or as otherwise determined dependent upon the institutionalized person: child, stepchild or grandchild; parent, stepparent or grandparent; aunt, uncle, niece or nephew; brother or sister, including relations of the step or half; cousin or in-law.

When the home is rented or vacant this has no bearing on the homestead exclusion, however, when the individual places his home on the market, intent to return no longer exists and home is not excluded.

When the client is incapable of indicating his intent, his Committee, legal representative or the person handling his financial matters will make the determination. The Worker must record the client's statement or intent in the case record. A written statement may be requested but no action may be taken to deny or stop benefits for failure to provide a written statement when the client has expressed his intent verbally or by gesture.

**NOTE:** Once Medicaid eligibility is established, the assets of the community spouse are not counted for the institutionalized spouse. In addition, when assets such as the home and attributed assets legally transferred to the community spouse are subsequently transferred by him, no penalty is applied to the institutionalized spouse.

D. HOME EQUITY

When the equity value of an individual's home exceeds the current maximum allowable amount, he is ineligible for Medicaid payment for nursing home care or waiver services, unless his spouse, child under 21 or disabled adult child resides in the home. Denial of LTC Services due to excessive home equity is subject to the Undue Hardship Waiver Provision. See Chapter 11, Section 11.1 for the definition and current amount.

E. LONG-TERM-CARE INSURANCE PARTNERSHIP (LTCIP) ASSET DISREGARD

1. Introduction and Purpose

West Virginia's participation in the Long-Term-Care Insurance Partnership (LTCIP) is established by §9, Article 4E-1 of the WV Code. The LTCIP Asset Disregard results from a combined effort between Federal Medicaid,

## NURSING FACILITY SERVICES

the Department, long-term-care insurers and the WV Insurance Commission in accordance with Section 1917 of the Social Security Act. The Disregard provides an incentive to individuals to provide for their own long-term-care needs through the purchase of a Qualified LTCIP Policy, while protecting their assets.

2. Definitions

For purposes of the LTCIP Asset Disregard only, the following definitions apply:

OFS-LTCIP-1 – This form is given to the applicant for completion by the individual's insurance carrier or other individual who can attest to the Policy's details and benefits paid. Other sources of verification are listed in Section 4.2.

Partnership (Qualified) States – States that are participating in the LTCIP. Each Partnership State has an approved State Plan Amendment (SPA) that indicates the date the State implemented the LTCIP. West Virginia's SPA implemented the LTCIP as of July 1, 2010.

Qualified LTCIP Policy – A LTC Policy that meets certain requirements of federal and state law. These Policies are issued by Partnership (Qualified) States as of the date the State implemented the LTCIP.

Reciprocity – A reciprocal relationship exists between Partnership States that allows a resident with a Qualified LTCIP Policy in one Partnership State who later moves to another Partnership State, the same asset protection he previously had.

3. Individuals Who May Receive the Disregard

The LTCIP Asset Disregard is available to the aged, blind or disabled institutionalized individual with income equal to or less than 300% of the SSI payment level for 1 but whose individual resources exceed the asset limit.

4. Verifications Required

When an individual states he has a LTC policy that has paid insurance benefits to him or on his behalf, the Worker evaluates him for the Disregard.

a. Verification of Individual's Residency and Status of Policy-Issuing State at the Policy's Issuance.

## NURSING FACILITY SERVICES

To be eligible for the Disregard, the Policy owner must have been a resident of a Partnership State AND the issuing State must have been a Partnership State at the time the Policy was issued.

- When a West Virginia resident verifies ownership of a Qualified LTCIP Policy issued by a WV Insurer or another Partnership State with an issuance date as of July 1, 2010 and the individual verifies insurance payments made to him or on his behalf as of that same date, his individual resources may be disregarded dollar-for-dollar in the same amount as the insurance payments made. His resources are protected in this same amount at Estate Recovery.

NOTE: Questions about the Estate Recovery process must be referred to the current contract agency. Information about this agency is in Appendix I.

**EXAMPLE:** Joan Arbuckle applies for Medicaid October 16, 2011 and states she has a WV-issued LTC policy that has been paying insurance benefits to her since her institutionalization August 2011. Her OFS-LTCIP-1 indicates her policy was purchased April 1, 2010. The applicant has a LTC policy but it is not a Qualified LTCIP Policy since WV was not a Partnership State until July 1, 2010. Joan's assets cannot be disregarded.

**EXAMPLE**: Troy Jacobs is a lifelong WV resident. He owns a Florida-issued Qualified LTCIP Policy purchased January 1, 2009 which is after the date Florida became a Partnership State, January 1, 2007. West Virginia became a Partnership State July 1, 2010; therefore, since Mr. Jacobs was not a resident of a Partnership State when his Policy was issued, he is ineligible for the Disregard.

**EXAMPLE:** Frederick Randolph is a lifelong WV resident. He purchased a Qualified LTCIP Policy from Minnesota September 1, 2010 and applied for Medicaid February 11, 2011. Since Minnesota became a Partnership State July 1, 2006, his Policy was issued by a Partnership State at the time of purchase and he was also a resident of WV, another Partnership State at that time; therefore, as long as he verifies insurance payments made after July 1, 2010, he is eligible for the Disregard to be applied to his individual resources in the amount of insurance payments made.

- When a West Virginia resident was a former resident of a Partnership State and purchased a Qualified LTCIP Policy issued by that state, as long as his Policy was issued as of the

## NURSING FACILITY SERVICES

date of his former State's SPA that implemented the LTCIP and insurance payments occurred as of that same date, he is afforded the same asset protection he previously had prior to becoming a WV resident.

**EXAMPLE**: Millard Clinton was a resident of Virginia before establishing WV residency in January 2011. He purchased a LTC policy from VA on May 1, 2007 the same day VA became a Partnership State. Mr. Clinton verifies being institutionalized in VA and his $62,000 in assets were disregarded due to insurance payments paid on his behalf in 2009 and 2010 that exhausted his $75,000 Policy. His assets continue to be protected by the Disregard and he is eligible for WV Medicaid.

**NOTE:** The Policy's benefits need not be exhausted before the Disregard is applied.

- When an individual exchanges a Qualified LTCIP Policy issued by his former state of residence for a WV Policy, eligibility for the Disregard is evaluated based on the first State's SPA, Policy issuance date and dates of insurance payments made.

  **EXAMPLE:** Mr. Walter Lytle was formerly an Ohio resident. He exchanges his Ohio-issued Qualified LTCIP Policy for a WV-issued Policy. He is evaluated for the Disregard based on the circumstances surrounding the first Policy's issuance. Ohio became a Partnership State September 1, 2007. His Policy was issued January 1, 2008 and insurance benefits were made after this same date; therefore as long as insurance payments made on his behalf equal or exceed his individual resources, the Disregard can be applied.

b. Verification of the Qualified LTCIP Policy

The LTCIP Asset Disregard requires that the LTC policy is a Qualified LTCIP Policy. The OFS-LTCIP-1 is used to verify information about the individual's policy. See Chapter 4, Section 4.2 for other sources of verification. When the individual provides the Worker with the Policy, the following determines if the policy is qualified for the Disregard:

- The individual was a resident of a Partnership State when his Policy was issued; AND

  **NOTE:** When an individual exchanges his Qualified LTCIP Policy issued by his former state of residence for a WV Policy, eligibility for the Disregard is evaluated based on the first

## NURSING FACILITY SERVICES

State's SPA date, Policy issuance date and dates of insurance payments made.

- The Policy meets the Internal Revenue's Code of 1986 requirements related to the LTCIP; AND

- The Policy's issuance date was no earlier than the effective date of the issuing Partnership State's SPA that implemented the LTCIP; AND

- The Policy meets the specific rules of the National Association of Insurance Commissioners (NAIC); AND

- The Policy includes inflation protection based on the age of the insured at the time of purchase

**NOTE**: Changes made to the LTCIP Policy after issuance will not affect the Disregard as long as the Policy continues to be Qualified.

**NOTE:** The LTCIP Asset Disregard is not revoked if a State withdraws from the Partnership.

**EXAMPLE**: An applicant states he has a LTC policy that has paid him $35.00 per day for each day of his institutionalization and he requests the Disregard applied to his $3,000 in excessive assets. The applicant provides the Worker with a copy of his policy. The policy does not indicate compliance with the IRS Code nor does it address inflation protection. The policy is not a Qualified LTCIP Policy and the applicant is ineligible for the Disregard.

c. Verification of Qualified LTCIP Insurance Benefits Paid

The OFS-LTCIP-1 is used to obtain information about the dates of, amount of Qualified LTCIP insurance benefits paid, and the remaining benefits available to the individual. When the individual does not complete this form, the Worker must verify the amount of insurance benefits paid to or on behalf of an individual as of July 1, 2010 when the individual is a WV resident with a WV-issued Qualified LTCIP Policy or owns a Qualified LTCIP Policy issued from another Partnership State.

**NOTE:** The Policy's benefits need not be exhausted before the Disregard is applied.

## NURSING FACILITY SERVICES

5. The Amount of the Disregard

The amount of the Disregard is specific to the individual. Resources are disregarded dollar-for-dollar in the same amount as the amount paid out by the insurance company.

Resources are disregarded in part or in entirety. See number 6 for how the Disregard is applied in the data system and documented.

6. Applying the LTCIP Asset Disregard at Application and Redetermination

a. Applying the Disregard at Application

When there is a community spouse, the countable assets of the couple are combined and the asset assessment is completed. The Disregard is applied to the individual's assets at eligibility determination.

The amount of the Disregard is determined by the amount of payments made to the individual or on his behalf since July 1, 2010. The Policy's benefits need not be exhausted for the Disregard to be applied. The resource(s) to which the Disregard is applied may be disregarded in part or in entirety.

When a resource is disregarded in its entirety, the Worker indicates in the data system that the resource is inaccessible and details in CMCC that the LTCIP Asset Disregard was applied. The corresponding insurance payments made, date of last payment and the amount of benefits remaining in the Policy is documented to track the assets that were protected.

**EXAMPLE:** Peggy Lohr is eligible for the Disregard. She has a bank account with a balance of $27,000. Insurance benefits from her Qualified LTCIP Policy totaling $27,000 have been paid to her. In the data system, an account totaling $27,000 is entered on AALA and listed as inaccessible. The Worker documents the application of the Disregard, dates of payments made that resulted in her becoming eligible for Medicaid and the amount of benefits remaining under Peggy's Policy.

An asset to which the Disregard is applied in part and results in eligibility being established is entered in the data system as two assets, one inaccessible and one with the remaining value after the Disregard is applied. Documentation is detailed on CMCC.

## NURSING FACILITY SERVICES

**EXAMPLE**: An individual has $12,000 in a savings account. He has a WV-issued, Qualified LTCIP Policy that was purchased August 1, 2010. The Worker verifies the Policy has paid out $10,000 on the applicant's behalf since that same date. The Worker applies the Disregard and enters a $10,000 savings account as inaccessible. The Workers enters the remaining $2,000 on a second screen and details the information on CMCC.

As long as the individual's assets remain the same, the protection of the resources that resulted in the recipients' eligibility continues throughout the recipient's Medicaid periods of eligibility. See item b below when the individual's resources increase in value or he transfers a resource for less than FMV.

**NOTE**: Even though an individual is eligible for the Disregard and Medicaid, a determination is necessary regarding to whom the LTCIP insurance payment is made. The Worker must determine if the payments are income to the individual or a third-party payment.

**NOTE**: If the individual is applying for additional benefits, the data system's asset screens are re-evaluated in accordance with each program's requirements and the absence of the LTCIP Asset Disregard.

b. Applying the Disregard at Redetermination

The Worker must track the assets of the recipient, insurance payments made to or on the recipient's behalf and assets disregarded since the previous application.

Medicaid eligibility is reevaluated when the recipient reports transferring a previously disregarded asset, obtaining an additional asset or an asset increasing in value.

**NOTE:** The LTCIP Asset Disregard is not revoked if a State withdraws from the Partnership.

A transfer of an asset that was previously disregarded is not subject to a transfer penalty.

## NURSING FACILITY SERVICES

If the value of the individual's assets increase or the individual obtains an additional countable asset that causes him to exceed the allowable asset amount, he will need to verify additional payments made on his behalf by the LTCIP Policy in addition to the amount of payments that were previously used to disregard the assets that were transferred. Additionally, the amount of the individual's estate that was protected from Estate Recovery is reduced by the same amount as the value of the asset that was transferred.

**NOTE**: Questions about the Estate Recovery process must be referred to the current contract agency. Information about this agency is in Appendix I.

**EXAMPLE**: Mr. Watts is in a nursing facility. On September 1, 2010, Mrs. Watts applied for LTC services for her husband. The couple's assets are combined at asset assessment and the spousal share is attributed to Mrs. Watts. Mr. Watt's income is less than 300% of the SSI payment for 1 but he has $12,000 in individual assets consisting of $5,000 in an accessible money market account and $5,000 in stocks. He is asset-ineligible for LTC by $10,000. He verifies ownership of a $100,000 Qualified LTICP Policy which he purchased July 12, 2010. The Worker verifies the Policy's status and that his Policy has paid for his care in July and August paying $10,000 to the nursing home. The Worker disregards his money market and stocks and Medicaid eligibility is effective September 1, 2010.

At redetermination, Ms. Watts reports transferring the stock to their son. The transfer is not subject to a penalty since the asset was previously disregarded. However, since insurance payments verified as paid by the LTCIP Policy on behalf of Mr. Watts were applied to disregard the value of the stock, and resulted in Mr. Watts being eligible for Medicaid, these same insurance payments cannot be used again to disregard other assets. Should Mr. Watt's money market increase in value or the he acquire additional countable assets, he must verify additional payments by the insurance company before any other assets can be disregarded.

## NURSING FACILITY SERVICES

Mr. Watt's amount of assets that were protected at Estate Recovery is also reduced from $10,000 to $5,000 since the previously disregarded stock was transferred to his son.

**NOTE:** Even though an individual is eligible for the Disregard and Medicaid, a determination is necessary regarding to whom the LTCIP insurance payment is made. The Worker must determine if the payments are income to the individual or a third-party payment.

**NOTE:** If the individual is no longer eligible for Medicaid under the 300% gross income test, his eligibility for other Medicaid groups is evaluated prior to closure and the data system's asset screens are re-evaluated in accordance with each program's requirements and the absence of the LTCIP Asset Disregard.