COMBINED MEDICAID 404-1
Asset Transfers

Supersedes: CMA 404-1 (June 16, 2022)

Reference: 42 U.S.C. §1396p (c)(1)(F) through (I) and 42 U.S.C. 1396p (e); ARM 37.82.101 and .417; P.L. 109-171; P.L. 109-432

Overview:
ACA and ABD: Institutionalized or Home and Community Based Service/Waiver (HCBS/Waiver) Medicaid benefits cannot be provided to otherwise eligible Medicaid clients if a disqualifying asset transfer has occurred.
A disqualifying asset transfer occurs when:

1. Assets are transferred for less than FMV (Fair Market Value);
2. The transfer occurred during either the 60-month look-back period or after Medicaid eligibility is established, AND;
3. The transfer is not an exempt transfer as described later in this section.

In addition to selling and giving away property, disqualifying asset transfers may include, <u>but are not limited to</u>, actions such as:

- Establishing a trust;
- Forgiving a debt without obtaining fair market value;
- Decreasing the extent of ownership interest in an asset;
- Forfeiting or assigning the right to a stream of income;
- Making an unsecured loan; or
- Giving up or limiting their rights or access to or interest in an asset, or in some instances, purchasing an annuity.

<u>LOOK-BACK PERIOD</u>:
The look-back period begins the date an institutionalized or HCBS/Waiver individual (married or single) requests Medicaid coverage. The look-back period is 60 months for all transfers, including trust payments to or for the benefit of a person or entity other than the Medicaid client.

NOTE: Uncompensated asset transfers made after application are also subject to penalty. The date of the first Medicaid application while the individual is either in a long-term care facility or qualifies for waiver services establishes the look-back period; application disposition (approved or denied for any reason) does not matter. Only one look-back period is established for each client, regardless of the number of times they are institutionalized or submit applications. Once the look-back period is established, all asset transfers after that date must be evaluated and, if necessary, a penalty calculated.

When retroactive coverage is requested, the look-back period begins the first day of the first retro month requested, provided LTC eligibility exists (e.g., application received December 15, 2015, and retro coverage is requested and LTC eligibility begins October 1, 2015, look-back period begins October 1, 2010).

ASSETS:

Assets include all resources and retained income the client and/or their spouse:

1. Owns;
2. Is entitled to receive;
3. Is entitled to receive the benefit of (such as being a beneficiary of a trust); or
4. Would be entitled to receive except for some action or inaction which results in failure to obtain the asset.

NOTE: Assets that comprise the client's $2000 allowable resources are NOT subject to asset transfer rules. However, excluded assets, specifically the client's home, are subject to these rules.

PURCHASE OF AN ANNUITY:

If either the client or their community spouse purchases an annuity, an uncompensated asset transfer is evaluated. Annuities purchased or converted on or after February 8, 2006, by a Medicaid client or community spouse are considered uncompensated asset transfers (subject to rebuttal) unless the:

1. The annuity payments are made to the Medicaid applicant/recipient or community spouse;
2. Periodic scheduled payments are required at least annually;
3. Payment contract calls for equal payments; no deferred or balloon payments;
4. Payment schedule is actuarially sound (equal payments are based on expectation of a full payout within the annuitant's life);
5. Annuity is irrevocable;
6. Annuity is non-assignable; **AND**
7. Annuity names the Montana Medicaid Program as the irrevocable first position residual beneficiary. Refer to CMA 402-1 Countable and Excluded Resources.

Certain changes to an annuity are considered annuity conversions. These include annuitizing a previously un-annuitized annuity or change an annuity from one type to another. Automatic events such as the start of pre-arranged payments or other actions taken by the annuity company that are not voluntary on the part of the annuity owner are

not considered conversions. If payments are made to the account owner, the following are not considered uncompensated asset transfers and do not require beneficiary assignment to the State of Montana Medicaid Program:

1. an individual retirement annuity [subsection (b) of section 408 of the IRS Code of 1986], a qualified employer plan annuity [subsection (q) of section 408 of the IRS Code of 1986];
2. purchase of an annuity with an IRA, employer or employee association account;
3. a qualified salary reduction arrangement [section 408(a), (c), or (p) of the IRS Code of 1986]; OR
4. a simplified employee pension [within the meaning of section 408(k) of the IRS code if 1986].

If one of these situations is alleged, request assistance from the policy specialist in determining whether the criteria are met.

ANNUITIES PURCHASED AFTER ELIGIBILITY DETERMINATION:

If the Medicaid client or their community spouse purchase an annuity after eligibility has been determined, they must report that purchase following normal change reporting requirements and must amend the annuity to meet the above requirements to remain eligible. If the community spouse refuses to make the Montana Medicaid Program the primary remainder beneficiary, the purchase is considered an uncompensated asset transfer and results in a penalty being imposed against the nursing home spouse. The exemptions listed below do not apply to this requirement. Even if the annuity meets #1-7 above, other events may result in an annuity being considered an uncompensated asset transfer. These include, but are not limited to, taking any action that causes the annuity to be inaccessible (versus irrevocable/non-assignable).

JOINTLY OWNED:

Any action taken to reduce the Medicaid client's or spouse's ownership, or control of an asset held in sole ownership, or with another individual under joint tenancy, tenancy in common, joint ownership or another similar arrangement, is considered a transfer.

EXAMPLES:

1. Jim adds his daughter's name to his checking account. If she uses any of the funds for anything other than providing for Jim, an asset transfer has occurred.
2. Tom decides to add his daughter's name to his home's title. She now must agree to sell/dispose of the home, which wasn't previously necessary. Because Tom's right to sell/dispose of his home has been limited, adding his daughter's name to the title is considered an asset transfer.
3. The community spouse (CS) removes her husband's (nursing home spouse) name from a joint CD and adds her daughter's name; this is done during the 90-day period when assets allocated to the CS must be transferred from the nursing home spouse to the CS. Substituting her daughter's name for the nursing home spouse's name on this document results in an uncompensated asset transfer.

The CS should have simply removed her husband's name so she had full ownership. Replacing his name with her daughter's is transferring his assets to a third party.

<u>WHO TRANSFERRED ASSET</u>:
Assets transferred by the client and/or their spouse are evaluated as if the client made the transfer. Assets are also considered transferred by the client or their spouse when they are transferred by:

- A parent;
- A guardian;
- A court; or
- Anyone acting on behalf of or at the direction of the client or their spouse, such as an attorney;
- A Community Spouse:

NOTE: If the client or their spouse refuses to accept an asset, it is considered a transfer. This includes, but is not limited to, waiving pension income or right to inherit, spouse's failure to seek their elective share of the deceased spouse's estate.
See ABD 404-5 Pursuing Claims on Property and Estates.

An asset transfer is evaluated when the:

1. institutionalized or community spouse transfers an individually or jointly owned asset to someone other than the community/institutionalized spouse prior to the Institutionalized or Waiver Medicaid be established for the institutionalized spouse or, within the 90-day Community Spouse Resource Maintenance Allowance (CSRMA) resource transfer process; and
2. institutionalized spouse transfers the own individually or jointly owned asset after the 90-day resource transfer process.
    a. If the Community Spouse transfers their own individually owned asset (or an asset jointly owned with someone other than the Institutionalized Spouse) after the 90-day CSRMA resource transfer process, the asset transfer will be evaluated if/when the Community Spouse later applies for Institutionalized or Waiver Medicaid for themselves.

Asset transfers are not evaluated when:

1. The asset was, under spousal impoverishment rules, transferred to a spouse prior to nursing home or waiver eligibility determination.
2. The institutionalized or waiver spouse transferred the asset to the community spouse during the 90-day transfer period or the asset was part of the Community Spouse Resource Maintenance Allowance.
3. The asset was transferred to the asset owner's disabled/blind (per SSA criteria) minor or adult child.
4. The client's home is transferred <u>and</u> the title is transferred to:
    a. The owner's spouse;
    b. The owner's child under age 21;

c. The owner's permanently blind or disabled (per SSA criteria) adult child;
d. The owner's child (of any age) who:
    i. Lived with the client for two years immediately prior to the client entering the nursing home; AND
    ii. Provided care that allowed the client to remain at home (doctor's statement must confirm that care provided delayed nursing home entry)
e. The owner's sibling who:
    i. Has equity interest in the home; AND
    ii. Continually lived in the home for at least one year prior to the client entering the nursing home.

5. The asset was transferred solely for a purpose other than qualifying for Medicaid, such as to satisfy a <u>legally enforceable</u> debt. The timing of debt payments must be considered. If an old debt that allegedly has been outstanding for years is suddenly remembered, but there is no convincing evidence that the client acknowledged or attempted to satisfy it or that the person(s) owed the debt previously attempted to collect it, debt validity and whether the debt is legally enforceable may be questionable.
6. The assets were transferred into the individual's qualifying Special Needs Trust (see CMA 402-3 Trust Funds).
7. The assets were transferred to the individual's pooled trust (see CMA 402-3 Trust Funds) before the individual reached age 65.
8. Eligibility denial will cause the client undue hardship.

<u>UNDUE HARDSHIP</u>:

An undue hardship exists <u>only</u> when:

1. The application of an asset transfer 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; OR
2. Fraud, misrepresentation, or coercion against the client and/or their spouse resulted in the transfer; AND
    a. The client and/or their spouse have explored and pursued all reasonable legal recourse to reacquire the asset or its value.

Legal recourse includes, but is not necessarily limited to, filing a civil court action, and once filed, diligently pursuing the civil action to its conclusion. Mediation may be a reasonable step in resolving a legal claim. If the proven costs of legal pursuit exceed the transferred asset's value, it is not considered reasonable legal recourse. Due to the potential availability of pro bono or reduced-fee legal services, costs of legal pursuit cannot be based solely on attorneys' fees.

NOTE: Filing criminal charges against the person who received the assets through fraud, misrepresentation or coercion or filing a police report does not fully satisfy the requirement to pursue all legal recourse.

The transferred resources are considered inaccessible once legal recourse is initiated (e.g., court action is filed) and remain inaccessible while legal recourse is diligently pursued to a conclusion.

RECOVERED ASSETS:
If transferred resources are recovered in whole or in part, the recovered assets are treated as if they were never transferred when determining eligibility.

DETERMINING UNCOMPENSATED VALUE:
An uncompensated asset transfer occurs when the owner receives less than the asset's FMV on the transfer date. Compensation means money, real or personal property, food, shelter, or services:
Compensation examples

- The client or spouse receives at or after the transfer in exchange for the resource IF compensation was provided under a legally enforceable agreement in effect when the transfer occurred, OR
- Received before the transfer occurred and provided under a legally enforceable agreement in which the client agreed to transfer the asset in exchange for the goods or services received.
- Compensation may also include assumption of the client's legal debt in exchange for the asset. Compensation does not include services or gifts previously provided to the client out of love or concern with no expectation or promise of payment.

Determine the value of future compensation (services, food, or shelter) based on the compensation's FMV for the time period the client is reasonably expected to receive the support or maintenance beginning with either the date of transfer or date of contract, whichever is earlier (See ABD 016 Life Expectancy Table).

Services provided through a personal care contract cannot duplicate services that are being provided or are available as part of another existing contract, or encompassed by the package of services provided by a nursing home, assisted living facility, or adult foster home in which the individual is residing.
For example, nursing homes provide dietary services, and, when necessary, assistance in eating; a separate contract paying a third party to also provide assistance in eating is not a valid personal care contract expense.
Contracts and payments for duplicative services are considered uncompensated asset transfers.

Personal care contracts drafted after 05/31/2022 must include the following:

1. Agreement/contract must be in writing prior to the delivery of the personal care services

2. Agreement/contract must be created before an application for Aged, Blind, or Disabled
3. Medicaid is received or before an additional level request (Nursing Home and/or Waiver) is received.
4. Agreement/contract must detail which services are included and which are excluded for the purposes of compensation (e.g., non-medical care only, meal preparation, light housekeeping, bookkeeping, transportation, assistance with activities of daily living).
5. Must be signed by both the care recipient and the person agreeing to perform the services. (If the recipient is unable to sign due to mental incapacity, their power of attorney must sign).
6. Agreement/contract must have a begin date and end date
   Such as:
   a. § Contract will end once individual enters the nursing home
   b. § Contract will end upon individual's death
   c. § Contract will end once personal care services are no longer needed
7. Must specify rates for services that are comparable to rates charged by commercial care provider located in the same general area – rates are charged at Fair Market Value.
   a. Based on the US Bureau of Labor Statistics Occupational Handbook (www.bls.gov)
8. Any unused amount of the contract is to be repaid to Montana Medicaid if the claimant passes away before their actuarial life expectancy.
   a. Providing that upon the death of the individual, the State Medicaid Program will receive all amounts of unpaid services remaining in the agreement/contract up to the total amount of medical assistance paid on behalf of the individual during his or her lifetime.
9. Services cannot be duplicative
   a. For example, nursing homes provide dietary services, and, when necessary, assistance in eating; a separate contract paying a third party to also provide assistance in eating is not a valid personal care contract expense.
10. Agreement/Contract is actuarially sound in accordance to the life expectancy table in ABD 016 Life Expectancy Table

Services will be considered an uncompensated asset transfer if:

1. Services are duplicative
   a. For example, nursing homes provide dietary services, and, when necessary, assistance in eating; a separate contract paying a third party to also provide assistance in eating is not a valid personal care contract expense.
   b. § Only the specific duplicative service will be looked at as an uncompensated asset transfer
2. Agreement/contract is created after an application for Medicaid is received

3. Service(s) provided is charged at a rate higher than Fair Market Value (FMV).
    a. FMV is determined by using the US Bureau of Labor Statistics Occupational Outlook Handbook (www.bls.gov)
4. Agreement/Contract is not actuarially sound in accordance to the life expectancy table in ABD-016
5. There is no repayment agreement to Montana Medicaid.

Legal Authority: Deficit Reduction Act of 2006

The uncompensated value is the asset's FMV less any compensation received per the above policy. A stream of income's FMV is the total annual payments multiplied by the life expectancy of the person on whose lifetime payments are based.

EXAMPLE:

Anthony, who is 85 years old, is entitled to $300 per month in annuity payments for the remainder of his life. The value of this 'stream of income' is $300/month X 12 months X 6.00 (Anthony's life expectancy per ABD 016 Life Expectancy Table), or $21,600.

NOTIFICATION:

The client must be notified that a disqualifying transfer penalty has been identified **before eligibility is approved or denied**. The notice must:

1. Notify the client an uncompensated asset transfer is identified;
2. Provide the transferred resource's value; and
3. Explain the client's right to rebut the presumption that the transfer was made to qualify for Medicaid.

If the client fails to respond within 15 days, it is assumed that no rebuttal will be received. The asset transfer penalty is established and applied to the case.

TRANSFER REBUTTAL STATEMENT:

All asset transfers are presumed to have been made in order to qualify for Medicaid. When the client rebuts the presumption that a transfer occurred to qualify for Medicaid, the client is responsible to provide proof the transfer occurred exclusively for another reason. The rebuttal statement must include:

1. The reason(s) the asset was transferred;
2. Documentation of attempts to sell the asset at fair market value;
3. Documentation that fair market value was received or the reason for accepting less than fair market value;
4. Proof the client had sufficient means to support themselves after the transfer; and
5. The client's relationship to the individual who received the asset in transfer.

CONVINCING EVIDENCE:

Factors that may indicate a transfer was not made to qualify for assistance include:

- One of the following occurs after the asset is transferred:

    - Traumatic onset disability;
    - Diagnosis of a previously undetected disabling condition;
    - Unexpected loss of income and/or resources with value sufficient to preclude Medicaid eligibility.
- Total countable assets (including those transferred) are less than the $2000/$3000 resource limit during each month of the look back period;
- The transfer was court-ordered in a contested court action; or
- Hardship applies (see above on this subject).

NOTE: Consider the transferred asset inaccessible when a civil suit has been filed in district court, and the suit is pending but being actively pursued, as required to maintain a hardship exemption.

LONG TERM CARE PARTNERSHIP ASSETS:

Asset transfer provisions apply to assets held under a Long Term Care Partnership. If the client transfers these assets prior to their death, asset transfer penalties are evaluated and applied, subject to other exceptions.

SEE BUSINESS PROCESSES: Asset Transfer Evaluation, and Asset Transfer Undue Hardship Exception Process

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