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SUBJECT: FAST-TRACK REGULATIONS

AGENCY: DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

21 Va. Regs. Reg. 2125

VIRGINIA ADMINISTRATIVE CODE CITATION: 12 VAC 30-40, 30-40-290, 30-40-300

TITLE 12. HEALTH

[A> UPPERCASE TEXT WITHIN THESE SYMBOLS IS ADDED <A]

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To view a specific page, enter p* and the page number. E.G. P*1.

Title of Regulation: 12 VAC 30-40. Eligibility Conditions and Requirements (amending 12 VAC 30-40-290 and 12 VAC 30-40-300).

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Public Hearing Date: N/A — Public comments may be submitted until June 3, 2005.

(See Calendar of Events section for additional information)

Effective Date: June 20, 2005.

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Basis: Section 32.1-325 of the Code of Virginia grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. Section 32.1-324 of the Code of Virginia authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the board's requirements. The Medicaid authority as established by § 1902(a) of the Social Security Act (*42 USC § 1396a*) provides governing authority for payments for services.

Sections 1917(c) and (d) of the Social Security Act permit policies regulating the use of annuities as vehicles used to shelter assets that could otherwise be available to individuals for their own purchase of long-term care services.

Purpose: This regulatory action is not expected to have a direct effect on the health, safety, and welfare of either Medicaid recipients or the citizens of the Commonwealth. It will, however, have an indirect effect by preventing individuals who could afford to purchase their own long-term care services, from using public funds thereby releasing the use of such funds for the truly impoverished.

This regulatory action is proposed to reduce the sheltering of assets through purchases of annuities by individuals as a means to impoverish themselves to enable their qualification for Medicaid eligibility. Such Medicaid eligibility permits these individuals who could afford to pay for their own long-term care services to obtain such services with public funds while passing along their protected assets to their heirs. This proposed action will establish rules to eliminate the loophole that currently exists.

Annuities are usually purchased in order to provide a source of income for retirement. However, they are also sometimes used to shelter assets so that the purchaser of the annuity or the purchaser's spouse can qualify for Medicaid. This regulatory package will eliminate the abusive sheltering of assets through the purchase of annuities in order to achieve Medicaid eligibility when those individuals who purchase annuities have the ability to pay for such care themselves.

Rationale for Using Fast-Track Process: DMAS is proposing this fast-track action as the most expedient way to close up the existing loophole in its current policies that permit wealthy individuals to protect their estates for the benefit of their heirs while using scarce Medicaid public funds to pay for their long-term care services. DMAS does not definitively expect objections to this proposed action but may receive them from wealthy individuals and their attorneys who benefit financially from the establishment of the annuities discussed herein.

Substance: Federal Medicaid law defines "assets" as all moneys received and everything owned.

Federal Medicaid law defines "resources" as cash and any other personal or real property that an individual (or spouse, if any) owns; has the right, authority, or power to convert to cash (if not already cash); and is not legally restricted from using for his/her support and maintenance.

Federal Medicaid law defines "patient pay" as that portion of the individual's costs of long-term care (usually nursing facility care) that the individual pays. Such patient pay amounts reduce the amount that Medicaid must contribute to the nursing facility for the cost of care for the individual.

Historically, Medicaid programs across the nation have increasingly observed individuals transferring their financial resources in order to deliberately impoverish themselves. Such resource transfers permits these individuals to secure the needed long-term care services, typically nursing facility care, while protecting their estates for their heirs. Such actions violate both the intent and spirit of Medicaid law that was originally designed to provide health care services for poor persons. These actions have come to be more prevalent as life expectancies have increased and as the costs of long-term care have steadily increased.

One consequence of these nationwide trends was the passage by Congress, in 1993, of the Omnibus Budget Reconciliation Act (OBRA 1993). One important provision of OBRA 1993 were restrictions on the transferring of resources that were codified at Title XIX, § 1917 (c) and (d).

As permitted by federal law, Medicaid currently disregards as a countable resource the value of an annuity, if the expected return on the annuity is actuarially sound, or is commensurate with a reasonable estimate of the life expectancy of the beneficiary. So long as the return on the annuity is commensurate with the annuitant's statistical life expectancy, the transfer is deemed a fair market value transaction and the payments from the annuity, no matter how large, are viewed as income and not as assets. If the amount of money transferred into an annuity is large, the Commonwealth will be [*2126] paying for the long-term care of an individual who has the ability to pay for such care himself. As long as an annuity pays out its full principal plus interest during an individual's life expectancy, the annuity is actuarially sound. If the individual lives to his full statistical life expectancy, the state and federal governments are not harmed because the income from the annuity will become part of the patient pay amount and accordingly reduce medical assistance payments to the long-term care provider. However, only a certain percentage of individuals will live as long as or longer than their statistical life expectancy. The remainder of individuals will die before reaching their statistical life expectancy. In these cases, the Commonwealth does not receive in income the full value of the purchase price of the annuity under the current regulations. Thus, the Commonwealth loses that part of the purchase price. The effect is the same as if the lost portion were to be given away without a transfer of asset penalty.

In recent years, the department has seen an increasing incidence of the purchase of annuities by applicants for Medicaid long-term care services. Many of the annuities are from an insurance company or bank; however, others are classified as "private annuities" or agreements between two individuals where assets other than cash are involved. Many of these annuities are actuarially sound based on life expectancy tables; however, they do not generate equal monthly payments based on the principal and oftentimes are set up wherein the beneficiary receives small annual payments of interest only and a final large balloon payment at the annuity's maturity date.

DMAS proposes to define, for Medicaid eligibility purposes, an annuity to be a contract reflecting payment to an insurance company, bank, or other registered or licensed entity by which one receives fixed, nonvariable payments, with no balloon-end-point payments, on an investment for a lifetime or a specified number of years. In addition to defining an annuity, these regulations address how an annuity will be evaluated as an asset/resource for Medicaid purposes. The regulations provide that:

1. An annuity containing a balloon payment will be considered an available resource.

2. A commercial (nonemployment-related) annuity purchased by or for an individual using that individual's assets will be considered an available resource unless it meets all of the following criteria. The annuity (i) is irrevocable; (ii) pays out principal and interest in equal monthly installments (no balloon payment) to the individual over the total number of months that equals the actuarial life expectancy of the annuitant; (iii) names the Commonwealth of Virginia as the residual beneficiary of funds remaining in the annuity, not to exceed the amount of any Medicaid funds expended for the individual during his lifetime for Medicaid-covered services; and (iv) is issued by an insurance company, bank, or other registered or licensed entity approved to do business in the Commonwealth of Virginia, or, if issued in a jurisdiction other than the Commonwealth, is licensed to do business in the jurisdiction in which the annuity is established. Payments from the annuity to the Commonwealth cannot exceed the total amount of funds for long-term care services expended on behalf of the Medicaid recipient.

3. Annuities issued prior to the effective date of these regulations that do not provide for pay out of principal and interest in equal monthly installments and for which documentation is received from the issuing company that the "pay out" arrangements cannot be changed, will be considered to meet these new requirements once amended to name the Commonwealth of Virginia as the residual beneficiary of funds remaining in the annuity, not to exceed the amount of any Medicaid funds expended on the individual during his lifetime.

Under these proposed regulations, annuities that contain a balloon payment will be counted as an available asset/resource. Annuities that feature a balloon payment have increased in popularity as a means to sheltering assets because such annuities pay out small amounts initially. This allows the owner to qualify for Medicaid since annuitized payments are considered income, not assets, under Medicaid rules. At the end of the contract period, the owner is due the remainder of the guaranteed payout of the annuity, which can be a large lump sum. If the owner remains alive at the contract's end, he could purchase another balloon annuity, effectively sheltering his assets again.

If an annuity is revocable, it can be redeemed or sold by the individual and its market value counted as a resource in determining the individual's Medicaid eligibility. These funds are available to the individual and the individual's assets should be utilized to pay for the individual's long-term care costs prior to the expenditure of public funds that are intended to provide services to the truly needy.

Compelling individuals to name the Commonwealth as a remainder beneficiary to their annuities narrows the loophole that currently exists. Under the proposed regulation, an individual will remain able to utilize annuities as a tool to turn his assets into an income stream for the care of himself or his community spouse; however, the individual will not be able to hide excess assets or remove them from the reach of the Commonwealth by placing them in an annuity. In essence, the Commonwealth is seeking to treat remaining annuity payments as excess assets belonging to the individual and asking for remaining funds to revert to the Commonwealth when they are no longer of use to the individual or his spouse.

The fair market value of annuities with the Commonwealth as a named remainder beneficiary will continue to depend on actuarial soundness. The expected return on the annuity must be commensurate with a reasonable estimate of life expectancy of the annuitant. Annuities with the Commonwealth as a beneficiary that are not actuarially sound will be deemed transfers for less than fair market value. Such annuities may cause ineligibility for the Medicaid payment of long-

term care services.

Issues: The primary advantage to the Commonwealth of these suggested regulatory changes is to close a current loophole that results in Virginia Medicaid currently covering the cost of nursing home care for individuals who have the ability to pay for their own care but who have transferred their assets into annuities. Findings indicate that annuities are a [*2127] major source of asset-sheltering activities to help persons qualify for Medicaid coverage of their long-term care expenses and these regulations are an effort to address this growing problem.

There are no disadvantages to the general public in the implementation of these suggested changes, and the department projects no negative issues in implementing these proposed changes. There are disadvantages to the public and the Commonwealth of not making these changes: wealthy persons will continue to shelter their assets and rely on the public funding of their long-term care services. These changes will assist the Commonwealth in its efforts to ensure that public funds appropriated for medical care are expended in the manner for which they were intended – to provide a wide range of high-quality medical services to the truly needy.

For those public persons who wish to shelter their assets for the benefit of their heirs, and their elder care attorneys who provide them with legal advice, such individuals are not expected to agree with this suggested change. These persons are expected to object, as they want the public funds of Medicaid to pay for their long-term care services while their heirs reap the benefits of their estates. Attorneys who specialize their practices in elder care and estate planning are expected to object because these changes would be likely to reduce the numbers of persons for whom they could create such annuities and therefore reduce their billing fees.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2–4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2–4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. The proposed regulations will no longer allow the sheltering of assets using annuities with a balloon payment when determining Medicaid eligibility.

Estimated economic impact. In order to qualify for Medicaid benefits, an applicant's income and resources must be below certain thresholds. The federal Medicaid rules allow disregarding of annuities as a resource provided that the annuity is a fair market transaction. An annuity is a financial instrument that provides a stream of payments or a one-time payment sometime in the future in exchange for a down payment today. Currently, an annuity is deemed a fair market transaction if the expected return on the annuity is actuarially sound, or is commensurate with the statistical life expectancy of the beneficiary. Thus, so long as the return on the annuity over the life expectancy of the beneficiary is actuarially reasonable, applicants can disregard any resources by sheltering them through an annuity transaction.

To illustrate, consider an individual who arranges for an annuity transaction with his heirs and exchanges a \$1 million house for a 15-year annuity that pays \$1 a year, (or does not pay anything at all) for the next 14 years with an end-point value of \$1.5 million (a balloon payment) on the 15th year. Under the current rules, this annuity would be considered actuarially sound provided that the statistical life expectancy of this individual is truly 15 years and the current interest rate is 3%. Because he will receive only \$1 per year (or receive nothing) for the next 14 years, he will meet the Medicaid income threshold (unless he has other sources of income). Because the annuity transaction is actuarially sound and he can disregard the value of the annuity, he will also meet the Medicaid resource eligibility criteria (unless he has other resources). As a result, this individual will qualify for Medicaid benefits for the next 14 years, at which time he may enter into another annuity transaction to maintain his eligibility longer. This loophole that exist under the current regulations defies the purpose of the Medicaid program, which is to provide health benefits to those who cannot afford them.

The Department of Medical Assistance Services (the department) has noticed a growing number of applicants, consistent

with national trends n1, taking advantage of the current loophole especially with the intent of qualifying for Medicaid long-term care services. The eligibility workers reported about 15 cases in the last year with questionable annuity transactions, but nonetheless had to approve eligibility under current regulatory language. There were probably many other cases not reported to the department as these types of transactions are allowed under the current rules. Even though a precise estimate of the number of cases with questionable annuity transactions is not available, the fiscal burden that each case puts on the Commonwealth is significant. For example, it costs about \$72,000 per year to provide nursing home care to a recipient and another \$4,695 to provide other Medicaid services. If the average length of time spent in a nursing home is about two to three years, the total cost per case becomes about \$153,390 to \$230,085. Then, for the 15 cases the department was notified about last year the total cost could be about \$2.3 million to \$3.4 million. Because the 15 cases are probably a gross underestimate, the actual costs of the loophole could be much higher.

n1 National Association of State Medicaid Directors, October 2003, "The Role of Annuities in Medicaid Financial Planning: A Survey of State Medicaid Agencies."

The proposed regulations will prevent individuals from impoverishing themselves in order to qualify for Medicaid benefits using annuity transactions. The proposed regulations will consider an annuity an available resource and allow disregarding of annuities from the resource test under certain conditions. One of the conditions is that the annuity provide equal monthly installments. This will effectively prevent annuities with a balloon payment from being used to qualify for Medicaid because the equal payments will be subject to income criteria. Another condition is that the annuity names the Commonwealth as the beneficiary of the funds remaining in the annuity, not to exceed the Medicaid expenses. This provision will enable the Commonwealth to recover its expenses before heirs get their share of the inheritance in the event the individual dies. The third condition is that the [*2128] annuity be irrevocable. The intent of this condition is to prohibit the individual changing the terms of the annuity so that the beneficiary status of the Commonwealth cannot be removed later. Finally, the annuity must be issued by an insurance company, bank, or other licensed business in order to avoid questionable annuity transactions among the family members, neighbors, or friends. Because of the basic principals of the administrative law that it cannot be retroactive, all cases with questionable annuity transactions that have been and will be approved before these regulations become effective will be grandfathered.

The main benefit of the proposed changes is to restrict the sheltering of assets through purchases of annuities by individuals as a means to impoverish themselves and enable them to qualify for Medicaid. The Commonwealth will realize cost savings, as public funds will not be expended on individuals who can afford to purchase their own long-term care. The Commonwealth will realize approximately one half of the cost savings and the federal government will realize the other half. The actual benefits of these changes will depend on how the expected savings are reallocated. They could be used to provide a myriad of other public services or goods, or alternately they could be used to reduce the tax burden. There is no available information as to what will eventually be done with these savings. However, there is no question that the proposed changes will provide the Commonwealth with net economic benefits as the moneys are directed to needed services, goods, or used to reduce tax burden. The main costs of this proposal will accrue to those individuals planning to use questionable annuity transactions and take advantage of the existing loophole in the current regulations in order to qualify for Medicaid assistance.

Businesses and entities affected. The proposed regulations will primarily affect the individuals entering into questionable annuity transactions to qualify for free public health care. The department is aware of 15 approved cases in the last year. However, as these transactions are legal under the current language, it is likely that eligibility workers approved many other transactions without notifying the department. Therefore, the actual number of cases is probably much greater than the 15 known cases.

Localities particularly affected. The proposed regulations apply throughout the Commonwealth.

Projected impact on employment. The proposed regulations' impact on employment depends on many factors that are impossible to predict. For example, the individuals becoming no longer eligible for Medicaid may continue to receive the health care services from their own resources or could stop receiving them. Also, the expected savings may be used to purchase other goods and services or not spent. Thus, the impact on employment could be positive, negative, or insignificant depending on how individuals and state respond to the proposed changes.

Effects on the use and value of private property. Similarly, the impact on the use and value of private property cannot be estimated with any reasonable degree of accuracy as it depends on responses of individuals and the state to this regulatory change.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The agency has reviewed the economic impact analysis prepared by the Department of Planning and Budget regarding the regulations concerning Eligibility Conditions and Requirements: Treatment of Annuities in Medicaid Eligibility Determination (12 VAC 30-40-290 and 12 VAC 30-40-300). The agency concurs with the economic impact analysis prepared by the Department of Planning and Budget regarding this regulation.

Summary:

[A> THE PROPOSED AMENDMENTS ELIMINATE THE SHELTERING OF ASSETS THROUGH THE PURCHASE OF ANNUITIES IN ORDER TO ACHIEVE MEDICAID ELIGIBILITY WHEN THOSE INDIVIDUALS WHO PURCHASE ANNUITIES HAVE THE ABILITY TO PAY FOR SUCH CARE THEMSELVES. <A]

12 VAC 30-40-290. More liberal methods of treating resources under § 1902(r)(2) of the Act: § 1902(f) states.

A. Resources to meet burial expenses. Resources set aside to meet the burial expenses of an applicant/recipient or that individual's spouse are excluded from countable assets. In determining eligibility for benefits for individuals, disregarded from countable resources is an amount not in excess of \$3,500 for the individual and an amount not in excess of \$3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by:

1. The face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources; and
2. The amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses.

B. Cemetery plots. Cemetery plots are not counted as resources regardless of the number owned.

C. Life rights. Life rights to real property are not counted as a resource.

D. Reasonable effort to sell.

1. For purposes of this section, "current market value" is defined as the current tax assessed value. If the property is listed by a realtor, then the realtor may list it at an amount higher than the tax assessed value. In no event, however, shall the realtor's list price exceed 150% of the assessed value.

2. A reasonable effort to sell is considered to have been made:

a. As of the date the property becomes subject to a realtor's listing agreement if:

(1) It is listed at a price at current market value; and

(2) The listing realtor verifies that it is unlikely to sell within 90 days of listing given the particular circumstances involved (e.g., owner's fractional interest; zoning restrictions; poor topography; absence of road frontage or access; absence of improvements; [*2129] clouds on title, right of way or easement; local market conditions); or

b. When at least two realtors refuse to list the property. The reason for refusal must be that the property is unsaleable at current market value. Other reasons for refusal are not sufficient; or

c. When the applicant has personally advertised his property at or below current market value for 90 days by use of a "Sale By Owner" sign located on the property and by other reasonable efforts, such as newspaper advertisements, or reasonable inquiries with all adjoining landowners or other potential interested purchasers.

3. Notwithstanding the fact that the recipient made a reasonable effort to sell the property and failed to sell it, and although the recipient has become eligible, the recipient must make a continuing reasonable effort to sell by:

a. Repeatedly renewing any initial listing agreement until the property is sold. If the list price was initially higher than the tax-assessed value, the listed sales price must be reduced after 12 months to no more than 100% of the tax-assessed value.

b. In the case where at least two realtors have refused to list the property, the recipient must personally try to sell the property by efforts described in subdivision 2 c of this subsection for 12 months.

c. In the case of a recipient who has personally advertised his property for a year without success (the newspaper advertisements and "for sale" sign do not have to be continuous; these efforts must be done for at least 90 days within a 12-month period), the recipient must then:

(1) Subject his property to a realtor's listing agreement at price or below current market value; or

(2) Meet the requirements of subdivision 2 b of this subsection which are that the recipient must try to list the property and at least two realtors refuse to list it because it is unsaleable at current market value; other reasons for refusal to list are not sufficient.

4. If the recipient has made a continuing effort to sell the property for 12 months, then the recipient may sell the property between 75% and 100% of its tax assessed value and such sale shall not result in disqualification under the transfer of property rules. If the recipient requests to sell his property at less than 75% of assessed value, he must submit documentation from the listing realtor, or knowledgeable source if the property is not listed with a realtor, that the requested sale price is the best price the recipient can expect to receive for the property at this time. Sale at such a documented price shall not result in disqualification under the transfer of property rules. The proceeds of the sale will be counted as a resource in determining continuing eligibility.

5. Once the applicant has demonstrated that his property is unsaleable by following the procedures in subdivision 2 of this subsection, the property is disregarded in determining eligibility starting the first day of the month in which the most recent application was filed, or up to three months prior to this month of application if retroactive coverage is requested and the applicant met all other eligibility requirements in the period. A recipient must continue his reasonable efforts to sell the property as required in subdivision 3 of this subsection.

E. Automobiles. Ownership of one motor vehicle does not affect eligibility. If more than one vehicle is owned, the individual's equity in the least valuable vehicle or vehicles must be counted. The value of the vehicles is the wholesale value listed in the National Automobile Dealers Official Used Car Guide (NADA) Book, Eastern Edition (update monthly). In the event the vehicle is not listed, the value assessed by the locality for tax purposes may be used. The value of the additional motor vehicle is to be counted in relation to the amount of assets that could be liquidated that may be retained.

F. Life, retirement, and other related types of insurance policies. Life, retirement, and other related types of insurance policies with face values totaling \$1,500 or less on any one person 21 years old and over are not considered resources. When the face values of such policies of any one person exceeds \$1,500, the cash surrender value of the policies is counted as a resource.

G. Resource exemption for Aid to Dependent Children categorically and medically needy (the Act §§ 1902(a)(10)(A)(i)(III), (IV), (VI), (VII); §§ 1902(a)(10)(A)(ii)(VIII), (IX); § 1902(a)(10)(C)(i)(III)). For ADC-related cases, both categorically and medically needy, any individual or family applying for or receiving assistance may have or establish one interest-bearing savings or investment account per assistance unit not to exceed \$5,000 if the applicant, applicants, recipient or recipients designate that the account is reserved for purposes related to self-sufficiency. Any funds deposited in the account shall be exempt when determining eligibility for medical assistance for so long as the funds and interest remain on deposit in the account. Any amounts withdrawn and used for purposes related to self-sufficiency shall be exempt. For purposes of this section, purposes related to self-sufficiency shall include, but are not limited to, (i) paying for tuition, books, and incidental expenses at any elementary, secondary, or vocational school, or any college or university; (ii) for making down payment on a primary residence; or (iii) for establishment of a commercial operation that is owned by a member of the medical assistance unit.

H. Disregard of resources. The Commonwealth of Virginia will disregard all resources for qualified children covered under §§ 1902(a)(10)(A)(i)(I), 1902(a)(10)(A)(i)(III), 1902(a)(10)(A)(ii)(VIII), and 1905(n) of the Social Security Act.

I. Household goods and personal effects. The Commonwealth of Virginia will disregard the value of household goods and personal effects. Household goods are items of personal property customarily found in the home and used in connection with the maintenance, use and occupancy of the premises as a home. Examples of household goods are furniture, appliances, televisions, carpets, cooking and eating utensils and dishes. Personal effects are items of personal property that are worn or carried by an individual or [*2130] that have an intimate relation to the individual. Examples of personal property include clothing, jewelry, personal care items, prosthetic devices and educational or recreational items such as books, musical instruments, or hobby materials.

J. Determining eligibility based on resources. When determining Medicaid eligibility, an individual shall be eligible in a month if his countable resources were at or below the resource standard on any day of such month.

[A> K. ANNUITIES. FOR ANNUITIES MEETING THE CRITERIA CONTAINED IN 12 VAC 30-40-300 E 3 H, THE AMOUNT OF FUNDS IN THE ANNUITY ACCOUNT ARE DISREGARDED AS COUNTABLE RESOURCES IN DETERMINING ELIGIBILITY. <A]

12 VAC 30-40-300. Transfer of resources.

The agency provides for the denial of eligibility by reason of disposal of resources for less than fair market value. This section includes procedures applicable to all transfers of resources.

A. Except as noted below, the criteria for determining the period of ineligibility are the same as criteria specified in § 1613(c) of the Social Security Act (Act): Transfer of resources other than the home of an individual who is an inpatient in a medical institution.

1. The agency uses a procedure which provides for a total period of ineligibility greater than 24 months for individuals who have transferred resources for less than fair market value when the uncompensated value of disposed of resources exceeds \$12,000.00. This period bears a reasonable relationship to the uncompensated value of the transfer. The computation of the period and the reasonable relationship of this period to the uncompensated value is described as follows:

This transfer of resources rule includes the transfer of the former residence of an inpatient in a medical institution.

2. The agency has provisions for waiver of denial of eligibility in any instance where the State determines that a denial would work an undue hardship.

B. Other than those procedures specified elsewhere in this section, the procedures for implementing denial of eligibility by reason of disposal of resources for less than fair market value are as follows:

1. If the uncompensated value of the transfer is \$12,000 or less: the individual is ineligible for two years from the date of the transfer.

2. If the uncompensated value of the transfer is more than \$12,000: the individual is ineligible two years, plus an additional 2 months for every \$1,000 or part thereof of uncompensated value over \$12,000, from the date of transfer.

C. Property Transfer – An applicant for or recipient of Medicaid is ineligible for Medicaid if he transferred or otherwise disposed of his legal equitable interest in real or personal property for less than fair market value. Transfer of property precludes eligibility for two years from the date of the transfer if the uncompensated value of the property was \$12,000 or less. If the uncompensated value was over \$12,000 an additional two months of ineligibility will be added for each \$1,000 of additional uncompensated value (see following Table). "Uncompensated value" means the current market value of the property, or equity in the property, at the time it was transferred, less the amount of compensation (money, goods, service, et cetera) received for the property.

Exceptions to this provision are:

1. When the transfer was not made with the intent of establishing or retaining eligibility for Medicaid or SSI. Any transfer shall be presumed to have been for the purposes of establishing or retaining eligibility for Medicaid or SSI unless

the applicant/recipient furnishes convincing evidence to establish that the transfer was exclusively for some other purpose.

a. The applicant/recipient has the burden of establishing, by objective evidence of facts rather than statement of subjective intent, that the transfer was exclusively for another purpose.

b. Such evidence shall include evidence that adequate resources were available at the time of the transfer for the applicant/recipient's support and medical care including nursing home care, considering his or her age, state of health, and life expectancy.

c. The declaration of another purpose shall not be sufficient to overcome this presumption of intent.

d. The establishment of the fact that the applicant/recipient did not have specific knowledge of Medicaid or SSI eligibility policy is not sufficient to overcome the presumption of intent.

2. Retention of the property would have no effect on eligibility unless the property is a residence of an individual in a nursing home for a temporary period.

3. When transfer of the property resulted in compensation (in money, goods, or services) to the applicant/recipient which approximated the equity value of the property.

4. When the receiver of the property has made payment on the cost of the applicant/recipient's medical care which approximates the equity value of the property.

5. When the property owner has been a victim of another person's actions, except those of a legal guardian, committee, or power-of-attorney, who obtained or disposed of the property without the applicant/recipient's full understanding of the action.

6. When prior to October 1, 1982, the Medicaid applicant transferred a prepaid burial account (plan) which was valued at less than \$1,500.00 for the purpose of retaining eligibility for SSI, and was found ineligible for Medicaid solely for that reason. The applicant, after reapplying, may be eligible regardless of the earlier transfer of a prepaid burial account if the applicant currently meets all other eligibility criteria.

7. When the property is transferred into an irrevocable trust designated solely for the burial of the transferor or his spouse. The amount transferred into the irrevocable burial trust, together with the face value of life insurance and any [*2131] other irrevocable funeral arrangements, shall not exceed \$2,000 prior to July 1, 1988, and shall not exceed \$2,500 after July 1, 1988.

PERIOD OF INELIGIBILITY DUE TO
TRANSFER OF PROPERTY
TABLE

Uncompensated	Value of property	Period of ineligibility
0	\$ 12,000	24 months
12,000.01	\$ 13,000	26 months
13,000.01	\$ 14,000	28 months
14,000.01	\$ 15,000	30 months
15,000.01	\$ 16,000	32 months

For each additional \$1,000 add two months of ineligibility.

D. The preceding policy applies to eligibility determinations on and before June 30, 1988. The following policy applies to eligibility determinations on and after July 1, 1988.

1. The State plan provides for a period of ineligibility for nursing facility services, equivalent services in a medical institution, and home and community-based services in the case of an institutionalized individual (as defined in paragraph (3) of § 1917(c) who, disposed of resources for less than fair market value, at any time during or after the 30-month period immediately before the date the individual becomes an institutionalized individual (if the individual is entitled to medical assistance under the State plan on that date) or, if the individual is not entitled on the date of institutionalization, the date the individual applies for assistance while an institutionalized individual.

a. 30 months, or

b. The total uncompensated value of the resources so transferred, divided by the average cost, to a private patient at the time of application, of nursing facility services in the State.

2. An individual shall not be ineligible for medical assistance by reason of paragraph 1. to the extent that –

a. The resources transferred were a home and title to the home was transferred to –

(1) The spouse of such individual;

(2) A child of such individual who is under age 21, or is blind or disabled as defined in § 1614 of the Social Security Act;

(3) A sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

(4) A son or daughter of such individual (other than a child described in clause (2)) who was residing in such individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual; and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

b. The resources were transferred to (or to another for sole benefit of) the community spouse as defined in § 1924(h)(2) of the Social Security Act, or to the individual's child who is under age 21, or is blind or disabled as defined in § 1614 of the Social Security Act.

c. A satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary of United States Department of Health and Human Services) that

(1) The individual intended to dispose of the resources either at fair market value, or for other valuable consideration. To show intent to receive adequate compensation, the individual must provide objective evidence that:

(a) For real property, the individual made an initial and continuing effort to sell the property according to the "reasonable effort to sell" provisions of the Virginia Medicaid State Plan;

(b) For real or personal property, the individual made a legally binding contract that provided for receipt of adequate compensation in a specified form (goods, services, money, etc.) in exchange for the transferred property;

(c) An irrevocable burial trust of \$2,500 or less was established on or after July 1, 1988 as compensation for the transferred money;

(d) An irrevocable burial trust over \$2500 was established on or after July 1, 1988, and the individual provides objective evidence to show that all funds in the trust are for identifiable funeral services; or

(2) The resources were transferred exclusively for a purpose other than to qualify for medical assistance; the individual must provide objective evidence that the transfer was exclusively for another purpose and the reason for the transfer did not include possible or future Medicaid eligibility; or

(3) Consistent with 1917(c)(2)(D), an institutionalized spouse who (or whose spouse) transferred resources for less than fair market value shall not be found ineligible for nursing facility service, for a level of care in a medical institution equivalent to that of nursing facility services, or for home and community-based services where the state determines that denial of eligibility would work an undue hardship under the provision of § 1917(c)(2)(D) of the Social Security Act.

3. In this section, the term "institutionalized individual" means an individual who is an inpatient in a nursing facility, or who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1902 (a)(10)(A)(ii)(VI). [*2132]

4. In this section, the individual's home is defined as the house and lot used as the principal residence and all contiguous property up to \$5,000.00.

E. Transfers And Trusts After August 10, 1993. The following policy applies to medical assistance provided for services furnished on or after October 1, 1993, with respect to assets disposed of after August 10, 1993, and with respect to trusts

established after August 10, 1993.

1. Definitions.

"Assets" means, with respect to an individual, all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action:

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

"Income" has the meaning given such term in section 1612 of the Social Security Act.

"Institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility or who is described in section 1902(a)(10)(A)(ii)(VI) of the Social Security Act.

"Resources" has the meaning given such term in section 1613 of the Social Security Act, without regard (in the case of an institutionalized individual) to the exclusion described in subsection (a)(1) of such section.

2. Transfer of Assets Rule. An institutionalized individual who disposes of, or whose spouse disposes of, assets for less than fair market value on or after the look-back date specified in subdivision 2.b. shall be ineligible for nursing facility services, a level of care in any institution equivalent to that of nursing facility services and for home or community-based services furnished under a waiver granted under subsection (c) of § 1915 of the Social Security Act.

a. Period of Ineligibility. The ineligibility period shall begin on the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other period of ineligibility under this section. The ineligibility period shall be equal to but shall not exceed the number of months derived by dividing:

- (1) The total, cumulative uncompensated value of all assets transferred as defined in E.1. on or after the look-back date specified in E.2.b by
- (2) The average monthly cost to a private patient of nursing facility services in the Commonwealth at the time of application for medical assistance.

b. Look-Back Date. The look-back date is a date that is 36 months (or, 60 months in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to this section or Section 3,) before the first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State Plan for Medical Assistance.

c. Exceptions. An individual shall not be ineligible for medical assistance by reason of this section to the extent that:

- (1) The assets transferred were a home and title to the home was transferred to:
 - (a) The spouse of the individual;
 - (b) A child of the individual who is under age 21, or is blind or disabled as defined in section 1614 of the Social Security Act,
 - (c) A sibling of the individual who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual, or
 - (d) A son or daughter of the individual (other than a child described in clause (b)) who was residing in the individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility.

- (2) The assets:

- (a) Were transferred to the individual's spouse or to another person for the sole benefit of the individual's spouse,
- (b) Were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,
- (c) Were transferred to the individual's child who is under age 21 or who is disabled as defined in § 1614 of the Social Security Act, or to a trust (including a trust described in 3.g.) established solely for the benefit of such child, or
- (d) Were transferred to a trust (including a trust described in 3.g.) established solely for the benefit of an individual under age 65 years of age who is disabled as defined in section 1614(a)(3) of the Social Security Act.

(3) A satisfactory showing is made that:

- (a) The individual intended to dispose of the assets either at fair market value, or for other valuable consideration, or [*2133]
- (b) The assets were transferred exclusively for a purpose other than to qualify for medical assistance, or
- (c) All assets transferred for less than fair market value have been returned to the individual, or
- (d) The Commonwealth determines that the denial of eligibility would work an undue hardship.

d. **Assets Held In Common With Another Person.** In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or other arrangement recognized under State law, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

e. **Transfers by Both Spouses.** In the cases of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance, the Commonwealth shall apportion the period of ineligibility (or any portion of the period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the State Plan.

3. **For Trust(s) Created After August 10, 1993.** For purposes of determining an individual's eligibility for, or amount of, medical assistance benefits, subject to 3.g., these rules shall apply.

a. **Trust(s) Defined.** The term "trust" includes any legal instrument or device that is similar to a trust but includes an annuity only to such extent and in such manner as the United States Secretary of Health and Human Services specifies for purposes of administration of § 1917(c) or (d) of the Social Security Act.

b. **Creation of Trust(s) Defined.** For purposes of this subsection, an individual shall be considered to have established a trust(s) if assets of the individual were used to form all or part of the corpus of the trust(s) and if any of the following individuals established the trust(s) other than by will:

- (1) The individual,
- (2) The individual's spouse,
- (3) 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,
- (4) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

c. **Proportional Interest In Trust(s).** In the case of a trust(s) the corpus of which includes assets of an individual (as determined under 3.b.) and assets of any other person or persons, the provision of this section shall apply to the portion of the trust(s) attributable to the assets of the individual.

d. **Trust(s) Affected.** Subject to 3.g., this section shall apply without regard to:

- (1) The purposes for which a trust(s) is established,
- (2) Whether the trustee(s) has or exercises any discretion under the trust(s),
- (3) Any restrictions on when or whether distributions may be made from the trust(s), or
- (4) Any restrictions on the use of distributions from the trust(s).

e. Revocable Trust(s). In the case of a revocable trust(s),

(1) The corpus of the trust(s) shall be considered resources available to the individual,

(2) Payments from the trust(s) to or for the benefit of the individual shall be considered income of the individual, and

(3) Any other payments from the trust(s) shall be considered assets disposed of by the individual for the purposes of E.2.

f. Irrevocable Trust(s). In the case of irrevocable trust(s),

(1) If there are any circumstances under which payment from the trust(s) could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income:

(a) To or for the benefit of the individual, shall be considered income of the individual, and

(b) For any other purpose, shall be considered a transfer of assets by the individual subject to E.2., and

(2) Any portion of the trust(s) from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust(s) (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of E.2., and the value of the trust(s) shall be determined for purposes of such section by including the amount of any payments made from such portion of the trust(s) after such date.

g. Exceptions. This section shall not apply to any of the following trust(s):

(1) A trust(s) containing the assets of an individual under age 65 who is disabled (as defined in section 1614(a)(3) of the Social Security Act) and which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual or a court if the Commonwealth will receive all amounts remaining in the trust(s) upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual under this State Plan. [*2134]

(2) A trust containing the assets of an individual who is disabled (as defined in section 1614(a)(3) of the Social Security Act) that meets all of the following conditions:

(a) The trust(s) is established and managed by a non-profit association,

(b) A separate account is maintained for each beneficiary of the trust(s), but, for purposes of investment and management of funds, the trust(s) pools these accounts.

(c) Accounts in the trust(s) are established solely for the benefit of individuals who are disabled (as defined in section 1614(a)(3) of the Social Security Act) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

(d) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust(s), the trust(s) pays to the Commonwealth from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under this State Plan.

[A> H. ANNUITIES. THE FOLLOWING SHALL GOVERN ANNUITIES: <A]

[A> DEFINITIONS. THE FOLLOWING WORDS AND TERMS WHEN USED IN THIS PART SHALL HAVE THE FOLLOWING MEANINGS UNLESS THE CONTEXT CLEARLY INDICATES OTHERWISE: <A]

[A> "ANNUITY" MEANS A CONTRACT OR AGREEMENT BY WHICH ONE RECEIVES FIXED, NONVARIABLE PAYMENTS ON AN INVESTMENT FOR A LIFETIME OR A SPECIFIED NUMBER OF YEARS. <A]

[A> (1) CRITERIA FOR AN ANNUITY. AN ANNUITY CONTAINING A BALLOON PAYMENT WILL BE CONSIDERED AN AVAILABLE RESOURCE. A COMMERCIAL (NONEMPLOYMENT RELATED) ANNUITY PURCHASED BY OR FOR AN INDIVIDUAL USING THAT INDIVIDUAL'S ASSETS WILL BE CONSIDERED AN AVAILABLE RESOURCE UNLESS IT MEETS ALL OF THE FOLLOWING CRITERIA. THE ANNUITY MUST: <A]

[A> (A) BE IRREVOCABLE; <A]

[A> (B) PAY OUT PRINCIPAL AND INTEREST IN EQUAL MONTHLY INSTALLMENTS (NO BALLOON PAYMENT) TO THE INDIVIDUAL OVER THE TOTAL NUMBER OF MONTHS THAT IS EQUAL TO OR LESS THAN THE ACTUARIAL LIFE EXPECTANCY OF THE ANNUITANT; <A]

[A> (C) NAME THE COMMONWEALTH AS THE RESIDUAL BENEFICIARY OF FUNDS REMAINING IN THE ANNUITY, NOT TO EXCEED ANY MEDICAID FUNDS EXPENDED ON THE INDIVIDUAL DURING HIS LIFETIME; AND <A]

[A> (D) BE ISSUED BY AN INSURANCE COMPANY, BANK OR OTHER REGISTERED OR LICENSED ENTITY APPROVED TO DO BUSINESS IN AND AUTHORIZED TO SELL ANNUITIES IN THE COMMONWEALTH, OR, IF ISSUED IN A JURISDICTION OTHER THAN THE COMMONWEALTH, IS ISSUED BY AN INSURER LICENSED TO DO BUSINESS IN THE JURISDICTION IN WHICH THE ANNUITY IS ESTABLISHED. PAYMENTS FROM THE ANNUITY TO THE COMMONWEALTH CANNOT EXCEED THE TOTAL AMOUNT OF FUNDS FOR LONG-TERM CARE SERVICES EXPENDED ON BEHALF OF THE MEDICAID RECIPIENT. <A]

[A> (2) ANNUITIES ISSUED PRIOR TO JUNE 20, 2005, THAT DO NOT PROVIDE FOR PAY OUT OF PRINCIPAL AND INTEREST IN EQUAL MONTHLY INSTALLMENTS AND FOR WHICH DOCUMENTATION IS RECEIVED FROM THE ISSUING COMPANY THAT THE PAY OUT ARRANGEMENTS CANNOT BE CHANGED WILL BE CONSIDERED TO MEET THE NEW REQUIREMENTS ONCE AMENDED TO NAME THE COMMONWEALTH AS THE RESIDUAL BENEFICIARY OF FUNDS REMAINING IN THE ANNUITY, NOT TO EXCEED ANY MEDICAID FUNDS EXPENDED ON THE INDIVIDUAL DURING HIS LIFETIME. THIS PROVISION APPLIES ONLY TO NEW APPLICATIONS RECEIVED ON OR AFTER JUNE 20, 2005. <A]

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