WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
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To: Medicaid Eligibility Handbook Users

From: Jori Mundy, Bureau Director
Bureau of Eligibility and Enrollment Policy

Re: **Medicaid Eligibility Release 21-02**

Release Date: 08/30/2021

Effective Date: 08/30/2021

EFFECTIVE DATE		The following policy additions or changes are **effective 08/30/2021** unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
1.1.2	**Subprograms of Medicaid**	Added reference to SSI Medicaid.
5.9.2.3	**Presumptive Disability Certification Process**	Updated cross reference link.
5.9.3	**Presumptive Disability Determined by DDB**	Updated cross reference link.
7.1.3	**Compact of Free Association**	Clarified policy regarding citizens of the Compacts of Free Association.
7.3.3	**Immigrants Eligible for Medicaid**	Updated text to refer to Medicaid rather than BC+.
7.3.3.1	**Qualifying Immigrants**	Added Citizens of the Compacts of Free Association.
7.3.8	**Immigration Status Chart**	Updated cross reference link.
15.3.26	**VA Allowances**	Clarified policy for veterans' expenses.
15.3.26.1	**Residents of a State Veterans Home**	Clarified meaning of "no spouse" for veterans.
15.3.30	**Federal Coronavirus Recovery Rebates (Stimulus Payments)**	Clarified Federal Recovery Rebates.
15.3.34	**Federal Income Tax Refunds and Credits**	New section.
16.7.7	**Income Tax Refunds**	Clarified policy for federal income tax.
16.7.8	**Earned Income Tax Credit**	Added Child Tax Credits.

16.7.33	**Federal Coronavirus Recovery Rebates (Stimulus Payments)**	Added economic impact payments.
17.1	**Divestment Defined**	Page rewritten.
17.2	**Evaluation of Transfers for Divestment**	Page rewritten.
17.3	**Penalty Period**	Page rewritten.
17.4	**Exceptions**	Deleted
17.5	**Penalty Period**	Deleted
17.6	**Multiple Divestments**	Deleted
17.7	**Jointly Held Assets**	Deleted
17.8	**Divesting by Paying Relatives**	Deleted
17.9	**Income Divestment**	Deleted
17.10	**Life Estates**	Deleted
17.11	**Annuities**	Deleted
17.12	**Promissory Notes**	Deleted
17.13	**Trusts**	Deleted
17.14	**Both Spouses Institutionalized**	Deleted
17.15	**Medicaid Card Services**	Deleted
18.6.2	**Community Spouse Income Allocation**	Updated community spouse income allocation amounts.
18.6.3	**Family Member Income Allowance**	Updated family income allowance amounts.
21.4.1.1	**Medicaid Card Services**	New section.
22.1	**Estate Recovery**	Updated formatting.
22.2.1.2	**Nonrecoverable Overpayment**	Updated policy for recovering overpayments during the COVID-19 public health emergency.
22.5	**Representatives**	Updated formatting.
26.5.3.2	**Advance Payments**	Removed obsolete Advance Payments policy.
27.11	**Institutions for Mental Disease**	Updated to identify facilities providing residential substance use disorder treatment.
28.6.4	**Cost Share Amount**	Updated to remove IRIS.
28.6.4.1	**Personal Maintenance Allowance**	Clarified Special Housing policy.
29.1	**Katie Beckett**	Updated contact information.
32.1.1	**Medicare Savings Programs Introduction**	Added ALS.
33.3.1	**SeniorCare Nonfinancial Requirements Introduction**	Clarified definition of inmate.
33.3.3	**Age Limitation**	Clarified policy.
33.3.5	**Creditable Coverage**	Clarified income policy for Medicare Part D.

33.5.1	**SeniorCare Benefit Period Introduction**	Updated SeniorCare benefit period information.
33.10.1	**SeniorCare Changes Introduction**	Updated policy for death and incarceration.
33.13	**Notice of Decision**	Clarified policy.
39.4.2	**Elderly, Blind, or Disabled Deductions and Allowances**	Updated spousal impoverishment values.

Contents

1.1 INTRODUCTION TO MEDICAID

1.1.2 Subprograms of Medicaid

There are different subprograms of Medicaid:

Full-Benefit EBD Medicaid Programs

- SSI-Related Medicaid
- Medicaid Purchase Plan (MAPP)
- Katie Beckett Medicaid
- Wisconsin Well Woman Medicaid (WWWMA)
- SSI Medicaid

Full-Benefit Long-Term Care Programs

- Institutional Medicaid
- ~~Home and~~ Community ~~Based~~ Waivers ~~(HCBWLTC), including:~~

  ~~Community Integration Program I (CIP 1A and CIP 1B)~~
  ~~Community Integration Program II (CIP II)~~

- ~~Children's Long Term Support Waiver~~ Programs ~~(CLTS)~~, which include:

  ~~Community Options Program Waiver (COP-W)~~

  - ~~Include, Respect, I Self-Direct (IRIS)~~

~~Long-Term Managed Care programs:~~

  - Family Care
  - Family Care Partnership
  - Program of All-Inclusive Care for the Elderly (PACE)
  - Include, Respect, I Self-Direct (IRIS)
  - Children's Long-term Support Waiver Program (CLTS)

Limited-Benefit EBD Medicaid Programs

- Tuberculosis-Related Medicaid (TB MA)
- Medicare Savings Program:

    - Qualified Medicare Beneficiary (*QMB*)
    - Specified Low-Income Medicare Beneficiary (*SLMB*)
    - Specified Low-Income Medicare Beneficiary Plus (*SLMB+*)
    - Qualified Disabled and Working Individual (*QDWI*)
- Emergency Medicaid
- SeniorCare

A person may qualify for one or more of the subprograms listed above, and will be found eligible if ~~he or she meets~~they meet all the requirements for a given subprogram. Individuals who do not qualify under a subprogram listed above may be eligible for BadgerCare Plus. See the BadgerCare Plus Handbook for more information.

People eligible for federal or state SSI are categorically eligible for SSI Medicaid and receive this form of Medicaid automatically. The Social Security Administration makes determinations of SSI eligibility for SSI recipients and receipt of SSI is the only eligibility criterion for SSI Medicaid.

5.9 PRESUMPTIVE DISABILITY

5.9.2 PD Determined By the IM Workers

5.9.2.1 Definition of Urgent Need

Example 1: An individual with schizophrenia who will need to be hospitalized if ~~he or she does~~they do not take prescribed medication has an 1; urgent need' if such medication is not available without Medicaid coverage.

5.9.2.3 Presumptive Disability Certification Process

A medical professional must complete and sign the Medicaid Presumptive Disability form, F-10130 attesting to both the urgent need and the impairment, before an IM worker may certify the applicant as presumptively disabled. The worker should not require any additional documentation from the medical professional beyond the Medicaid Presumptive Disability form. Once completed, place a copy of this form in the case file to document the Medicaid Presumptive Disability decision. If the applicant is otherwise eligible for EBD Medicaid, certify Medicaid eligibility (see Section 5.9.5 Eligibility).

Changes in Urgent Need Prior to Presumptive Disability Medicaid Certification
Sometimes, an individual's medical condition improves between the date of the presumptive disability Medicaid application and the date of the presumptive disability Medicaid certification. This improvement results in the individual no longer meeting the urgent need criteria at the time of the presumptive disability Medicaid eligibility determination. The most common example of this situation is that of a person who is hospitalized on the date of the presumptive disability Medicaid application, but released from the hospital prior to being certified by the IM worker for presumptive disability Medicaid eligibility. Under these circumstances, if the presumptive disability applicant no longer has an urgent need as of the date that you are making the presumptive disability Medicaid eligibility determination/certification, the presumptive disability request must be denied. Follow the procedures described in Section 5.9.6.1 DDB Returns a Negative Presumptive Disability Decision when notifying the applicant that their request for a presumptive disability eligibility determination has been denied.

Example 2: Bob is 55 years old and has been hospitalized since February 01, 2008 after suffering his second stroke in the last 4 months. Bob applies for Medicaid on February 07, 2008. His physician attests in writing that Bob has an urgent need (he is hospitalized), and that he has one of the impairments listed on the Medicaid Presumptive Disability form (F-10130). The IM worker has requested verification of Bob's non exempt assets and completion of the Medicaid Disability Application (MADA), F-10112. On February 14, 2008 Bob returns the completed MADA and asset verification information to his IM worker. He also indicates that he was released from the hospital on February 11, 2008 and is recuperating at home. On February 14, 2008, the IM worker has all the necessary information to make a

presumptive disability Medicaid eligibility determination. Since Bob no longer has an urgent need on that date, his request for presumptive disability Medicaid must be denied.

Regardless of whether the IM worker makes the presumptive disability determination or DDB makes the presumptive disability determination, the Medicaid Disability Application (MADA) (F-10112) must be completed before the IM worker certifies the member for presumptive disability.

The following forms are required for the presumptive disability process:

- Wisconsin Medicaid for the Elderly, Blind or Disabled Application Packet, F-10101
- Medicaid Disability Application (MADA), F-10112
- Medicaid Presumptive Disability, F-10130
- Authorization to Disclose Information to Disability Determination Bureau (DDB), F-14014
- Authorized Representative, F-10126A Person or F-0126B Organization (if applicable)

Once a presumptive disability decision has been made, the IM worker must still follow the disability application process (see Section 5.3 Disability Application Process and Process Help ~~Chapter 12~~, section 9.4 Automated Medicaid Disability Determination). The Medicaid Disability Application (MADA) (F-10112) must be completed and sent to the DDB along with the necessary copies of the Authorization to Disclose Information to Disability Determination Bureau (DDB) (F-14014).

The DDB will then process the disability application and make a final disability determination.

5.9.3 Presumptive Disability Determined By DDB

If the applicant has an urgent need, but does not have one of the listed impairments, the IM worker must request DDB to make a presumptive disability determination. The IM worker must take the following actions once a medical professional has attested in writing, with the Medicaid Presumptive Disability form, F-10130, that there is an urgent need for medical services.

Note: If someone has an impairment, but not an urgent need, follow the normal disability application process (see Section 5.3 Disability Application Process).

1. Document the urgent need by placing the Medicaid Presumptive Disability form, F-10130 in the case file.
2. Complete, with assistance from the applicant as necessary, the following two forms:

a. The MADA form (Medicaid Disability Application form, F-10112, formerly DES 3071).
b. Release to Disability Determination Bureau form, F-14014.

3. See Process Help ~~Section~~, section 9.4 Automated Medicaid Disability Determination for submissions of the forms, if necessary. This process is now automated. However, if the automated process isn't working, send via fax (608-266-8297) each of the three forms listed above to DDB for both a presumptive and final disability determination.

DDB will make a presumptive disability finding on these cases and communicate their finding to the local IM agency within three business days of receiving the request for presumptive disability and the Medicaid Disability Application form, F-10112 form (not including the day the fax was received).

Federal Regulations generally require the evaluation of certain disabilities after a three month period of recovery from the original injury or medical event (major head injuries, stokes, heart attacks, etc.) It may not be possible to establish disability, either on a presumptive or final basis during that period. However, all applications should be submitted and a complete medical review will be made.

7.1 US CITIZENS AND NATIONALS

7.1.3 ~~Compact~~Compacts of Free Association ~~States~~

~~Persons from~~Citizens of the ~~Compact~~Compacts of Free Association ~~States (*CFAS*)~~ are not considered U.S. citizens or nationals. The ~~Compact~~Compacts of Free Association ~~States~~ include the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau. Citizens of the ~~Compact~~Compacts of Free Association ~~States~~(COFA) have a special status with the US that allows them to enter the country, work here, and acquire an SSN without obtaining an immigration status. ~~They are not eligible for Medicaid, unless they have obtained a qualifying immigration status. Those CFAS citizens who do not have one of the immigration statuses listed in Section 7.3.8 Immigration Status Chart may qualify for Medicaid Emergency Services only.~~

As of December 27, 2020, COFA citizens may be eligible for health care if they meet all other eligibility requirements. In addition, COFA citizens are not subject to the 5-year waiting period. However, COFA citizens who adjust their status and become Lawful Permanent Residents are subject to the 5-year waiting period.

7.3 IMMIGRANTS

7.3.3 Immigrants Eligible for Medicaid

Immigrants may be eligible for ~~BadgerCare Plus~~Medicaid if they meet all other eligibility requirements and are either Qualifying Immigrants or are Lawfully Present as described below.

7.3.3.1 Qualifying Immigrants

Immigrants of any age meeting the criteria listed below are considered Qualifying Immigrants.

1. A refugee admitted under Immigration and Nationality Act (INA) Section 207. A refugee is a person who flees ~~his or her~~their country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group. An immigrant admitted under this refugee status may be eligible for Medicaid even if his or her immigration status later changes.

2. An asylee admitted under INA Section 208. Similar to a refugee, this is a person who seeks asylum and is already present in the U.S. when ~~he or she requests~~they request permission to stay. An immigrant admitted under this asylee status may be eligible for Medicaid even if his or her immigration status later changes.

3. An immigrant whose deportation is withheld under INA Section 243(h) and such status was granted prior to April 1, 1997, or an immigrant whose removal is withheld under INA Section 241(b)(3) on or after April 1, 1997. An immigrant admitted under this status may be eligible for Medicaid even if his or her immigration status later changes.

4. A Cuban/Haitian entrant. An immigrant admitted under this Cuban/Haitian entrant status may be eligible for Medicaid even if his or her immigration status later changes.

5. An American Indian born in Canada who is at least 50 percent American Indian by blood or an American Indian born outside the U.S. who is a member of a federally recognized Indian tribe.

6. Victims of a severe form of trafficking in accordance with 107(b)(1) of the Trafficking Victims Protection Act of 2000 (P.L. 106-386).

7. Lawfully admitted for permanent residence under the INA.*

8. Paroled into the U.S. under INA Section 212(d)(5).*

9. Granted conditional entry under immigration law in effect before April 1, 1980 [INA Section 203(a)(7)]*

10. An immigrant who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.*

11. An immigrant whose child has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.*

12. An immigrant child who resides with a parent who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.*

13. Citizens of the Compacts of Free Association (COFA). (See Section 7.1.3 Compacts of Free Association).

7.3.8 Immigration Status Chart

Please see Process Help, Section 82.6 VIS SAVE Verification Responses Table for a list of SAVE Responses and the appropriate Registration Status Code in CWW to apply.

CARES Registration Status Code	Immigration Status	Arrived Before August 22, 1996	Veteran* Arrived Before August 22, 1996	Arrived On or After August 22, 1996	Veteran* Arrived On or After August 22, 1996	Children Under 19 and Pregnant Women; Arrived on or after August 22, 1996
01	Lawfully admitted for permanent residence	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009 Eligible
02	Permanent resident under color of	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible

	law (PRUCOL)					
03	Lawfully present under Section 203(a)(7)	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009 Eligible
04	Lawfully present under Section 207(c)	Eligible	Eligible	Eligible	Eligible	Eligible
05	Lawfully present under Section 208	Eligible	Eligible	Eligible	Eligible	Eligible
06	Lawfully present under Section 212(d)(5	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009 Eligible
07	IRCA (No longer valid)	N/A	N/A	N/A	N/A	N/A
08	Lawfully admitted - temporary	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
09	Undocumented Immigrant	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
10	Illegal Immigrant	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
11	Cuban/Haitian Entrant	Eligible	Eligible	Eligible	Eligible	Eligible
12	Considered a Permanent Resident by USCIS	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
13	Special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible	Eligible

14	Additional special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
15	Withheld deportation - Section 243(h)	Eligible	Eligible	Eligible	Eligible	Eligible
16	Battered Immigrant	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009 Eligible
17	Amerasian	Eligible	Eligible	Eligible	Eligible	Eligible
18	Foreign-Born Native American	Eligible	Eligible	Eligible	Eligible	Eligible
19	Victims of Trafficking**	Eligible	Eligible	Eligible	Eligible	Eligible
20	Lawfully Residing	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
21	Victims of Trafficking Subject to 5 Year Bar	Eligible	Eligible	Ineligible for 5 years	Eligible	Eligible

* "Veteran" includes certain veterans and active duty servicemen and women, their spouses, dependent children, or certain surviving spouses.

**Some victims of trafficking may need to provide certain verification to be exempt from the five-year bar. See Section 4~~1~~7.3.~~10~~11 Victims of Trafficking for more information.

15.3 EXEMPT/DISREGARDED INCOME

15.3.26 VA Allowances

Disregard the following VA allowances~~:~~ for eligibility and, if applicable, post-eligibility*:

- ~~Unusual~~Any unreimbursed (sometimes referred to as "unusual") medical expenses that are received as an allowance by a veteran, his or her surviving spouse, or his or her dependent.
- Aid and attendance and housebound allowances received by veterans, spouses of disabled veterans and surviving spouses.

~~Unusual medical expenses, aid and attendance, and housebound allowances for institutionalized and community waiver cases, in eligibility and post-eligibility determinations, except for residents~~*Note: Residents of the State Veterans Homes at King, Chippewa Falls, or Union Grove have different rules for post-eligibility calculation of income for patient liability and cost share (see Section 15.3.26.1 Residents of a State Veterans Home).

Example 3: Jack is a single veteran living in his home. He is disabled (as determined by the VA) and receives VA pension benefits in the amount of $1,450 per month. Because he requires assistance with his daily living tasks, ~~Jack receives~~his VA pension benefits include an aid and attendance allowance ~~that is part of the $1,450. The aid and attendance allowance that Jack receives is~~of $589 per month. Aid and attendance is disregarded income.

$1,450 VA pension
- 589 aid and attendance allowance (disregarded income)
$ 861 budgetable income

Example 4: Donald is a married veteran living with his wife and two children. He is disabled (as determined by the VA) and receives VA compensation benefits in the amount of $2,600 per month. He does not receive aid and attendance, housebound, or unusual medical expense allowances.

The full $2,600 is budgetable income to the household.

15.3.26.1 Residents of a State Veterans Home

~~For~~Eligibility: for any veteran who resides at a State Veterans Home at King, Chippewa Falls, or Union Grove, in the eligibility determination, exempt the amounts identified by

the VA as unreimbursed (sometimes called "unusual") medical expenses, aid and attendance, and housebound allowances.

~~In the post~~Post-eligibility ~~test,~~: exempt $90 for those who meet **all** of the following conditions:

- He or she receives aid and attendance, unusual medical expense, or housebound allowance payments in an amount greater than $90.
- He or she is a veteran who currently has no spouse (i.e., he or she never married, or is divorced or widowed) or dependent child or is a childless surviving spouse of a veteran.

15.3.30 Federal Coronavirus Recovery Rebates (Stimulus Payments~~)~~/Economic Impact Payments)

Do not count Federal Recovery Rebates (sometimes referred to as Coronavirus stimulus payments~~) received as part of the federal CARES Act.~~ or economic impact payments) issued by the IRS in response to the federal COVID-19 public health emergency.

~~**Note:** These payments were tax rebates from the IRS issued in 2020 and amounted to a maximum of $1,200 per taxpayer, and $500 per qualifying child.~~

15.3.34 Federal Income Tax Refunds and Credits

Federal income tax refunds (including refundable tax credits) and advance payments of any tax credits, including the Earned Income Tax Credit and the Child Tax Credit, are totally disregarded as income.

16.7 LIQUID ASSETS

16.7.7 Income Tax Refunds

~~Federal and state~~State income tax refunds are available assets.

Federal income tax refunds are disregarded in the month received and for the 12 months following the month of receipt.

After the 12-month disregard period has passed, count any remaining federal income tax refund as an available, non-exempt asset.

16.7.8 Earned Income and Child Tax ~~Credit~~Credits

Disregard all *EITC* and Child Tax Credits, including advance payments of these credits, in the month received and for 12 months following the month of receipt.

After the 12-month disregard period has passed, count any remaining EITC or Child Tax Credit payments as available, non-exempt assets.

16.7.33 Federal Coronavirus Recovery Rebates (Stimulus Payments~~)~~/Economic Impact Payments)

Federal Recovery Rebates (sometimes referred to as Coronavirus stimulus payments~~)~~ ~~received as part of~~ or economic impact payments) issued by the IRS in response to the federal ~~CARES Act~~COVID-19 public health emergency should be disregarded as assets for 12 months ~~from the date~~following the ~~payment was received~~month of receipt.

~~**Note:** These payments were tax rebates from the IRS issued in 2020 and amounted to a maximum of $1,200 per taxpayer, and $500 per qualifying child.~~

Note: After the 12-month disregard period has passed, count any remaining amount as an available non-exempt asset.

17.1 DIVESTMENT DEFINED

Divestment is the act of transferring ownership of assets or income and receiving less than fair market value *FMV* in return. Applicants or members seeking Medicaid-covered long-term care services are subject to a set of special rules about transferring assets and income. Wisconsin refers to these as "divestment rules."

If someone subject to divestment rules transfers an asset and/or income and is seeking Medicaid coverage of long-term care services (see 17.1.1 Applicable Health Care Programs), the transfer must be evaluated (see 17.2 Evaluation of Transfers for Divestment). Divestment rules do not apply to the applicants or members listed in 17.1.2 Excluded Applicants and Members.

Divestment rules apply even if someone else transfers the applicant or member's assets or income. Divestments can be made by:

- An institutionalized person.
- An institutionalized person's spouse.
- A person, including a court or an administrative body, with legal authority to act in place of or on behalf of the institutionalized person or the person's spouse.
- A person, including a court or an administrative body, acting at the direction or upon the request of the institutionalized person or the person's spouse. This includes relatives, friends, volunteers, and authorized representatives.

Note: An **Institutionalized Person** is someone who meets one of the following criteria:

1. Participates in a Home and Community-Based Waivers program
2. Has resided in a medical institution for 30 or more consecutive days for a purpose other than receiving residential substance use disorder treatment
3. Is likely to reside in a medical institution for 30 or more consecutive days for a purpose other than receiving residential substance use disorder treatment, as attested to by the medical institution.

An exception to the 30-day period is that a resident of an IMD for a purpose other than receiving residential substance use disorder treatment is considered an institutionalized person until they are discharged.
The 30-day period includes situations in which the person resides in more than one medical institution during 30 or more consecutive days.

Example 1: Don enters a nursing home and applies for Institutional Medicaid. Don's daughter, Stacy, donates his boat and all the money in his savings account to

charity. Divestment rules apply to this transfer even though Don did not make the gift himself.

17.1.1 Applicable Health Care Programs

Divestment rules apply to long-term care services provided through the following programs:

- Adult Community Waivers programs, regardless of the member's form of Medicaid.
  - Family Care.
  - Family Care Partnership.
  - PACE.
  - IRIS programs.
- Institutional Medicaid.
- Medicaid Purchase Plan (MAPP) members.
- BadgerCare Plus for institutionalized childless adults.

Example 2: Henry is enrolled in MAPP and moves into a skilled nursing facility. He is over the asset limit for institutional Medicaid, so he remains enrolled in MAPP, which covers his long-term care services in the nursing home. Henry sells his home and gives the money to his daughter. Even though Henry is not enrolled in institutional Medicaid, divestment rules apply to his gift because Medicaid is paying for his long-term care services.

Example 3: Keisha is enrolled in BadgerCare Plus. She has complications from surgery that impact her motor functions. Keisha enrolls in the Family Care program to get extra services to remain in her home. Keisha's income and asset transfers are now subject to divestment rules.

17.1.2 Excluded Applicants and Members

Divestment rules do not apply to transfers made by or on behalf of:

- Children under 19 years old.
- Children under 22 years old who are enrolled in the Children's Long-term Support (CLTS) waiver program.
- A person of any age receiving residential substance use disorder (SUD) treatment in any setting, if the person is only there to receive residential SUD treatment.

Example 4: Cedric is 22 years old, has a disability determination, and is institutionalized. He applies for institutional Medicaid and reports on his application that he gifted money to his brother. The IM agency requests more information and discovers Cedric was 17 when he gave away the money. Due to his age at the time he gave the money away, this is not a divestment.

17.2 EVALUATION OF TRANSFERS FOR DIVESTMENT

IM agencies evaluate information provided about a transfer to determine if it is a divestment. If a divestment occurs, the agency determines if it is allowed or if it requires a penalty period. Note: Divestment rules do not apply to the applicants or members listed in 17.1.2 Excluded Applicants and Members.

The evaluation of a transfer for divestment includes:

- 17.2.1 Exemption or Disregarded Status of Income and Assets
- 17.2.2 Date of Transfer
- 17.2.3 Transfers that are Not Divestment
- 17.2.4 Determining Fair Market Value
- 17.2.5 Verification
- 17.2.6 Allowed Divestments
- 17.2.7 Divestments that are Not Allowed and Result in a Penalty Period

17.2.1 Exemption or Disregarded Status of Income and Assets

Transfers of exempt income and assets do not count as divestments. For the purposes of divestment, exempt and disregarded have the same meaning. This chapter uses the word exempt.
Income and assets are either exempt or nonexempt following the policies in Chapter 15 Income and Chapter 16 Assets.

- Transfers of **exempt** income and assets are **not** divestment with the exception of homestead property 17.2.7.1 Transfer for Less Than Fair Market Value (see 17.2.3 Transfers that are Not Divestment).
- Transfers of **nonexempt** income and assets **are evaluated** for divestment rule applicability.

17.2.2 Date of Transfer

Any transfer of nonexempt income or nonexempt assets that occurs during the lookback period (see 17.2.2.1 The Look Back Period) or while a person is eligible for long-term care services must be evaluated for divestment.

The exact date of each transfer is needed to evaluate the transfer for divestment rule applicability.

For *real property*, such as homestead property, the date of transfer is the date the Quit Claim Deed was signed and notarized or authenticated by an attorney. The date the county Register of Deeds recorded the transfer is not the date of transfer.

17.2.2.1 The Look Back Period

Per federal law, transfers of nonexempt income or assets that occur during the 60 months (five years) prior to the month of application must be evaluated for divestment. This 60-month period is the "lookback period."

17.2.2.1.1 Beginning of the Look Back Period

The first month (month one) of the lookback period is the more recent of either:

- The month before the institutional Medicaid application month.
- The month before the Community Waivers program application month.

The application month is the first month all of these conditions are true:

Program	Conditions
Institutional Medicaid	• The applicant is institutionalized. • The applicant has applied for health care.
Community Waivers Programs	• The applicant is determined to be *functionally eligible*. • The applicant has requested one of the Community Waivers programs. • The applicant is otherwise eligible for enrollment in Family Care, Family Care Partnership, PACE, or IRIS.

Example 1: Kaylee was institutionalized on March 2. She submitted a signed application for Medicaid to the agency on May 5. Her lookback period begins with April as month one.

Example 2: Judas had options counseling with the ADRC and submitted a signed Medicaid application and request for Family Care on June 19. He was found

functionally eligible on May 5 and was otherwise eligible for enrollment in FC through Waiver Medicaid. His lookback period begins with May as month one.

17.2.2.1.2 Transfers Prior to the Look Back Period

Transfers that occur before the 60-month (five-year) lookback period are not subject to divestment rules. This includes the irrevocable assignment of an asset or purchase of an annuity that has not been changed (see 17.2.3 Transfers that are Not Divestment).

17.2.2.1.3 Transfers during the Look Back Period

An applicant or member may be ineligible for long-term care services if the applicant or member, their spouse, or anyone acting on their behalf divests the applicant's or member's income or assets during the lookback period. The period of long-term care ineligibility is based on the value of the divestment. Applicants must report any divestment that occurred during the lookback period when they apply.

17.2.2.1.4 Transfers during the Look Back Period that are Reported Late

Divestments that occurred during the lookback period and are reported or discovered after eligibility was established must be evaluated. A divestment reported after eligibility was established doesn't result in an overpayment but may result in a penalty period. See 17.3 Penalty Period.

Example 3: Trisha is 70, institutionalized, and applies for institutional Medicaid. She reports no divestment on her application. Several years later, Trisha reports that she gave her granddaughter $10,000 four years prior to her initial institutional Medicaid application. This divestment happened during her lookback period, which is now seven years ago. Because this divestment occurred during the lookback period and was required to be reported in her application, the divestment must now be evaluated.

17.2.2.1.5 Transfers Made by the Community Spouse Who Later Applies for Medicaid

If a community spouse applies for Long Term Care services, any divestment that occurred during their own lookback period must be evaluated. This includes allowed divestments made by the community spouse that were previously evaluated for the institutionalized person. See also 17.3.8 Both Spouses Institutionalized.

Example 4: Brent is an institutionalized person. Eight years after Brent was found eligible for Long Term Care services, Brent's community spouse, Sven, applied for

Long Term Care services. Sven reported a gift of $15,000 to his niece six months before he applied for Long Term Care services. Because this divestment occurred over 60 months (five years) after Brent was found eligible, the divestment was allowed and didn't impact Brent's eligibility. See 17.2.6.6 Divestment by the Community Spouse After Five Years.

This divestment must still be evaluated for Sven's Long Term Care eligibility because it occurred during Sven's lookback period.

17.2.3 Transfers that are Not Divestments

Once a transfer is determined not to be a divestment, it has no impact on eligibility.

17.2.3.1 Transfers for Fair Market Value

A transfer for fair market value (*FMV*) is not a divestment. See 17.2.4 Determining Fair Market Value. This includes:

- Receiving equal value in return for an asset.
- Converting an asset from one form to another of equal value.

Example 5: Tally purchases a sailboat for $12,000. He verifies the value of the sailboat to be $12,500. Because this purchase was converting a cash asset into another asset (the sailboat), purchasing and keeping the sailboat isn't a divestment. Tally's assets now count the $12,500 sailboat instead of the $12,000 in cash used to purchase the boat.

Example 6: Sterling transferred ownership of his RV to his parents. In payment, his parents signed over to Sterling the deed to their cottage. The *FMV* of the RV was the same as the FMV of the cottage. This transfer is not a divestment because Sterling received FMV for his transfer, and the cottage will be evaluated as a countable asset.

17.2.3.2 Transfers of Exempt Income or Assets

Income or assets determined to be exempt (except homestead property per 17.2.7.1 Transfer for Less Than Fair Market Value) are not subject to divestment rules.

Example 7: Hattie is eligible for Medicaid and receiving long-term care services. She owns one car. Hattie transfers ownership of the car to her sister. Hattie buys another car, and now once again owns one car. She gives this car to her father. Because one car is an exempt asset, these transfers are not subject to divestment rules.

Assets can be permanently or temporarily exempt (16.7 Liquid Assets). The transfer of temporarily exempt assets is not subject to divestment rules during the time they are exempt. This includes, but is not limited to, giving away funds from:

- Retroactive Social Security payments during the nine months after the payment was received.
- Patient liability or cost share refunds during the nine months after the refund was received.
- Federal Economic Impact payments made during the Coronavirus Pandemic during the 12 months after the payment was received.

Example 8: On February 15, Sri received a cost share refund of $5,000. This refund is exempt in February and remains exempt for nine months (March through November). Sri gives away the entire $5,000 to her mother and reports that gift to the IM agency.

- If Sri gave the $5,000 to her mother between February 15 and November 30, the gift is not a divestment because it was exempt during that time.
- If Sri gave the $5,000 to her mother December 1 or later, the gift is a divestment and must be evaluated.

17.2.3.3 Prenuptial Agreements

The act of signing a prenuptial agreement is not a divestment.

17.2.3.4 Payments to a Relative while the Institutionalized Person Received Room and Board

An institutionalized person paying a relative for room and board is not a divestment if the payments do not exceed fair market value, the institutionalized person is actually receiving room and board, and the institutionalized person provides a written lease that existed during the time they received room and board from the relative.

17.2.3.5 Ownership Returned before Application

Returning the ownership or full value of a divested asset during the lookback period is not divestment. This is because both the transfer and the return occurred before the request for Long Term Care services.

Example 9: Dan transfers ownership of his lake house (not homestead property) to his daughter, Cile, as a gift. Two years later, Dan and his daughter realize that this transfer affects his future eligibility for Medicaid, so Cile signs the lake house back over to Dan. Later that year, Dan applies for Long Term Care services. No divestment penalty period is imposed for the transfer of his lake house to his daughter because ownership was returned to him prior to his application.

17.2.4 Determining Fair Market Value

Fair market value *FMV* is an estimate of the price an asset has when sold on the open market. The FMV is based on the time an asset is transferred and not when the transfer is reported to or evaluated by the IM agency.
The FMV of real property can be established by:

- **Assessment**
  Property tax assessments or appraisals may document a property's *FMV* if both the IM agency and applicant or member agree that it accurately represents the FMV.

- **Statements from Realtors**
  Statements from one or more realtors giving the *FMV*.

- **Comparative Market Analysis**
  Prepared by a realtor, a Comparative Market Analysis estimates the *FMV* of the applicant or member's property by evaluating the recent sale prices of comparable properties. If the IM agency requests this document, the agency must pay for it.

The applicant or member has the right to file a fair hearing if they disagree with the FMV of the property determined by the IM agency.

Example 10: Paul applied for institutional Medicaid this month and reported transferring ownership of his house to a friend three years ago. Today, the house is worth $70,000, but three years ago, the value of the house was $54,000. The *FMV* is $54,000 for divestment purposes as that is the value Paul could have received if he had sold it three years ago.

17.2.5 Verification

Verification of a divestment can be provided by the applicant, member, spouse, or someone acting on their behalf. Statements from physicians, insurance agents, insurance documents, and/or bank records that confirm the person's statements should be considered. Self-attestation is not sufficient verification.

Verification to show that the divestment was allowed must include both:

- Proof of the specific purpose and reason for the transfer.
- Information establishing that the resource was transferred for a purpose other than to qualify for Medicaid.

17.2.6 Allowed Divestments

A divestment must be checked against all types of allowed divestments described in this section before checking it against those that are disallowable as described in 17.2.7 Divestments that are Not Allowed and Result in a Penalty Period.

There is no penalty period for allowed divestments.

This section does not include a comprehensive list of all allowed divestments. The member or applicant's intent must be evaluated to determine whether it is an allowed divestment.

Prior to determining whether a transfer is an allowed divestment or not, the transfer must be evaluated as a divestment based on the following:

- 17.2.1 Exemption or Disregarded Status of Income and Assets
- 17.2.2 Date of Transfer
- 17.2.3 Transfers that are Not Divestment
- 17.2.4 Determining Fair Market Value
- 17.2.5 Verification

17.2.6.1 Sufficient resources for five years of long-term care

A transfer by an applicant or member who has sufficient financial resources or Long Term Care insurance for at least a five-year period at the time of the transfer is an allowed divestment and doesn't result in a penalty period.

For the average monthly nursing home cost of care in effect at the time of a divestment, see 39.4.3 Institutional Cost of Care Values. This cost per month multiplied by 60 months provides the amount to compare to the income, assets, and insurance held by the individual at the time of the divestment.

> **Example 11:** Lucius had a money market account that could pay for more than five years of Long Term Care services. At that time, Lucius gave a graduation present to his granddaughter worth $25,000. Two years later, Lucius suffers a traumatic brain injury and is institutionalized. Because the cost of specialized nursing home care is significantly greater than a regular nursing home, Lucius must apply for institutional Medicaid after only two years. Because Lucius had enough money to pay for five years of care at a regular nursing home at the time he gave the gift to his granddaughter, the gift is an allowed divestment and doesn't result in a penalty period.

> **Example 12:** Pierce had an investment portfolio with assets that could pay for more than five years of Long Term Care services. At that time, Pierce paid for his granddaughter to take a trip to Europe. Later, his investments plummeted in value due to the stock market, and he quickly spent his remaining assets on his care. Pierce then applied for Medicaid to continue receiving his necessary Long Term Care services. Because Pierce had assets to pay for his long-term care for five years when he made the gift to his granddaughter, the gift is an allowed

divestment and doesn't result in a penalty period even though gift was in Pierce's lookback period

17.2.6.2 Life expectancy of less than five years

A divestment is allowed and doesn't result in a penalty period if both:

- The institutionalized person's life expectancy was less than five years at the time of the transfer.
- The institutionalized person's resources, insurance, or both were sufficient to pay for their Long Term Care services for their remaining life expectancy.

For the average monthly nursing home cost of care in effect at the time of the divestment, see 39.4.3 Institutional Cost of Care Values. This cost per month multiplied by 60 months provides the amount to compare to the income, assets, and insurance held by the individual at the time of the divestment.

17.2.6.3 Unexpected Need

An unexpected need is evaluated by considering the institutionalized person's health and age at the time of the divestment. If the institutionalized person did not anticipate the need for Long Term Care services in the next five years and divested, it is an allowed divestment and doesn't result in a penalty period.

Example 13: Gerard had no health issues, was gainfully employed, and was 50 years old when he gave $50,000 to his daughter. Two years later, Gerard experienced a heart attack that caused him to need Long Term Care services for the rest of his life. When he gave the $50,000 to his daughter, Gerard was not expected to have set aside resources for five years of long-term care. This gift is an allowed divestment and doesn't result in a penalty period.

17.2.6.4 Pattern of Gifting

If the institutionalized person had a pattern of gifting money, such as to family members or charities, prior to the lookback period, similar divestments during the lookback period are allowed and don't result in a penalty period if both:

- The total yearly gifts don't exceed 15 percent of the individual's or couple's annual gross income (the same year as the gift) and
- There is no gap in the years or occasions the gifts occurred (see Example 14).

This allowed divestment is not limited to gifts made on traditional gift-giving occasions such as birthdays, graduations, and weddings. It can include a pattern of giving to assist family members with educational or vocational goals.

> **Example 14:** Jacques has five grandchildren and gave each $2,000 when they graduated from high school. Two of Jacques's grandchildren graduated during his lookback period. Jacques can show a pattern of gifting the $2,000 for graduation to the other grandchildren prior to the lookback period. The $4,000 he gifted to two of his grandchildren during the lookback period is an allowed divestment and doesn't result in a penalty period.

17.2.6.5 Spending Resources on Support of Dependent Relatives

The institutionalized person's current support of dependent relatives living with them or their spouse is an allowed divestment and doesn't result in a penalty period when either:

- The applicant, member, or spouse claims the relative as a dependent for IRS tax purposes, or
- The member or spouse provides more than 50 percent of the cost of care and support for the dependent relative.

17.2.6.6 Divestment by the Community Spouse After Five Years

The transfer of assets (e.g., liquid, homestead, etc.) by a community spouse more than 60 months (five years) after the institutionalized person was determined eligible is an allowed divestment and doesn't result in a penalty period or impact eligibility for the institutionalized spouse.

> **Example 15:** Chu is married and applied for Medicaid when he entered a nursing home. He was determined eligible for institutional Medicaid. Six years after Chu became eligible, Edith, Chu's community spouse, gave $30,000 to her nephew. This divestment is allowed and doesn't result in a penalty period.

> **Example 16:** When Chu applied for institutional Medicaid, he and Edith owned a home together. After Chu became eligible, he transferred complete ownership of the home to Edith. When Chu had been eligible for institutional Medicaid for five years, Edith transferred the homestead property to someone else for less than fair market value. Chu's eligibility was not affected. This divestment is allowed and doesn't result in a penalty period.

Edith applies for Long Term Care services two years later. Her transfer of the homestead property is in her lookback period and must be evaluated by the agency for divestment.

17.2.6.7 Divorce or Separation Action

The division of property as part of a divorce or separation action is an allowed divestment and doesn't result in a penalty period.

17.2.6.8 Involuntary Loss of Property

The loss of property due to foreclosure or repossession is an allowed divestment and doesn't result in a penalty period.

17.2.6.9 Intent to Sell for Fair Market Value (FMV)

The disposal of an asset by an institutionalized person who can prove they intended to receive *FMV*, is an allowed divestment and doesn't result in a penalty period.

Example 17: Gary sells a boat and agrees to two payments that total the *FMV* of the boat. He cashes a check for the first payment, but the second payment is a bad check. Gary shows proof of the bad check and that he has been unable to recover the boat or the second payment. When Gary applies for Medicaid, this is an allowed divestment and doesn't result in a penalty period.

17.2.6.10 Undue Hardship Request is Granted

Any divestment associated with an undue hardship waiver request that is approved by the IM agency per 22.4 Undue Hardship, is an allowed divestment and doesn't result in a penalty period.

17.2.6.11 Homestead Property Given to Spouse or Certain Children or Siblings

The transfer of homestead property by an institutionalized person or their spouse for less than *FMV* is an allowed divestment and doesn't result in a penalty period when the transfer is to:

- The institutionalized person's spouse
- The institutionalized person's child who meets at least one of the following criteria:
    - The child is younger than 21 years or

- The child is blind or
- The child is permanently and totally disabled or
- The child is at least 21 years old and meets all of the following:
  - The child resided in the institutionalized person's home for at least two years immediately before the person moved to a medical institution; and,
  - The child provided care to the institutionalized person, which permitted him or her to reside at home rather than in the institution; and, and
  - The child provided care for the entire two years immediately before the person moved to a medical institution.

The child's provision of care must be verified by a notarized statement from the institutionalized person's physician or someone else who has personal knowledge of the circumstances. A notarized statement from the child is not sufficient.

- The institutionalized person's sibling if the sibling both:
  - Resided in the institutionalized person's home for at least one year immediately before the institutionalized person moved to a medical institution, and
  - Has a verified equity or ownership interest in the home. The equity or ownership interest must be verified by documentation such as a copy of the deed or land contract. The sibling's name on the document is not sole proof, so other documentation such as canceled checks and receipts may be needed.

17.2.6.12 Non-Homestead Property given to Spouse or certain Children

A non-homestead asset that an institutionalized person or their community spouse transfers for less than *FMV* is an allowed divestment and doesn't result in a penalty period if the transfer is to either or both:

- A spouse.
- A child of any age of either spouse who meets at least one of the following criteria:
  - Is blind or
  - Is permanently and totally disabled

17.2.6.13 Certain Payments to Relatives for Services Provided

Payments (or transfer of ownership of something of value) by an institutionalized person to a relative for services provided to the institutionalized person is an allowed divestment and doesn't result in a penalty period if either:

- The amount is **less** than 10 percent of the maximum Community Spouse asset share (CSAS) and meets both of the following:
  - The services directly benefited the institutionalized person.
  - The payment did not exceed reasonable compensation for the services provided.
- The amount is **greater** than 10 percent of the maximum Community Spouse asset share and meets all of the following:
  - The services directly benefited the institutionalized person.
  - The payment did not exceed reasonable compensation for the services provided.
  - The institutionalized person and the relative providing the service have a written, notarized agreement that meets all of the following:
    - Specifies the service being provided to the institutionalized person
    - Specifies the amount to be paid to the relative providing the services
    - Was notarized at the time the relative began to provide the services

Example 18: Kerry requests enrollment in Family Care on January 10. She paid her son $3,500 to remodel her bathroom the previous month. Her son installed new tile and fixtures, which directly benefitted Kerry. Kerry provides verification from a local contractor who estimates the he would have charged $4,000 for the same job. This amount is less than the maximum Community Spouse asset share at the time, so Kerry doesn't need a notarized agreement.

Since the bathroom remodel directly benefited Kerry and she did not pay more than reasonable compensation for the service, the payment to her son is an allowed divestment and doesn't result in a penalty period.

Example 19: Rosemary enters a nursing home and applies for Medicaid on November 1. When asked if she has transferred any assets in the past 60 months, Rosemary indicates that she paid her daughter $30,000 in exchange for her daughter providing personal care for her over the past two years. Rosemary provides an estimate from a home care provider that a similar amount of care from one of their employees would have cost $32,000 for two years. This payment is above 10 percent of Rosemary's Community Spouse asset share, so Rosemary must provide a notarized agreement. Rosemary provides the IM agency with an agreement that is dated and notarized at the time her daughter began providing care.

Rosemary provided the required notarized agreement and did not pay more than reasonable compensation for the service her daughter provided. The payment to her daughter is an allowed divestment and doesn't result in a penalty period.

17.2.6.14 Payments to Relatives While the Institutionalized Person Did Not Receive Room and Board

A payment for room and board made to relatives by an institutionalized person after they were institutionalized is an allowed divestment and doesn't result in a penalty period if the payment is only for the month immediately preceding the month that they entered the institution, the payment was for *FMV*, and the agreement is verified with a lease that existed during the time the institutionalized person received room and board from the relative.

17.2.6.15 Trusts Established by a Will

A trust established by a will is an allowed divestment and doesn't result in a penalty period.

17.2.6.16 Regulated Gambling Losses

Money lost from participating in gambling at a casino, racetrack, or other regulated gambling is an allowed divestment and doesn't result in a penalty period.

17.2.6.17 Irrevocable Annuities

An irrevocable annuity purchased, created, or changed during the lookback period or after eligibility is established may be an allowed divestment.

A changed annuity means any action taken by an individual that changes the course of payments made under an annuity or the treatment of the income or principal of an annuity. This includes all of the following:

- An addition of principal.
- An elective withdrawal.
- A request to change the distribution of the annuity.
- An election to annuitize the contract.
- A change in ownership.

An irrevocable annuity purchased, created, or changed during the lookback period or after eligibility is established is an allowed divestment if both 1 and 2 below are true.

1. The annuity names the "Wisconsin Department of Health Services Estate Recovery Program" as the remainder *beneficiary* and one of the following is true:
    a. The Estate Recovery Program is the primary remainder beneficiary if there is no spouse, disabled child, or minor child.

b. The Estate Recovery Program is the secondary remainder beneficiary if there is a spouse, disabled child, or *minor* child.

2. At least one of the following is true:
   a. **A retirement account conversion**
      The annuity was created from funds in a Roth IRA, 408 IRA, or other employer-sponsored retirement plan.
   b. **An individual retirement annuity**
      - The annuity is considered an individual retirement annuity according to Sec. 408(b) of the Internal Revenue Code of 1986 (IRC), or
      - The annuity is a deemed IRA under a qualified employer plan according to Sec. 408(q) of the IRC.
   c. **Purchased**
      - The annuity is purchased from a life insurance company or other commercial company that sells annuities as part of its normal course of business.
      - The purchased annuity must meet all of the following:
        1. **Currently Issuing Equal monthly payments**
           The annuity is currently issuing substantially equal monthly payments to the institutionalized person or spouse with no balloon, deferred, or graduated payments. Payment amounts may vary due to changes in interest rates.
        2. **Full Payback (Period Certain)**
           The annuity is a period-certain annuity that returns the full principal and interest within the annuitant's life expectancy as listed in the Period Life Table.
        3. **Actuarially Sound**
           The number of months that annuity payments will be issued should be less than the number of months of the individual's life expectancy (multiply figure from the Period Life Table by 12).

           Note: Annuities that provide for indefinite "lifetime payments" may not return the full principal and interest within the member's life expectancy and are not actuarially sound.

Example 20: Rashon applies for HBCW. He had invested in a Roth IRA while he was working. He converted the IRA to an irrevocable annuity when he retired 6 months ago and named the Wisconsin Department of Health Services Estate Recovery Program as the beneficiary. Since the annuity meets the conditions in 17.2.6.17 Irrevocable Annuities, the purchase of the annuity is an allowed divestment.

Example 21: Bowen applied for institutional Medicaid on July 28. On July 18, his community spouse Yun used $126,500.00 of the couple's resources to purchase an irrevocable 9-year period certain immediate annuity from the XYZ Life Insurance Company. Yun is the annuitant. Yun was 74 years old on the date the annuity was purchased and had a life expectancy of 9.75 years (117 months). The annuity will issue regular monthly checks of $1,488.75 for a set period of 9 years or 108 total months. The insurance company will pay out a total of $160,785.00 over the period of the annuity contract.

The contract date of the annuity was July 18 and the first monthly payment was issued on August 18. The annuity names the Wisconsin Department of Health Services Estate Recovery Program as the beneficiary, was purchased from a life insurance company, will issue regular monthly payments, is currently issuing payments and will provide for full return of principal and interest during the community spouse's life expectancy. Therefore, since the annuity meets the conditions in 17.2.6.17 Irrevocable Annuities, the purchase of the annuity is an allowed divestment.

17.2.6.18 Promissory Notes, Loans, Land Contracts, and Mortgages

The purchase of a promissory note, loan, land contract, or mortgage purchased during the lookback period or after eligibility is established is an allowed divestment when the terms meet all of the following criteria:

1. **Actuarially Sound:**
   The repayment term must be within the lender's life expectancy as determined by the Office of the Chief Actuary of the Social Security Administration, found at the following link: https://www.ssa.gov/OACT/STATS/table4c6.html
   The date the promissory note, loan, land contract, or mortgage purchased during the lookback period or after eligibility is established was signed is used to calculate the lender's life expectancy. The promissory note, loan, land contract, or mortgage purchased during the lookback period or after eligibility is established is actuarially sound if, when it was purchased, the lender was expected to live long enough to receive payment in full during their lifetime.
2. **Equal Payments**
   The repayment terms must include these conditions:
   1. Repayments must be in equal amounts during the term of the loan.
   2. Deferrals of repayment are prohibited.
   3. *Balloon payments* are prohibited.
      Note: Voluntary prepayments that exceed the required regular monthly payment amount ("paying extra") are not balloon payments.
3. **No Cancellation**
   The terms must not allow cancellation of repayment of the balance upon the death of the lender.

4. **Originally Allowed Cancellation but Terms were Amended**
   If the promissory note, loan, land contract, or mortgage purchased during the lookback period or after eligibility is established allows cancellation of repayment of the balance upon the death of the lender, the note can be amended to remove this language to avoid or cure a divestment penalty. If amended, it meets the criterion of not allowing the cancellation of repayment of the balance upon the death of the lender.

17.2.7 Divestments that are Not Allowed and Result in a Penalty Period

This section discusses unallowable divestments that result in a penalty period (17.3 Penalty Period).
This section doesn't include all situations in which a divestment is not allowed. For situations not listed here, the member or applicant's intent must be evaluated individually to determine whether it is an unallowable divestment.
Prior to determining whether a transfer is an allowed divestment or not, the transfer must be evaluated as a divestment based on the following:

- 17.2.1 Exemption or Disregarded Status of Income and Assets
- 17.2.2 Date of Transfer
- 17.2.3 Transfers that are Not Divestment
- 17.2.4 Determining Fair Market Value
- 17.2.5 Verification
- 17.2.6 Allowed Divestments

17.2.7.1 Transfer for less than Fair Market Value (FMV)

The transfer of ownership of a nonexempt asset for less than *FMV* is an unallowable divestment and results in a penalty period. Some examples of unallowable divestments are:

-

- Gifting money to others or making donations, even to non-profit organizations, when either:
  - The yearly gifted amount exceeds 15 percent of the individual or couple's annual gross income at the time the gift is transferred.
  - The pattern of gifting is not consistent because there is a gap in the pattern or occasions.
- Selling or giving away property, land, nonexempt vehicles, or other nonexempt assets for less than fair market value.
- Going on vacations and paying for someone other than the community spouse or a caretaker to accompany.
- Selling an exempt asset and then giving the money received to someone else.

- Transferring ownership of the exempt homestead property for less than fair market value except those listed in 17.2.6.11 Homestead Property Given to Spouse or Certain Children of Siblings.

17.2.7.2 Making an Asset Unavailable

An asset used in a way by a member or spouse that makes it unavailable and for which they don't receive *FMV* in return is an unallowable divestment and results in a penalty period.

> **Example 22:** Mitch allowed his non-homestead property to be used as collateral for his son's business loan. Mitch's non-homestead property was considered a nonexempt asset. Because using it as collateral makes it unavailable, his use of this asset is an unallowable divestment and results in a penalty period.

17.2.7.3 Refusal to Claim

Refusal to take action to claim a portion of the estate of a deceased spouse or parent despite statutory entitlement to that portion is an unallowable divestment and results in a penalty period.
This includes situations in which the will of the institutionalized person's spouse precludes any inheritance for the institutionalized person. Under Wisconsin law, a person is entitled to a portion of their spouse's estate. If the institutionalized person does not contest their spouse's will in this situation, the inaction is an unallowable divestment and results in a penalty period if both:

- The value of the abandoned portion is clearly identified.
- There is certainty that a legal claim action will be successful as determined by the IM agency's Corporation Counsel. The IM agency may not consider the actions taken to avoid income or assets a divestment without this determination from the agency's Corporation Counsel.

17.2.7.4 Avoiding Receipt

The action of avoiding the receipt of income or assets a member is entitled to is an unallowable divestment and results in a penalty period. This type of divestment includes:

- Irrevocably waiving pension income.
- Disclaiming an inheritance.
- Not accepting or accessing injury settlements.
- Diverting tort settlements into a trust or similar device.
- Refusing to take legal action to obtain a court-ordered payment that is due to the institutionalized person, such as child support or alimony.

17.2.7.5 Payments for services provided by the relative

The transfer of income or assets to a relative as payment for care or services provided to the institutionalized person is an unallowable divestment and results in a penalty period unless it meets the criteria to be an allowed divestment per 17.2.6.13 Certain Payments to Relatives for Services Provided.

Example 23: Jennifer enters a nursing home on December 12 and applies for Medicaid. She reports she paid her daughter $7,000 in December for making dinner every night for two months.

- The IM agency checks with a local meal service that reports reasonable compensation for each meal provided is $2.
- $7,000 is less than 10% of the maximum Community Spouse asset share at the time, so Jennifer is not required to provide a notarized agreement.

Jennifer's daughter provided 61 meals. Reasonable compensation for these meals was $122. Jennifer's payment to her daughter is an unallowable divestment and results in a penalty period. The divested amount for this payment is $6,878 ($7,000-$122).

17.2.7.6 Room and Board

The payment of room and board by an institutionalized person to a relative after the person has been institutionalized is an unallowable divestment and results in a penalty period unless it meets the criteria for an exception per 17.2.3.4 Payments to a Relative while the Institutionalized Person Received Room and Board.

17.2.7.7 Community Spouse Divestment that Impacts the Institutionalized Person

The transfer of assets by a community spouse is a divestment and must be evaluated if the transfer occurred within five years of the institutionalized person becoming eligible for long-term care Medicaid.

Example 24: Ralph, a married man, went into the nursing home and applied for and was determined eligible for institutional Medicaid. One year after Ralph became eligible, Edith, Ralph's community spouse, gave $30,000 to a nephew. This is an unallowable divestment and results in a penalty period for Ralph because it occurred within the first five years of his eligibility.

17.2.7.8 Transfer of Income in the Month of Receipt

Income received and transferred in the month of receipt for less than *FMV* is an unallowable divestment and results in a penalty period.

> **Example 25:** Monte resides in a nursing home. He receives a pension check of $3,000 on January 1. Monte signs the check over to his son on January 5 and doesn't receive anything in return. This is an unallowable divestment and results in a penalty period.

Unless there is reason to believe otherwise, assume that monthly household income was spent by the institutionalized person on normal costs of living.

17.2.7.9 Transfer of the Right to Receive Income

Transferring the right to receive nonexempt income by an applicant or member to someone else is a divestment and results in a penalty period.

When a person has transferred income or the right to receive income, the penalty period is calculated based on the total amount of income transferred.

> **Example 26:** Donald transfers his rights to his $325,000 pension, which is paid in monthly payments of $4,500, to his daughter. This is an unallowable divestment and results in a penalty period. The worker must determine the divestment amount and penalty period. The divested amount is $325,000, not the $4,500 the daughter expects to receive each month from the pension.

17.2.7.10 Life Estate – Transferring the Property for Less than FMV

The transfer of property originally owned by a life estate holder to a remainder person without receiving *FMV* is an unallowable divestment and results in a penalty period. The *divested amount* is the FMV of the property at the time of the transfer minus the life estate value. To determine the life estate value, multiply the FMV of the property by the number from the 39.1 Life Estate and Remainder Interest table corresponding to the age of the life estate holder at the time the property was transferred.

> **Example 27:** Marion, age 83, gave her home to her son John, retaining a life estate. The *FMV* of the house at the time of the transfer was $87,000. Two years later, Marion applied for Long Term Care Medicaid. Since the transfer of her home occurred in the lookback period, it is an unallowable divestment and results in a penalty period. The worker must determine the divestment amount and penalty period. The divestment amount is the FMV of the house at the time of transfer, minus the life estate value.

To determine the life estate value, multiply $87,000 by .38642 (the number from 39.1 Life Estate and Remainder Interest table that corresponds to Marion's age, 83, at the time of transfer).

Marion is the life estate holder. John is the remainder person.

The divested amount is $87,000 - $33,618.54 = $53,381.46.

17.2.7.11 Life Estate - Divestment by Joint Owners

The transfer of a life estate on a property by joint owners without receiving *FMV* based on their share is an unallowable divestment and results in a penalty period.

To determine the life estate value, or share, for each individual, divide the property's FMV by the number of life estate holders. Then calculate the life estate value by multiplying the individual share of the FMV by the number in 39.1 Life Estate and Remainder Interest table corresponding to the individual's age at the time of the transfer or termination of the life estate.

Example 28: Marie and George transferred ownership of their home to their three sons and retained a life estate on the property. The *FMV* of the home at the time of the transfer was $140,000. At the time George was 82 and Marie was 68. One year later, George applied for Long Term Care Medicaid. This is an unallowable divestment and results in a penalty period. Since the transfer occurred in the lookback period, the worker must determine the amount of the divestment and the penalty period. To calculate the total divestment, the worker must first determine the life estate values.

$140,000 divided by 2 = $70,000

George's age at the time of the transfer was 82. Multiply 70,000 x .40295 (see 39.1 Life Estate and Remainder Interest for this value.) = 28,206.50

Marie's age at the time of transfer was 68. Multiply 70,000 X .63610 = 44,527.00

The total life estate value for both Marie and George is $72,733.50.

The divested amount is the *FMV* minus the life estate value ($140,000 - $72,733.50 = $67,266.50).

17.2.7.12 Life Estate – Termination and Payment of Less than FMV

The termination of a life estate by its holder before their death without receiving the *FMV* of the life estate is an unallowable divestment and results in a penalty period.

The *divested amount* is the *FMV* of the property at the time of termination minus the life estate value. To determine the life estate value, multiply the FMV of the property by the number from 39.1 Life Estate and Remainder Interest table corresponding to the age of the life estate holder at the time the life estate was terminated.

Example 29: Marion, age 83, gave her home to her son John, retaining a life estate. The *FMV* of the house at the time of the transfer was $87,000.
Two years later, Marion applied for Long Term Care Medicaid. Since the transfer of her home occurred in the lookback period, it is an unallowable divestment and results in a penalty period. Marion served a divestment penalty period for this divestment.

Marion is the life estate holder. John is the remainder person.

John sold the home for the current FMV of $102,000, and Marion terminated the life estate. John took the proceeds from the home and bought another house. He did not pay Marion for the value of the life estate which is an unallowable divestment and results in a penalty period. The divestment amount is the life estate value at the time the life estate was terminated.

To determine the life estate value, multiply $102,000 (value of the house at the time the life estate was terminated) by .33764. (The number is from the table in 39.1 Life Estate and Remainder Interest corresponding to Marion's age, 86, at the time the life estate was terminated.)

$102,000 X .33764 = $34,439.28

The divested amount is $34,439.28 (see 17.3.4 Penalty Period Begin Date for Members).

Example 30: When James was 75 years old, he sold his home to his son Robert. The home was worth $95,000. Robert paid James $50,000 for the home and James retained a life estate. The life estate value is $49,541.55 (95,000 X .52149). (See 39.1 Life Estate and Remainder Interest for this value.) Since James received both $50,000 from Robert and retained a life estate worth $49,541.55, the total value he received is more than the *FMV* of the home.

Because the value he received is greater than the FMV of the home, it is not a divestment.

17.2.7.13 Life Estate - Divestment by the Remainder Person

The sale of property for *FMV* by a remainder person that gives the estate holder more than FMV for their life estate interest is an unallowable divestment and results in a penalty period for the remainder person.

Example 31: Fey is a remainder person and owns a property on which her mother holds a life estate. Fey sells the property for *FMV* but gives her mother $10,000 more than the amount she owes to buy out her mother's life estate. If Fey applies for Long Term Care Medicaid in less than 5 years, this $10,000 is considered an unallowable divestment and results in a penalty period for Fey.

17.2.7.14 Purchase of a Life Estate in the Home of Another Person

The purchase of a life estate interest in another individual's home is an unallowable divestment and results in a penalty period, unless the purchaser verifies that both:

- The purchaser resided in the home for a period of at least 12 consecutive months after the date of purchase as detailed in 17.2.7.14.2 Residence Requirement,
- The purchaser paid *FMV* for the life estate interest.

If the 12-month residence requirement is not met at the time of the application for Long Term Care Medicaid, the full purchase price of the life estate is used to determine the divested amount.
The divestment penalty remains in effect until one of the following, whichever is earlier:

- The end of the penalty period.
- The date the purchaser meets the residence requirement.

There is no pro-ration of the divestment penalty period for living in the home for part of the 12 months.

17.2.7.14.1 Couple Holds Life Estate in Another Person's Home

When a couple jointly holds a life estate in another person's home, the institutionalized person must reside in the home for 12 consecutive months, or their portion of the life estate value is an unallowable divestment and results in a penalty period. See 17.2.7.11 Life Estate - Divestment by Joint Owners for instructions on calculating the spouse's portion of the life estate value.

17.2.7.14.2 Residence Requirement

These four rules determine if a person has resided in the home for 12 consecutive months:

1. **Residence start date**
   The 12-month period of continuous residence may start immediately after the purchase or at any time after the purchase.
2. **Absence less than 30 days**
   Absences from the life estate home for less than 30 consecutive days do not affect the 12-month determination.

> **Example 32:** Ralph purchases a life estate interest in his brother's home on January 5 and moves into that home on the same date. He goes to Florida on January 20 and returns to the home three weeks later, on February 10. January and February count as whole months of residence because Ralph's absence was less than 30 consecutive days.

3.
4. **Voluntary absence of 30 days or more**
   Absences from the life estate home for 30 days or more for vacations, trips, or to stay elsewhere on a voluntary basis result in the 12-month period starting over.

> **Example 33:** VIcki purchases a life estate interest in her sister's home on January 20 and moves into that home on the same date. On March 3, Vicki goes to Bermuda for a family vacation and returns on April 15. The consecutive months of residency string breaks because Vicki was absent from the home for 30 or more consecutive days because of vacation. Her 12-month residence clock is reset with April being her "new" first month of residence.

5.
6. **Involuntary absence for 30 days or more**
   Absences from the life estate home for 30 days or more because of hospitalization or a rehabilitation stay do not count toward the 12 consecutive months.

   These types of absences do not result in the 12-month period starting over. The individual must continue residing in the home for the number of month(s) they were absent due to hospitalization or rehabilitation to achieve 12 total months of residence.
   When the individual lives in the home for at least one day of the month, it is considered a month of residence.

3.

Example 34: Jim purchases a life estate interest in his cousin's home on January 20 and moves into that home on the same date. Jim resides in the home until April 10, at which time he is hospitalized. Jim remains in the hospital until August 5 and returns home. Jim then resides in the home from August 5 until December 24.

To determine months of residence, the worker considers:

- Jim's residence in the home for the months of January, February, March, and April count as four consecutive months.
- May, June, and July are not included in the consecutive month count because Jim is absent from the home for those full calendar months. The absence from the home for those months doesn't cause the 12-month clock to restart because Jim's absence was the result of his hospitalization.
- When Jim returns to the home on August 5, August counts as the fifth month of continuous residency.
- Jim will meet the 12 months of continuous residency requirement in March, the fifteenth month of his ownership.

4.

17.2.7.14.3 Life Estate FMV when purchased from another person's home

If the 12-month residence requirement is met by the time of the application for Long Term Care, the worker must also determine if the applicant paid *FMV* for the life estate. The *FMV* of the life estate is determined using the age of the life estate holder and the property's FMV on the creation date of the life estate. Multiply the property's FMV by the life estate multiplier on the table in 39.1 Life Estate and Remainder Interest. The result is the value of the property's life estate interest as of that date. If the applicant paid more than FMV for the life estate interest, it is an unallowable divestment and the difference (what was paid minus the fair market value) is the divested amount.

Example 35: Joyce, who is 75 years old, has $200,000 in her savings account. On February 3, she gives $200,000 to her son in exchange for a life estate interest in her son's home. The *FMV* of the son's home as of this transfer was $300,000. Joyce moved into her son's home on March 5 and resided there continuously for more than 12 consecutive months. Fifteen months after moving in, Joyce applies for Family Care, meeting the functional eligibility criteria and all other Medicaid eligibility requirements.

To determine if a divestment occurred, the worker applies the following tests:

1. Residence Test:
   Joyce establishes that as of her application date for Community Waivers programs, she has resided in her son's home for more than 12 consecutive months.
2. *FMV* Test:
   Using the table in 39.1 Life Estate and Remainder Interest, Joyce's life estate interest was worth $156,447 ($300,000 FMV of the home X .52149 based on Joyce's age) at the time of the purchase. Since Joyce paid $200,000 for a life estate that was worth $156,447, the divested amount is $43,553. Joyce is subject to a penalty period based on this amount.

17.2.7.15 Revocable Trusts

Any payment made from a revocable trust created with an institutionalized person's assets that is not to or for their benefit is an unallowable divestment and results in a penalty period.

Example 36: Ray created a revocable trust with his assets. That trust is considered an available asset to Ray. Ray goes on vacation and takes several friends, paying for their lodging. Because this payment was not for Ray's benefit, the payment is an unallowable divestment and results in a penalty period.

17.2.7.16 Irrevocable Trusts Assigned or Created During or After the Look Back Period

Irrevocable trusts assigned or created during or after the lookback period may be unallowable divestments and result in a penalty period. Examples of this are:

- The institutionalized person created an irrevocable trust using his or her assets for some or all the trust. The *divested amount* is the total amount of the created trust.

- Sometimes revocable trusts contain a clause allowing them to become irrevocable later in the life of the trust. The divestment occurs on the date the trust changed from revocable to irrevocable. The divested amount is the amount in the trust on that date.

Example 37: In 1998, Benny created a revocable trust fund of $100,000 for his daughter. There was a clause in the trust stating the trust would become irrevocable if Benny became incompetent. He was determined incompetent on February 2, 2007, and the trust changed from revocable to irrevocable. Benny entered an institution and applied for Medicaid in July 2008. The trust changing from a revocable trust to an irrevocable trust is an unallowable divestment and results in a penalty period. He divested the total amount of the trust on February 2, 2007.

- The institutionalized person added funds to the irrevocable trust. The divested amount is the amount of the added funds.

17.2.7.17 Irrevocable Trusts Created Prior to the Look Back Period: Payments Made to Anyone Other Than Institutionalized Person

Any payment made from an irrevocable trust created with an institutionalized person's assets that is not to or for the benefit of them during or after the lookback period is an unallowable divestment and results in a penalty period, even if the trust was created prior to the lookback period.

17.2.7.18 Third Party Establishes a Pooled Trust

A third party establishing a pooled trust is an unallowable divestment and results in a penalty period for the third party if it meets all of the following criteria:

- The beneficiary of the trust is disabled and age 65 or older.
- The beneficiary of the trust is not the third party's disabled child.
- The third party applies for Long Term Care Medicaid or is already eligible for it.
- The trust was established during the third party's lookback period or after they became eligible for Long Term Care Medicaid.

The divested amount is the total amount of funds transferred to establish the pooled trust.

17.2.7.19 Third Party Adds Funds to a Pooled Trust

Any funds added during the lookback period or after eligibility is established by a third party to a trust for a disabled individual after the beneficiary turns age 65 is an unallowable divestment and results in a penalty period **for the third party** when all of the following are met:

- The beneficiary of the trust is disabled and age 65 or older.
- The beneficiary of the trust is not the third party's disabled child.

- The third party applies for Long Term Care Medicaid or is already eligible for it.
- The funds were added to the trust during the third party's lookback period or after they became eligible for Long Term Care Medicaid.

The divested amount is the total amount of funds added to the pooled trust.

17.2.7.20 Irrevocably Assigned Life Insurance Funded Burial Contracts with a Remaining Cash Surrender Value

Irrevocable life insurance funded burial contracts (LIFBC) must be evaluated as assets per 16.5.3.1 Irrevocable Assignment of Life Insurance-funded Burial Contracts in order to evaluate for divestment. If the calculations of cash surrender value *CSV* have any amount left over, that amount is the divested amount. It is an unallowable divestment and results in a penalty period.

Example 38: Les has irrevocably assigned the ownership of his life insurance policy to a funeral home to fund a burial contract. The face value of the LIFBC is $3,000. The Statement of Funeral Goods and Services shows $3,000 for the pre-arrangement of the funeral, of which $1,300 is designated for a casket and $1,700 for funeral expenses (services and cash advances for such things as flowers and the obituary).

The $1,700 funeral expense portion reduces the $1,500 burial fund exclusion (see 16.5.5 Burial Funds), and so $1,500 of this LIFBC is his exempt burial fund. The $1,300 casket doesn't reduce the burial fund exclusion (see 16.5.5 Burial Funds) and is not a countable asset because it is a purchase of a burial space.

Because the LIFBC was assigned irrevocably, it must be determined if Les is receiving other goods or services at *FMV* for the remaining $200 designated for funeral expenses. If he is not receiving goods or services at fair market value, consider the remaining $200 a divestment.

17.2.7.21 Irrevocably Assigned Life Insurance Funded Burial Contracts with a Face Value that Exceeds the Statement of Funeral Goods and Services

If the face value of the LIFBC exceeds the total amount shown on the Statement of Funeral Goods and Services, the cash surrender value of the LIFBC must be determined at the time it was assigned. Any portion of an irrevocably assigned LIFBC for which no goods and services are received at *FMV* is the divested amount.

Example 39: Joey has irrevocably assigned the ownership of his life insurance policy to a funeral home to fund a burial contract. The face value and the cash value of the LIFBC is $3,200. The Statement of Funeral Goods and Services

shows $3,000 for the pre-arrangement of the funeral. A divestment in the amount of $200 occurs because the cash value of the LIFBC exceeds the expenses of the pre-arrangement of the funeral.

17.2.7.22 Unregulated Gambling Losses

Money lost by making personal bets with friends, relatives, or from other unregulated gambling is an unallowable divestment and results in a penalty period.

17.2.7.23 Voluntary Foreclosure or Repossession

Voluntarily signing ownership of an asset over to the financial institution holding the loan rather than trying to sell the item is an unallowable divestment and results in a penalty period. This includes situations in which someone wants an alternative to foreclosure or repossession due to defaulting on the loan.

Example 40: Quince cannot pay his mortgage on his lake house. He must either sell the lake house to pay the mortgage or sign the property over to the mortgage holder to avoid foreclosure. Quince feels the amount of money he would get to keep after selling the lake house is not worth the time it would take to get it ready to sell, so he signs it over to the bank. This is an unallowable divestment and results in a penalty period.

17.2.7.24 Homestead Property

Homestead property, usually an exempt asset, is given special consideration in the Medicaid divestment policy. A divestment of homestead property is unallowable and results in a penalty period unless it meets the criteria under 17.2.6.11 Homestead Property given to Spouse or certain Children or Siblings.

17.2.7.25 Jointly Held Assets and Value of the Asset is Transferred

The transfer during the lookback period or anytime thereafter of an asset owned by an institutionalized person in common with another person is an unallowable divestment and results in a penalty period if either:

- The transfer reduces or eliminates the institutionalized person's ownership or control of the asset.
- The transfer limits the institutionalized person's right to sell or otherwise dispose of the asset.

Example 41: For many years Debra held a joint account with her daughter, Julie. On October 15, Julie withdraws $13,000 from it and purchases a certificate of deposit in her name. On December 3 of that year, Debra enters a nursing home and applies for Medicaid. The $13,000 withdrawal is an unallowable divestment and results in a penalty period.

17.2.7.26 Adding Someone as an Additional Owner of an Asset

The addition of another person's name to the ownership of an institutionalized person's asset is an unallowable divestment and results in a penalty period if either:

- The addition of another individual's name limits the individual's right to sell or otherwise dispose of the asset.
- The addition of another individual's name requires the other individual agree to the sale or the disposal of the asset, where no such agreement was necessary before.

Example 42: John bought a piece of property with his nephew, Carl. Three months later John applied for a Community Waivers program. John explained that Carl refused to sell the property, making it unavailable and that it should not count as an asset. The purchase of the property was during the lookback period and the nephew's refusal to make it available through liquidation is a divestment. John is subject to a penalty period starting from the date he requested Long Term Care Medicaid if he was otherwise eligible.

17.3 PENALTY PERIOD

17.3.1 Penalty Period Introduction

If an unallowable divestment occurs, the institutionalized person is ineligible for Medicaid coverage of long-term care services for a time period known as the penalty period.

The length of the penalty period is based on the value of the divestment. If an undue hardship waiver is requested and granted, then the penalty period will be waived per 22.4 Undue Hardship.

Penalty periods only impact someone's eligibility for LTC services and do not affect an applicant or member's eligibility for Medicaid card services (21.4.1.1 Medicaid Card Services) when they are residing in a medical institution. An individual ineligible for Community Waivers programs due to a divestment may still be eligible for other types of Medicaid that do not cover long-term care services.

17.3.1.1 Institutions and the Penalty Period

During the penalty period, Medicaid doesn't pay the institutionalized person's daily care rate in the nursing home, although they are still eligible for Medicaid card services (see 21.4.1.1 Medicaid Card Services).

> **Example 1:** Martha resides in a nursing home and applies for institutional Medicaid. Martha is ineligible for Medicaid to pay for her long-term care services in the nursing home for five months due to a divestment. She is eligible for institutional Medicaid, but Medicaid will only pay for her card services during the five-month penalty period. Once the penalty period is over, Martha's institutional Medicaid will pay for her long-term care services.

17.3.1.2 Community Waivers Programs and the Penalty Period

A person is not eligible to enroll in Community Waivers programs during a divestment penalty period. However, a person who is ineligible for Community Waivers programs due to a divestment penalty may be eligible for other programs during the penalty period. They cannot be eligible for Waivers Medicaid or Institutional Medicaid, but they can become eligible for a form of Medicaid not based on receipt of long-term care services, such as SSI-related Medicaid or MAPP, if they meet the eligibility requirements for that program.

Example 2: Joe applies for Community Waivers programs through Waivers Medicaid and is determined ineligible for nine months due to a divestment. The IM agency determines that Joe can become eligible for SSI-Related Medicaid by meeting a deductible. Even if Joe meets the deductible and becomes eligible for Medicaid, he may not enroll in any Community Waivers programs until his nine-month divestment penalty period ends.

17.3.2 Calculating the Penalty Period

The divestment penalty period is calculated in days using the average daily nursing home private pay rate. For divestments that occurred during or after the lookback period, the penalty period is calculated using the average daily nursing home private pay rate in effect at the time of application.

For subsequent divestments that occur when a person is already in a divestment penalty period, the additional penalty period is calculated using the average daily nursing home private pay rate currently in effect at the time the divestment penalty period is being determined. (see 17.3.6 Divestments During a Penalty Period)

The rate effective January 1, 2021 is $303.38. This rate may be updated annually (see 39.4.3 Institutional Cost of Care Values).

Example 3: Jeff moved to a nursing home and applied for Medicaid on 3/1/21. One month earlier, Jeff transferred $18,500 in cash to his son and it is determined to be a divestment. At the time of application, Jeff is otherwise eligible for LTC Medicaid. Since $18,500 divided by the average daily nursing home rate at the time Jeff applied of $303.38 equals 60.97 days, Jeff will have a divestment penalty period of 60 days.

17.3.2.1 Multiple Divestments During the Look Back Period

Multiple divestments that occur during the look back period must be calculated by adding the individual divestment amounts together to get the total divestment amount. The total is used to calculate the divestment penalty period.

To cure multiple divestments that occurred during the look back period, the applicant must receive the full amount of the total divestment that occurred during the look back period.

17.3.2.2 Multiple Divestments Occurring in Different Months

Multiple divestments that occur while the member is eligible for Medicaid are considered separate divestments unless they occur in the same month.

17.3.2.3 Multiple Divestments Occurring in the Same Month

Multiple divestments that occur in the same month while the member is eligible for Medicaid are added together to calculate the total amount.

17.3.3 Penalty Period Begin Date for Applicants

The penalty period for an applicant begins on the date that meets all of the following:

- The person applies for institutional Medicaid or requests one of the Community Waivers programs (Family Care, Family Care Partnership, PACE, or IRIS).
- The person enters an institution or meets the appropriate *LOC* and functional screen criteria.
- The person meets all other Medicaid nonfinancial and financial eligibility requirements.

An enrollment date is not required for Community Waivers programs applicants to meet the criteria.

Note: An applicant who divests excess assets during the application period, including any backdated months, is ineligible due to excess assets until the month that they divested the assets. The divestment penalty period as well as the potential eligibility for card services begins on the date of the divestment.

> **Example 4:** Jeff requested enrollment in Family Care and was determined functionally eligible on March 1. He applied for Waiver Medicaid on March 5. One month earlier, Jeff had transferred $18,500 in cash to his son, which is a divestment. At the time of application, Jeff is otherwise eligible for Waiver Medicaid. Jeff's penalty period begins on March 5, the date by which he requested Family Care, met the functional screen criteria, and applied for Waiver Medicaid.

> **Example 5:** Joan entered a nursing home on March 1 and applied for Medicaid on March 4. On her application, Joan reported that, in the previous month, she gave her adult daughter a $100,000 cash gift, which is a divestment. All requested verification is received on March 27, and Joan meets all other Medicaid eligibility requirements. Joan's divestment penalty period begins on March 1.

Example 6: John applied for a Community Waivers program on April 7. He indicated on his application that he gave his adult son a $60,000 cash gift three months earlier, which is a divestment. As of April 7, John meets the community waiver functional screen criteria and all other Medicaid eligibility requirements. He doesn't have an enrollment date at this time. John's penalty period begins on April 7.

Example 7: Jeff entered a nursing home on March 1. He applied for Medicaid on April 15 and requested that his eligibility be backdated to March 1. John meets all other Medicaid eligibility requirements in March and April. However, he reported transferring $100,000 in stocks and bonds to his brother in February, which is a divestment. John's divestment penalty period begins on March 1, which is the date he was institutionalized, applied for Medicaid LTC, and was otherwise eligible for Medicaid except for the imposition of the divestment penalty.

Example 8: Sam entered a nursing home on October 1. He applied for Medicaid on January 3 and requested that his eligibility be backdated to October 1. He reported giving away an inheritance on November 23 which is a divestment. All necessary verification is received on January 17. Sam is denied Medicaid for being over assets in October and approved and eligible as of November 1. Sam's divestment penalty period would begin on November 23, which is the date that he was institutionalized, applied for Medicaid, and was otherwise eligible for Medicaid except for the imposition of the divestment penalty. Sam will receive Medicaid card services during his penalty period.

17.3.4 Penalty Period Begin Date for Members

An enrolled member's penalty period begins on the first of the month after they are given timely notice. Timely notice is outlined in the Income Maintenance Manual, Section 3.2 Adverse Action and Appeal Rights.

Example 9: Joe was determined eligible for institutional Medicaid effective March 1. On July 2, he sold his home and gave the proceeds to his son. Joe reported the divestment on July 12. The worker entered the divestment in CARES on July 16, which impacted Joe's institutional Medicaid effective August 1. The penalty period begins August 1, the date the worker was able to give timely notice of the penalty period. If the worker had not entered the divestment in CARES until after adverse action in July, the penalty period begin date would be September 1, the first day

his LTC services could be impacted with timely notice. Joe will receive only Medicaid card services during the divestment penalty period.

17.3.5 Curing a Divestment

Curing a divestment penalty period occurs when the entire divested resource or equivalent value is returned to the individual. The individual's eligibility for LTC services must be redetermined back to the start date of the previously imposed penalty period. If they met all other eligibility requirements during the retroactive period, the individual must be certified for Medicaid-covered LTC services. The returned assets are counted as available assets at the beginning of the month they were returned.

Example 10: Scott gave a *CD* to his adult son on March 10. On October 1, Scott entered a nursing home and applied for Medicaid. Based on the value of the CD that he divested to his son, Scott was ineligible for Medicaid coverage of the cost of his institutional care for 38 days. The divestment penalty period started on October 1 and ended on November 7. Scott was certified for institutional Medicaid on November 8.

Scott's son had already cashed in the CD, but, on December 5, he returned the entire value in cash to Scott. Since the equivalent value of Scott's previously transferred asset was returned, Scott is now potentially eligible for institutional Medicaid services for the period of October 1 through November 7.

Scott met all other eligibility requirements during that retroactive period, and he is certified for institutional Medicaid services for that same period. The cash that Scott received from his son and reported on December 5 is counted as an asset beginning in December. Because the value of the cash exceeds the program asset limit, it would make him ineligible for Medicaid, effective January 1, unless his assets are reduced to meet the asset limit prior to January 1.

17.3.5.1 Curing Multiple Divestments Occurring in the Look Back Period

An applicant or member can cure their divestment period penalty that resulted from multiple divestments during the look back period by showing that all the assets divested during the look back period, or amounts equal to their value, have been returned.

17.3.5.2 Curing Multiple Divestments Occurring in the Same Month

After eligibility is established, a member can cure their unallowable divestments that occurred in the same month by receiving the full amount of the divestments.

17.3.5.3 No Partial Cure

The total value of the divested amount must be given to the institutionalized person to cure the divestment. A penalty period is not recalculated based on a partial repayment.

> **Example 11:** Jerry divested cash to his daughter prior to applying for institutional Medicaid. He has a 373-day penalty period. His daughter returned half of the *divested amount*. Jerry's penalty period remains 373 days. If Jerry's daughter returned the entire amount, the divestment would be cured, and Jerry would no longer have a penalty period.

17.3.6 Divestments During a Penalty Period

Divestments that occur during the penalty period incur an additional penalty period. This calculation is based on the average daily nursing home private pay rate in effect when the additional divestment penalty period is determined. The new penalty period doesn't begin until the existing period(s) expires. The penalty periods cannot run concurrently.

> **Example 12:** Jeff has a penalty period that lasts until July 25. In May, he transferred a large amount of cash to friends. Based on the value of this divestment and the average daily nursing home private pay rate currently in effect, Jeff's additional divestment penalty period is 154 days. The new divestment period of 154 days begins July 26, the day after the original divestment penalty period has ended.

17.3.7 Changing Divestment Penalty Periods

There are circumstances that require updates to existing penalty periods. These include shortening a penalty period based on a fair hearing decision, curing divestment penalty periods, and other changes. See Process Help 11.6.6 Changing Divestment Periods after Confirmation for information about changing divestment penalty periods.

17.3.8 Both Spouses Institutionalized

If the *community spouse* makes a divestment resulting in a penalty period for the institutionalized person (17.2.7.7 Community Spouse Divestment that Impacts the Institutionalized Person), split the remaining penalty period between the spouses at the time the community spouse enters an institution, applies for Medicaid, and is found otherwise eligible.

> **Example 13:** Joe is in a nursing home. Joe's wife, Mildred, is his community spouse. Joe inherited $84,000 and immediately transferred it to Mildred. Mildred

gave it to her church. This divestment resulted in a penalty period for Joe. Now Mildred is entering the nursing home and applying for Medicaid. The time that remains on Joe's penalty period must be divided between the spouses.

The penalty period must be determined as follows:

1. Find the *divested amount* used to calculate the original penalty period.
2. Calculate how much of the divested amount remains to be satisfied by:
    a. Multiplying the average nursing home private pay rate used to calculate the original divestment penalty period times the number of days already served of the penalty period.
    b. Subtracting the result from the original divested amount.
3. Calculate the penalty period for the remaining divested amount by using the current average nursing home private pay rate.
4. Divide the new penalty period equally between the two spouses.

Refer to Process Help Section Process Help Section 11.6.6.5 Spousal Split.

If either spouse leaves the institution or dies, add the remainder of his or her penalty period to the other spouse's penalty period.

~~17.4 EXCEPTIONS~~

~~A divestment that occurred in the look-back period or any time after does not affect eligibility if any of the following exceptions apply:~~

- ~~The person who divested shows that the divestment was not made with the intent of receiving Medicaid.~~

    - ~~The person must present evidence that shows the specific purpose and reason for making the transfer, and establish that the resource was transferred for a purpose other than to qualify for Medicaid. Verbal assurances that he or she was not trying to become financially eligible for Medicaid are not sufficient. Take into consideration statements from physicians, insurance agents, insurance documents, and bank records that confirm the person's statements.~~

    - ~~Any of the following circumstances are sufficient to establish that the *applicant/member* transferred resources without an intent to qualify for Medicaid.~~

- ~~The applicant/member had made arrangements to provide for his or her long term care needs by having sufficient financial resources and/or long term care insurance to pay for long term care services for at least a five-year period at the time of the transfer.~~

    - ~~An exception to this requirement is allowed if the individual had a life expectancy of less than five years at the time of transfer. If the individual's life expectancy was less than five years at the time of the transfer, a divestment penalty is not applied if resources and/or insurance were sufficient to pay for his or her long term care services for his or her remaining life expectancy.~~

    - ~~To measure "sufficient resources," use the average monthly nursing home cost of care in effect at the time of the divestment multiplied by 60. Compare that number to the income, assets, and insurance held by the individual at the time of the divestment, **or**~~

- ~~Taking into consideration the individual's health and age at the time of the transfer, there was no expectation of long-term care services being needed for the next five years. For example, someone who was gainfully employed and 50 years old at the time of the divestment is not expected to have set aside sufficient resources for five years of long-term care, **or**~~

    -

- If an individual or couple had a pattern of charitable gifting or gifting to family members (i.e., birthdays, graduations, weddings, etc.) prior to the look-back period, similar transfers during the look-back period would not be considered to have been given with the intent to divest as long as the total yearly gifts did not exceed 15 percent of the individual's or couple's annual gross income. If the yearly gifted amount exceeds 15 percent of the individual's or couple's annual gross income, and/or there is a gap in the years the gifts occurred, the total amounts gifted for the years in the look-back period shall be considered divestment. This exception is not limited to gifts made on traditional gift-giving occasions and does not preclude a pattern of giving to assist family members with educational or vocational goals, or

- Resources spent on the current support of dependent relatives living with the individual are not considered to be divestments. The individual must either claim the relative as a dependent for *IRS* tax purposes, or otherwise provide more than 50 percent of the cost of care and support for the dependent relative.

This list is not intended to be all inclusive when describing divestments which are permissible because the transfer was made without the intent to qualify for Medicaid. Other situations will arise and in those instances, the person's "intent" must be evaluated on a case-by-case basis to determine whether or not a divestment occurred. The fact that a person does not meet the criteria for a specific exception does not create a presumption that the person cannot show that the transfer was made for a purpose other than qualification for Medicaid. For example, a person may be able to show that a transfer to a dependent relative not living at home was made for a purpose other than qualifying for Medicaid.

- The community spouse divested assets that were part of the community spouse asset share **and** this transfer occurred more than five years after the institutionalized spouse was determined eligible. If it is more than five years after the institutionalized person is determined eligible, the community spouse can divest assets.

> **Example 1:** When Ralph went into a nursing home and applied for Medicaid, Edith's community spouse asset share was $42,000. Six years after Ralph became eligible, Edith gave $30,000 of the community spouse asset share to a favorite nephew. This divestment did not affect Ralph's eligibility. Edith is allowed to divest all or any part of the community spouse asset share, as long as it is more than five years after Ralph was determined eligible. If Edith applies for long-term care services within five years though, the gift to her nephew may be considered divestment when determining her eligibility.

> **Example 2:** When Ralph went into the nursing home and applied for Medicaid, Edith's community spouse asset share was $42,000. One year after Ralph became eligible, Edith gave $30,000 to a favorite nephew. This

divestment will result in a divestment penalty period for Ralph because it occurred within the first five years of his eligibility.

The transfer of *homestead* property to the community spouse and then to another person is treated as a divestment depending on when the transfers occur. If the institutionalized person transfers the homestead to the community spouse, and then the community spouse transfers it to someone else within five years of the institutionalized person becoming eligible for long-term care Medicaid, this would be considered a divestment, and it would affect the institutionalized person's eligibility. However, if five years have passed since the institutionalized person became eligible for long-term care Medicaid, the community spouse can transfer the homestead property without affecting the institutionalized person's eligibility.

Example 3: When Ralph applied for Institutional Medicaid, he and Edith owned a home together. After Ralph became eligible, he signed his 1/2 share of the home over to Edith. After five years have passed, Edith can transfer the part of the homestead Ralph gave her without Ralph's eligibility being affected.

Note: While these examples show that in some circumstances the community spouse's divestments occurring more than five years after the determination do not affect the institutionalized person's eligibility, they may affect the community spouse's eligibility if he or she later enters an institution and applies for Medicaid.

- The ownership of the property is returned to the person in the fiscal group who originally disposed of it.
- Division of property as part of a divorce or separation action, and loss of property due to foreclosure or repossession are not divestment. An exception to this is if someone voluntarily signs the property deed over to the bank rather than trying to sell the property or foreclosing due to defaulting on their loan. Banks may refer to this as a "voluntary foreclosure," which would be considered divestment.
- The person intended to dispose of the asset either at fair market value or other valuable consideration.

Example 4: Gary had a lucky 3-cent postage stamp that he carried in his wallet. A friend admired it, so Gary sold it to him for $0.03, unaware that it was worth more. The friend sold it to a stamp dealer for $7,300. When Gary applies for Medicaid, this divestment will be disregarded.

- The agency determines that denial of eligibility would result in undue hardship for the person (see Section 22.4 Undue Hardship).
- The institutionalized person or his or her spouse divests homestead property to his or her:

- Spouse
- Child who meets at least **one** of the following conditions/situations:
  - Is younger than 21 years old
  - Is blind
  - Is permanently and totally disabled
  - Has been residing in the institutionalized person's home for at least two years immediately before the person moved to a medical institution, and provided care to him or her which permitted him or her to reside at home rather than in the institution. This care must have been provided for the entire two years immediately before the person moved to a medical institution. Get a notarized statement that the person was able to remain in his or her home because of the care provided by the child.

    Note: The statement must be from his or her physician or from someone else who has personal knowledge of his or her living circumstances. A notarized statement from the child does not satisfy these requirements.
- Sibling who:
  - Was residing in the institutionalized person's home for at least one year immediately before the date the person moved to a medical institution.

    Verify that the sibling was residing in the institutionalized person's home for at least one year immediately before the person moved to a medical institution. Do not require a specific type of verification. Some examples of verification are written statements from non-relatives, social services records, tax records, and utility bills with the address and the sibling's name on them.

    and
  - Has a verified equity interest in the home.

    "Equity interest" means an ownership interest in a homestead.

    Ask to see a copy of the *deed* or the land contract or some other document to verify the sibling's equity interest in the homestead. Since the sibling's name on the document is not sole proof, you may need to require other documentation such as canceled checks and receipts.

- The institutionalized person or his or her community spouse divests a non-homestead asset or assets to:
  - A spouse
  - A child of any age of either spouse who is either blind or permanently and totally disabled or both.

- The institutionalized person gives away an exempt asset. This includes an asset that is temporarily disregarded, but only during the time that it is being disregarded. This would include, but is not limited to, giving away funds from the following:
  - Retroactive Social Security payments during the nine months after the payment was received,
  - Patient liability or cost share refunds during the nine months after the refund was received, or
  - Federal Coronavirus Recovery Rebate during the 12 months after the payment was received.

17.5 PENALTY PERIOD

17.5.1 Penalty Period Introduction

If there was a divestment during the look-back period or any time after and if none of the exceptions in Section 17.4 Exceptions apply, the institutionalized person must be determined ineligible for long-term care services for a period of time.

During this penalty period, Medicaid will not pay the institutionalized person's daily care rate in the nursing home. He or she may, however, still be eligible for Medicaid card services (see Section 17.15 Medicaid Card Services).

A person applying for *HCBW*s would be ineligible for HCBW services for a period of time. A person ineligible for HCBWs due to a divestment may still be eligible for other non-LTC Medicaid, such as SSI-related Medicaid or MAPP, if they meet the eligibility requirements of the non-LTC Medicaid program.

17.5.2 Calculating the Penalty Period

For divestments on or after January 1, 2009, the divestment penalties are calculated by days using the average daily nursing home private pay rate. The rate effective January 1, 2021 is $303.38. This rate may be updated annually (see Section 39.4.3 Institutional Cost of Care Values).

CWW will calculate the penalty period once a worker enters the appropriate information into the Transfer/Divestment of Assets page, runs eligibility, and confirms.

> **Example 1:** Jeff applied for Family Care. One month earlier, Jeff had transferred $18,500 in cash to his son. At the time of application, Jeff is otherwise eligible for Family Care. Since $18,500 divided by $303.38 equals 60.97 days, CWW will calculate a divestment penalty period of 60 days for Jeff.

17.5.3 Penalty Period Begin Date for Applicants

For divestments that occurred **on or after January 1, 2009**, the penalty period for an applicant begins on the date **all** of the following have occurred:

- The person applies for Institutional LTC Medicaid, HCBW, or Managed LTC/IRIS.
- The person enters an institution or meets the appropriate *LOC* and functional screen criteria.
- The person meets all other Medicaid nonfinancial and financial eligibility requirements (for waiver applicants this can be met regardless of whether or not the waiver funding is actually available).

Note: If a person who had excess assets divests those assets during the three-month backdated period of an application, he or she is ineligible for excess assets until the

~~date that he or she divested those assets. The divestment penalty period as well as the potential eligibility for card services would begin on the date of the divestment.~~

> ~~**Example 2:** Jeff applied for Family Care on March 5. One month earlier, Jeff had transferred $18,500 in cash to his son. At the time of application, Jeff is otherwise eligible for Family Care. The worker receives verification of the divestment on March 30. Jeff's penalty period would begin on March 5, the date he applied for Family Care.~~

> ~~**Example 3:** Joan entered a nursing home on March 1 and applied for Medicaid on March 4. On her application, Joan reported that, in the previous month, she gave her adult daughter a $100,000 cash gift, which is determined to be a divestment. All requested verification is received on March 27, and Joan meets all other Medicaid eligibility requirements; therefore, Joan's divestment penalty period would begin on March 1. If Joan had been over the asset limit at the time of application, she would not have been "otherwise eligible for Medicaid," so her divestment penalty period would not start until she was under the asset limit.~~

> ~~**Example 4:** John applied for a HCBW program on April 7. He indicated on his application that he gave his adult son a $60,000 cash gift three months earlier. John meets the community waiver functional screen criteria and all other Medicaid eligibility requirements. He resides in a county that does not have any available waiver slots, and he is therefore put on a waiting list. Verification was received on April 20, and the $60,000 cash gift was determined to be a divestment. John is therefore ineligible for HCBW for the length of the penalty period. His penalty period would begin on April 7, the day he applied for the HCBW program.~~

> ~~**Example 5:** Jeff entered a nursing home on March 1. He applied for Medicaid on April 15 and requested that his eligibility be backdated to March 1. John meets all other Medicaid eligibility requirements in March and April; however, he reported transferring $100,000 in stocks and bonds to his brother in February. John's divestment penalty period would begin on March 1, which is the date he was institutionalized, applied for Medicaid LTC, and was otherwise eligible for Medicaid except for the imposition of the divestment penalty.~~

> ~~**Example 6:** Sam entered a nursing home on October 1. He applied for Medicaid on January 3 and asked for a three-month backdate. He reported giving away an inheritance on November 23. All necessary verification is received on January 17, and Sam is denied Medicaid for being over assets until November 23. Sam's divestment penalty period would begin on November 23, which is the date that he was institutionalized, applied for Medicaid LTC, and was otherwise eligible for Medicaid except for the imposition of the divestment penalty.~~

~~17.5.4 Penalty Period Begin Date for Members~~

A member's penalty period begins on the first of the month after timely notice is given. Timely notice is outlined in the Income Maintenance Manual, Section 3.2 Adverse Action and Appeal Rights.

Example 7: Joe was determined eligible for institutional Medicaid effective March 1. On July 2, he sold his home and gave the proceeds to his son. Joe reported the divestment on July 12. The worker entered the divestment in CARES on July 16, which impacted Joe's institutional Medicaid effective August 1. The penalty period begin date would be August 1, the date the worker was able to enter the divestment and give timely notice of the penalty period. If the worker had not entered the divestment in CARES until after *adverse action* in July, the penalty period begin date would be September 1, the first day the benefit could be terminated with timely notice.

17.5.5 Recalculation of Penalty Periods

17.5.5.1 Full Refund

When the entire divested resource or equivalent value is returned to the individual, the entire penalty period is nullified or cured. You must then re-evaluate the individual's Medicaid eligibility for LTC services retroactively, back to the beginning date of the previously imposed penalty period. The individual can then be certified for Medicaid LTC services if he or she met all other eligibility requirements during this retroactive adjustment period. The refunded resources will be counted as available assets beginning with the month in which they were returned.

Example 8: Scott gave a *CD* to his adult son on March 10. On October 1, Scott entered a nursing home and applied for Medicaid. Based on the value of the CD that he divested to his son, Scott was ineligible for Medicaid coverage for the cost of his institutional care for 38 days. The divestment penalty period started on October 1 and ended on November 8. Scott was certified for Medicaid LTC on November 9.

Scott's son had already cashed in the CD, but, on December 5, he returned the entire value in cash to Scott as a refund of the prior gift from his father. Since the equivalent value of Scott's previously transferred asset has been returned, Scott is now potentially eligible for Medicaid LTC services for the period of October 1 through November 8. Scott met all other eligibility requirements during that retroactive period, and he is certified for Medicaid LTC services for that same period. The cash that Scott received from his son and reported on December 5 is counted as an asset beginning in December. Because the value of the cash exceeds the program asset limit, it would make him ineligible for Medicaid, effective January 1, unless his assets are reduced to program limits prior to January 1.

Full Refund for Multiple Divestments Occurring in the Lookback Period

A divestment penalty period resulting from multiple divestments that occurred during the lookback period can be cured when the applicant or member has demonstrated that all of the assets divested during the lookback period, or cash equal to the value of those assets, have been returned (Wis. Stat. § 49.453[8][a][1]).

17.5.5.2 No Reduction for Partial Refund

Beginning with penalty periods with a start date of November 11, 2013, or later, the total value of the divested amount must be returned in order to "cure" the divestment. A penalty period will no longer be recalculated based on a partial repayment (Wis. Stat. § 49.453[8][a]).

> **Example 9:** Jerry divested cash to his daughter prior to applying for institutional Medicaid. He has a 373-day penalty period. His daughter returned half of the *divested amount*. Jerry's penalty period remains 373 days. If Jerry's daughter returned the entire amount that was divested, the divestment would be "cured," and Jerry would no longer have a penalty period.

17.5.5.3 Divestments During a Penalty Period

If another divestment occurs when a penalty period is in effect, another penalty period must be calculated for the most recent divestment. This calculation would use the divestment penalty divisor currently effective. The new penalty period will not begin until the existing period has expired. The penalty periods cannot run concurrently.

> **Example 10:** Jeff had a penalty period that lasted until July 25. In June, he transferred a large amount of cash to friends. Based on the verified value of this divestment, Jeff's additional divestment penalty period is 154 days. The new divestment period of 154 days begins July 26, the day after the original divestment penalty period has ended. The new divestment penalty period does not run concurrently with the original divestment period.

17.5.5.4 Changing Divestment Penalty Periods

If it is necessary to change an existing penalty period, IM workers must update the information in CARES and confirm. However, if the divestment penalty period has been shortened or removed (for example, it was cured), IM workers must also notify the fiscal agent. See Process Help Section 11.6.3 Changing Divestment Penalty Details for instructions.

17.6 MULTIPLE DIVESTMENTS

Multiple divestments are two or more separate divestments made within the look back period or at any time thereafter.

During the Look Back Period

All divestments made by the institutionalized person or his or her spouse during the look back period must be added together to arrive at a total divestment amount. That total will be used to calculate the appropriate divestment penalty period. The total divestment amount must be returned in order to cure any divestment that occurred during the look back period.

After the Look Back Period

For multiple divestments that occur after the look back period, the worker must enter each individual divestment that occurred on separate Transfer/Divestment of Assets page sequences unless the divestments occurred in the same month. If the divestments occurred after the look back period, but in the same month, the worker must enter those divestments on one Transfer/Divestment of Assets page sequence, as they are considered one divestment, per Wis. Admin. Code § DHS 103.065(4)(am).

17.7 JOINTLY HELD ASSETS

When an institutionalized person owns an asset in common with another person and when he or she or the other person or any person acting on his or her behalf transfers the asset during the look back period or anytime thereafter, he or she may be penalized for divestment if the transfer:

- Reduces or eliminates the institutionalized person's ownership or control of the asset, or
- Limits the institutionalized person's right to sell or otherwise dispose of the asset.

"Holding an asset in common" means holding it through joint tenancy, tenancy in common, joint ownership, or partnership.

> **Example 1:** For many years Debra held a joint account with her daughter, Donna. On October 15, 1996, Donna withdraws $13,000 from it. On December 3, 1996, Debra enters a nursing home and applies for Medicaid. The $13,000 withdrawal is a divestment. A penalty period must be calculated and imposed.

If placing another individual's name on the account, or asset actually limits the individual's right to sell or otherwise dispose of the asset, such placement would constitute a transfer of assets. For example, the addition of another individual's name requires that the other individual agree to the sale or the disposal of the asset, where no such agreement was necessary before.

> **Example 2:** John bought a piece of property with his nephew, Carl. Three months later John requested to participate in the community waivers program. John explained that his nephew, Carl, refused to sell the property and, therefore, it was unavailable and should not be counted as an asset. The *IM* worker agreed with John that the land was not available and would not be counted as an asset. But, the purchase of the property and the nephew's refusal to make it available (through liquidation) to meet John's needs was divestment. Therefore, John is subject to a penalty period starting from the first of the month in which the jointly owned property was purchased.

When a person's name appears as co-owner of a jointly held asset, assume he or she is part owner of the property. However, you must inform him or her that he or she has a right to present evidence showing he or she is not an owner (see Section 16.3 Separate and Mixed Assets).

17.8 DIVESTING BY PAYING RELATIVES

17.8.1 Introduction

Divestment may occur when an institutionalized person transfers resources to a relative in payment for care or services the relative provided to him or her and any of the conditions below are not met. A relative is anyone related to the institutionalized person by blood, marriage, or adoption.

Count all the payments for care and services that the institutionalized person made to the relative in the last 60 months. Payment can include cash, property, or anything of value transferred to the relative. It is not divestment if all of the following conditions exist:

- The services directly benefited the institutionalized person.
- The payment did not exceed reasonable compensation for the services provided. "Reasonable compensation" is the prevailing local market rate for the service at the time the service is provided.

> **Example 1:** Kerry applies for community waivers on January 10. She paid her son $3,500 to remodel her bathroom the previous month. She shows that her son installed new tile and fixtures. You check with a local contractor who estimates the he would charge $4,000 for the same job. Since Kerry received *fair market value*, it is not divestment.

> **Example 2:** Jennifer enters a nursing home on December 12 and applies for Medicaid. She reports she paid her daughter $7,000 in December for coming to her house each evening and fixing dinner for the previous two months. You check with a local agency that provides meals to homebound people. They charge $2 for each meal. Jennifer's daughter provided 61 meals. The fair market value of the meals was $122. You determine Jennifer overpaid her daughter. The *divested amount* is $6,878 ($7,000-$122).

If the amount of total payment exceeds 10 percent of the *community spouse* asset share (see Section 18.4.3 Calculate the Community Spouse Asset Share), the institutionalized person must have a written, notarized agreement with the relative. The agreement must:

- Specify the service and the amount to be paid
- Exist at the time the service is provided.

Example 3: Rosemary enters a nursing home and applies for Medicaid on November 1, 2016. When asked if she has transferred any assets in the past 36 months, Rosemary indicates that she paid her daughter $10,000 in exchange for her daughter providing personal care for her over the past two years. This $10,000 payment would ordinarily be counted as a divestment since it is above 10 percent of Rosemary's community spouse asset share; however, she shows you a written, notarized statement, dated October 9, 2014, in which she promises to pay $10,000 to her daughter for the specified care. As a result, there is no divestment.

If there is no community spouse, use 10 percent of the highest possible community spouse asset share indicated in Section 18.4.3 Calculate the Community Spouse Asset Share.

17.8.2 Room and Board

If an institutionalized person has made room and board payments to a relative, *disregard* them if **both** the following are true:

- The payments do not exceed fair market value of the room and board.
- The payments are for periods when the institutionalized person was receiving the room and board.

If the room and board is paid after the person has been institutionalized, treat the payment as divestment unless **one** of the following is true:

- The payment is only for the month immediately preceding the month that he or she entered the institution.
- The person provides a written lease that existed during the time that he or she was receiving room and board from the relative.

17.9 INCOME DIVESTMENT

Income received by an institutionalized person and transferred in the month of receipt is considered divestment.

> **Example 1**: Mr. M. resides in a nursing home. He receives a pension check of $3,000 a month. Mr. M. immediately signs the check over to his son. This is a divestment.

Unless there is reason to believe otherwise, assume that ordinary household income was legitimately spent on the normal costs of living.

However, there may be divestment if the person transferred amounts of regularly scheduled income that he or she ordinarily would have received. Such a transfer usually takes the form of a transfer of the right to receive income.

When you find the institutionalized person has transferred income or the right to receive income, calculate a penalty period based on the total amount of income transferred.

> **Example 2:** Donald transfers his rights to his $325,000 pension to his daughter. The *divested amount* is $325,000, not the $4,500 the daughter expects to receive each month from the pension.

17.10 LIFE ESTATES

17.10.1 Life Estates Introduction

A life estate is created when a property holder transfers ownership of the property to someone else and retains the right to live on the property and the income from it. The new owner of the property is referred to as the remainder person.

Because he or she no longer owns the property, the life estate holder does not have the right to sell or dispose of the property. Because he or she cannot sell or dispose of the property, it is not counted as an available asset to the life estate holder. If the remainder person applied for *EBD* Medicaid and did not live in the home, the property, minus the value of the life estate, would be counted as an available asset to him or her (the remainder interest).

The value of the life estate is also not considered an available asset to the life estate holder.

If the property holder transferred the property to the remainder person for less than *FMV*, a divestment has occurred. The *divested amount* is the FMV of the property at the time of the transfer minus the life estate value. To find the life estate value, multiply the FMV of the property by the number from the Section 39.1 Life Estate and Remainder Interest table that corresponds to the age of the life estate holder at the time the property was transferred.

Note: Property tax assessments can be used to determine a property's FMV if both the local agency and *applicant* or *member* agree that it accurately represents the price it would sell for on the open market in that geographic area. If both parties do not agree, statements from one or more realtors could be sufficient. If the local agency requests a comparative analysis, they are required to pay for it. Regardless of what process is used, the member always has the right to appeal the agency decision if he or she thinks it is incorrect.

There can also be divestment if the life estate is terminated and the life estate holder is not paid for the value of the life estate. To calculate the divested amount, multiply the FMV of the property at the time the life estate was terminated by the number from the Section 39.1 Life Estate and Remainder Interest table that corresponds to the age of the life estate holder at the time the life estate was terminated.

Example 1: Marion gave her home to her son John, retaining a life estate. The FMV of the house at the time of the transfer was $87,000. Two years later, Marion applied for Family Care. Since the transfer of her home occurred in the look back period, the worker will have to determine a divestment penalty period. The

divestment amount is the FMV of the house as of the time of transfer, minus the life estate value.

To determine the life estate value, multiply $87,000 by .38642 (the number from the Section 39.1 Life Estate and Remainder Interest table that corresponds to 83 years old).

The divested amount is $87,000 - $33,618.54 = $53,381.46.

Example 2: Three years later, John (from Example 1 above) sold the home for the current FMV of $102,000, and Marion terminated the life estate. He took the proceeds from the home and bought another house. He did not pay Marion for the value of the life estate, so a divestment has occurred. The divestment amount is the life estate value at the time the life estate was terminated.

To determine the life estate value, multiply $102,000 (value of the house at the time the life estate was terminated) by .33764. (The number is from the table in Section 39.1 Life Estate and Remainder Interest that corresponds to Marion's age, 86, at the time the life estate was terminated.)

$102,000 X .33764 = $34,439.28

The divested amount is $34,439.28 (see Section 17.5.4 Penalty Period Begin Date for Members).

Example 3: James sold his home to his son Robert when he was 75 years old and the home was worth $95,000. Robert paid James $50,000 for the home and James retained a life estate. The life estate value is $49,541.55 (95,000 X .52149).(See Section 39.1 Life Estate and Remainder Interest for this value.) Since James received both $50,000 from Robert and retained a life estate worth $49,541.55, the total value he received is more than the FMV of the home. Because the value he received is greater than the FMV of the home, there was no divestment.

A year later, James moved to a *CBRF*, and the home was rented out; however, James continued to retain the life estate. The home is not an available asset to James even though he is no longer living in the home. Because he holds a life estate on the home, James is entitled to any income produced by the property. The net rent from the home is countable income for James (see Section 15.6.4 Self-Employed Income Sources).

17.10.2 Joint Owners

When two or more people hold a life estate on a property, determine the life estate value for each individual by dividing the FMV of the property by the number of life estate holders to find each individual's share of the FMV. Then calculate the life estate value by multiplying the individual share of the FMV by the number in the Section 39.1 Life

Estate and Remainder Interest table that corresponds with the individual's age at the time of the transfer or termination of the life estate.

Example 4: Marie and George transferred ownership of their home to their three sons and retained a life estate on the property. The FMV of the home at the time of the transfer was $140,000. At the time George was 82 and Marie was 68. One year later, George applied for Family Care. Since the transfer occurred in the look back period, the worker must determine the amount of the divestment and the penalty period. To calculate the total divestment, the worker must first determine the life estate values.

$140,000 divided by 2 = $70,000

George's age at the time of the transfer was 82. Multiply 70,000 x .40295 (see Section 39.1 Life Estate and Remainder Interest for this value.) = 28,206.50

Marie's age at the time of transfer was 68. Multiply 70,000 X .63610 = 44,527.00

The total life estate value for both Marie and George is $72,733.50.

The divested amount is the FMV minus the life estate value ($140,000 - $72,733.50 = $67,266.50).

17.10.3 Purchase of a Life Estate in the Home of Another Person

The purchase of a life estate interest in another individual's home on or after January 1, 2009, is a divestment unless the purchaser:

- Resides in the home for a period of at least 12 consecutive months after the date of purchase; **and**
- Received FMV for the purchase.

Residency

Apply the following rules to determine if a person has resided in the home for 12 consecutive months:

- The 12-month period may start immediately after the purchase or at any time after the purchase.
- Absences from the life estate home for less than 30 consecutive days will not affect the 12-month determination.

Example 5: Ralph purchases a life estate interest in his brother's home on January 5 and moves into that home on the same date. He goes to Florida on January 20 and returns to the home three weeks later on February 10. January and February count as whole months of residence because Ralph's absence was less than 30 consecutive days.

Absences from the life estate home for 30 days or more for vacations, trips, or to stay elsewhere result in the 12-month period starting over.

> **Example 6:** Vicki purchases a life estate interest in her sister's home on January 20 and moves into that home on the same date. On March 3, Vicki goes to Bermuda for a family vacation and returns on April 15. Since Vicki was absent from the home for 30 or more consecutive days, the consecutive month of residency string is broken. Vicki's 12-month residency clock is reset with April being her "new" first month of residency.

Absences from the life estate home for 30 days or more because of hospitalization or a rehabilitation stay do not count toward the 12 consecutive months. However, such absences do not result in the 12-month period starting over.

> **Example 7:** Jim purchases a life estate interest in his cousin's home on January 20 and moves into that home on the same date. Jim continues to reside in the home until April 10, at which time he is hospitalized as a result of an auto accident. Jim remains in the hospital until August 5 when he is discharged and returns home. Jim continues to reside in the home from August 5 until December 24.
>
> Jim's residency in the home for the months of January, February, March, and part of April count as four consecutive months of residency. The months of May, June, and July are not included in the consecutive month count because he is absent from the home for those full calendar months. However, the absence from the home for those months does not cause the 12-month clock to be restarted because Jim's absence was the result of his hospitalization. When Jim returns to the home on August 5, August counts as the fifth month of continuous residency. Jim will meet the 12 months of continuous residency requirement in March, the fifteenth month of his ownership.

If the 12-month residency requirement has not been met at the time of the application for *LTC* Medicaid, the full purchase price of the life estate is used to determine the divested amount.

The divestment penalty remains in effect until the penalty period ends or the date the individual meets the 12-month residency requirement, whichever occurs first. There is no pro-ration of the divestment penalty period for living in the home for part of the 12 months.

Fair Market Value

If the 12-month residency requirement has been met at the time of the application for LTC, the local agency must also determine if the applicant paid the FMV for the life estate. The FMV of the life estate is determined using the age of the life estate holder on the date that the life estate was created and the property's FMV on that date. Multiply the FMV by the life estate multiplier on the table in Section 39.1 Life Estate and Remainder Interest. The result is the value of the property's life estate interest as of that

date. If the applicant paid more than the life estate interest value, the difference is the divested amount.

Example 8: Joyce, who is 75 years old, has $200,000 in her savings account. On February 3, she gives $200,000 to her son in exchange for a life estate interest in her son's home. The FMV of the son's home as of this transfer was $300,000. Joyce moved into her son's home on March 5 and has resided there continuously for more than 12 consecutive months. Fifteen months after moving in, Joyce applies for a community waiver program and meets the functional screen and all other Medicaid eligibility requirements. Joyce also establishes that as of her application date for community waivers, she has resided in her son's home for more than 12 consecutive months.

The divestment issue that now needs to be resolved is whether or not Joyce received FMV for the $200,000 that was used to purchase the life estate. Using the table in Section 39.1 Life Estate and Remainder Interest, it is determined that Joyce's life estate interest was worth $156,447 at the time of the purchase. Since Joyce paid $200,000 for a life estate that was worth $156,447, the divested amount is $43,553. Joyce is subject to a penalty period.

When a couple jointly holds a life estate, the institutionalized *spouse* must reside in the home for 12 consecutive months or his or her portion of the life estate value will be considered a divestment. See Section 17.10.2 Joint Owners for instructions on calculating the spouse's portion of the life estate value.

17.11 ANNUITIES

17.11.1 Treatment of Revocable Annuities

The following policy applies to both an *annuity* purchased by a *member* and an annuity purchased by a *community spouse*.

- Determining Resource Value
- When the annuity is revocable and the funds deposited can be withdrawn, the value of the annuity principal, plus accumulated interest, is a countable resource.
- When an annuity company will apply a financial penalty for early withdrawal of the funds in an annuity account, the amount that the member would receive upon full surrender of the annuity contract is the counted resource value of the annuity.
- Treatment of Withdrawals and Interest
- When a member makes withdrawals from the principal or accumulated interest on an annuity account, the withdrawals are a conversion of a resource.
- Interest accruing on an annuity account that is paid to the *annuitant* as it is earned is excluded income.
- Interest earned on a revocable annuity that is left in the account to accumulate is not considered income but instead is considered as an increase in the resource value of the annuity account.

17.11.2 Evaluating Irrevocable Annuities for Divestment

17.11.2.1 Irrevocable Annuities That Are Not Considered Divestment

Irrevocable annuities that are not considered divestment must name the "Wisconsin Department of Health Services Estate Recovery Program" (hereafter referred to as "the State") as the remainder *beneficiary* if purchased or created on or after January 1, 2009. In cases where there is a spouse, disabled child, or *minor* child, the State must be the beneficiary in the second position.

In addition, the annuity must be **one** of the following:

- Created from funds in a Roth *IRA*, 408 IRA, or other employer-sponsored plan
- Considered an individual retirement annuity (according to Sec. 408(b)) of the Internal Revenue Code of 1986 (IRC) or a deemed IRA under a qualified employer plan (according to Sec. 408(q) of the IRC)
- Purchased from a life insurance company or other commercial company that sells annuities as part of its normal course of business **and** be actuarially sound, meaning that it meets **all** of the following:
- Provides substantially equal monthly payments with no balloon, deferred, or graduated payments (variations in payment amounts due to changes in interest rates are allowed)
- Is *annuitized* for the individual or spouse (currently issuing payments)

- Is a period-certain annuity that will return the full principal and interest within the annuitant's life expectancy as listed in the Period Life Table.
- The number of months that annuity payments will be issued should be less than the number of months of the individual's life expectancy (multiply figure from the Period Life Table by 12).

Note: Annuities that provide for indefinite "lifetime payments" may not return the full principal and interest within the member's life expectancy and are not actuarially sound.

Example 1: The member applies for HBCW. He had invested in a Roth IRA while he was working. He converted the IRA to an irrevocable annuity when he retired 6 months ago and named the State as the beneficiary. Since the annuity meets the conditions above, the purchase of the annuity is not considered divestment.

Example 2: The member applied for Institutional Medicaid on 7/28. This is a community spouse case. On 7/18, the community spouse used $126,500.00 of the couple's resources to purchase an irrevocable 9-year period certain immediate annuity from the XYZ Life Insurance Company. The community spouse is the annuitant. The community spouse was 74-years-old on the date the annuity was purchased and had a life expectancy of 9.75 years (117 months). The annuity will issue regular monthly checks of $1,488.75 for a set period of 9 years or 108 total months. The insurance company will pay out a total of $160,785.00 over the period of the annuity contract.

The annuity names the State as the beneficiary in the position after the institutionalized spouse. The contract date of the annuity was 7/18 and the first monthly payment was issued on 8/18. The annuity, which was purchased by the community spouse, names the State as the beneficiary, was purchased from a life insurance company, will issue regular monthly payments, is currently issuing payments and will provide for full return of principal and interest during the community spouse's life expectancy. Therefore, since the annuity meets the requirements above, the purchase of the annuity is not considered divestment. The monthly annuity payments count as income to the community spouse.

17.11.2.2 Irrevocable Annuities that are considered divestment

When the annuity does not meet the criteria in Section 17.11.2.1 above, the annuity is considered as a divestment. The value of the annuity is considered a divestment as of the date the annuity was purchased, or the date it became irrevocable, whichever is later.

Example 3: The member applied for HCBW on 9/15. Also on 9/15, the member used $20,000 of his cash resources to purchase an immediate annuity from the ABC Insurance Company. The contract date is 9/15 and the first payment will be

issued on 10/15. The annuity will issue payments of $200 per month for 10 years (120 monthly payments). This would result in a return of $24,000 over the proposed period of the contract. The member is currently 79-years-old and has a life expectancy of 7.40 years (88.8 months). The annuity does not name the State as the primary beneficiary.

In this example, the annuity was purchased from a life insurance company, will issue regular monthly payments and is currently issuing payments. However, the annuity does not meet the requirements because the state is not named as the primary beneficiary and the proposed period of payments (10 years) exceeds the member's life expectancy (7.40 years). Therefore, the full purchase price of the annuity is considered divestment. (See MEH 17.5 for policy regarding the penalty period begin date.) The $200 per month annuity payments are also counted as income in determining eligibility.

17.11.3 Verification

- Verify the terms of a revocable or irrevocable annuity by obtaining a copy of the annuity contract and account statements from the annuity or insurance company;
- Verify the beneficiary of an irrevocable annuity by obtaining:
- A copy of the annuity application the member signed at the time the member purchased the annuity (Annuity contracts generally never contain the name of the annuity beneficiary. The beneficiary will be listed on the application that the member signed at the time the annuity was purchased. Usually, it is a one page form completed by hand.)

17.11.4 Disclosure

Beginning January1, 2009, all applicants for Medicaid long term care services and all members of Medicaid long term care services undergoing an eligibility review are required to disclose information about any annuities purchased on or after January 1, 2009, in which they or their community spouses have an interest.

This requirement also applies to annuities purchased before January 1, 2009, if any action is taken by the individual that changes either the course of payment from the annuity or the treatment of the income or principal of the annuity. These transactions include:

- Additions of principal,
- Elective withdrawals,
- Requests to change the distribution of the annuity,
- Elections to annuitize the contract,
- A change in ownership, **or**
- Any other non-routine action not listed below.

The following types of changes and events would not subject an annuity purchased prior to January 1, 2009 to treatment under the new policy rules:

- Routine transactions such as notification of an address change, notification of death or divorce of a remainder beneficiary, and other similar circumstances;
- Changes that occur based on terms of the annuities which existed prior to January 1, 2009 and which do not require a decision, election or action to take effect; **or**
- Changes beyond the control of the individual, such as a change in law, a change in the policy of the issuer, or a change in the terms based on other factors, such as the issuer's economic status.

A separate annuity disclosure form (Annuity Information - Disclosure F-10192) must be completed by applicants for each annuity owned by the *applicant* or the applicant's community spouse in order to meet the disclosure requirement. This form must also be sent to *SSI* recipients who are applying for HCBW and MLTC programs. The Disclosure form must be sent to all applicants and recipients who indicate that they have an annuity. A copy of the completed form and any documents verifying the status of the annuity must be scanned into the electronic case file (ECF).

The Wisconsin Medicaid for the *Elderly*, Blind, and Disabled Application (F-10101) has been updated to collect additional information about annuities and provide information about the requirement to designate the State as a remainder beneficiary of the annuities owned by applicants for LTC Medicaid or their spouses.

If the applicant/ member or his or her spouse (or representative) refuses to disclose the required information related to the annuity, the applicant/member is ineligible for Medicaid for the failure to cooperate in providing requested information.

17.11.5 Remainder Beneficiary Designation

The local agency must then send a copy of the completed and signed beneficiary designation form(s) to the annuity issuer with the cover form (Issuer of Annuity - Notice of Obligation, F-10190) that instructs the issuer to make the state a remainder beneficiary. Allow the issuer up to 30 days to confirm the designation has been made.

When the issuer responds and indicates that the State has been designated the remainder beneficiary, or that there is no death benefit available under this annuity, treat this annuity as meeting the designation requirement and proceed with the LTC eligibility determination.

If the issuer does not respond within 30 days of the date the Notice of Obligation form was sent, the *IM* agency must contact the issuer by phone and request that the issuer respond within 10 days.

If the form from the annuity issuer indicates that the remainder beneficiary designation change is in process and provides a date by when the designation will be completed, the IM agency should treat this annuity as meeting the designation requirement and proceed with the LTC eligibility determination. If the issuer fails to confirm that the designation change has been completed by the date indicated on the form, the IM agency must contact the issuer and request that they confirm within 10 days that the changes have been completed.

Once the state has been designated as the remainder beneficiary, the annuity issuer must notify the local agency about any changes made to that annuity to ensure the annuitant does not change the terms of the annuity beneficiary designation at a later date. The issuer acknowledges this obligation by completing and returning the Issuer of Annuity - Notice of Obligation (F-10190). Copies of all of these completed forms must be scanned into the ECF.

Pend the Medicaid LTC application until one of the following occur:

- The applicant provides the required disclosure or beneficiary designation forms by the verification due date,
- Verification has been received that the State of Wisconsin has been legally named as the appropriate remainder beneficiary of the annuity, or that no death benefit is available under the annuity,
- Verification has been received that the beneficiary designation change is in process,
- The issuer indicates that the applicant, member or spouse failed to cooperate with the issuer's process to name the State as a remainder beneficiary, **or**
- You receive direction from the CARES Call Center to certify the applicant/member for LTC coverage.

A divestment penalty period must be imposed for applicants and members who refuse to cooperate in this annuity beneficiary designation process. The divestment date is the date the annuity was purchased, or the date of the latest annuity transaction. The amount of the divestment is the full purchase price of the annuity.

17.12 PROMISSORY NOTES

17.12.1 Promissory Notes Prior to January 1, 2009

It is divestment if an institutionalized person signs a promissory note prior to January 1, 2009, that has at least one of the following:

- A provision that forgives a portion of the principal
- A balloon payment
- Interest payments only with no principal payments
- An inadequate interest rate (relative to current market rates) at the time the promissory note was signed

17.12.2 Promissory Notes on or after January 1, 2009

The purchase of a promissory note, loan, land contract, or mortgage, on or after January 1, 2009, is a divestment unless such note, loan, land contract, or mortgage meets all of the following criteria:

- Has a repayment term that is actuarially sound (paid out in the person's life expectancy). The standards that must be used to decide whether or not a promissory note, loan, land contract, or mortgage is actuarially sound are those determined by the Office of the Chief Actuary of the *SSA*. The standards are found in the Period Life Table, which is available on the SSA website. Use this table to calculate the person's life expectancy as of the date the promissory note, loan, and contract, or mortgage agreement was initiated. Determine if the lender was expected to live long enough so that he or she would receive payment in full during his or her lifetime.
- Provides for payments to be made in equal amounts during the term of the loan with no deferral or *balloon payments* made. (Note: Voluntary prepayments that exceed the required regular monthly payment amount are not considered balloon payments.)
- Does not allow cancellation of the promissory note, loan, land contract, or mortgage upon the death of the lender. Under Wisconsin law, the outstanding loan balance on these types of contracts is not automatically canceled upon the death of the lender. Cancellation of the loan balance can only occur if the contract contains specific language to this effect. If a promissory note, loan, land contract, or mortgage contains language to cancel the balance upon the death of the lender, the promissory note, loan, land contract, or mortgage can be amended to remove this language and avoid a divestment penalty.

If all of the criteria above are not met, the purchase of the promissory note, land contract, loan, or mortgage is a divestment. The *divested amount* is the value of the outstanding balance due on the promissory note, loan, land contract, or mortgage as of the date of application for Medicaid *LTC* services.

If all of the criteria above are met, the purchase of the promissory note, land contract, loan, or mortgage is not a divestment. This applies even if the promissory note, land contract, loan, or mortgage cannot be sold because it is not negotiable, assignable, enforceable, or otherwise marketable.

Example 1: On February 1, 2009, Mary gave her adult daughter $50,000 in exchange for a promissory note, which was expected to be paid back in full during her life expectancy. The terms of the note required Mary's daughter to repay the loan within a 48-month period by making payments of $100 per month for the first 47 months and a $45,300 payment in the 48th month. Twelve months later, on February 1, 2010, Mary enters a nursing home and applies for Medicaid. She is otherwise eligible for Medicaid but acknowledges the promissory note transaction that occurred during her look-back period.

Since the terms of the promissory note contained a provision for a balloon payment, the purchase of the promissory note is a divestment. As of the date of Mary's application for Medicaid LTC services (February 1, 2010), Mary's daughter has repaid her mother only $1,200, and the outstanding balance on the note is $48,800. Mary's divested amount is $48,800 which will be used to calculate a penalty period beginning February 1, 2010.

Example 2: John purchased a $60,000 promissory note from his brother Al on April 1, 2009. At that time, John was 80 years old, with a life expectancy of 7.62 years. The terms of the note required equal monthly payments over a 10-year period. Since John's life expectancy was less than the repayment term, the note is not actuarially sound. Several years later, John enters a nursing home and applies for Medicaid. The outstanding balance on the promissory note on the date of John's application for Medicaid LTC services is $40,000. The divested amount that will be used in calculating John's divestment penalty period is $40,000.

Example 3: Jean gave her adult son $50,000 in exchange for a promissory note, which was expected to be paid back in full during her life expectancy with regular monthly payments. Later that year, Jean entered a nursing home and applied for Medicaid. Since the terms of the promissory note were actuarially sound (meeting all the conditions in Section 17.12.2 Promissory Notes on or After January 1, 2009), the transfer was not considered a divestment. As of the date of Jean's application for Medicaid LTC services, her son had repaid her only $1,200, and the outstanding balance on the note was $48,800. The promissory note would be considered an available asset for Jean with an assumed value of $48,800.

17.13 TRUSTS

17.13.1 Trusts Introduction

"Trust" is any arrangement in which a person (the "grantor") transfers property to another person with the intention that person (the "trustee") hold, manage, or administer the property for the benefit of the grantor or of someone designated by the grantor (the "*beneficiary*"). The term “trust” includes any legal instrument or device that is similar to a trust.

"Legal instrument or device similar to a trust" means any legal instrument, device, or arrangement which, even though not called a trust under state law, has the same attributes as a trust. That is, the grantor transfers property to the trustee and the grantor's intention is that the trustee hold, manage, or administer the property for the benefit of the grantor or of the beneficiary. For purposes of this section, an individual shall be considered to have established a trust if assets of the individual are used to form all or part of the *corpus* (principal) of the trust.

"Grantor" may be:

- The Medicaid *member*.
- His or her *spouse*.
- A person, including a court or an administrative body, with legal authority to act in place of or on behalf of the member or his or her spouse. This includes a power of attorney or a guardian.
- A person, including a court or an administrative body, acting at the direction or upon the request of the member or his or her spouse. This includes relatives, friends, volunteers, or authorized representatives.

17.13.2 Revocable Trusts

A *revocable trust* is a trust that can be revoked, canceled, or modified by the grantor or by a court. A trust which is called irrevocable, but which will terminate if some action is taken by the grantor, is considered a revocable trust.

- The trust principal of a revocable trust is an available asset. “Trust principal” is the amount placed in trust by the grantor plus any trust earnings paid into the trust and left to accumulate.
- All payments from the trust to or for the benefit of the institutionalized person are income.
- All payments from the trust that are not to or for the benefit of the institutionalized person are divestment.

17.13.3 Irrevocable Trusts

An irrevocable trust is a trust that cannot, in any way, be revoked by the grantor.

The following actions are divestment if they took place during the look back period (see Section 17.3 Look Back Period) or any time after:

- An irrevocable trust was created. The *divested amount* is the total amount of the created trust.

  Sometimes revocable trusts contain a clause that causes them to become irrevocable at a later date in the life of the trust. Divestment occurs on the date the trust changed from revocable to irrevocable.

  Example 1: In 1998, Benny created a revocable trust fund of $100,000 for his daughter. There was a clause in the trust stating the trust would become irrevocable if Benny became incompetent. He was determined incompetent on February 2, 2007, and the trust changed from revocable to irrevocable. Benny entered an institution and applied for Medicaid in July 2008. He divested the total amount of the trust on February 2, 2007.

- Funds were added to the irrevocable trust. The *divested amount* is the amount of the added funds.

If either of these actions took place before the look back period, apply the following rules:

- Payments to the institutionalized person from trust income or from the body of the trust are income.
- Payments that could be disbursed to the institutionalized person from trust income or from any portion of the body of the trust but that are not disbursed are available assets.
- Payments from the trust to anyone other than the institutionalized person are divestment.

17.13.4 Exceptions

The policies described in this trusts section do not apply to any of the following trusts.

- Annuities (see Section 17.11 Annuities).
- Irrevocable burial trusts (see Section 16.5.1 Burial Trusts).
- Trusts established by a will.
- Special needs trust: A trust containing assets of a person under age 65 who is totally and permanently disabled (under *SSI* program rules). *Disregard* the trust if it meets the conditions in Section 16.6.5 Special Needs Trust.
- Pooled trusts (Effective 09-01-08).

  Pooled Trusts Not Subject to Divestment
  Pooled Trusts Subject to Divestment
  Third Party Funded Pooled Trusts For Individuals Not Yet Declared Disabled
  List of Pooled Trusts

Pooled Trusts Not Subject to Divestment

These are trusts for disabled persons as determined by SSI rules. Disregard them if they meet the following conditions:

- Are established and managed by a non-profit association, **and**
- Have separate accounts, within each fund, which are maintained for each beneficiary or the trust, but for purposes of investment and management of funds, the trust pools these accounts. There may be a separate fund with accounts that include or benefit people who do not have a disability, **and**
- Contain accounts with the funds of disabled individuals (based upon SSI and Medicaid rules) that are established solely for their benefit by a parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

Note: If a WISH trust includes a residential dwelling, the individual must reside in that dwelling, but a spouse, caregiver or housemate can also live there with the Medicaid applicant/member. This does not apply to a WisPACT trust**, and**

- Repay Medicaid to the extent that amounts remaining upon death are not retained by the trust.
- This requirement can be satisfied when the individual trust account contains liquid assets and has a balance by returning that amount to the Medicaid program after subtracting a reasonable amount for administrative costs.
- This requirement can also be satisfied when the pooled trust account includes real property, and the real property is retained by the pooled trust so long as the property continues to be used by another Medicaid member who is disabled (as established under SSI rules) or elderly (age 65 years or older). In addition, if the account contains liquid assets that had been used to help maintain the real property, the account funds may be retained to continue to maintain the housing that will be used by another Medicaid member**, and**
- The trust was established with the funds of a disabled individual of any age. These would be considered "self-funded" trusts, and the age of the disabled individual at the time the trust was created, is irrelevant.

- **Pooled Trusts Subject to Divestment**

A pooled trust established with the funds of a third party on or after September 1, 2008, for a disabled individual, age 65 or over will not be exempt from the divestment penalty provisions, if the third party subsequently applies for Medicaid. The divestment penalty is applied to the third party who created the pooled trust unless the trust beneficiary is the third party's disabled child. Similarly, contributions/additions to a pooled trust by a third party, made after the disabled beneficiary turns 65 will also be

subject to divestment penalty provisions if the third party (trust grantor) subsequently applies for Medicaid.

Third Party Funded Pooled Trusts For Individuals Not Yet Declared Disabled

Third party funded pooled trusts for individuals applying for disability status are not subject to divestment if:

- They have placed their assets in a potential pooled trust, and
- They meet all of the conditions in 5 I above, and
- The potential disabled individual has initiated the disability determination process prior to September 1, 2008, and
- They are over age 65.

"Initiating the disability determination process" means that the individual must have asked either the county agency, the SSA, or DDB for a disability determination.

- Trusts for Disabled Individuals. A trust for a disabled individual is a trust established solely for the benefit of the grantor's disabled child (regardless of the child's age), or solely for the benefit of any other disabled individual who is under 65 years of age. The disability status is the same as that which is determined under SSI rules. The exception continues after the beneficiary turns age 65, provided he or she continues to be disabled. However, a grantor cannot add to the trust after the beneficiary turns age 65, unless the beneficiary is his or her disabled child. Anything added to the trust after the beneficiary turns age 65 (except for a beneficiary who is the grantor's disabled child) is a divestment. Money added before the beneficiary turns age 65 is not a divestment.

Note: Unlike special needs and pooled trusts, trusts for disabled individuals are not required to have any type of Medicaid "payback provision" which becomes effective upon the death of the beneficiary.

17.14 BOTH SPOUSES INSTITUTIONALIZED

If the *community spouse* made a divestment that resulted in a penalty period for the institutionalized *spouse* (see Section 17.4 Exceptions), split the remaining penalty period between the spouses at the time the community spouse enters an institution, applies for Medicaid, and is found otherwise eligible.

> **Example:** Joe is in a nursing home. Joe's wife, Mildred, is his community spouse. Joe inherited $84,000 and immediately transferred it to Mildred. Mildred gave it to her church. This divestment resulted in a penalty period for Joe. Now Mildred is entering the nursing home and applying for Medicaid. The time that remains on Joe's penalty period must be apportioned to both spouses.

The penalty period must be apportioned follows:

- Find the *divested amount* that was used to calculate the original penalty period.
- Calculate how much of the divested amount remains to be satisfied by:
- Multiplying the average nursing home private pay rate used to calculate the original divestment penalty period times the number of days of the penalty period already served.
- Subtracting the result from the original divested amount.
- Calculate the penalty period for the remaining divested amount by using the current average nursing home private pay rate.
- Divide the new penalty period equally between the two spouses.

CARES will calculate the new penalty period and amount left to be served for workers to apportion to the spouse's case.

If either spouse leaves the institution or dies, add the remainder of his or her penalty period to the other spouse's penalty period.

17.15 MEDICAID CARD SERVICES

Medicaid card services are all the Medicaid-covered services (see Section 21.1 Benefits Introduction) except *SNF/ICF* payments and ancillary services (Wis. Admin. Code § DHS 107.09(2) and (4)(a). These excepted services consist of the routine, day-to-day health care services that are provided to Medicaid members by a nursing home and that are reimbursed within the daily care rate.

17.15.1 Nursing Home

A person who, because of divestment, is not eligible for services reimbursed within the daily institutional care rate is still eligible for Medicaid card services.

17.15.2 Home and Community-Based Waivers

Home and Community-Based Waivers (HCBW) applicants/members who have divested cannot be tested using HCBW eligibility criteria. They are only eligible for card services if eligible under non-LTC Medicaid methodology (such as for *SSI*-Related Medicaid, *MAPP*).

18.6 SPOUSAL IMPOVERISHMENT INCOME ALLOCATION

18.6.2 Community Spouse Income Allocation

To determine how much of the institutionalized spouse's income to allocate:

1. The community spouse maximum income allocation is one of the following:
    a. $2,~~873~~903.34 plus excess shelter allowance (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances) up to a maximum of $3,~~216.00~~259.50.

"Excess shelter allowance" means shelter expenses above $~~862~~871.00. Subtract $~~862~~871.00 from the community spouse's shelter costs. If there is a remainder, add the remainder to $2,~~873~~903.34 (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances).

Community spouse shelter costs include the community spouse's expenses for:

- Rent
- Mortgage principal and interest
- Taxes (including special assessments) and insurance for principal place of residence. This includes renters insurance.
- Any required maintenance fee if the community spouse lives in a condominium or cooperative.
- The standard utility allowance established under FoodShare:

18.6.3 Family Member Income Allowance

The institutionalized person can allocate up to $~~718.34~~725.84 per month to each dependent family member who lives with the community spouse.

The allocated amount is the difference between $~~718.34~~725.84 and the actual monthly income of the dependent family member.

21.4 COVERED SERVICES

21.4.1.1 Medicaid Card Services

Medicaid card services are the Medicaid-covered services included in the ForwardHealth Online Handbook at https://www.forwardhealth.wi.gov/WIPortal/Default.aspx **except** Skilled Nursing Facility or Intermediate Care Facility payments and ancillary services. These excepted services consist of the routine, day-to-day health care services that are provided to Medicaid members by a nursing home and that are reimbursed within the daily care rate. See Section 17.3.1 Penalty Period Introduction for information on how Divestment impacts covered services for applicants and members receiving long-term care services.

22.1 ESTATE RECOVERY

22.1.1 Estate Recovery Program Definition

The state seeks repayment of certain correctly paid health and *LTC* benefits by:

- *Liens* against a home
- Claims against estates
- Affidavits
- Voluntary recoveries

These procedures are the *ERP*. No ERP recovery may be made for Medicaid services provided before October 1, 1991.

22.1.2 Recoverable Services

Not all services provided by Medicaid are recoverable. Recoverability depends on what was provided and the *member's* age and residence when he or she received the benefit.

The following are the services for which ERP may seek recovery:

1. All Medicaid services received while living in a nursing home on or after October 1, 1991.
2. All Medicaid services received while institutionalized in an inpatient hospital on or after July 1, 1995.
3. Home health care services received by members age 55 or older on or after July 1, 1995, consisting of:
    a. Skilled nursing services.
    b. Home health aide services.
    c. Home health therapy and speech pathology services.
    d. Private duty nursing services.
    e. Personal care services received by members age 55 or older on or after April 1, 2000.
4. All *HCBW* services (*COP-W*, *CIP* 1A, CIP 1B, CIP II, Brain Injury Waiver, Community Opportunities and Recovery, and Community Supported Living Arrangements) received by members age 55 or older between July 1, 1995, and July 31, 2014:
    . Prescription/legend drugs received by waiver participants.
    a. Benefits paid associated with a waiver participant's inpatient hospital stay. These include inpatient services that are billed separately by providers and services that are noncovered hospital services.

5. Family Care services received by members age 55 or older between February 1, 2000, and July 31, 2014:
    . Prescription/legend drugs received by waiver participants.
    a. Benefits paid associated with a waiver participant's inpatient hospital stay. This includes inpatient services that are billed separately by providers and that are non-covered hospital services.
6. All Family Care Partnership HCBW services, prescription/legend drugs and benefits associated with an inpatient hospital stay that are received by members age 55 or older between March 1, 2009, and July 31, 2014.
7. All *IRIS* services, prescription/legend drugs and benefits associated with an inpatient hospital stay that are received by members age 55 or older before August 1, 2014.
8. All Medicaid services received by members age 55 or older participating in a LTC program on or after August 1, 2014.

    LTC programs include all HCBW programs (including COP-W, CIP 1A, CIP 1B, CIP II, Brain Injury Waiver, Community Opportunities and Recovery, Community Supported Living Arrangements, FamilyCare, FamilyCare Partnership, IRIS, and *PACE*). The capitation payment made to the *MCO* on or after August 1, 2014, will be recovered for members receiving LTC program services through managed care.

9. Costs that may be recovered through a lien are:
    . Medicaid costs for services received on or after October 1, 1991, during a nursing home stay or services received while institutionalized in a hospital on or after July 1, 1995.
    a. Medicaid costs of all other recoverable services as listed in Items 1-5 that are received on or after April 1, 2000, by members age 55 or older as of the date of the service.

22.1.2.1 Medicare Savings Programs

As of January 1, 2010, payments for premiums, copayments, and deductibles for QMB and Medicare Part B for any *MSP* member are not recoverable through ERP.

22.1.3 Nursing Home Definition

For ERP purposes, a "nursing home" is a place that provides 24-hour services, including room and board, to three or more unrelated residents who, because of their mental or physical condition, require nursing or personal care more than seven hours a week. This includes *SNF*, *ICF*, in-patient psychiatric facilities, and Facilities for the Developmentally Disabled (FDD). A "nursing home" does not include:

1. A convent or facility owned or operated exclusively by and for members of a religious order that provides reception and care or treatment.

2. A hospice, as defined in Wis. Stat. § 50.90(1), that directly provides inpatient care.
3. Community waiver residence.
4. *IMD*.

22.1.4 Liens

Example 1: ~~Mr. A~~Aaron applies for Medicaid on March 6, 1995. He has a home and his circumstances require a lien. The *IM* agency sends a Notice of Intent to File a Lien on March 10, 1995. ERP staff cannot file a lien until April 24, 1995, because of the required 45 day waiting period. ~~Mr. A's~~Aaaron's legal representative sells the property on April 10, 1995. Recovery of ~~Mr. A's~~Aaron's Medicaid payments by a lien on that property is not possible as the property was sold before a lien was filed. The IM agency contacts the ERP Lien Specialist to report on the home's sale.

22.1.4.1 Notice of Intent to File a Lien

Complete a Notice of Intent to File a Lien (F-13038 paper form) when a Medicaid member meets all the following criteria. ~~He or she~~They:

1. ~~Lives~~Live in a nursing home or inpatient hospital and ~~is~~are required to contribute to the cost of care. (Individuals eligible under a *MAGI* group are not required to contribute to the cost of care and are not subject to liens on their homes.)
2. ~~Has~~Have a home (see Section 16.1 Assets Introduction).
3. ~~Is~~Are not expected to return to live at that home.

   Base this decision on the person's medical condition. ~~His or her~~Their physician's statement that he or she can reasonably be expected to return home is sufficient support for the person's claim that he or she will return.

22.1.5.5 Real Property as Part of the Estate

When a real property **is part of the estate,** ERP may file a lien equal to the Medicaid payments even if one of these persons is alive:

1. The spouse.
2. A child under age 21.
3. A disabled or blind child of any age.

Recovery through the lien will not be enforced as long as any of these persons meet the criteria and is alive.

Example 2: Mr. ~~A~~Arnold dies. A claim on his estate is filed and the estate includes his real property. His spouse is deceased, and he has no blind or disabled child. He

has a child, age 19. This child lives outside Mr. ~~A's~~Arnold's home. A lien is placed on the real property but cannot be enforced because the minor child is still alive. The child later turns 21. As there is then no living spouse, child under 21, or disabled or blind child, the lien can be enforced.

22.2 CORRECTIVE ACTION

22.2.1.2 Nonrecoverable Overpayments

Do not initiate recovery for a Medicaid overpayment if it resulted from a non-member error, including the following situations:

- The member reported the change timely, but the worker could not close the case or reduce the benefit due to the 10-day notice requirement.
- Agency error (keying error, math error, failure to act on a reported change).
- Normal prospective budgeting projections based on the best available information.
- A change in the Medicaid category if the benefits in the new category are the same as the original, and the post-eligibility contribution, if any, remains the same.

> **Example 5:** A Medicaid EBD member reports on March 25, 2014, that he received a $50,000 inheritance on March 23, 2014. The agency sends the member the required Notice of Decision discontinuing his eligibility effective April 30, 2014. Even though the member had excess assets during March and April 2014, there is no Medicaid overpayment for those months because the change was reported timely, and the agency was required to provide appropriate and timely notice before discontinuing the member's eligibility. Benefits issued only because of the timely notice requirements are not overpayments and are not subject to recovery.

Do not initiate recovery for a Medicaid overpayment for any months when rules preventing health care terminations during the COVID-19 public health emergency were in effect. This means benefits issued March 2020 and any months after March 2020 for which the policy is in effect. This includes individuals whose health care was extended due to agency or state error. The only exception to recovering overpayments during this time period is when there is a fraud conviction.

22.5 REPRESENTATIVES

22.5.1 Authorized Representatives

Applicants or members can appoint either an individual or an organization as authorized representative. An authorized representative can be appointed through any of the following means:

- ~~1~~ ACCESS, when applying
- ~~2~~ Federally Facilitated Marketplace (Note: When a Marketplace application is processed by the agency and an applicant has appointed an authorized representative in the application, the agency must honor this appointment of an authorized representative.)
- ~~3~~ Paper form:
  Appoint, Change, or Remove an Authorized Representative~~: Person,~~ (F-~~10126A~~10126)

~~Appoint, Change, or Remove an Authorized Representative: Organization, F-10126B~~

If an applicant or member is represented by a legal guardian of the person and the estate, legal guardian of the estate, legal guardian in general, or conservator, the legal guardian or conservator must appoint the authorized representative. If the applicant or member only has a legal guardian of the person, the applicant or member must appoint the legal guardian of the person as an authorized representative if the applicant or member would like the legal guardian of the person to act on his or her behalf. If the applicant or member has a power of attorney, the applicant or member can still appoint an authorized representative.

A valid authorized representative appointment requires all contact information of the authorized representative and the signatures of the applicant or member, the authorized representative, and a witness. If the applicant or member is signing with an “X,” a valid appointment requires a witness signature. If any of the required signatures are missing, the following three conditions apply:

- ~~4~~ The authorized representative appointment is not valid.
- ~~5~~ This authorized representative cannot take action on behalf of the applicant or member.
- ~~6~~ The agency cannot disclose information about the case to the invalid authorized representative.

There can be only one authorized representative at a time on a case. There is no time limit on how long a person or organization can act as authorized representative. The appointment of the authorized representative is valid until the applicant or member notifies the agency of a change or removal in writing. Once appointed, the authorized representative has ability to act for all open programs on the case.

Organizations acting as authorized representatives must provide the name and contact information of a person from the organization. Once the organization has been appointed as the authorized representative, anyone from the organization will be able to take action on behalf of the applicant or member (not just the person who signed the form on behalf of the organization). If an organization is only changing the contact person for the organization, the member is not required to complete a new Appoint, Change or Remove Authorized Representative form if the organization is going to remain as the authorized representative.

The authorized representative should be familiar with the applicant or member's household situation and is expected to fulfill their responsibilities to the same extent as the individual being represented. An authorized representative is limited to doing any or all of the following on behalf of the applicant or member:

- ~~7~~ Apply for or renew benefits
- ~~8~~ Report changes in the applicant or member's circumstances or demographic information
- ~~9~~ Receive copies of the applicant or member's notices and other communications from the agency
- ~~10~~ Work with the IM agency on any benefit related matters
- ~~11~~ File grievances or appeals regarding the applicant or member's eligibility

To change an authorized representative, the member must complete and submit the Appoint, Change, or Remove an Authorized Representative form (Person F-10126A or (Organization F-10126B) to his or her IM agency.

To remove an authorized representative, the member needs to let the agency know of the removal in writing. For example, by completing Section One of the Appoint, Change, or Remove an Authorized Representative form or submitting a signed letter indicating the removal. The member does not need to gather additional signatures from the authorized representative or a witness to complete the removal of an authorized representative. Authorized representatives can also request in writing (for example, a signed statement) to be removed if they no longer want to act as the authorized representative. If an authorized representative is requesting to be removed, a signed statement is not needed by the member. An authorized representative designation is valid on a case until a written and signed request is received for removal.

> **Example 1:** Penny is due for renewal of her BadgerCare Plus benefits on August 31. In July, she receives her case summary as part of the administrative renewal process. Penny's case summary lists her mom, Darlene, as her authorized representative. Penny no longer wants Darlene to be her authorized representative.
>
> Penny crosses out the authorized representative information on the case summary, signs it, and mails it to the IM agency. The IM agency receives the case summary on August 3. Based on Penny's handwritten update on

the case summary, the IM agency removes Darlene as Penny's authorized representative effective on August 3.

22.5.2 Additional Responsibilities

The applicant or member can choose to appoint the person who is acting as his or her authorized representative to receive the member's ForwardHealth card and is also be allowed to do the following tasks:

- ~~12.~~ Enroll the applicant or member in an HMO
- ~~13.~~ Contact Member Services or the HMO about a bill, service or other medical information, including Protected Health Information (PHI)

An authorized representative who is appointed by the member to have these additional functions is coded in CARES as a Medicaid (MA) Payee. The authorized representative and the MA Payee must be the same person, and the MA Payee cannot be an organization. If the member's authorized representative is an organization and the member wants to appoint a MA Payee, the member will need to change the authorized representative to a person and authorize that person to have the MA Payee functions.

The applicant or member can appoint ~~his or her~~their authorized representative to fulfill the additional responsibilities listed on Section 1 Part C of the Appoint, Change, or Remove an Authorized Representative: Person form (F-10126A). The applicant or member acknowledges that ~~he or she is~~they are authorizing the disclosure of PHI to the authorized representative since the authorized representative will have access to medical information such as health care services or treatments, medical bills, etc.

There is no time limit on the MA Payee designation. An applicant or member can request removal of the MA Payee in writing at any time. For example, the applicant or member can submit the Appoint, Change or Remove Authorized Representative form or write a letter indicating the MA Payee removal.

22.5.3 Community Spouse as Representative

In Spousal Impoverishment cases, when a Community Spouse cooperates with providing ~~his/her~~their signature at application and/or renewal (see Section 2.5.3 Spousal Impoverishment Medicaid Signatures), the Community Spouse can act on the applicant's/member's behalf without requiring the completion of the Appoint, Change, or Remove an Authorized Representative form (F-10126A). The act of signing the application/renewal allows the Community Spouse to do the following on the applicant's/member's behalf:

26.5 MAPP PREMIUMS

26.5.3.2 Advance Payments

~~Members can make advance payments, but the payment cannot exceed the certification period. If paying in advance, the payments must be the full amount of subsequent month's premiums (no partial month payments). If the income amount changes, recalculate the premium. The member will be notified through CARES that his or her premium amount has changed. If the premium amount has decreased, the fiscal agent will refund any excess premium that was paid. If the premium amount has increased and the premium coupon has not been sent for that month, the member will receive a coupon with the new premium amount. If the premium coupons have already been sent, the member will need to pay the additional amount owed. The member will not receive a coupon for the difference that is owed.~~

Premiums may not be paid in advance.

27.11 INSTITUTIONS FOR MENTAL DISEASE

Some institutions for mental disease (IMD) provide residential substance use disorder (SUD) treatment, and special eligibility rules apply to IMD residents receiving residential SUD treatment (see Section 27.1.2 Institutions for Mental Disease and Section 27.4.1 Institutionalized Person). Therefore, the IMDs that provide residential SUD treatment are specified below.

Brown
Bellin Psychiatric Center, Green Bay
Libertas Center, Green Bay (aka St. Joseph's)
Willow Creek Behavioral Health, Green Bay

Dane
5 Door Recovery/Hope Haven/Rebos United, Madison (provides residential SUD treatment)
Mendota Mental Health Institute, Madison

Eau Claire
Lutheran Social Services – Affinity House, Eau Claire (provides residential SUD treatment)
Lutheran Social Services – Fahrman Center, Eau Claire (provides residential SUD treatment)

Fond du Lac
Fond du Lac County Health Care Center

Milwaukee
Aurora Psychiatric Hospital, Milwaukee
Genesis Behavioral Services Inc. – Jeanetta Robinson House, Milwaukee (provides residential SUD treatment)
Matt Talbot Recovery Services, Milwaukee (provides residential SUD treatment)
Rogers Memorial Hospital Inc., Brown Deer
Rogers Memorial Hospital Inc., Milwaukee
Milwaukee County Behavioral Health, 144 bed psychiatric hospital - license #229, Milwaukee

Oneida
Options Counseling Services, LLC, Rhinelander (provides residential SUD treatment)

Trempealeau
Trempealeau County Health Care Center IMD, Whitehall - license # 2961
Trempealeau County IMD, Whitehall - license # 5001

Washington
Exodus Transitional Care Facility, Kewaskum (provides residential SUD treatment)

Waukesha

Lutheran Social Services – Aspen Center, Waukesha (provides residential SUD treatment)
Rogers Memorial Hospital Inc., Oconomowoc
Waukesha County Mental Health Center, Waukesha

Winnebago
Winnebago Mental Health Institute, Winnebago

Note: The Milwaukee County Behavioral Health and the Trempealeau County Health Care Center are multi-purpose complexes which include Nursing Homes, Facilities for the Developmentally Disabled and IMD's. In order to make a correct Medicaid eligibility determination for the residents of these 2 complexes, it will be necessary to accurately identify the type of facility in which the Medicaid *applicant* /member resides.

28.6 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE ELIGIBILITY GROUPS AND COST SHARING

28.6.4 Cost Share Amount

The cost share amount is the monthly amount Group B and B Plus members must pay toward the cost of their waiver services. The cost share amount is calculated in CARES by applying the cost share deductions to Group B and B Plus members' gross income. For former SSI members who are not eligible for Special Status Medicaid (Section 25.0 Special Status Medicaid Introduction) special status disregards are not used in the Cost Share calculation. Members who owe a cost share must pay one in the month that they enroll in a community waiver program, even if they only receive services for part of a month. If the member changes from one MCO to another MCO in the same month after paying a cost share to the original MCO, ~~he or she does~~they do not owe a cost share to the new MCO that month.

~~IRIS,~~ Family Care, Family Care Partnership, or PACE members institutionalized in a medical institution pay a patient liability calculated according to Chapter 27 Institutional Long-Term Care rather than cost share under this section.

28.6.4.1 Personal Maintenance Allowance

A personal maintenance allowance for room, board, and personal expenses must be deducted from income when calculating cost share. Do not give the special housing amount to waiver participants under age 18.

The personal maintenance allowance (Line 6 and Page 2 of the worksheet) is the total of the following:

1. Community Waivers Basic Needs Allowance (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances).
2. Sixty-five dollars and ½ earned income deduction (see Section 15.7.5 $65 and ½ Earned Income Deduction).
3. Special housing amount equal to monthly housing costs over $350. If the waiver applicant's housing costs are over $350, add together the following costs and subtract $350 to get the special housing amount:
    - Rent.
    - Home or renters insurance.
    - Mortgage.
    - Property tax (including special assessments).
    - Utilities (heat, water, sewer, electricity).

- "Room" amount for members in a CBRF, Residential Care Apartment Complex, or an Adult Family Home. The case manager determines and provides this amount.

If both spouses are applying and both have income, divide the special housing amount ~~equally between them~~in whatever way results in the lowest total cost share for the members. See Process Help 11.5.3.3.

~~**Example 1:** Two spouses applying with income:~~
~~$600 rent~~
~~- 350~~
~~= 250/2 spouses = $125 that each can set aside~~

If only one *spouse* has income and both spouses are applying, allocate the full special housing amount to the spouse with income.

When one spouse has income and both are applying:

1. And they reside together in the same residence, allocate the full special housing amount to the spouse with income.
2. And they reside in separate rooms in a substitute care facility, but there is only one room and board contract for both, allocate the full housing amount to the spouse with income.
3. And they reside in separate rooms in a substitute care facility, but each has an individual room and board contract, only the spouse with income gets a deduction for the special housing amount, and it is based on their individual "rent" costs that are obtained from the care manager.

~~**Example 2:** Emma and Herbert are living in the same residence. Herbert has income of $1,000 per month. Emma does not have any income. The total housing costs are $650 for both of them. Allocate the full special housing amount to Herbert ($650-$350 = $300 special housing amount).~~

~~**Example 3:** Bert and Ingrid live in separate rooms in a substitute care facility, but there is only one room and board contract for both. Bert has income of $1,000 per month. Ingrid does not have any income. The total rent amount is $650 for both of them. Allocate the full special housing amount to Bert ($650-$350 = $300 special housing amount).~~

Example 4: Ned and Maria live in separate rooms in a substitute care facility, and each of them has an individual room and board contract. Ned has income of $1,000 per month. Maria does not have any income. Ned's "rent" from the room and board amount is $550 and Maria's "rent" from the room and board amount is $400. Calculate Ned's special housing amount ($550-$350 = $200 special housing amount). Do not consider Maria's room and board amount when calculating Ned's special housing amount.

When both spouses have income and both are applying:

1. And they reside together in the same residence, divide the special housing amount equally between thenin whatever way results in the lowest total cost share for the members.
2. And they reside in separate rooms in a substitute care facility, but there is only one room and board contract for both, divide the special housing amount equally between themin whatever way results in the lowest total cost share for the members.
3. And they reside in separate living arrangements (e.g., they reside in two different substitute care facilities OR they reside in the same substitute care facility but each has a private room and his or her own individual room and board contract) then calculate a separate special housing amount for each, based on their individual "rent" costs that are obtained from the care manager.

Example 5: Emma and Herbert are living in the same residence. Herbert has income of $1,000 per month, and Emma has income of $500 per month. The total housing cost for both of them is $650. Divide the special housing amount equally between them ($650-$350 = $300 special housing amount, so the special housing amount for Emma and Herbert is $150 each).

Example 6: Bert and Ingrid live in separate rooms in a substitute care facility, but there is only one room and board contract for both. Bert has income of $1,000 per month, and Ingrid has income of $500 per month. The total "rent" from the room and board amount for both of them is $650. Divide the special housing amount equally between them ($650-$350 = $300 special housing amount, so the special housing amount for Bert and Ingrid is $150 each).

Example 7: Ned and Maria live in separate rooms in a substitute care facility, and each of them has an individual room and board contract. Ned has income of $1,000 per month, and Maria has income of $500 per month. Ned's "rent" from the room and board amount is $550 and Maria's "rent" from the room and board amount is $400. Calculate the special housing amounts separately. Ned's is calculated as

~~follows: $550-$350 = $200 special housing amount. Maria's is calculated as follows: $400- $350= $50 special housing amount.~~

The total of 1, 2, and 3 must not be greater than the EBD Maximum Personal Maintenance Allowance (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances).

29.1 KATIE BECKETT

The Katie Beckett Program tests qualified blind and/or disabled minors for Medicaid. It does not deem assets and income from the natural or adoptive parents.

To qualify under the Katie Beckett Program, a blind or disabled minor:

- Must require a level of care provided in a hospital, *SNF*, or *ICF*.
- Can appropriately receive this care in his or her home.
- Would be nonfinancially eligible for Medicaid if ~~he or she~~they were in a hospital, SNF, or ICF.
- Must have income below the Institutions Categorically Needy Income Limit (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Table). The only income used in this calculation is the child's income. There is no asset test for children.

Families may contact the Katie Beckett Program by:

- Calling ~~608-266-3236~~888-786-3246.
- Emailing DHSKatieBeckett@dhs.wisconsin.gov.
- Faxing information to ~~608-226-5420~~888-786-3261.
- Writing to the following address:

Katie Beckett Program
Division of Medicaid Services
Bureau of Children's ~~Long Term Support~~ Services
1 West Wilson Street, Room 418
Madison, WI 53707

32.1 MEDICARE SAVINGS PROGRAMS

32.1.1 Medicare Savings Programs Introduction

Medicare is the health insurance program administered by *CMS* for people 65 years old, people determined disabled for two years or more, or people with end-stage renal disease (permanent kidney failure requiring dialysis or transplant~~).~~) or amyotrophic lateral sclerosis (ALS). People who receive Medicare are referred to as Medicare beneficiaries.

33.3 NONFINANCIAL REQUIREMENTS

33.3.1 SeniorCare Nonfinancial Requirements Introduction

To be non-financially eligible for SeniorCare, an *applicant* must:

1. Be at least 65 years of age.
2. Be a Wisconsin resident. A Wisconsin resident is an individual who meets at least one of the following criteria:
    - Has a permanent residence in Wisconsin
    - Is considered a Wisconsin resident for tax purposes
    - Is a registered voter in Wisconsin

    A SeniorCare member may temporarily live outside the state of Wisconsin, as long as ~~he or she maintains~~they maintain permanent residency in Wisconsin. Residency in a Wisconsin nursing home or an assisted living facility will meet this requirement. There is also not a specific period of time the applicant must be a Wisconsin resident before applying for SeniorCare.

3. Be a U.S. citizen or have qualifying immigrant status. (see Section Section 7.1 US Citizens and Nationals). An applicant who is a not a U.S. citizen will need to have a qualifying immigrant status to be eligible for SeniorCare (see Section 7.3 Immigrants). The applicant will need to provide his or her immigration registration number. Verification of the applicant's immigration status will be made through the U.S. Citizenship and Immigration Services' Systematic Alien Verification for Entitlements (SAVE) program. In some cases, the individual may need to provide an official government document. For example, if the applicant's immigration status cannot be verified through SAVE or there are discrepancies between reported and verified data, supporting legal documentation must be provided by the applicant.

    If current SSDI, SSI, Medicare, Foster Care, or Adoption Assistance benefits have been verified, the applicant is exempt from documenting their citizenship (see Section 7.2 Documenting Citizenship and Identity).

4. Provide an SSN or be willing to apply for one, unless they are exempt from the SSN requirement (see Section 10.1.1 Social Security Number Requirements).

    SeniorCare applicants only need to provide a number, which is verified through the data exchange with Social Security. If the SSN validation process returns a mismatch record, then the applicant must provide the Social Security card or another official government document with the SSN displayed. If an applicant does not yet have a SSN, ~~he or she~~they must be willing to apply for one.

If an applicant requires assistance in obtaining a SSN, the SeniorCare Program will assist him or her in applying for one. “Assisting the applicant” may include helping with filing the SS-5 SSN Application form, obtaining a birth certificate on behalf of the applicant, or assisting with obtaining another document needed to apply for the SSN.

SeniorCare applications without the SSN or with an incorrect SSN will not be returned. Applicants will be contacted and given an opportunity to provide a valid SSN or apply for one. The SeniorCare program will honor the original application date for individuals who initially provide an incorrect SSN or who need assistance in applying.

If the individual is not willing to provide or apply for an SSN or the proof of application is not received within 30 days of application for the SeniorCare application date, eligibility will be denied and any enrollment fee received will be refunded. The individual can reapply once they are willing to provide or apply for an SSN. The eligibility begin date will be based on the new application receipt date.

The member should be informed if the SSN validation process indicates another individual is using the same SSN. The member should contact the Social Security Administration and request they conduct an investigation. The IM worker cannot provide the member with any information that would identify the individual who is using the member's SSN.

If the Social Security Administration finds that the SSN has been used fraudulently it may:

- Recommend further action be taken
  and/or
- Provide the member with the information on the fraudulent action so that the member may pursue action through the legal system.

Verify the SSN only once.

5. Not be a full-benefit Medicaid member (see Section 21.2 Full-Benefit Medicaid). This includes members who are covered by BadgerCare Plus (see the BadgerCare Plus Handbook).
   Individuals are not considered Medicaid members for SeniorCare if they have an unmet Medicaid deductible (see Section 24.2 Medicaid Deductible Introduction) or receive one of the following:

   - Medicare Savings Program (see Section 32.1 Medicare Savings Programs).
   - ~~TB-related Medicaid (see Chapter 30~~ Tuberculosis~~)~~ (TB) Related Medicaid
   - Family Planning Only Services

6. Not be an inmate of a public institution ~~(6.9.3 General Medicaid Application Process~~. An inmate is someone who resides in a public institution on an involuntary basis through operation of law enforcement authorities. For example, a prisoner in a jail, prison, or other correctional facility is considered an inmate.

   The following individuals are not considered to be inmates for ~~Inmates~~the purposes of ~~State~~ SeniorCare:

   - A staff person voluntarily residing in a public institution is not considered an inmate.
   - An individual voluntarily residing in an institution while waiting for other living arrangements to be made that are appropriate to the person's needs.
   - An individual who is legally confined to his or her home by a monitoring device, such as an ankle bracelet.
   - People who are on parole, probation, or have been released to the community pending trial (including those under pre-trial supervision).

   A public institution is an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. This includes correctional facilities operated by or under contract with a governmental unit. A public institution does not include a medical institution (see Section 27.1 Institutions), a publicly operated community residence that serves no more than 16 residents, or a child care institution in which Foster Care maintenance payments are made under Title IV-E. People residing in these situations are not inmates.

   Even though the following institutions may accommodate 16 or fewer residents, they are not considered to be publicly operated community residences. People residing in these institutions may be inmates if they are residing there on an involuntary basis through operation of law enforcement authorities:

   - Residential facilities located on the grounds of, or immediately adjacent to, any large institution or multiple purpose complex.
   - Correctional ~~Institutions).~~or holding facilities for people who are prisoners, have been arrested or detained pending disposition of charges, or are held under court order as material witnesses or juveniles.

   Some inmates may be allowed to leave jail for various reasons under the Huber Law, also known as the Huber Program. Huber Law prisoners who are released from jail to attend to the needs of their families can become eligible for SeniorCare if both the following are true:

   - They intended to return to the home.
   - They continue to be involved in the planning for the support and care of their minor children.

   Huber Law prisoners who are released for a purpose other than attending to the needs of their families are not eligible for SeniorCare.

~~6.~~7. Cooperate with providing information and/or verification necessary to determine eligibility (see Chapter 20 Verification) and for quality assurance purposes.

If a person requires assistance in obtaining the required verification, the SeniorCare program will assist him or her.

If a person is not able to produce the required verification and the SeniorCare program is not able to produce the required verification, the SeniorCare program may not deny assistance.

If a person is able to produce required verification but refuses or fails to do so, the application will be denied.

33.3.3 Age Limitation

SeniorCare is for people who are 65 years of age or older. The earliest SeniorCare eligibility can begin is the month after an applicant's 65th birthday.

A single applicant should apply for SeniorCare no sooner than the calendar month of his or her 65th birthday.

When a couple applies where one *spouse* is 65 or older and the other is under 65 at the time of application, only the spouse that is 65 or older can be determined eligible. If both apply, the younger spouse would be denied SeniorCare unless ~~he or she is~~they are turning 65 within the current or next calendar month. If the younger spouse will turn 65 within the 12-month enrollment period, ~~he or she~~they will receive a notice pending ~~his or her~~their eligibility for the enrollment fee approximately one month prior to ~~his or her~~their 65th birthday.

33.3.5 Creditable Coverage

Wisconsin's SeniorCare prescription drug assistance program is considered to be creditable prescription drug coverage. This means SeniorCare meets or exceeds the standard Medicare Part D plan. If an individual chooses to enroll in SeniorCare instead of Medicare Part D, they will not have a penalty for Medicare Part D.

If an individual is enrolled in SeniorCare, they can keep SeniorCare and not pay extra if they decide to enroll in Medicare Part D later. However, if their SeniorCare coverage ends and ~~he or she does~~they do not enroll in a Medicare Part D plan right away, they may have to pay more to enroll in Medicare Part D at a later date.

If an individual goes without creditable prescription drug coverage for 63 days or longer, their monthly premium for Medicare Part D will go up at least one percent for each month they did not have creditable coverage. For example, if they go nine months

without coverage, their premium will always be at least nine percent higher that if they had enrolled in Medicare Part D right away.

If individuals enroll in a Medicare Part D plan, their coverage will typically begin about a month after they enroll. If they need help paying for their prescription drugs and they are enrolled in SeniorCare, they may choose to remain enrolled in SeniorCare until their Medicare Part D coverage begins.

If an individual does not enroll in a Medicare Part D plan when they are eligible, they may have to wait until the next enrollment period before they can enroll. The enrollment period is from October 15 through December 7 each year, and coverage begins January 1.

Individuals with limited income and resources may be able to get extra help paying premiums, deductibles, and copayments for Medicare Part D. They can apply or get more information about Extra Help, also called the Low Income Subsidy, by calling the Social Security Administration at 800-722-1213 or visiting www.socialsecurity.gov/extrahelp.

If applicants have questions about SeniorCare and Medicare Part D, or need help choosing which prescription drug plan is best for them, they should be referred to a benefits specialist at their local aging and disability resource center (ADRC) or the Wisconsin Medigap Part D and Prescription Drug Helpline at 1-855-677-2783~~ for questions about Medicare Part D and other prescription drug coverage options.~~ .

33.5 BENEFIT PERIOD

33.5.1 SeniorCare Benefit Period Introduction

The benefit period for SeniorCare is 12 consecutive months. The benefit period and eligibility remain intact unless the member:

1. Moves out of state,
2. Reapplies (33.11 Re-Application),
3. Requests to withdraw from the program (33.12 Early Termination), ~~**or**~~
4. Dies**, or**
~~4.~~5. Becomes an inmate of a public institution.

Once eligibility has been established, any changes in income will not be considered until the next renewal, unless the individual reapplies for a new benefit period.

33.10 CHANGES

33.10.1 SeniorCare Changes Introduction

The following changes must be reported to the SeniorCare program within 10 days:

1. Address (including a change in mailing address or permanent residency outside of Wisconsin).
2. Household Composition (including marriage, divorce, separation, or someone moving to a nursing home or other medical facility).
3. Death.

Changes may be reported by phone to the SeniorCare Customer Service hotline at 1-800-657-2038.

Changes may also be reported by writing to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

Members are asked to include an *SSN* or case number on any written correspondence.

If an individual reports any changes before the case has been confirmed in CARES, the new information will be used in his or her SeniorCare eligibility determination.

Changes reported after the case has been confirmed in CARES will be applied to the member's SeniorCare benefits as follows:

1. Address change:
    a. Reports of address changes within Wisconsin will result in SeniorCare notices being sent to the new address. SeniorCare benefit levels will not change for the current benefit period.
    b. Address changes that result in termination of Wisconsin residency result in discontinuation of SeniorCare benefits. The member will be provided with at least 10 days notice before the effective date of an *adverse action*.

    Note: Reporting an out-of-state address does not necessarily signify that an *applicant* is not a Wisconsin resident (see Section 33.3 SeniorCare Nonfinancial Requirements).

2. Death

~~A member's death ends SeniorCare eligibility on the date of death. A 10-day notice for adverse action is not required when an adverse action is the result of a participant's death. The "early termination date" for the member should be equal to the member's date of death.~~

If a member passes away, their SeniorCare eligibility will end as of the notice date.

If a member's *spouse* dies, the member will remain eligible at the same benefit level through the current SeniorCare benefit period. The member may wish to re-apply to establish a new benefit level if the spouse's death will result in a reduction in income.

3. Change in household composition

If a member experiences a change in household composition, the SeniorCare benefit level will not change through the remainder of the SeniorCare benefit period. The member may wish to re-apply to establish a new benefit level if the change in household composition will result in a better level of participation.

4. Inmate of a *Public Institution* (~~See General Medicaid Application Process for Inmates of State Correctional Institutions).~~see Section 33.3.1 SeniorCare Nonfinancial Requirements Introduction, Number 6).

~~An~~If a member becomes an inmate of a public institution ~~is ineligible for~~, their SeniorCare ~~on the date incarceration begins. The member~~ eligibility will ~~be provided adequate notice before the effective date~~end as of the ~~adverse action. The "early termination date" is equal to the notice mailing~~ notice date.

If a member's spouse is an inmate of a public institution the member benefit level will remain eligible as the same benefit level through the current SeniorCare benefit period. The member may wish to re-apply to establish a new benefit level if the spouse's incarceration will result in a better level of participation.

5. ~~5.~~ Change in Circumstance

If an applicant needs to correct their application, or has a change in circumstances during the application processing period, ~~he or she~~they may need to report this information before their eligibility is determined in order to have the change impact their SeniorCare eligibility and participation level.

Depending on the nature of a client-reported error or agency-discovered error, a member's eligibility will be redetermined (see Section 33.10.2 Correction of Errors). The member will be provided with at least 10 days notice before the effective date of an adverse action.

If the case has already been confirmed in CARES, and the individual reports a change in circumstances since they applied (for example, a job loss), eligibility will not be redetermined. The applicant may opt out and reapply if ~~he or she~~they so ~~desires~~desire.

33.13 NOTICE OF DECISION

A written notice is sent to the *applicant* indicating SeniorCare certification, benefit reduction, denial, or termination.

The initial notice of decision will provide information regarding total income used for determining the participation level. It will also provide the member with information regarding spenddown, deductible and co-payment amounts.

For reductions, denials, or terminations, the notice contains reasons for the action, with any supporting regulations. It also specifies fair hearing rights and the circumstances under which SeniorCare benefits will be continued if a hearing is requested.

SeniorCare members will be notified of an *adverse action* at least 10 days prior to the effective date of the adverse action, except under certain circumstances.

Timely notice requirements do not apply when:

1. A prescription drug billing must be reversed due to an incorrect billing, and that reversal results in a benefit or service change.
2. A member chooses to withdraw from the program.
3. A member requests to establish a new benefit period and eligibility for the previous benefit period is terminated (see Section 33.11 Re-Application).
4. A person is an inmate of a public institution.
5. A member passes away.

39.4 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLES

39.4.2 Elderly, Blind, or Disabled Deductions and Allowances

The cost-of-living adjustments in the following table were effective January 1, 2021.

Description		Amount
Personal Needs Allowance (effective 7/1/01)		$45.00
EBD Maximum Personal Maintenance Allowance		$2,382.00
EBD Deeming Amount to an Ineligible Minor		$397.00
Community Waivers Basic Needs Allowance		$974.00
Parental Living Allowance for Disabled Minors	**1 Parent** **2 Parent**	$794.00 $1,191.00

The spousal impoverishment values in the following table were effective July 1, ~~2020~~2021.

Description	Amount
Community Spouse Lower Income Allocation Limit	$2,~~873~~903.34
Community Spouse Excess Shelter Cost Limit	$~~862~~871.00
Community Spouse Maximum Income Allocation (monthly)	The lesser of $3,259.50 (as of 1/2021) or the Lower Income Allocation

	Limit plus excess shelter expenses
Family Member Income Allowance	$~~718.34~~725.84
Community Spouse asset share (CSAS) maximum	$130,380.00 as of 1/2021