DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SOCIAL SERVICES
Division of Social Services

20000 Medicaid Long Term Care

20100 Long Term Care Introduction

Programs under Long Term Care (LTC) Medicaid include:

- Diamond State Health Plan Plus
  - Nursing Facility Program
  - Long Term Care Community Services
- Program of All-inclusive Care for the Elderly (PACE)
- Developmentally Disabled Waiver
- Long Term Acute Care Program

Common to all long term care programs is the requirement to be medically and financially eligible.

15 DE Reg. 1716 (06/01/12)

20100.1 Nursing Facility Program - General Information

Persons who need nursing facility care, and who would be eligible for SSI if they were not institutionalized, are eligible for Medicaid. Nursing facility care may be needed if an individual is too disabled to be cared for in a home care situation but does not need acute care hospitalization.

20100.2 Categorically Eligible Groups

20100.2.1 SSI Recipients

20100.2.2 Individuals Whose Income is 250% of SSI

20100.2.3 Institutionalized Individuals Who Were Eligible in December 1973

20100.2.1 SSI Recipients

Residents of skilled or intermediate nursing facilities who would be eligible for SSI if they were not institutionalized, are eligible for Medicaid. DSS does not make the SSI eligibility determination.

If an individual has less than $50.00 income, she/he may be eligible for an SSI payment while in the institution. In this case, the client may be requested to make an application for eligibility determination.

20100.2.2 Individuals Whose Income is 250% of SSI

Effective 1/1/96, two income limit standards will be applied to the LTC Acute Care Program. The 250% standard applies only to nursing facility residents. Individuals hospitalized for 30 consecutive days may be eligible only if their monthly income is 100% of the SSI standard or less.

Effective October 1, 1994, the eligibility standard for individuals in nursing facilities and HCBS Waiver programs became 250% of the SSI standard.

On October 1, 1993, the eligibility standard for individuals in nursing facilities was raised to 230% of the current SSI standard. The income standard had been at 210% of the SSI standard since January 1, 1991. All other SSI standards (resources, living arrangements, etc.) apply to this group of eligibles.

For cases prior to 1/1/96, in accordance with Public Law 99-272, the 250% standard starts with the beginning of any consecutive 30-day period of institutionalization (nursing facility or hospital or combination of both) counting only the date of admission and not the date of discharge. For example, if a patient enters an institution on July 2nd and is continually

institutionalized until August 2nd, eligibility is based on the 250% standard from July 2nd on. Workers may assume, when an applicant enters a nursing facility, that the applicant will remain institutionalized for 30 consecutive days and authorize vendor payment. This assumption can only be made for nursing facility placement and does not apply to hospitalization. Vendor payment cannot be authorized unless the individual's income is below the SSI standard or the individual has been or is assumed will remain institutionalized 30 consecutive days.

20100.2.3 Institutionalized Individuals Who Were Eligible in December 1973

Federal Regulation 42 CFR 435.132

The agency must provide Medicaid to individuals who were eligible for Medicaid in December 1973, or any part of that month, as inpatients of medical institutions or residents of intermediate care facilities that were participating in the Medicaid program and who:

For each consecutive month after December 1973

(a) Continue to meet the requirements for Medicaid eligibility that were in effect under the State's plan in December 1973 for institutionalized individuals; and

(b) Remain institutionalized; and

(c) Are determined by the State or a professional standards organization to continue to need institutional care.

In accordance with this regulation, any nursing facility resident who has been continuously institutionalized since December, 1973, and who is ineligible by current SSI standards, must have his eligibility evaluated by 1973 standards.

20101 Application Process - Long Term Care Services

The application process is twofold. Applicants for Medicaid must be medically and financially eligible to receive coverage. Referrals for Medicaid may come from many sources: the applicant, the family of the applicant, persons in the community, hospital social workers, etc. The potential nursing facility or Home and Community Based Waiver patient may be in an adult foster care home, in his own home, in the hospital or in a nursing facility as a private pay patient.

Rarely does the applicant himself initiate the referral. This means it is extremely important in the case of the mentally competent patient that the Division of Medicaid and Medical Assistance (DMMA) nurse determine initially if the patient is aware that a referral for nursing facility admission or Home and Community Based Waiver has been made. The person must be willing to enter a nursing facility or accept Waiver services, otherwise placement or referral cannot be made. The DMMA nurse and social worker may assist the family or others in helping the patient to accept the need for nursing facility or Waiver care, but the main responsibility belongs to the family or persons acting as family.

If the patient is not competent, the family or someone acting responsibly as defined in 42 CFR 435.907(a) will act on behalf of the patient.

It is not the responsibility of DMMA to find a nursing facility placement for a patient although they may give assistance when they have knowledge of available, Medicaid certified beds.

22 DE Reg. 66 (07/01/18)

20102 Medical Eligibility Determinations

The first of two steps in the application process is to determine medical eligibility. This is usually determined by Pre-Admission Screening (PAS). Referrals to PAS may come from the family of the applicant as well as other sources.

20102.1 Four Levels of Nursing Facility Care

There are four levels of nursing facility care for which Medicaid can make payment to qualified providers.

20102.1.1 Skilled Nursing Facility Level of Care

20102.1.2 Intermediate Nursing Facility Level of Care

20102.1.3 Intermediate Care - Facility for the Mentally Retarded

20102.1.4 Intermediate Care - Facility for Mental Disease

20102.1.1 Skilled Nursing Facility Level of Care

Skilled Nursing Facility Level of Care - Skilled nursing facility (SNF) is an institutional setting which provides skilled nursing or rehabilitation services for mental or physical conditions. Such a setting includes availability of around the clock professional nursing observations, assessment or intervention.

Super Skilled indicates a payment methodology to accommodate respirator and some other skilled level patients as recommended by the DSS Medical Operations Administrator.

20102.1.2 Intermediate Nursing Facility Level of Care

Intermediate Nursing Facility Level of Care Intermediate care nursing facility (ICF) is an institutional setting in which nursing and allied health care and support services are provided on a daily basis. Such services are supervised by but not necessarily given by a licensed nurse.

20102.1.3 Intermediate Care Facility for the Mentally Retarded Level of Care

Intermediate Care Facility for the Mentally Retarded (ICF/MR) An intermediate care facility for the mentally retarded (ICF/MR) is a residential setting which offers comprehensive habilitative and support services to persons with mental retardation or related conditions. To qualify for an ICF/MR level of care, individuals exhibit significant deficits in age-appropriate functioning in multiple domains. As a consequence, they require frequent assistance or supervision to competently or safely engage in activities of daily living (ADLs).

20102.1.4 Intermediate Care Facility for Mental Disease Level of Care

Intermediate Care Mental Disease Level of Care (ICF/MD) results from a primary psychiatric diagnosis and indicates a need for services in an institution licensed to care for psychiatric patients. Medicaid vendor payments can only be made for persons who are 65 years of age and older.

An intermediate care facility for mental disease (ICF/MD) is a residential setting which offers comprehensive clinical and support services to persons with significant behavioral health disorders. Such disorder must compromise functioning in multiple areas and require frequent or intensive medical or behavioral interventions (e.g., drug therapy; professional counseling; behavior management techniques).

20102.2 Medical Necessity Procedures

There are two ways to determine the medical necessity of nursing facility care. These are:

20102.2.1 Pre-Admission Screening

20102.2.2 Medical Review Team

20102.2.1 Pre-Admission Screening

The Medicaid Long Term Care Unit's Pre-Admission Screening team performs a level of care determination for individuals in hospitals or in the community who will be entering a privately funded or public skilled or intermediate care facility. This includes individuals currently residing out-of-state who are seeking nursing facility placement in Delaware. The determination is made in accordance with guidelines established by the Medicaid program. The initial determination for applicants requiring a super skilled level of care is made by PAS. The Medical Review Team then confirms the determination of the necessity of super skilled care.

20102.2.2 Medical Review Team

The Medical Review Team determines the level of care for the following groups:

individuals seeking out of state inpatient rehabilitation hospital care,

superskilled Reimbursement level of care,

Children Community Alternative Disability Program.

A MAP-25 (Comprehensive Medical Report) is completed by the attending physician and is submitted to the State Office Medical Review Team along with any supporting documentation for approval.

PAS POL 20102.3 PRE-ADMISSION SCREENING AND RESIDENT REVIEWS (PASRR) OVERVIEW

By Federal mandate, all individuals applying for placement in a Medicaid certified nursing facility, regardless of pay source, must have a Level I Pre-Admission Screening and Resident Review (PASRR) for Mental Illness (MI) or Mental Retardation (MR)/Related Condition (RC).

Based on results of a Level I PASRR Screening, the PAS RN may determine that further screening, a Level II PASRR, is warranted. A Level II PASRR evaluates clients with MI and MR/RC and determines if nursing home placement, either with or without specialized services, is appropriate. In addition to the PAS RN, an Independent Contracted Psychiatrist also makes placement recommendations. However, the final decision on appropriate placement for individuals with MI or MR/RC is made by the State Mental Health Authority for MI or the Division of Developmental Disabilities Services for MR/RC.

PAS POL 20102.3.1 PRE-ADMISSION SCREENING AND RESIDENT REVIEWS (PASRR)

This applies to all nursing home applicants or residents of a Medicaid certified nursing facility (NF) regardless of payment source or diagnoses.

1. DMMA is Responsible for PASRR Oversight

DMMA will assure PASRR program operates in accordance with federal regulations.

2. A Level I PASRR Screening is completed on all residents or potential residents of a Medicaid certified Nursing home.

A Level I screening is the process of identifying individuals who are suspected of having a mental illness or mental retardation or if categorical determinations are met.

The Nursing Facility is responsible for completing the Level I screening for non-Medicaid individuals.

The Division of Medicaid and Medical Assistance is responsible for completing the Level I screening for Medicaid and potential Medicaid individuals when notified.

3. Determination is made regarding the need for a Level II PASRR screening.

Based on the Level I screening, the individual will meet one of three categories:

- No indication of mental illness/mental retardation/related condition – nursing home admission/continued stay is appropriate - No further evaluation is needed.
- There are indicators of mental illness/mental retardation/related condition however individual meets any of the following Physician's Exemption Criteria:
  - Primary Diagnosis of Dementia or related disorder.
  - Convalescent Care not to exceed 30 days - PAS nurses will track this exemption and initiate Level II PASRR evaluation prior to expiration if continued NF stay is warranted.
  - Terminal Illness – a life expectancy of 6 months or less if the illness runs its normal course.
  - Medical dependency with a severe physical illness.

No further evaluation is needed at this time.

- There are indicators of mental illness, mental retardation/related conditions – Needs complete PASRR Assessment (Level II).

4. DMMA will coordinate the Level II screening for all Medicaid and non-Medicaid individuals.

DMMA PAS nurse will gather data for Level II PASRR screening.

Data is reviewed with DMMA Nurse Supervisor for approval to continue with the Level II screening.

5. The individual and/or legal representatives must receive written notice that further evaluation is needed.

The notice must inform them that the individual is being referred for Level II Evaluation to DSAMH due to mental illness indicators or to DDDS due to mental retardation/related condition.

6. An Independent Psychiatric Consultant (IPC) will complete the Level II Evaluation for those with mental illness/indicators.

The IPC will assess individual and review documentation to verify whether or not there is a serious MI.

DDDS will assess individual and review documentation to verify whether or not diagnostic criteria of mental retardation or related conditions are met.

The Level II evaluation may be terminated at any time if the evaluator determines that no Mental Illness is present.

7. DDDS will complete the Level II Evaluation for those with mental retardation/indicators.

DDDS will assess individual and review documentation to verify whether or not diagnostic criteria of mental retardation or related conditions are met.

The Level II evaluation may be terminated at any time if the evaluator determines that no Mental Retardation [or related conditions] is present.

8. DSAMH or DDDS Determines Need For Specialized Services and /or NF Services.

DSAMH will review IPC's recommendations and determine need for Specialized Services and/or NF services.

9. DMMA is notified by DSAMH/DDDS of final determination.

10. DMMA will send final determination letter to:

- Individual/applicant;
- Legal Representative;
- Admitting or retaining NF;
- Attending Physician;
- Discharging hospital – if exemption is not applicable.

Final PASRR determinations will be issued by DMMA.

14 DE Reg. 895 (03/01/11)

20103 Financial Eligibility Determination

In accordance with section 1413(b)(1)(A) of the Affordable Care Act, the agency must accept an application from the applicant, an adult who is in the applicant's household, as defined in 42 CFR §435.603(f), or family, as defined in section 36B(d)(1) of the United States Code (U.S.C.), an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant, and any documentation required to establish eligibility -

(1) Through commonly available electronic means;

(2) By telephone;

(3) Via mail;

(4) In person

The Application, Affidavit of Citizenship and Responsibility Statement must be signed by the individual or a representative of their choice. For individuals who are minors or incapacitated a signature is required by someone acting responsibly on the applicant's behalf. The date of application is the date the application is received by LTC Medicaid Office.

42 CFR 435.906; 42 CFR 435.907(a) and Social Security Act 1943(b)

9 DE Reg. 997 (12/01/05)

22 DE Reg. 66 (07/01/18)

20103.1 Agency Responsibilities

20103.1.1 Time Standard

20103.1.2 Timely Documentation

20103.1.3 Time Standard Extension

20103.1.1 Time Standard

The Federal regulation at *42 CFR 435.911* requires that Medicaid determine eligibility within 90 days for applicants who apply for Medicaid on the basis of disability. This time standard covers the period from the date of application to the date Medicaid mails notice of its decision to the applicant.

20103.1.2 Timely Documentation

The DMMA Medicaid worker must explain this 90-day time standard to the applicant or representative. It must be emphasized to the applicant or their representative, that all documentation needed for the worker to determine Medicaid eligibility must be received by the date indicated on the "Request for Verification" letter (Form 415) or the application will be

denied. In cases where verification is incomplete, the worker will give the applicant 15 days to return the information on the initial "Request for Verification" letter (Form 415). The date by which all documentation must be received must be clearly noted on this form.

22 DE Reg. 66 (07/01/18)

20103.1.3 Time Standard Extension

The Medicaid worker will automatically give all applicants an extension of 15 days, if needed, using a second "We Need" letter (Form 415) to note the required documentation and the deadline date. At the request of the applicant, a second extension of 15 days may be granted using a third Form 415. With supervisory approval, a further extension may be granted in cases with unusual circumstances. Unusual circumstances include, but are not limited to, awaiting placement in a Medicaid nursing facility bed or difficulty obtaining an out-of-state deed. Medicaid is held to the 90 day timeliness standard except in unusual circumstances. If the information is not received by the given deadline date, the application will be denied.

20103.2 Applicant's Responsibilities

It is the applicant or representative's responsibility to obtain the documentation needed to determine the applicant's eligibility for Medicaid. The applicant should provide the required documentation by the deadline date. The applicant will be given an extension of 15 days via a second Form 415. An additional 15 day extension will be granted upon the applicant/ representative's verbal or written request. A further extension is not granted except in cases of unusual circumstances.

20110 Managed Care Enrollment Requirements

Individuals who are found eligible must enroll with a managed care organization. The Health Benefits Manager (enrollment broker) will be responsible for the enrollment process.

15 DE Reg. 1716 (06/01/12)

20200 Income

20200.1 Available Income

Available income Is the total amount of money authorized (designated by the payor) for the recipient's benefit, whether received by the recipient directly or received by a representative payee. Income includes anything received by the individual, in cash or in kind, that can be used to meet needs for food, clothing or shelter.

20200.2 Excluded Income

Excluded income is money which is income by definition but does not count in determining eligibility. Some income is excluded when determining eligibility, but may be included when calculating patient pay amount. The following items are excluded income:

(a) Victims compensation payments from a State established fund.

(b) German reparations payments. These payments are not counted in the eligibility nor post eligibility process.

(c) Effective 9/1/91 Austrian social insurance payments specifically based on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act.

(d) Japanese-American, Japanese-Canadian and Aleutian restitution payments.

(e) Agent orange settlement payments.

(f) Impairment-related work expenses.

(g) Radiation Exposure Compensation Trust Fund payments.

(h) Cash or other assistance received under a Federal statute because the President has declared a major disaster.

(i) Payments made under the Netherlands' Act on Benefits for Victims of Persecution 1940-1945 (acronym WUV).

(j) Income of Native Americans derived from tribal trust lands; and effective 1/1/94, up to $2,000 per year in payments derived from individual interests in Indian trust or restricted land.

9 DE Reg. 239 (8/1/05)

20200.3 What is Not Income

Some items that an individual receives are not income because they do not meet the definition of income. An item received is not income if it is neither food, clothing, or shelter nor can be used to obtain food, clothing, or shelter. The following items are not income:

(a) Certain assistance under medical or social service programs
(b) Personal services
(c) Room and board received during a medical confinement
(d) Conversion or sale of a resource
(e) Rebates and refunds of money an individual has already paid
(f) Income tax refunds and Earned Income Tax Credit payments
(g) Payments by credit life or credit disability insurance
(h) Proceeds of a loan
(i) Bills paid by a third party
(j) Return of erroneous payments
(k) Weatherization assistance (insulation, storm doors and windows, etc.)

Replacement of income already received and counted as income in determining eligibility. (If income is lost, stolen, or destroyed and the claimant receives a replacement, e.g., for a stolen Title II check, the replacement is not income.)

20200.4 Gross Income

Income from all sources after business expenses, where applicable, have been deducted and before any disregards, exemptions or deductions such as taxes, health insurance premiums such as Medicare, life insurance premiums, loan payments, garnishments, credit union, alimony, child support (including court ordered), union dues etc. have been applied.

20200.5 When Income is Counted

Income is counted at the earliest of the following points: when it is received; or, when it is credited to an individual's account; or when it is set aside for his or her use. Income is determined monthly and counted in the month it is received. (*20 CFR 416.1111* and *416.1123*)

Occasionally, a regular periodic payment is received in a month other than the month of normal receipt. As long as there is no intent to interrupt the regular payment schedule, consider the funds to be income in the normal month of receipt. For example, a check may be advance dated because the regular payment date falls on a weekend or holiday.

20200.6 Unearned Income

Income which is paid because of a legal or moral obligation rather than for work activity performed. It is all income that is not earned income. This includes Social Security, Railroad Retirement, pensions, benefits, interest and other types of payments. Since different exclusions apply to earned income than to unearned income, it is important to recognize the difference between them.

20200.7 Earned Income

Income which is received as a result of work activity. This includes gross wages, salaries, tips and commissions before taxes or other deductions such as pension fund, garnishment, or optional deductions such as insurance premiums or savings bonds or accounts.

20200.8 Infrequent or Irregular Income

We can apply an exclusion to income which is received either infrequently or irregularly provided the total of such income does not exceed: $10 per month of earned income; and/or $20 per month of unearned income.

Infrequent income is received no more than once in a calendar quarter from a single source. A single source of earned income is an employer, a trade, or a business. A single source of unearned income is an organization, an investment (a single financial account) or an individual. Irregular income is income that an individual could not reasonably expect to receive.

This exclusion can apply to both earned and unearned income in the same month provided the total of each does not exceed the limits. This means it is possible to exclude as much as $30 per month under this provision. This exclusion is separate from the $20 general income exclusion described in Section 20240.1 "Budgeting Income for Eligibility

This exclusion does not apply to any income received on an infrequent or irregular basis if the total of such income exceeds the amounts described above ($10 and $20). We exclude all of the infrequent or irregular income (when it meets the definition of infrequent or irregular income) or none of it (when it exceeds the limits).

20200.9 Relationship of Income to Resources

Generally, anything received in a month, from any source, is income to an individual if it meets the definition of available income - Section 20200.1 Anything the individual owned prior to the month under evaluation, is subject to the resource rules. An item received in the current month is income for the current month only. It becomes a resource the following month.

20210 Types of Income

20210.1 Interest Income

Interest income may be excluded if it meets the definition and limits of infrequent or irregular income. It is included in patient pay amount calculation.

20210.2 Rental Income

Rental income is paid as compensation for the use of real or personal property. Rental deposits used to pay rental expenses become income at the point of use. Rental income is unearned income unless it is earned income from self employment (a real estate broker, or anyone in the business of renting properties). Therefore, rental payments received by those individuals would be considered earned income.

20210.3 Net Rental income

Gross rental receipts less allowable expenses paid in the same taxable year. The net amount is unearned income. Allowable expenses include but are not limited to:

property taxes
interest payments on mortgage
incidental repairs
advertising for tenants
landscaping/lawn maintenance/snow removal
utilities

20210.3.1 Nondeductible Expenses

These include the principal portion of a mortgage payment and capital expenditures. A capital expenditure is an expense for an addition or increase in the value of property which is subject to depreciation. For allowable income expenses (e.g., whether it is an incidental repair or a capital expenditure) refer to IRS Publication 527 or call the IRS.

20210.3.2 Net Rental Computation

Subtract deductible expenses paid in a month from gross rent received in the same month. If deductible expenses exceed gross rent in a month, subtract the excess expenses from the next month's gross rent and continue doing this as necessary until the end of the tax year in which the expenses are paid. Do not carry excess expenses over to other tax years nor use them to offset other income.

The individual's most recent Federal tax return including schedules will help identify past expenses and estimate future rental income. Estimate net rental income for the next 12 months deducting only predictable expenses (utilities, interest, payments, taxes, etc).

Divide net rental income equally among joint owners. If the gross rent is split between two joint owners before expenses are paid, deduct expenses paid by the applicant/recipient from their portion of the gross rent.

20210.3.3 Room Rentals

For rooms rented out in an individual's single residence, prorate allowable expenses based on the number of rooms designated for rent compared to the number of rooms in the house. Do not count bathrooms as rooms in the house. Count basements and attics in the number of rooms only if they have been converted to living spaces (i.e., recreation rooms). For example, a Waiver client rents out a room in his house to his cousin. The house has 6 rooms excluding the bathroom. The allowable expenses (mortgage interest, utilities, etc.) are for the whole house. Only 1/6 of the allowable expenses is deducted from the gross rent.

20210.4 Royalties

Royalties are payments to the holder of a copyright or patent. Royalties earned by an individual in connection with any publication of his or her work (for example, a manuscript, magazine article, artwork, etc.) are earned income.

Royalties may also be paid to the owner of a mine, oil well, timber tract, or other resource, for extraction of a product, including proceeds from the direct sale of the product. Royalty compensation may be expressed as a percentage of receipts from using the property or as an amount per unit produced. Some documents verifying royalty payments will provide both a gross and a net payment amount. When the difference between the gross and the net figures is due to income taxes withheld or windfall profit tax deductions, use the gross figure when determining income. When the difference between the gross and net figures represents a production or severance tax (most oil royalties will be reduced by this tax), use the net figure when determining income.

20210.5 Payments in Foreign Currency

The U.S. dollar value of a payment made in foreign currency, less expenses, is income.

20210.6 Black Lung Benefits

Black Lung benefits are paid to miners and their survivors under the provisions of the Federal Mine Safety and Health Act (FMSHA). They are unearned income. Benefits under Part B of the FMSHA are paid by the Social Security Administration and benefits under Part C of the FMSHA are paid by the Department of Labor. In general, Part B benefits are paid on the third of the month while Part C benefits are paid on the fifteenth of the month.

Both Part B and C benefits may be reduced by offsets and liens. Countable income will be the amount paid after application of an offset (such as workers compensation or work deductions) but before the collection of any garnishments or overpayments.

20210.7 Veterans Affairs Payments

The Department of Veteran Affairs has numerous programs which make payments to veterans and their families.

20210.7.1 VA Pensions

Pension payments are unearned income based on a combination of service and a nonservice-connected disability or death. All VA pension payments (except those resulting from Aid and Attendance or Housebound Allowance, paid on the

basis of a Medal of Honor or paid under a special act of Congress) are based on need and do not receive the $20 general income exclusion.

The Veterans' Benefits Act of 1992 (Public Law 101-508) enacted October 1, 1992, limits VA Improved Pensions for a veteran and a surviving spouse (with no children) residing in Medicaid nursing facilities. The VA Improved Pension is limited to $90 a month and is not counted as income in the eligibility or post-eligibility process. There is not interaction between the reduced pension and the personal needs allowance. If the veteran has income from other sources that is considered countable for the purposes of post-eligibility, perform the post-eligibility calculations to determine the amount of the veteran's liability to his or her cost of care.

20210.7.2 VA Compensation Benefits

Compensation payments are unearned income based on service-connected disability or death. Compensation payments made to a veteran, spouse, child or widow(er) are non-needs based and do receive the $20 general income exclusion. Compensation payments to a surviving parent of a veteran are based on need and as such do not receive the $20 general income exclusion.

20210.7.3 VA Aid and Attendance and Housebound Allowance

VA pays an allowance to veterans, spouses of disabled veterans and surviving spouses who are in regular need of the aid and attendance of another person or who are housebound. These allowances do not meet the definition of income because they are assistance for medical and social services. The payments are not included in the post eligibility calculation. Aid and Attendance payments may be used for whatever purpose the veteran wishes without penalty. The veteran is free to make this income available to the community spouse.

20210.7.4 VA Clothing Allowance

A clothing allowance is not income and is not included in the post eligibility calculation.

20210.7.5 VA Payment Adjustment for Unusual Medical Expenses

Unreimbursed expenses which exceed 5% of the maximum annual VA payment rate are considered unusual. Effective 7/1/94, payments for unusual medical expenses do not meet the definition of income and are not included in the post eligibility calculation. The veteran is required to use these payments for medical expenses.

20210.8 Child Support

Support payments are considered unearned income to the child. One-third of the support payment is excluded as income in the eligibility determination. The entire support payment is included in the post eligibility calculation.

20210.9 Alimony

Alimony is an allowance made by a court from the funds of one spouse to the other spouse in connection with a suit for separation or divorce. Alimony is unearned income.

20210.10 Prizes

A prize is generally something won in a contest, lottery or game of chance. A prize is unearned income. Do not subtract gambling losses from gambling winnings in determining countable income.

20210.11 Workers' Compensation

The workers' compensation payment less any expenses incurred in getting the payment is unearned income. Any portion of an award or payment that the authorizing or paying agency designates for medical expenses or legal or other expenses attributable to obtaining the award is not income. The expenses may be past, current, or future. The payments designated for such expenses may be received in a lump sum or as a continuing payment.

20210.12 Vacation Pay

Vacation pay is considered earned income even if donated to the individual by co-workers.

20210.13 Sick Pay

Sick pay is either wages or unearned income. Sick pay is earned income if received within 6 months after stopping work. To determine the 6-month period after stopping work: begin with the first day of nonwork, include the remainder of the calendar month in which work stops, and include the next 6 full calendar months. For example, if an individual stops work on May 5, the 6-month period begins on May 6 and runs through November 30.

Any sick payments made more than 6 months after work stops are unearned income.

20210.14 Inheritances

An inheritance is cash, a right or a noncash item received as the result of someone's death. An item is not income until it has a value that can be used for food, clothing, or shelter. An inheritance is unearned income in the first month it has value and can be used.

20210.15 Indemnity Benefit Payments

Indemnity Benefit Payments are a fixed amount of money payable to the insured individual when he or she becomes an inpatient of a hospital or a nursing facility. If the benefit payments are made directly to a facility, they are not income since they are not received by the individual. Amounts paid to a facility for purposes other than medical care are considered income if the money is available to the individual to use for food, clothing or shelter. An insurance payment made directly to an individual is considered income unless it is restricted to the purchase or reimbursement of medical services. Indemnity plans which are restricted to the purchase or reimbursement of medical services are a potential third party liability resource. Insurance payments which are countable income must be included in the posteligibility patient pay calculation. If the policy limits the benefits to medical care, the premium for the indemnity insurance plan may be deducted or "protected" from income in the patient pay calculation.

20210.16 Self Employment

Repealed 07/01/06)

9 DE Reg. 564 (10/01/05)

10 DE Reg. 143 (07/01/06)

20240 Budgeting Income for Eligibility

20240.1 Gross Income

Gross income is counted in the month it is actually received. Each applicant will have $20.00 of his available income disregarded in order to determine his/her eligibility. There is only one $20.00 disregard from total combined income for a couple. An exception is that "need" based payments (such as veteran's pensions) does not get a $20.00 disregard.

20240.2 Needs or Non-Needs Based Income

It is important to distinguish between "need" based and "non-need" based income. This becomes a consideration with applicants/recipients of Veterans benefits. Disability compensation is a non-need based benefit paid to veterans injured in the Service. VA pensions are generally need based. A veteran receives a need based pension on the basis of other income and/or disability. Need based benefits are not age related. They are strictly a means of bringing a veterans income up to the minimum level set by the Veterans Administration if the veteran has a financial and/or medical need.

20240.3 Earned Income

For applicants who have earned income the following disregards apply to the monthly gross earned income:

deduct	$20.00
deduct	$65.00
then	1/2 of remainder

Note: The $20.00/month exclusion is applied in the manner that is most advantageous to the individual. If the individual has both earned and unearned income, it is most advantageous to apply the exclusion to the unearned income.

20300 Resources

Effective 1/1/89 the SSI resource limit for an individual is $2,000 and for a couple is $3,000. An additional $1500 is allowed as a burial exclusion for burial expenses per individual.

Resources that are in effect on the first moment of the first day of a calendar month are considered as available for the entire month. The only exception to this occurs during the time of application at the beginning of a continuous period of institutionalization. In that period only, applicants will be determined eligible as of the date the resources are within the resource limit.

20300.1 Liquid Resources

Funds or other property that can be converted to cash within 20 working days.

The following items are examples of liquid resources: bank accounts, stocks, bonds, CDs, money market funds, promissory notes and mortgages.

20300.2 Non-Liquid Resources

Assets that require more than 20 working days to convert to cash are considered non-liquid.

The following types of resources are non-liquid, including but not limited to: annuities and their streams of income, household goods and personal effects, automobiles, trucks, tractors, and other vehicles, machinery and livestock, buildings and land, non-cash business property.

8 DE Reg. 1312 (3/1/05)

20300.3 Resource Ownership

If the individual has the right, authority or power to liquidate the property or his or her share of property, it is considered a resource. In order to be considered a resource, the individual must have:

- some form of ownership interest in the property;
- a legal right to access the property;
- the legal ability to use the property for his/her own support and maintenance.

20300.3.1 Resource Access

An individual is considered to have free access to, and unrestricted use of property even when he can take those actions only through an agent. An agent is anyone acting in a fiduciary capacity, whether formal or informal, and regardless of the title (representative payee, conservator, guardian, etc.). It is not required that an individual undertake litigation in order to gain access. Acquiring guardianship in order to access a bank account is a petition to the court as opposed to litigation. An account will be considered a countable resource while access to the account is pending guardianship.

20300.3.2 When Income Becomes a Resource

When an individual receives something in cash or in kind during a month, we evaluate it under the income rules in the month of receipt. If the individual retains the item into the month following the month of receipt, it is evaluated under the resource rules. The same asset is not evaluated under two sets of counting rules for the same month.

If an individual sells, exchanges, or replaces a resource, what he or she receives in return is not income. It is a different form of resource.

20300.3.3 Increase or Decrease of Resource

Any increase or decrease in the value of an individual's resources affects eligibility as of the first moment of the month following the month in which:

the value of an existing resource increases (the value of a share of stock goes up);

an individual acquires an additional resource (inherits property);

an individual replaces an excluded resource with one that is not excluded (sells an excluded car for nonexcluded cash);

the value of an existing resource decreases (the value of a share of stock goes down);

an individual spends a resource (withdraws $150 from a savings account to pay a bill);

an individual replaces a countable resource with one that is not countable (trades a countable piece of real property for an excluded car).

EXCEPTION: Application period is an exception to the above. See Section 20300.

20310 Resource Exclusions

20310.1 Place of Residence/Real Property

An applicant/recipient's principal place of residence and any land that adjoins is excluded if certain conditions are met.

20310.1.1 Intent to Return

The principal place of residence, if located in Delaware, may be excluded if the individual intends to return home after any length of time.

Temporary Institutionalization - If the attending physician has certified that a recipient is likely to return to his own home within a definite period (not to exceed 2 months) up to $75.00 per month may be protected for maintenance of the home.

15 DE Reg. 362 (09/01/11)

20310.1.2 Spouse and/or Dependent Relative

If the applicant/recipient's home is used by a spouse and/or dependent relative during the individual's absence it may be excluded.

20310.2 Jointly Owned Real Property

Jointly owned real property may be excluded if the sale would cause undue hardship, due to loss of housing, to a co-owner.

20310.3 Attempts to Sell

Real property may be excluded when an individual has made reasonable but unsuccessful efforts to sell throughout a 9-month period of conditional benefits, as long as the individual continues to make reasonable efforts to sell it. (See DSSM 20360)

20310.4 Indian Lands

Any lands that are restricted allotted Indian lands are excluded.

20310.5 Automobiles

20 CFR 416.1218

SI 01130.200

An automobile is any registered or non-registered vehicle that is used for transportation.

One automobile, per household, is excluded if:

- Used for transportation of the eligible individual or
- Used for transportation of a member of the eligible individual's household.

If there is more than one vehicle used for transportation, the automobile with the greatest equity value will be excluded. The equity value of all additional automobiles will be evaluated as a non-liquid resource.

11 DE Reg. 1479 (05/01/08)

20310.7 Life Insurance

20310.7.1 Face Value

20310.7.2 Death Benefits

20310.7.1 Face Value

Life insurance is excluded if the total face value of the policies is $1500 or less and the individual has no revocable designated burial funds.

(See Section 20340.1.3 Relation to Burial Allowance for the relationship between life insurance and the burial allowance)

20310.7.2 Death Benefits

The face value of term or death benefit only policies that do not generate a cash surrender value and burial insurance policies are excluded for eligibility. Term, death benefit policies or burial insurance with a face value equal to or greater than $10,000.00 must designate the State of Delaware as the beneficiary in the first position. The State will retain the amount no greater than the Medicaid expenditures. In situations where there are other burial funds available to cover the burial expenses, there will be no $10,000.00 allowance. Naming the State of Delaware as the Beneficiary is a condition of eligibility. Applicants/recipients may request a hardship consideration.

10 DE Reg. 533 (09/01/06)

20310.8 Burial Exclusions

20310.8.1 Designated Burial Funds

20310.8.2 Burial Spaces for Relatives

20310.8.3 Burial Space Items

20310.8.4 Burial Site Services

20310.8.5 Prepaid Burial Contract

20310.8.1 Designated Burial Funds

Burial funds in the amount of $1500 that are separately identifiable and are clearly designated for burial expenses will be excluded.

20310.8.2 Burial Spaces for Relatives

A burial space or burial space item is excluded if held for the burial of the applicant/recipient, his/her spouse, or any other member of his/her immediate family. Immediate family includes parents, adoptive parents, minor or adult children (including adoptive and stepchildren) siblings (including adoptive and step) and the spouses of these relatives. If the relative's relationship to the recipient is by marriage only, the marriage must be in effect in order for the burial space exclusion to continue to apply. For example, a burial space held for a sister-in-law is no longer excludable if she and the recipient's brother divorce.

20310.8.3 Burial Space Items

A burial plot, gravesite, crypt, mausoleum, urn, niche, or other repository customarily and traditionally used for the deceased's bodily remains, vaults, headstones, markers, or plaques if pre-paid are excluded.

20310.8.4 Burial Site Services

The opening and closing of the gravesite and the care and maintenance of the gravesite if prepaid are excluded.

20310.8.5 Prepaid Burial Contract

A prepaid burial contract (sometimes funded by a life insurance policy) that cannot be revoked and cannot be sold without significant hardship is excluded.

20310.9 Retroactive Social Security Administration Lump Sum Payments

The unspent portion of retroactive SSI and Title II Retirement, Survivors, and Disability insurance (RSDI) benefits is excluded from resources for the nine calendar months following the month of receipt. (See Social Security Administration's Program Operations Manual System (POMS) SI 01130.600 for exclusion of retroactive RSDI benefits.)

14 DE Reg. 1364 (06/01/11)

20310.10 Reparations

German Reparation payments must not be considered available in the eligibility or post eligibility treatment of income and resources. They can no longer be applied toward the personal needs allowance, community spouse income allowance, family member allowance nor cost of care. If German reparations payments are retained beyond the month of receipt, they must be considered exempt resources whether received while the person was in the community or after becoming institutionalized. These funds should be kept separate from other income and resources. Interest earned on these resources must be considered available income.

9 DE Reg. 239 (8/1/05)

20310.11 Disaster Assistance Funds

Any unspent Federal disaster assistance funds are excluded for 9 to 18 months.

20310.12 Agent Orange Payments

Any unspent Agent Orange settlement payments are excluded.

20310.13 Victims Compensation Payments

Victims compensation payments from a State established fund are excluded from resources for a period of 9 months after the month of receipt.

20310.14 Radiation Exposure Compensation

Any unspent Radiation Exposure Compensation Trust Fund Payments are excluded.

20310.15 Unspent Cash for Medical or Social Services

The unspent cash paid to an individual to help the individual pay for a medical or social service is not a resource for 1 full calendar month following the month of receipt.

20310.16 Netherlands' Act for Victims of Persecution

Any unspent payments from the Netherlands' Act on Benefits for Victims of Persecution 1940-1945 (WUV) are excluded.

20310.17 Earned Income Tax Credit

EITC (Earned Income Tax Credit) payments are excluded from resources in the month following the month of receipt.

20310.18 Tax Refunds and Advance Payments

The Tax Relief, Unemployment Insurance Reauthorization and Job Creation Act of 2010 (P. L. 111-312), which was signed into law on December 17, 2010, includes a provision that requires all programs funded in whole or in part with Federal funds, to disregard Federal tax refunds for a period of twelve months from the month of receipt.

Tax refunds and advance payments with respect to a refundable tax credit received after December 31, 2009 through December 31, 2012 are excluded from resources for the twelve calendar months following the month of receipt.

Any portion of the refund or payment that is still retained after that twelve- month period will be a countable resource.

Any retained portion of a tax refund and/or advance payment that was received on or after January 1, 2013 will be a countable resource the month following receipt.

14 DE Reg. 1364 (06/01/11)

16 DE Reg. 1077 (04/01/13)

20320 Ownership of Real Property by Institutionalized Individuals

Real property is land, including houses or immovable objects attached permanently to the land. The terms real estate, realty, and real property are used synonymously with one another and designate real property in which an individual has ownership rights and interests. When an applicant/recipient of Medicaid institutional services is the owner of real property, the following procedure and eligibility rules apply.

20320.1 Types of Ownership

20320.1.1 Fee Simple

20320.1.2 Tenancy in Common

20320.1.3 Tenancy in the Entirety

20320.1.4 Joint Tenancy

20320.1.5 Life Estate

12 DE Reg. 1324 (04/01/09)

20320.1.1 Fee Simple

In fee simple ownership, the owner is completely free of conditions imposed by others.

20320.1.2 Tenancy in Common

In tenancy in common ownership, each owner has a part interest in the property and each portion can be sold separately.

20320.1.3 Tenancy in the Entirety

Tenancy by the entirety only applies to married couples. If a husband and wife are sole owners of a property and the deed does not specify type of ownership, there is a precedent in Delaware law that allows the presumption that ownership is "tenancy by the entirety". These terms refer to property owned by a husband and wife where each member has ownership interest in the whole property which is indivisible. Ownership by the entirety can only be dissolved by death or divorce.

20320.1.4 Joint Tenancy

In the case of joint tenancy each owner has an equal interest in the whole property and each equal part can be sold with the agreement of the co-owners.

20320.1.5 Life Estate

In the case of lifetime rights the individual may live in or use the property during their lifetime, but has no ownership rights. The individual merely has the right to live in the property.

10 DE Reg. 1596 (04/01/07)
12 DE Reg. 1324 (04/01/09)

20320.2 Eligibility Factors of Types of Ownership

20320.2.1 Joint Owners
20320.2.2 Life Estate
12 DE Reg. 1324 (04/01/09)

20320.2.1 Joint Owners

20320.2.1.1 Tenancy by the Entirety
20320.2.1.2 Joint Tenancy
20320.2.1.3 Principal Place of Residence

20320.2.1.1 Tenancy by the Entirety

If ownership is a tenancy by the entirety and both spouses are still living the property will not be considered a resource. If the ownership is in fee simple or tenancy by the entirety with one spouse deceased, the entire equity value of the property is considered a resource according to sections 20320.3, 20320.4, and 20320.5.

20320.2.1.2 Joint Tenancy

In the case of joint tenancy where the co-owners do not agree to sell, the property will not be considered a resource. A statement from the co-owner(s) indicating refusal to sell must be placed in the case record. The refusal to sell creates a legal bar so the property is excluded as a resource. DSS/Medicaid does not require the individual to sue the co-owner to accomplish sale or access.

If ownership is joint tenancy (where the co-owners agree to sell) or tenancy in common, the applicant/recipient's share in the equity must be treated as a resource according to sections 20320.3, 20320.4, and 20320.5.

20320.2.1.3 Principal Place of Residence

If the property is the principal place of residence <u>for the joint owner(s)</u> and it would cause undue hardship (loss of housing) to sell the jointly owned property it can be disregarded.

20320.2.2 Life Estates

Life Estate is an ownership interest in real property. The right of ownership exists for the lifetime of an individual(s). Upon the death of the individual(s) the ownership passes to the "remainderman." A life estate may be sold or otherwise transferred. As per the Deficit Reduction Act of 2005 (DRA), effective 4/1/06, a life estate in a home property may be an excluded resource provided the purchaser resides in the home for a period of at least 1 year after the date of purchase and continues to live in the property.
10 DE Reg. 1596 (04/01/07)

20320.2.2.1 Non-Home Property

A life estate in <u>nonhome</u> property must be counted as a resource. See section 20320.3 - Principal Place of Residence Section.
10 DE Reg. 1596 (04/01/07)

20320.2.2.2 Transfer of Assets

In a life estate transaction, a transfer of assets is involved when the applicant or spouse, as owner of the property, transfers ownership of that property to another individual while retaining lifetime rights. This transfer is for less than fair market value whenever the value of the transferred asset (i.e. ownership of the property) is greater than the value of the life estate. See Section 20350 - Transfer of Assets to determine whether a penalty is assessed because of a life estate

transaction. In addition, effective 4/1/06, a transfer of assets has occurred when an individual purchases a life estate in another individual's home when the purchaser has not lived there for at least 1 year.

10 DE Reg. 1596 (04/01/07)

20320.2.2.3 Calculations of Life Estate Value

To calculate the value of the life estate, use the life estate table. Determine the value of the life estate by multiplying the current market value of the property by the life estate decimal that corresponds to the life estate owner's age.

See Life Estate and Remainder Interest Table 20350

10 DE Reg. 1596 (04/01/07)

20320.2.2.4 Life Estate with Powers

Under a life estate with powers, the owner of the property creates a life estate for himself or herself, retaining the power to sell the property, with a remainder interest to someone else such as a child. Since the life estate holder retains the power to sell the property, its value as a resource is the property's full equity value (unless it is an otherwise excludable resource).

20320.2.2.5 Remainder Interest

When the owner of property gives it to one party in the form of a life estate, and designates a second party to inherit it upon the death of the life estate holder, the second party has a remainder interest in the property. Determine the value of a remainder interest by multiplying the current market value of the property by the remainder interest decimal that corresponds to the individual's age.

See Life Estate and Remainder Interest Table 20350

10 DE Reg. 1596 (04/01/07)

20320.2.2.6 Rebuttal

The applicant may be given an opportunity to rebut the value placed on the life estate. The rebuttal must include an estimate from a disinterested, knowledgeable source (such as a broker or appraiser) showing that the value is less than our determination or that the property has no marketable value.

20320.3 Principal Place of Residence

An individual's home is property in which he or she has an ownership interest and that serves as his or her principal place of residence. An individual's principal place of residence is the dwelling the individual considers his or her established or principal home and to which, if absent, he or she intends to return. A dwelling cannot be considered as an individual's principal place of residence until the individual has actually lived in it and used it as such. The principal place of residence includes the plot of land on which the home is located and any land that adjoins it. The land adjoins the home if it is not completely separated by land in which the individual has no ownership interest. Easements and public rights of way (utility lines, roads, etc.) do not separate the other land from the home. The home includes all related buildings on the adjoining land.

20320.4 Principal Place of Residence Exclusions

20320.4.1 Intent to Return

20320.4.1.1 Sale of House or Mental Condition Change

20320.4.1.2 Purchase of House After Nursing Facility Admission

20320.4.1.3 Use of Residence by Relative

20320.4.1 Intent to Return

The applicant must be able to express the desire to return to their principal place of residence located in Delaware. The record must include a written statement of intent to return to the home. The case record must indicate if the applicant gives intent verbally to DMMA social worker.

If someone other than applicant writes the statement, there must be an indication that this is in fact the intent of the applicant (i.e. signature or mark of applicant). If an institutionalized applicant/recipient is mentally capable of indicating that he intends to return to his principal place of residence in Delaware (even if medical evidence indicates that he will never recover sufficiently to return home), then the home may be excluded as a resource. In no case can the family declare this intent for the applicant/recipient.

15 DE Reg. 362 (09/01/11)

20320.4.1.1 Sale of House or Mental Condition Change

Statements of intent to remain valid until the home is sold. If the home is sold, the proceeds then become a countable resource. If the applicant becomes incompetent after a valid statement of intent is signed, it does not invalidate the statement. The home remains excluded as long as the applicant owns it regardless of changes in mental conditions.

20320.4.1.2 Purchase of House After Nursing Facility Admission

For an individual with no spouse or other dependents, the value of a home purchased after admission to a medical institution cannot be excluded with an intent to return home statement. This is because the individual has not actually lived in the home.

20320.4.1.3 Use of Residence by Relative

The applicant/recipient's home is used by a spouse and/or dependent relative during the absence. Relatives are: child, stepchild, grandchild, parent, stepparent, grandparent, aunt, uncle, niece, nephew, brother, sister, stepbrother, stepsister, half brother, half sister, cousin or an in-law of any of these.

The record must show contact with the spouse or dependent relative indicating that she/he continues to reside in the house, the relationships between the individuals, and the basis of dependency (financial, medical, etc.). In addition, the applicant/recipient's statement of what he considers his principal place of residence to be should be obtained and placed in the case record.

20320.5 Property Essential to Self-Support

The Social Security Act provides for the exclusion from resources property that is essential to an individual's means of self-support. Property excluded under this provision generally falls into 3 categories.

20320.5.1 Property Excluded Regardless of Value or Rate or Return

The following conditions need to be met to exclude the essential to self-support property regardless of value of rate or return.

a. the property (including liquid resources used in the operation) is used in a trade or business

b. the property requires a government permit to engage in an income producing activity (i.e. commercial fishing permit granted by the State Commerce Commission)

c. the personal property is used by an individual to perform his/her work such as tools, uniforms, etc.

d. the property is required by an employer for work

20320.5.2 Property Excluded Up To $6,000 Equity, Regardless Of Rate Of Return

Property can be excluded up to $6,000 equity regardless of rate of return if it is a nonbusiness property used to produce goods or services essential to daily activities. For example, land used to produce vegetables or livestock solely for consumption by the individual's household.

20320.5.3 Property Excluded Up To $6000 Equity If It Produces a 6% Rate of Return

The property essential to self-support may be excluded up to $6,000 if it produces a 6% rate of return and meets the following two conditions.

a. The property is used in a trade or business in the period before 5/1/90

b. The property is nonbusiness income-producing property, for example rental property. Up to $6,000 of the equity value can be excluded from resources if the property produces a net annual return equal to at least 6% of the excluded equity. Any portion of the property's equity value in excess of $6,000 is not excluded. If the property produces less than a 6% return, the exclusion can apply only if the lower return is for reasons beyond the individual's control and there is a reasonable expectation that the property will again produce a 6% return.

20320.5.3.1 Equity Determination

Equity is the current market value less legal debts such as mortgages, liens, etc. Document the file with a copy of the appraisal of the fair market value. Determine rate of return based on income and value figures shown on the individual's Schedule E of Form 1040 for the prior year. If no tax return is available, obtain other appropriate evidence, for example a copy of the lease agreement. In addition obtain the estimated net and gross income from the property for the current tax year.

20320.5.4 Current Use of Property

The property excluded under the above categories (20320.5.1, 20320.5.2, 20320.5.3) must be in current use in the type of activity described. If not in current use, there must be a reasonable expectation that the required use will resume within 12 months of last use. The 12-month period can be extended for an additional 12 months if nonuse is due to a disabling condition.

20320.6 Non-Home Real Property

Non-home real property consists of land and buildings or immovable objects that are attached permanently to the land and that do not meet the definition of home or principal place of residence.

20320.6.1 Non-Home Real Property Current Market Value (CMV) Documentation

Obtain the current market value (CMV) of the real property. The (CMV) may be determined by an estimate of the property's CMV from a knowledgeable source. The estimate must show:

a. the name of the person providing the estimate;

b. the name, address and telephone number of the business or agency for whom the person providing the estimate works;

c. the basis for the estimate, including a description of the property and its condition and the value of similar property in the same area; and

d. the period for which the estimate applies.

Knowledgeable sources include but are not limited to real estate brokers, mortgage companies, banks, savings and loan associations, or similar lending institutions, or an official of the local property tax jurisdiction.

The value of the property as a resource is its CMV minus the outstanding principal balance on any loan or mortgage unless there is a legal bar to the sale of the property. (See Section 20300.3 Resource Ownership)

20320.7 Substantial Home Equity

The policy in this section applies to nursing facility and HCBS recipients who are receiving Long-Term Care (LTC) Medicaid on or after January 1, 2006. It does not apply to recipients who were receiving LTC Medicaid prior to January 1, 2006, and who maintain continuous Medicaid eligibility as per the Deficit Reduction Act section 6014.

10 DE Reg. 1700 (05/01/07)

20320.7.A Receiving LTC Before 01-01-2006

If a Medicaid recipient started receiving LTC Medicaid before January 1, 2006, do not evaluate home equity at the next redetermination. As long as he remains continuously eligible for Medicaid, do not evaluate home equity. If the recipient is found ineligible for Medicaid, and he subsequently re-applies for LTC Medicaid, home equity must be evaluated when he reapplies.

10 DE Reg. 1700 (05/01/07)

20320.7.B Receiving LTC On/After 01-01-2006

If a Medicaid recipient started receiving LTC Medicaid on or after January 1, 2006, evaluate home equity at the next redetermination.

Verification of the equity value of the home is required. Equity value is determined by using the current market value of the home minus any encumbrance (e.g. mortgage; loan; lien on the home.

Individuals with equity value in home property that exceeds the home equity cap as set by federal regulations are NOT eligible for Medicaid payment of long-term care services unless the home is lawfully occupied by:

- a spouse,
- a dependent child under age 21 years, or
- a blind or disabled child of any age.

*Note: This is not a change in the general rule that excludes a home of any value for purposes of determining eligibility for Medicaid. It applies only to medical assistance payment for nursing facility services, or other long-term care services referred to in 1917(c)(i)(C)(i).

Individuals with substantial home equity may be eligible for Medicaid payment of other covered services if they meet all the other Medicaid eligibility requirements.

See DSSM 20320.7.E for current home equity cap.

10 DE Reg. 1700 (05/01/07)

16 DE Reg. 639 (12/01/12)

20320.7.B.1 Reverse Mortgages

Reverse mortgages do not reduce equity value until payments are being received from the reverse mortgage.

10 DE Reg. 1700 (05/01/07)

20320.7.B.2 Home Equity Credit Lines/Loans

A home equity line of credit or home equity loan does not reduce the equity value until credit line or loan has been used or payments from the credit line or loan have been received. DMMA shall verify that the home equity credit line or loan was not transferred for less than Fair Market Value.

10 DE Reg. 1700 (05/01/07)

20320.7.C Co Owners

When there are co owners to the property, divide the total equity interest by the number of shared owners proportional to their interest in the property. Husband and wife are considered as one owner.

10 DE Reg. 1700 (05/01/07)

20320.7.D Definition of Home

The home is defined as any residential property in which the applicant and/or spouse possess an ownership interest that also serves as the principal place of residence of the applicant and /or, spouse, or dependent child. An applicant and spouse may have an ownership interest in several residential properties, but only one shall be considered a home for the purposes of this section. See DSSM 20320.3.

10 DE Reg. 1700 (05/01/07)

20320.7.E Substantial Home Equity Cap

Beginning in the year 2011, the limit on the substantial home equity will be increased yearly based on the Consumer Price Index (CPI).

Effective Date	Home Equity Cap
January 1, 2006	$ 500,000
January 1, 2011	$ 506,000

January 1, 2012 $ 525,000

10 DE Reg. 1700 (05/01/07)
16 DE Reg. 639 (12/01/12)

20320.7.F Hardship

Applicants/recipients may request a hardship waiver. See DSSM 20400.12.1 for definition of hardship.

10 DE Reg. 1700 (05/01/07)

20330 Countable Resources Computation

20330.1 Automobiles

For the purpose of Medicaid, automobile is defined as any registered or unregistered vehicle used for transportation.

One vehicle may be excluded under Section 20310.5.

Only one vehicle may be excluded per married couple/household.

If one vehicle cannot be excluded under Section 20310.5, or there is more than one vehicle, the equity value is a non-liquid resource if it:

Is owned by an eligible individual/spouse; or

Cannot be excluded under another provision (e.g. property essential to self support - DSSM 20320.5; co-owner refuses to sell) or conditional benefits do not apply (DSSM 20360).

The equity value is the price it can reasonably sell for on the open market in Delaware minus any encumbrances.

11 DE Reg. 1479 (05/01/08)

20330.2 Financial Institutions Accounts

Financial institution accounts which include savings accounts, checking accounts, certificates of deposit, etc., are an individual's resource if the individual owns the account and can use the funds for his or her support and maintenance. We determine whether an individual owns the account and can access the funds by looking at how the account is titled.

An exception to this policy would be for Achieving a Better Life Experience (ABLE) Savings Accounts. These accounts are not included in the countable resources computation. Please review 20330.2.1 for policy applicable to ABLE Savings Accounts.

If an individual is designated as sole owner by the account title, all of the funds are that individual's resource unless legal restrictions preclude the owner from using the funds for his or her support and maintenance. We do not provide an opportunity for the owner of an individually-held account to rebut the presumption of 100% ownership.

If the account is in the name of a Medicaid applicant/recipient and another Medicaid applicant/recipient, assume all account funds belong to each individual in equal shares. If the account is in the name of a Medicaid applicant/recipient and another individual who is not applying for Medicaid or who is not a Medicaid recipient, then assume all of the funds belong to the Medicaid applicant/recipient.

If the applicant or recipient disagrees with the ownership presumption on jointly-held accounts, we give the individual the opportunity to rebut the presumption. Rebuttal is a procedure which permits an individual to furnish evidence and establish that some or all of the funds in a jointly-held account do not belong to him or her. Obtain the individual's statement on a form containing the penalty clause regarding who owns the funds, why there is a joint account, who has made deposits to and withdrawals from the account, and how withdrawals have been spent. Inform the individual that he or she must submit the following evidence within 30 days:

A corroborating statement from the other account holder(s). If the other account holder is incompetent or a minor, have the individual submit a corroborating statement from anyone aware of the circumstances surrounding establishment of the account; account records showing deposits, withdrawals and interest paid for the months that ownership is an issue; if the individual owns none of the funds, evidence showing that he or she can no longer withdraw funds from the account; if the individual owns only a portion of the funds, evidence showing removal from the account of the individual's funds or removal of the funds owned by the other account holder(s) and redesignation of the account.

Any funds that the evidence establishes were owned by the other account holder(s) are not and were not the individual's resources. The effect of a successful rebuttal is retroactive as well as prospective.

20 DE Reg. 283 (10/01/16)

20330.2.1 Delaware Achieving a Better Life Experience (ABLE) Savings Accounts
Stephen Beck, Jr., Achieving a Better Life Experience (ABLE) Act of 2014,
Pub. L. 113-295, 128 Stat. 4010

The Stephen Beck, Jr., Achieving a Better Life Experience Act (ABLE Act) of 2014 established a tax-advantaged account that can be used to save funds for the disability-related expenses of the account's designated beneficiary. The designated beneficiary must be blind or disabled by a condition that began prior to the individual's twenty-sixth (26^{th}) birthday.

Eligible individuals can be the designated beneficiary of only one ABLE account. The Delaware Achieving a Better Life Experience (ABLE) Program is administered by the Plans Management Board as per 16 Delaware Code Ch. 96A.

Funds in qualifying ABLE accounts, and qualified disability expenses withdrawn from these accounts, are not to be counted towards the determination of eligibility for state or local assistance programs.

20 DE Reg. 283 (10/01/16)

20330.2.1.1 Definitions

The following terms, when used in this regulation, have the following meaning unless the context indicates otherwise:

"**ABLE Program**" means a program established and maintained by a State or consortium of states (or agency or instrumentality thereof) through which interested individuals can open ABLE accounts.

"**Contributions**" means the deposit of funds into an ABLE account. Any person can contribute to an ABLE account. (Note that "person," as defined by the Internal Revenue Code, includes an individual, trust, estate, partnership, association, company, or corporation.) However, the Internal Revenue Service (IRS) limits the total annual contributions any ABLE account can receive from all sources to the amount of the per-donee gift-tax exclusion in effect for a given calendar year.

"**Designated beneficiary**" means the eligible individual who established and is the owner of the ABLE account.

"**Distributions**" means the withdrawal or issuance of funds from an ABLE account. The designated beneficiary or the person with signature authority determines when distributions are made. Distributions may be made only to or for the benefit of the designated beneficiary.

"**Eligible Individual**" means a resident of this State or any state in which an ABLE program is established, who is:

- Entitled to benefits based on disability or blindness under Title II or XVI of the Social Security Act, and such blindness or disability began before the age of twenty-six (26); or
- An individual with respect to whom a disability certification, meeting the requirements of the Stephen Beck, Jr., ABLE Act of 2014, is filed.

"**Person with signature authority**" means a person who can establish and control an ABLE account for a designated beneficiary. If the designated beneficiary is not able to exercise signature authority over his or her ABLE account, or chooses to establish an ABLE account but not exercise signature authority, references to the designated beneficiary with respect to his or her actions include actions by the designated beneficiary's agent under a power of attorney or, if none, a parent or legal guardian of the designated beneficiary.

"**Qualified disability expense**" or "**QDE**" means an expense related to the blindness or disability of the designated beneficiary and that are for the benefit of the designated beneficiary. In general, a QDE includes, but is not limited to, the following types of expenses:

- Education;
- Housing;
- Transportation;
- Employment training and support;
- Assistive technology and related services;
- Health;
- Prevention and wellness;
- Financial management and administrative services;
- Legal fees;
- Expenses for professional ABLE account oversight and monitoring;
- Funeral and burial; and,
- Basic living expenses.

"**Qualified disability expense for housing**" means expenses for purposes of an ABLE account are the same as they are for in-kind support and maintenance purposes, except that they do not include food. QDEs for housing are payments for:

- Mortgage (including property insurance required by the mortgage holder);
- Real property taxes;
- Rent;
- Heating fuel;
- Gas;
- Electricity;
- Water;
- Sewer; and
- Garbage removal.

"**Rollover**" means the distribution of all or some of the funds from one ABLE account to the ABLE account of a member of the original, designated beneficiary's family. For the purposes of a rollover, a member of the designated beneficiary's family means a sibling, which includes step-siblings and half-siblings, whether by blood or by adoption.

20 DE Reg. 283 (10/01/16)

20330.2.1.2 ABLE Account Verification

When documenting whether an applicant is the designated beneficiary of an ABLE account, obtain evidence that contains the following information:

20330.2.1.2.1 The name of the designated beneficiary;

20330.2.1.2.2 The State or consortium ABLE program that is administering the account;

20330.2.1.2.3 The name of the person who has signature authority (if different from the designated beneficiary);

20330.2.1.2.4 The unique account number assigned by the State to the ABLE account;

20330.2.1.2.5 The account opened date; and

20330.2.1.2.6 The first-of-the-month account balance or information sufficient to derive a first-of-the-month balance.

If the available evidence does not provide this information, contact the appropriate ABLE program to obtain it.

20 DE Reg. 283 (10/01/16)

20330.2.1.3 ABLE Account Contributions

ABLE account funds must be excluded from the countable resource computation when determining the designated beneficiary's eligibility. This includes rollovers from a family member's ABLE account to a recipient's ABLE account.

Contributions made to an ABLE account by persons other than the designated beneficiary shall not be excluded from the countable income of the person who makes the contribution. The fact that a person uses the person's own income to contribute to an ABLE account does not mean that income is not countable for Medicaid purposes.

20 DE Reg. 283 (10/01/16)

20330.2.1.4 ABLE Account Earnings

The funds in an ABLE account are invested and can accrue interest, earn dividends, and otherwise appreciate in value. Such earnings increase the account's balance. Exclude any earnings an ABLE account receives from the countable resource computation when determining the designated beneficiary's eligibility.

20 DE Reg. 283 (10/01/16)

20330.2.1.5 ABLE Account Balance

Exclude the balance of a designated beneficiary's ABLE account from the beneficiary's countable resource computation when determining the designated beneficiary's eligibility.

20 DE Reg. 283 (10/01/16)

20330.2.1.6 ABLE Account Distributions

A distribution from an ABLE account is not considered income but rather a conversion of a resource from one form to another. Distributions are evaluated based on the criteria below, to determine if they are to be excluded from the

designated beneficiary's countable resources.

20 DE Reg. 283 (10/01/16)

20330.2.1.6.1 Exclusion of Retained Distributions for Non-Housing Qualified Disability Expenses (QDE)

Distributions for QDEs not related to housing should be excluded as a resource if retained beyond the month received. This exclusion applies for as long as:

20330.2.1.6.1.1 The designated beneficiary maintains, makes contributions to, or receives distributions from the ABLE account.

20330.2.1.6.1.2 The distribution is unspent; and

20330.2.1.6.1.3 The distribution is identifiable.

(NOTE: Excludable funds commingled with non-excludable funds must be identifiable in order to be excluded.)

20 DE Reg. 283 (10/01/16)

20330.2.1.6.2 Retained Distributions for Housing-Related Qualified Disability Expenses (QDE) or Expenses That Are Not QDEs

Distributions from a designated beneficiary's ABLE account for housing-related QDEs or for expenses that are not QDEs that are retained into the month following the month of receipt are countable as a resource. If the distribution is spent within the month of receipt it has no effect on eligibility.

20 DE Reg. 283 (10/01/16)

20330.3 Promissory Notes, Loans and Property Agreements

A loan is an advance from a lender to a borrower that the borrower must repay, with or without interest. DMMA does not count loan proceeds as income to a borrower because of the borrower's obligation to repay. Any portion of the borrowed funds that the borrower does not spend is a countable resource if it is retained into the month following the month of receipt.

If a Medicaid applicant is the owner of a promissory note, loan, or property agreement (mortgage), DMMA will assume that the value of the agreement is its outstanding principal balance.

If the outstanding principal balance plus other countable resources exceeds the resource limit, we will inform the individual that DMMA will use the outstanding principal balance to determine the value of resources unless the individual successfully rebuts the value. See 20330.3.1.

DMMA will consider the value of a promissory note, loan, or mortgage as a transfer for less than fair market value unless:

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

In determining the amount of the asset transferred, DMMA looks at the value of the outstanding balance of the note, loan or mortgage at the date of the individual's application for Medicaid coverage of services listed in section 1917(c)(1)(C)of the Act.

Payments received against the principal balance are not income. They are conversion of a resource. The portion of the payment which represents interest is unearned income.

The SSA Life Expectancy Table can be found at

www.ssa.gov/OACT/STATS/table4c6.html.

10 DE Reg. 1596 (04/01/07)

11 DE Reg. 314 (09/01/07)

20330.3.1 Rebutting the Value

DMMA will give the applicant an opportunity to rebut the value placed on the promissory note, loan or mortgage. The rebuttal must include a written estimate from a disinterested, knowledgeable source (such as a broker or appraiser)

showing that the value is less than our determined value. An applicant may also assert that there is a legal bar to the sale of the instrument by offering documentary or other evidence of a bar or impediment to the sale of the instrument.

10 DE Reg. 1596 (04/01/07)

11 DE Reg. 314 (09/01/07)

20330.4 Retirement Funds

Retirement funds are annuities or work-related plans for providing income when employment ends, such as pensions, individual retirement accounts (IRA), disability, Keogh plans and some profit sharing plans.

The value of a retirement fund is the amount of money that an individual can currently withdraw. Pension plans that allow withdrawals are known as Defined Contribution Plans. If there is a penalty for early withdrawal, the fund's value is the amount available after the penalty deduction. Any taxes due are not deductible in determining the fund's value. A retirement fund is not a resource if an individual must terminate employment in order to obtain any payment.

If an individual is eligible for periodic retirement benefits, the individual must apply and accept the periodic benefit. If the individual has a choice between periodic benefits and a lump sum, the individual must choose the periodic benefits.

Defined Benefit Plans are retirement funds that are not accessible until the recipient meets eligibility criteria outlined in the retirement plan contract (e.g. actual retirement and reaching a predetermined age). These plans are not considered a countable resource until the individual is eligible to begin receiving benefits as outlined in the retirement plan. Defined Contribution Plans and Defined Benefit Plans are not considered countable resources when owned by an ineligible spouse. An ineligible spouse is a legally married husband or wife who is not eligible for Medicaid benefits.

10 DE Reg. 1436 (03/01/07)

20330.5 Stocks

Shares of stock represent ownership in a business corporation. Their value shifts with demand and may fluctuate widely. If the stock has co-owners, assume that each owner owns an equal share of the value of the stock and that the owner can sell them at current value. Broker fees do not reduce the value that stocks have as resources. Obtain a copy of the stock certificate or most recent statement of account from the firm that issued or is holding the stock.

The value of a stock as a resource is its current market value. The current market value of a stock is its closing price on any given day and can usually be found in a regular or financial newspaper. A closing price of 22 3/4 equals $22.75. The values of over-the-counter stocks are shown on a "bid" and "asked" basis. For example, "18, bid, 19 asked." Use the bid price as the current market value. The "par value" or "stated value" shown on some stock certificates is not the market value.

The stock of some corporations is held within close groups and traded very infrequently. The sale of such stock is often handled privately and is subject to restrictions. The evidence for this kind of stock can be a written statement from the firm's accountants giving their best estimate of the stock's value and the basis for the estimate, such as most recent sale, most recent offer from outsiders, current market value of assets less any debts on them, etc.

A stock option is the right to sell or buy stock at a specified price by a specified date. A stock option controls 100 shares of stock, but options are quoted on the price per share. Options come due and are quoted for each January, April, July and October. A closing price of 1/4 equals $25.00.

20330.6 Mutual Fund Shares

"Mutual Fund" is a term that encompasses a wide range of investments. It is a pool of assets (stocks, bonds, etc.) managed by an investment company. A mutual fund share represents ownership interest in this pool as opposed to a particular stock or bond. The documentation guidelines for stocks also apply to mutual funds. Many newspapers contain a separate table showing the values of funds not traded on an exchange.

20330.7 U.S. Savings Bonds

U.S. Savings Bonds are obligations of the Federal Government. They are not transferable and can only be sold back to the Federal Government. Normally, they cannot be redeemed for six months after the issue date specified on the face of the bond. For Series EE, and I Savings Bonds, the redemption period has been extended to 12 months. They become

resources (not income) as of the 7th or 13th month. A bond may not roll over or renew in order to prolong the minimum retention period. Actual redemption (converting to cash) of one bond is required before purchasing a new bond. However, the U.S. Treasury regulation authorizes the Commission of Public Debt to waive the regulatory provisions pertaining to U.S. Savings bonds including the redemption period in order to "relieve any person or persons of unnecessary hardship". A request for a refund because the person now requires Nursing Home care and so needs the funds used to purchase the bonds may constitute hardship. A written request to the Commissioner of Public Debt requesting a waiver to the redemption period is all that is required. The bondholder may simultaneously tender the bond(s) for redemption. If the Treasury receives the bond(s) and grants the waiver, it will issue the individual a check. Since bonds are redeemable due to hardship, the redemption value is treated as an available resource.

The individual in whose name a U.S. Savings Bond is registered owns it. The Social Security Number shown on a bond is not proof of ownership. The co-owners of a bond (bond titled AND/OR) own equal (50%) shares of the redemption value of the bond. The bond may show an owner followed by POD (proof of death) and another name. This is a survivorship type of bond. The name of the first individual owns 100% of the bond. The second individual will own 100% of the bond upon the death of the first individual.

Physical possession of a U.S. Savings Bond is a requirement for redeeming it. This is true for sole or joint ownership. If an individual alleges that he or she cannot submit a bond because a co-owner or other individual will not relinquish physical possession of the bond, obtain a signed statement from the co-owner or the other individual that he or she: has physical possession of the bond; will not allow the applicant to cash the bond; and if co-owner, will not cash the bond and give the applicant his or her share.

The Table of Redemption Values for U.S. Savings Bonds is used to determine the value of a bond. These are available from a local bank. The bank will need the series, denomination, date of purchase or issue date. The value of a series H or HH bond is its face value.

Treasury Retail Securities Services

P.O. Box 9150

Minneapolis, MN 55480-9150

(844) 284-2676

www.treasurydirect.gov/savings-bonds/cashing-a-bond/affected-by-a-disaster

See 20330.7 U.S. Savings Bonds - History

8 DE Reg. 1313 (03/01/05)

10 DE Reg. 1601 (04/01/07)

27 DE Reg. 46 (07/01/23)

20330.8 Municipal, Corporate and Government Bonds

A bond is a written obligation to pay a sum of money at a specified future date.

A municipal bond is the obligation of a State or a locality (county, city, town, village, or special purpose authority such as a school district).

A corporate bond is the obligation of a private corporation. Corporations sell corporate bonds to raise capital. Corporate bonds are issued in two forms: registered, which pay interest to their registered owner; and bearer or coupon bonds, which pay interest to whomever holds the bond. Zero coupon bonds do not pay current interest. The accrued interest is paid at maturity.

A government bond, distinct from a U.S. Savings Bond, is a transferable obligation issued or backed by the Federal Government. They include Treasury bills, notes and bonds, and Federal agency securities, such as Federal Home Loan Mortgage Corporation (FREDDIE MAC) and Government National Mortgage Association (GINNIE MAC).

Bonds are negotiable and transferable. Their value as a resource is their current market value. The redemption value, which is available only at maturity, is immaterial. The documentation for these bonds is similar to stocks.

20330.9 Uniform Gifts to Minors Act

Delaware has adopted the Uniform Gifts to Minors Act (UGMA) which permits making gifts to minors that are free of tax burdens. The UGMA is sometimes called the Uniform Transfers to Minors Act (UTMA).

Under Delaware UGMA law:

- An individual may make an irrevocable gift of money or other property to a minor. If such a gift is made, then;
- The gift, plus any earnings it generates, is under the control of a custodian until the child reaches the age of majority established by State law;
- The custodian has discretion to provide to the minor or spend for the minor's support, maintenance, benefit or education as much of the assets as he/she deems equitable; and
- The child automatically receives control of the assets upon reaching the age of majority (his/her 18th birthday). At this time, the UGMA property becomes a countable asset for the purpose of program eligibility.

UGMA property including any additions or earnings is not income to the minor. However, any disbursements from the UGMA account to the minor will be considered income to the minor.

Verification

DSS will verify all allegations of existence of a UGMA gift by obtaining a copy of the document of ownership (e.g., deed, certificate of deposit, savings account, etc.) or other written document from the issuing source. If there is no document designating a UGMA gift, then the asset will be considered a countable resource.

8 DE Reg. 1712 (6/1/05)

20330.10 Annuities

20330.10.A Defining Annuity

For Medicaid purposes, an annuity is a financial device between an individual and a commercial company that conveys a right to receive periodic payments for life or a fixed number of months or years.

20330.10.B Disclosure of Interest in an Annuity

1. Any interest an applicant or community spouse has in a revocable or irrevocable annuity must be disclosed at the time of application.

2. Failure to disclose interest in an annuity may result in denial of payment for long term care services or denial of Medicaid eligibility.

20330.10.C Determining If Annuity is Income and or a Resource

1. The equity value of a revocable annuity is a countable resource.

2. An assignable annuity (the owner or payee may be changed) is a countable resource. The resource value is the amount the assignable annuity can be sold for on the secondary market.

3. An annuity purchased by a third party, e.g. applicant's employer, as a retirement benefit to the applicant will not be counted as an available resource. (DSSM 20330.4)

4. The stream of income generated by an annuity, whether a countable resource or not, is countable income.

20330.10.D State's Rights as a Preferred Remainder Beneficiary

1. The DMMA will notify, in writing, the issuer of an annuity owned by an applicant that the State is the preferred remainder beneficiary.

This notice will require the issuer to notify the State of any changes in the amount of income, principal or beneficiary to the annuity.

This notice will require the issuer to notify the State of any changes in the amount of income, principal or beneficiary to the annuity.

2. Certain transactions that occur on or after February 8, 2006 will subject an annuity purchased prior to this date to the DRA provisions. (DSSM 20330.10.E, DSSM 20330.10.F)

These transactions include such things as an addition to the principal, elective withdrawal, requests to change beneficiary, or elections to annuitize the contract.

20330.10.E State Named Remainder Beneficiary in All Annuities Purchased on or after February 8, 2006

1. The State of Delaware must be named as a beneficiary in the correct position.

The State must be named beneficiary in the first position for the total amount of medical assistance paid on behalf or the institutionalized spouse, unless there is a community spouse, minor child, or disabled child who resides in the applicant's home.

In such a case, the State must be named in a secondary or remainder position.

2. If the State is not named as a remainder beneficiary the purchase of the annuity will be considered a transfer for less than fair market value.

3. The full purchase value of the annuity will be considered the amount transferred.

20330.10.F Purchase of an Annuity is Considered a Transfer of Assets

1. The transfer of assets provisions should be applied to all annuities purchased on or after February 8, 2006 unless:

A. The annuity is considered either:

An individual retirement annuity (according to Sec. 408 (b) of the Internal Revenue Code of 1986); or

A deemed Individual Retirement Account under a qualified employer plan (according to Sec. 408 (q) of the Internal Revenue Code of 1986).

OR

B. The annuity is purchased with proceeds from one of the following:

A traditional IRA (IRC Sec. 408a); or

Certain accounts or trusts which are treated as traditional IRAs (IRC Sec. 408 §(c)); or

A simplified retirement account (IRC Sec. 408 §(p)); or

A simplified employee pension (IRC Sec. 408 §(k)); or

A Roth IRA (IRC Sec. 408A).

OR

C. The annuity meets all of the following requirements:

The annuity is irrevocable and non-assignable; and

The annuity is actuarially sound; and

The annuity provides payments in approximately equal amounts, with no deferred or balloon payments.

11 DE Reg. 676 (11/01/07)

20340 Life Insurance and Burial Resource Computation

20340.1 Life Insurance

20340.1.1 Life Insurance Terminology

20340.1.2 Life Insurance as a Resource

20340.1.3 Relation to Burial Allowance

20340.1.1 Life Insurance Terminology

Insured is the individual whose life is covered by the policy.

Beneficiary is the individual who receives the proceeds upon the insured's death.

Owner is the individual who is designated as the owner on the policy or by the insurance company.

Face Value (FV) is the amount of basic death benefit contracted for at the time the policy is purchased.

Cash Surrender Value (CSV) is a form of equity value that is acquired over time. The owner of a policy can obtain its CSV only by turning the policy in for cancellation before it matures or the insured dies. A loan against a policy reduces its CSV.

Dividends are shares of company earnings paid to the policy owner. The dividends are not income but the interest on dividends is income.

Dividend Additions are amounts of insurance purchased with dividends and added to the policy, increasing its death benefit and CSV. The table of CSV's that comes with a policy does not reflect the added CSV of any dividend additions.

Dividend Accumulations are dividends that the policy owner has constructively received but left in the hands of the insurance company to accumulate at interest, like money in a bank account. They are not a value of the policy; the owner can obtain them at any time without affecting the policy's FV or CSV.

Dividend accumulations cannot be excluded from resources under the life insurance exclusion, even if the policy that pays the accumulations is excluded from resources. Dividend accumulations are a separate resource (they are not considered as an increase in CSV) and must be designated as burial funds separate from the life insurance policy itself. Unless they can be designated and excluded as burial funds, they are a countable resource.

20340.1.2 Life Insurance as a Resource

Life insurance is only considered a resource if the applicant is the owner of policy. A life insurance policy is an excluded resource if its FV and the FV of any other life insurance policies the individual owns total $1500 or less.

The policy/policies original face value(s) is considered when determining if the cash surrender value of a policy is countable. Do not include the FV of dividend additions. If the original face value of the policy/policies exceeds $1500, the cash surrender value, including the CSV of dividend additions, is counted toward the applicant's total resources. Applicants have the option to designate life insurance for burial or to retain it as a liquid resource. The individual can also designate any dividend accumulations on the life insurance policy.

Some life insurance companies offer to pay the owner of a life insurance policy money that would normally go to the beneficiary of the policy after the death of the insured. These payments are referred to as "accelerated life insurance payments". Some payments are made as a lump sum, others are paid out monthly. The plans vary from company to company but they all involve early payout of some or most of the proceeds of the policy to the insured.

Since these accelerated life insurance payments can be used to meet food, clothing, or shelter needs, the payments are income in the month received and a resource if retained into the following month. The receipt of an accelerated payment is not treated as a conversion of a resource. This is because the individual receives proceeds from the policy and not the policy's resource value-which is its cash surrender value. Accelerated payments are not "benefits" for purposes of the requirement to file for other benefits. We do not require a policyholder to apply for accelerated payments as a condition of eligibility.

20340.1.3 Relation to Burial Allowance

The $1500 burial funds allowance is reduced by the FV of any life insurance policy or policies excluded under the life insurance exclusion. A total of $1500 FV life insurance is excluded as a resource but must be considered if the individual wants to designate other revocable burial funds. If the individual has burial funds in an irrevocable arrangement, then the maximum $1500 burial allowance is reduced by the face value of any life insurance that has been excluded as a resource AND any amount held in an irrevocable arrangement.

SEE:

Section 20340.2 - Burial Allowance

Section 20340.4 - Life Insurance Funded Burial Contracts

Section 20340.5 - Irrevocable Funeral Arrangements

If a Medicaid applicant is the beneficiary of another's life insurance, upon death of the insured, the proceeds that are not used to pay for last medical or burial expenses of the deceased would be considered as income for the applicant in the month of receipt. If an expense has been incurred but not yet paid, assume the individual will pay the expense and do not count the death benefit as a resource until the second calendar month following the month of receipt.

20340.2 Burial Allowance

We can exclude up to $1500 each in funds set aside for the burial expenses of the individual and the individual's spouse. This exclusion is separate from and in addition to the burial space exclusion.

The $1500 burial allowance may consist of revocable burial contracts, burial trusts, other burial arrangements, cash, accounts, or other financial instruments (documents which have a definite cash value).

20340.2.1 Burial Allowance Reductions

The $1500 burial allowance is reduced by:

a. the face value of any life insurance policy that has been excluded as a resource and
b. amounts held in an irrevocable arrangement for the individual's (or spouse's) burial.

20340.2.2 Burial Allowance Combinations

An individual can have BOTH an irrevocable burial trust or a funeral funded by an irrevocable assignment of ownership AND separate life insurance with a face value of $1500 or less. If the funeral arrangement is revocable or the individual has designated burial funds, the life insurance of $1500 or less must also be counted toward the $1500 burial allowance. If the face value of life insurance exceeds $1500, the CSV is a countable resource.

20340.2.3 Burial Funds Kept Separate

The $1500 burial exclusion applies only to funds set aside for burial expenses that are kept separate from all other resources not intended for burial of the individual (or spouse) and that are clearly designated as set aside for the individual's (or spouse's) burial expenses. If excluded burial funds are mixed with resources not intended for burial, the exclusions will not apply to any portion of the funds.

Remember that a burial fund, such as a certificate of deposit, can include both designated, excludable burial funds (up to $1500) and non-excluded burial funds. For example, an applicant has a $2500 CD which is designated for burial. All of the CD's value is burial-related; however, the maximum burial allowance is $1500. This means that $1500 are excludable burial funds and $1000 are non-excluded burial funds. The $1000 is countable toward the liquid resource limit.

Current recipients who have been eligible since 7/11/90 who have had burial funds excluded which do not meet all the new requirements must convert or separate such funds to meet these requirements unless there is an impediment to such conversion or separation; i.e., a circumstance beyond the individual's control which makes the conversion/separation impossible or impracticable. For as long as such impediment exists, the burial funds will continue to be excluded if the individual remains otherwise eligible for the exclusion.

20340.2.4 Declarative Designation Statement

A declarative designation statement must be signed by the applicant/representative in order for funds to be excluded. In cases where funds are not designated for burial, the funds may be excluded as of the first day of the month in which the applicant/representative signs the Burial Designation Statement. Within 30 days from the date the statement is signed, documentary evidence must be submitted that funds have been set aside. A copy of the documentary evidence must be made a permanent part of the case record.

If an individual has a burial fund that was established prior to application, the value of the burial fund as of the date of application rather than the original amount will be countable toward the resource limit.

20340.3 Prepaid Burial Contracts

20340.3.1 Prepaid Burial Contract Definition

20340.3.2 Burial Funds/Funeral Services

20340.3.3 Burial Space Exclusion

20340.3.1 Prepaid Burial Contract Definition

A prepaid burial contract is an agreement entered into in which an individual prepays burial expenses and the seller agrees to furnish the burial. A contract must identify and distinguish between funeral services (burial funds) and burial space items.

20340.3.2 Burial Funds/Funeral Services

Funeral services include items and services relative to preparing the body. Such preparation includes, for example, transportation of the body, embalming, cremation, funeral/memorial services, flowers, clothing, etc.

20340.3.3 Burial Space Exclusion

Purchased burial space items are excluded. An item is considered purchased even if the specific model number of the item is not mentioned or is not in existence, since the burial space exclusion applies to any burial space item.

As long as the contract/agreement results in the individual's right to the items listed, value at the amount indicated, the requirement for exclusion as a burial space is met - a burial space item is being held for the individual (i.e. there was a purchase). A burial space is "held for" an individual when someone currently has: title to and/or possesses a burial space or a contract with a funeral home for specified burial spaces for the individual's burial. Until the purchase price is paid in full, a burial space is not "held for" an individual under an installment contract if:

the individual does not currently own the space;

the individual does not currently have the right to use the space;

the seller is not currently obligated to provide the space.

If the burial space is not being currently held for an individual under an installment contract, the amounts paid may be considered burial funds rather than burial space items.

20340.4 Life Insurance Funded Burial Contracts

A life insurance funded burial contract involves an individual purchasing a life insurance policy on his life and then assigning, revocably or irrevocably, either the proceeds or ownership of the policy to a funeral provider. The purpose of the assignment is to fund a burial contract. The burial contract itself has no resource value. The value of the burial arrangement is the value of the life insurance policy.

20340.4.1 Revocable Assignment of Ownership

The burial space exclusion does not apply if the assignment of ownership is revocable. This is because the funeral provider has not received any payment and no purchase of burial spaces has been made. The burial funds exclusion applies. The resource value is equal to the CSV of the life insurance policy subject to the $1500 burial funds exclusion.

20340.4.2 Irrevocable Assignment of Ownership

To determine irrevocability a copy of the "irrevocable assignment of ownership" is required along with a complete copy of the policy and burial contract. Any portion of the contract that represents the purchase of a burial space is excluded. The life insurance policy and the burial contract are not resources because the individual no longer owns them. The face value of the burial funds portion of the contract offsets the $1500 burial funds exclusion because the contract represents an irrevocable arrangement available to meet the individual's burial.

20340.5 Irrevocable Funeral Arrangements

Effective January 30, 1992, Delaware law allows the establishment of irrevocable trust accounts for prepaid funerals. The irrevocable trust may represent all funds or any portion of payments made under the burial agreement, contract or plan. The principal sum (excluding accrued interest) may not exceed $5,000. Effective January 1, 2008 the principal sum may not exceed $15,000. Irrevocable trusts established under Title 5, Chapter 34 of the Delaware Code must contain the following mandatory provisions.

11 DE Reg. 1051 (02/01/08)

20340.5.1 Irrevocable

The trust must include a provision which expressly identifies the trust as irrevocable for the lifetime of the beneficiary.

20340.5.2 Alternative Disposition

The trust must include a provision for the alternative disposition of trust funds upon discontinuation of business or inability to provide goods or services in accordance with the terms of the trust.

20340.5.3 Inadequate Funds

The trust must include a provision which sets forth that in the event funds paid into the trust are inadequate, at the time of the death of the beneficiary, to cover anticipated funeral expenses, the trustee shall contribute all trust funds toward payment of the actual funeral expenses for the funeral of the beneficiary.

20340.5.4 Excess Funds

The trust must include a provision which sets forth that in the event the sum held by the trust exceeds the total actual costs of the goods and services for the funeral of the beneficiary, the excess funds shall be paid to the estate of the beneficiary.

20340.5.5 Contributions to Trust

The trust must include a provision which sets forth that the trustee may, from time to time, accept periodic monetary contributions to the trust, provided that the principal sum contributed, exclusive of interest earned, shall not exceed $15,000.00.

11 DE Reg. 1051 (02/01/08)

20340.5.6 Maximum Amount

The trust must include a provision which shall state "In no event shall the principal amount of the trust exceed $15,000.00 plus interest".

Once an irrevocable trust is executed in conjunction with a burial contract, the funds are not available to the buyer. Any written request for a refund of money is no longer an option. The irrevocable trust arrangement will offset the $1500 burial allowance. This is effective for irrevocable trust arrangements executed on or after January 30, 1992.

11 DE Reg. 1051 (02/01/08)

20340.6 Burial Funds in Excess of $1500

Upon application, any burial funds which exceed $1500 must be counted toward the recipient's $2000 resource limit.

Mrs. Jones has a prepaid burial contract of which $2000 is countable and no life insurance.

$2000	countable prepaid burial contract
-$1500	burial exclusion
= 500	countable resource

The excess $500 must be counted toward her resources. As long as her total resources (including the excess $500) do not exceed the current applicable SSI resource limit, the recipient would remain eligible.

20340.7 Use of Burial Funds After Designation

Any designated burial funds used for another purpose will be counted as income in the month withdrawn. The penalty for using excluded burial funds for some other purpose applies only to those whose resources would have been over the limit without benefit of this exclusion. The budgeting of this additional income could result in the recipient exceeding the monthly income limit. As a result, Medicaid benefits would be terminated.

20340.8 Interest on Burial Funds and Burial Spaces

Interest and other accruals on the $1500 burial funds and spaces is excluded from countable income and resources. Interest on and appreciation in value of an excluded burial fund are excluded if left to accumulate and become part of the

excluded fund. In the event the recipient loses Medicaid eligibility, the appreciated value (accrued interest) will be counted toward the resource limit upon reapplication.

20340.9 Funds Added to Existing Burial Accounts

If someone has a burial fund that is less than the $1,500 limit, the recipient can add funds to it to bring it up to the $1,500 limit. The money added would have to be from the recipient's personal needs money or other liquid resources. The recipient couldn't divert patient pay or accept money from friends/relatives to place in the account. Contributions from friends/relatives would be considered income.

20345 Qualified State Long-Term Care Insurance Partnership Program

This policy applies to Long-Term Care Insurance Partnership policies purchased on or after November 1, 2011.

1. Defining a Qualified State Long-Term Care Insurance Partnership.

The Delaware Qualified State Long-Term Care (LTC) Insurance Partnership is a partnership between States that implement a Partnership program, private insurance companies that offer long term care insurance policies and State insurance departments. The term “Qualified State Long-Term Care Insurance Partnership” means an approved State plan amendment (SPA) that provides for the disregard of any assets or resources from Medicaid estate recovery in an amount equal to the insurance benefits paid by certain LTC insurance policies, where those benefits were disregarded in determining an individual’s Medicaid eligibility. The term “long-term care insurance policy” includes a certificate issued under a group insurance contract.

Purchasing or owning a Qualified State Long-Term Care Insurance Partnership policy does not guarantee Medicaid eligibility. All other financial, non-financial and medical eligibility requirements must be met.

Policies must meet specific conditions and the State Insurance Commissioner must certify that a policy meets those conditions, in order for the State to apply the disregard from estate recovery.

The long-term care partnership policy is designed to do all of the following:

a. Provide incentives for individuals to insure against the costs of providing for their long-term care needs.

b. Provide a mechanism for individuals to qualify for coverage of the cost of their long-term care needs under Medicaid without first being required to substantially exhaust their resources.

c. Reduce Medicaid expenditures by delaying or eliminating the need for Long-Term Care Medicaid.

2. Long-term care insurance policies purchased prior to November 1, 2011 are not Partnership policies.

3. Long-term care insurance policies purchased on or after November 1, 2011 may or may not be Partnership policies.

A long-term care partnership program policy means a policy that must meet all of the following requirements:

a. The policy must have been issued on or after November 1, 2011.

b. The covered individual must be a resident of a Qualified Partnership State when coverage first becomes effective. If a policy is exchanged for another policy, the residency rule applies to the issuance date of the original policy.

c. The policy must meet the definition of a “qualified long-term care insurance policy” as stated in section 7702B(b) of the Internal Revenue Code of 1986.

d. The policy must meet specific requirement of the National Association of Insurance Commissioners (NAIC) Long Term Care Insurance Model Regulations Act and Model Act.

e. The policy must include inflation protection.

i. For purchasers under 61 years of age, compound annual inflation protection.

ii. For purchasers 61 to 76 years of age, some level of inflation protection; or

iii. For purchasers 76 years of age or older, inflation protection may be offered, but is not required.

4. A Partnership policy allows for assets to be disregarded from eligibility.

The amount of the disregard is equal to the dollar amount of insurance benefits that have been paid to or on behalf of the individual.

This amount is limited to the amount paid as of the month of application, even if additional benefits are available under the terms of the policy.

5. Assets are also protected from the Medicaid Estate Recovery Program.

The amount of the assets disregarded in the eligibility process is not recoverable under the Medicaid estate recovery program.

6. Disregarded assets are counted in the Spousal Resource Assessment.

The disregarded assets are included in determining the amount of the community spouse resource allowance in a Spousal Impoverishment case.

However, the disregarded asset is not counted in determining the individual's eligibility.

7. Disregarded assets may be transferred without penalty.

If an individual becomes eligible for Medicaid through the application of a QLTCP disregard, then transfers all or part of the disregarded resources that would otherwise be considered an improper transfer, no restricted Medicaid coverage period applies. The disregarded value of the transferred resource continues to be considered part of the individual's QLTCP disregard.

If an individual becomes eligible for Medicaid through the application of a QLTCP disregard after making a transfer that would otherwise be considered an improper transfer:

a. If the individual's QLTCP disregard plus resource limit equals or exceeds the individual's countable resources plus the value of the transferred resource, no penalty period applies. The disregarded value of the transferred resource is considered part of the individual's QLTCP disregard.

b. If the individual's QLTCP disregard plus resource limit is less than the individual's countable resources plus the value of the transferred resource:

i. Determine the individual's available QLTCP disregard by adding the individual's QLTCP disregard to the individual's resource limit, then subtracting the individual's current countable resources and any amounts that have previously been transferred without a restricted Medicaid coverage period as a result of a QLTCP disregard.

ii. Subtract the individual' available QLTCP disregard from the amount that would otherwise have been considered improperly transferred. The remainder is the amount improperly transferred; a restricted Medicaid coverage period is calculated for the remainder.

8. Reciprocity with other states.

DMMA will accept partnership policies issued in other States with qualified long-term care insurance partnership programs.

9. Exhaustion of Benefits.

An individual who owns a Qualified State Long-Term Care Insurance Partnership policy can apply for Medicaid before exhausting policy benefits.

The partnership policy is treated as a third party liability and Medicaid will pay for services not covered. Medicaid will be payor of last resort.

10. Verification of the Partnership policy.

A Qualified State Long-Term Care Insurance Partnership policy must meet all relevant requirements of federal and state law. Qualified partnership policies are certified by the Delaware Department of Insurance (DOI).

15 DE Reg. 1014 (01/01/12)

20350 Transfer of Assets

Transfer of assets occurs when an institutionalized individual, or the individual's spouse, has sold, given away (including establishment of a trust or contribution to a charity) or otherwise transferred any asset. Assets transferred by a parent, guardian, court or administrative body, or anyone acting in place of or on behalf of or at the request or direction of the individual or spouse, are considered to be transferred by the individual or spouse. Medicaid law provides for a period of ineligibility when an institutionalized individual or the individual's spouse disposes of assets for less than fair market value (FMV) on or after a specified look-back date.

Section 13611 of the Omnibus Budget Reconciliation Act of 1993 (P. L. 103-66) enacted 8/10/93, revised the rules on Transfer of Assets. The new rules are effective for long term care applications filed on or after 10/1/93 and assets transferred on or after 8/11/93. The new rules do not apply to assets transferred on or before 8/10/93.

20350.1 Definitions

20350.1.1 Institutionalized Individual

20350.1.2 Spouse

20350.1.3 Assets

20350.1.1 Institutionalized Individual

An institutionalized individual is an individual who is:

- an inpatient in a nursing facility, or
- an inpatient in a medical institution with respect to whose eligibility is based on an appropriate level of care for that medical institution, or
- a home and community-based services recipient described in section 1902(a)(10)(A)(ii)(VI).

20350.1.2 Spouse

This is a person who is considered legally married to an individual under the laws of the State in which the individual is applying for or receiving Medicaid.

20350.1.3 Assets

Assets include all income and resources of the individual or the individual's spouse. NOTE: PRIOR TO OBRA 93 THE DEFINITION OF ASSETS DID NOT INCLUDE INCOME.

Assets would also include assets that the individual or spouse is entitled to receive but does not because of an action taken by:

- the individual, or
- the individual's spouse, or

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

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

20350.1.3.1 Actions Which Result in Non-Receipt of Assets

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

irrevocably waiving pension income;

- waiving an inheritance;
- not accepting or accessing injury settlements;
- tort settlements which are diverted by the defendant into a trust or similar device to be held for the benefit of the plaintiff;
- refusal to take legal action to obtain a court ordered payment that is not being paid, such as alimony.

20350.1.3.2 Failure to Receive

However, failure to cause assets to be received does not constitute a transfer of assets in all cases. For example, the individual may not be able to afford to take the necessary action to obtain the assets or the cost of obtaining the assets may be greater than the assets are worth. The specific circumstances of each case must be examined before making a decision whether an uncompensated asset transfer has occurred.

20350.1.3.4 Joint Assets

In the case of jointly owned assets (joint tenancy, tenancy in common, or similar arrangement) any action taken by the individual or by any other person that reduces or eliminates the individual's ownership or control of the asset will be penalized as an uncompensated transfer. See Section 20350.8 Treatment of jointly owned assets

20350.1.4 Resource Transfer

The definition of a resource is the same definition as used by the SSI program, except that the home is NOT excluded for institutionalized individuals. In determining if a transfer of assets involves a SSI-countable resource, take into account those resource disregards used by the SSI program.

20350.1.5 Income Transfer

The definition of income is the same definition as used by the SSI program. In determining whether a transfer of assets involves SSI-countable income, take into account those income disregards used by the SSI program.

20350.1.6 For the Sole Benefit of Requirement

A transfer is considered to be for the sole benefit of a spouse, child who is blind or disabled, or an individual with a disability if the transfer is arranged in such a way that no individual or entity except that spouse, child who is blind or disabled, or an individual with a disability can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not the spouse, child who is blind or disabled, or an individual with a disability is not considered to be established for the sole benefit of one of these individuals. In order for a transfer to be considered to be for the sole benefit of one of these individuals, the instrument document must provide for the spending of the funds involved for the benefit of the individual on a basis that is actuarially sound based on the life expectancy of the individual involved.

An exception to the "for the sole benefit of" requirement exists for certain trusts. Under these exceptions, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the State, up to the amount of Medicaid benefits paid on the individual's behalf. In these instances, it is a requirement that the State is also a beneficiary of the trust.

15 DE Reg. 202 (08/01/11)

20350.1.7 Fair Market Value (FMV)

Fair market value is an estimate of the value of an asset, if sold at the prevailing price at the time it was actually transferred. In order to appraise the value of an asset, use the same criteria and methods that are used when determining Medicaid eligibility.

For an asset to be considered transferred for fair market value, or to be considered to be transferred for valuable consideration, the compensation received for the asset must be in a tangible form. A transfer for "love and consideration", for example, is not considered a transfer for fair market value. While relatives and family members legitimately can be paid for care they provide to the individual, it is presumed that services provided for free at the time were intended to be provided without compensation. Thus, a transfer to a relative for care provided for free in the past is considered a transfer of assets. However, an individual can rebut this presumption with tangible evidence that is acceptable to Medicaid.

20350.1.8 Valuable Consideration

Valuable consideration means that an individual receives in exchange for his or her right or interest in an asset some act, object, service, or other benefit which has a tangible value to the individual that is roughly equivalent to or greater than the value of the transferred asset.

20350.1.9 Uncompensated Value (UV)

The uncompensated value is the difference between the fair market value at the time of transfer (less any outstanding loans, mortgages or other encumbrances on the asset) and the compensation received for the asset.

20350.1.10 Average Monthly Cost

Average monthly cost is the average cost to a private patient for a month of nursing facility services in Delaware at the time of application. The monthly rate is determined based on 365 days divided by 12 months or 30.42 days per month. This is not the average Medicaid per diem rate.

20350.2 Look-Back Date and Look-Back Period

20350.2.1 Look-Back Date

20350.2.2 Look-Back Period

20350.2.3 Look-Back Period for Transfers of Assets Involving Trusts

20350.2.1 Look-Back Date

The look-back date is the earliest date on which a penalty for transferring assets for less than fair market value can be assessed. Penalties can be assessed for transfers which take place on or after the look-back date.

Penalties cannot be assessed for transfers which take place prior to the look-back date. See Section 20350.2.3 Look-back period for transfer of assets involving trusts

For long term care applications filed on or after 2/8/06 and assets transferred on or after 2/8/06, the look-back date is 60 months prior to the baseline date. The baseline date is the first date as of which the individual was:

institutionalized; AND

has applied for medical assistance under the state plan.

When an individual applies for Medicaid more than once (for example, he or she applies for Medicaid, is denied eligibility because of excess resources, and applies again 6 months later), the look-back date is 36 months prior to the baseline date. The baseline date is the first date (first time) the individual has applied for long term care Medicaid. Each individual has only one look-back date, regardless of the number of periods of institutionalization, applications for Medicaid, periods of eligibility, or transfers of assets. All transfers of assets after that date fall within the look-back period.

10 DE Reg. 1613 (04/01/07)

20350.2.2 Look-Back Period

The look-back period is the period that begins with the look-back date and ends with the baseline date. It is the period of time prior to the baseline date (see above) during which a previous transfer of assets for less than fair market value can be penalized. It is important to remember that transfers which occur after the baseline date are also subject to penalty if they are made for less than fair market value.

Effective 2/8/06, the date of the Deficit Reduction Act of 2005 (DRA) enactment, the look-back period was extended from 36 months to 60 months. Any transfers that occur on or after 2/8/06 will be subject to a 60 month look-back period.

10 DE Reg. 1613 (04/01/07)

20350.2.3 Look-Back Period for Transfers of Assets Involving Trusts

When an individual establishes a revocable trust and a portion is disbursed to someone else and not for the benefit of the grantor, that portion is treated as a transfer of assets. For a revocable trust, the transfer is considered to take place on the date upon which the payment to someone other than the grantor was made.

When an individual establishes an irrevocable trust in which all or a portion of the trust cannot be disbursed to or on behalf of the individual, that portion (the portion that is unavailable) is treated as a transfer of assets. For an irrevocable trust, the transfer is considered to have been made as of the date the trust was established or, if later, the date upon which payment to the grantor was foreclosed.

Whenever a portion of a trust is treated as a transfer (as described above), the look-back period is 60 months.

When a trust is irrevocable but some or all of the trust can be disbursed to or for the benefit of the individual (the portion that could be made available to the individual), the look-back period applying to disbursements made from this portion to another person is 60 months. Effective 2/8/06, the date of the DRA enactment, all trusts will be subject to a 60 month look-back period.

When an individual places assets into an irrevocable trust and can still benefit from those assets, the amount transferred is equal to any of those assets which are paid out for a purpose other than to or for the benefit of the individual. When an individual places assets in an irrevocable trust and can no longer benefit from some or all of those assets, that unavailable portion is considered as a transfer. The value of these assets is not reduced by any payments from the trust which may be made from these unavailable assets as a later date.

10 DE Reg. 1613 (04/01/07)

20350.3 Penalty Period and Penalty Date

The penalty period is a period of ineligibility for long term care Medicaid services that is imposed when an individual makes a transfer of assets for less than fair market value. Under OBRA 93 there is no maximum limit on the penalty period for assets transferred after 8/10/93. The length of the penalty period is based on the value of the assets transferred and the cost of nursing facility care. The penalty period cannot exceed 30 months for assets transferred on or before 8/10/93.

The penalty date is the beginning date of each penalty period that is imposed for an uncompensated transfer. The penalty date for all individuals who transfer assets is the first day of the month in which the asset was transferred, provided that date does not occur during an existing penalty period. When a transfer takes place during an existing penalty period, whether imposed under the pre-OBRA 93 or post-OBRA 93 rules, a new penalty period cannot begin until the existing penalty period has expired.

The penalty period for an institutionalized individual is equal to:

- the total, cumulative uncompensated value of all assets transferred by the individual or spouse on or after the look-back date

divided by

- the average monthly cost to a private patient for nursing facility services at the time of application.

The resulting figure is the number of months the applicant will be ineligible for Medicaid.

In figuring periods of ineligibility, count full months only, regardless of the date in a month a transfer actually occurs. A full month is counted at the beginning of a period of ineligibility. That is, a period of ineligibility begins with the first day of the month in which a transfer has occurred. For example, if an individual has made a transfer on September 28, the period of ineligibility begins on September 1. If a calculation of the penalty period results in a partial month, round the days down to the end of the preceding month. For example, from a September 28 transfer, round down to make August the last month in the period. However, do not round a month up to the end of the month in which the transfer occurred. For example, do not round September 28 up to include the whole month of September.

20350.3.1 Penalty Period for assets transferred on or after 2/8/06

Section 6011(b) for the Deficit Reduction Act amends section 1917(c)(1)(D) of the Act to change the start date of the penalty period, which is the period during which an individual is ineligible for Medicaid payment for long term care services because of a transfer of assets for less than fair market value.

The ineligibility period will begin with the LATER of:

The month during which assets have been transferred for less than fair market value; or

The date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level of care services (based on an approved application for such services) that, were it not for the imposition of the penalty period, would be covered by Medicaid.

The penalty period cannot begin until the expiration of any existing period of ineligibility. The penalty period will continue to run for the number of days determined by dividing the total value of assets transferred within the look back period by the State's average daily cost to a private patient of a nursing facility services in the State. Once the penalty period is imposed, it will not be interrupted, but will continue to run even if the individual stops receiving institutional level of care.

For non-institutionalized individuals, the penalty date will not begin until the individual is receiving an institutional level of care.

Upon imposition of a period of ineligibility for long-term care level services because of an asset transfer, applicants/recipients will be notified of the right to request an undue hardship waiver. In addition, long-term care providers may file an undue hardship waiver on behalf of the individual with the consent of the individual or the personal representative of the individual. See DSSM 20400.1.12.1.

10 DE Reg. 1613 (04/01/07)

20350.4 Multiple Transfers

OBRA 93 provides that the penalty period will be based on the total, cumulative uncompensated value of the assets transferred. When a single asset is transferred, or a number of assets are transferred, the penalty period is calculated using the total value of the asset(s). When assets are transferred at different times, use the following methods for calculating the penalty periods. This policy applies to assets that were transferred on or after 2/8/06 and applications that were filed on or after 4/1/06.

10 DE Reg. 1439 (03/01/07)

20350.4.1 Transfers Made So That Penalty Periods Overlap

When assets have been transferred in amounts and/or frequency that would make the calculated penalty periods overlap, add together the value of all assets transferred to calculate a single penalty period. Fractional periods of ineligibility shall not be rounded down or otherwise disregarded when determining the penalty for a transfer of assets.

10 DE Reg. 1439 (03/01/07)

20350.4.2 Transfers Made So That Penalty Periods Would Not Overlap

Repealed

10 DE Reg. 1439 (03/01/07)

20350.5 Return of Assets

The penalty period can be shortened to account for assets that are returned. If all assets transferred are returned to the individual, no penalty for transferring assets is assessed. Where a penalty has been imposed and eligibility has been denied, a return of the assets requires a retroactive adjustment back to the beginning of the penalty period. However, the assets that are returned must be counted in determining eligibility and may result in the individual being ineligible for Medicaid because of excess income/resources.

In order to void the penalty, all of the asset or its fair market equivalent must be returned. If, for example, the asset was sold by the individual who received it, the full market value of the asset must be returned to the transferor, either in cash or another equivalent value. If only part of an asset or its equivalent value is returned, the penalty period can be modified, but not eliminated.

20350.6 Transfers by a Spouse

When a spouse transfers an asset that results in a penalty for the individual (applicant) and then the spouse also applies for Medicaid and is otherwise eligible, the penalty period is apportioned between the spouses. The total penalty imposed on both spouses must not exceed the length of the penalty originally imposed on the individual.

20350.7 Penalty Period When Individual Leaves Institution

A penalty period imposed for a transfer of assets runs continuously from the first date of the penalty period (the penalty date), regardless of whether the individual remains in or leaves the institution (or waiver program). If the individual leaves the institution, the penalty period continues to run until the end of the calculated period. If the individual is readmitted, the remaining penalty period (if any) must be imposed.

20350.8 Treatment of Jointly Owned Assets

Where an asset is held by an individual in common with another person, or persons, via joint tenancy, tenancy in common, joint ownership, or similar arrangement, the asset is considered transferred by the individual when any action is taken, either by the individual or any other person, that reduces or eliminates the individual's ownership or control of the asset.

Under this provision, merely placing another person's name on an account or asset as a joint owner might not constitute a transfer of assets depending upon the specific circumstances of the situation. The individual may still possess ownership rights to the account or asset and therefore have the right to withdraw all of the funds in the account or possess the asset at any time. The account or asset is still be considered to belong to the individual. However, actual withdrawal of funds from the account, or removal of the asset, by the other person removes the funds or property from the control of the

individual and this constitutes a transfer of assets. Although the withdrawal of funds is subject to the transfer of assets provision, the individual is provided an opportunity to rebut the presumption.

Also, if placing another person's name on the account or asset actually limits the individual's right to sell or dispose of the asset, this would constitute a transfer of assets. In other words, by adding another person's name the individual cannot sell or dispose of the asset without the other person's consent. For example, an individual has sole ownership of real property and adds another person's name as joint tenancy. He can no longer dispose of the property by himself. He has to have the other person’s consent to do so.

20350.9 Treatment of Income as an Asset

Under OBRA 93, income, in addition to resources, is defined as an asset for transfer (and trust) purposes. Where an individual's income is given or assigned in some manner to another person, this is considered a transfer of assets for less than fair market value.

In determining whether income has been transferred, do not scrutinize an individual's spending habits during the 60 month look-back period. Absent evidence to the contrary, assume that ordinary household income was legitimately spent on the normal costs of daily living.

Attempt to determine whether the individual has transferred lump sum payments actually received in a month. Such payments, while counted as income in the month received for eligibility purposes, are counted as resources in the following month if they are retained. Therefore, disposal of such lump sum payments before they can be counted as resources could constitute an uncompensated transfer of assets.

Also, attempt to determine whether amounts of regularly scheduled income have been transferred. Normally, such a transfer takes the form of a transfer of the right to receive income. For example, a private pension may be diverted to a trust, and no longer be paid to the individual. An exception to the transfer of assets penalty for diverted income is a transfer into a Miller trust.

Explore the possibility of a transfer of income based on information given on the Medicaid application and through active questioning of the individual concerning sources of income, income levels in the past versus present, direct questions about giving income to others, etc.

When an individual has transferred income, or the right to income, a penalty for that transfer must be imposed. If a single lump sum is transferred (for example, a stock dividend check is given to another person in the month in which it is received by the individual), the penalty period is calculated on the basis of the value of the lump sum payment.

When a stream of income, or the right to a stream of income (such as a pension) is transferred, calculate the penalty period based on a determination of the total amount of income expected to be transferred during the individual's life based on an actuarial projection of the individual's life expectancy. Calculate the penalty period on the basis of the projected total income.

To make this determination, use the life expectancy tables, compiled from information published by the Office of the Actuary of the Social Security Administration.

See 20350.9 Life Expectancy Tables.

Tables

20350.9 Life Expectancy Table - Females

Age	Life Expectancy
1	78.42
2	77.48
3	76.51
4	75.54
5	74.56
6	73.57

7	72.59
8	71.60
9	70.61
10	69.62
11	68.63
12	67.64
13	66.65
14	65.67
15	64.68
16	63.71
17	62.74
18	61.77
19	60.80
20	59.83
21	58.86
22	57.89
23	56.92
24	55.95
25	54.98
26	54.02
27	53.05
28	52.08
29	51.12
30	50.15
31	49.19
32	48.23
33	47.27
34	46.31
35	45.35
36	44.40
37	43.45
38	42.50
39	41.55
40	40.61
41	39.66
42	38.72
43	37.72
44	36.85
45	35.92
46	35.00
47	34.08

48	33.17
49	32.27
50	31.37
51	30.48
52	29.60
53	28.72
54	27.86
55	27.00
56	26.15
57	25.31
58	24.48
59	23.67
60	22.86
61	22.06
62	21.27
63	20.49
64	19.72
65	18.96
66	18.21
67	17.48
68	16.76
69	16.04
70	15.35
71	14.66
72	13.99
73	13.33
74	12.68
75	12.05
76	11.43
77	10.83
78	10.24
79	9.67
80	9.11
81	8.58
82	8.06
83	7.56
84	7.08
85	6.63
86	6.20
87	5.79
88	5.41

89	5.05
90	4.71
91	4.40
92	4.11
93	3.84
94	3.59
95	3.36
96	3.16
97	2.97
98	2.80
99	2.64
100	2.48
101	2.34
102	2.20
103	2.06
104	1.93
105	1.81
106	1.69
107	1.58
108	1.48
109	1.38
110	1.28
111	1.19
112	1.10
113	1.02
114	0.96
115	0.89
116	0.83
117	0.77
118	0.71
119	0.66

20350.9 Life Expectancy Table - Males

Age	Life Expectancy
1	71.53
2	70.58
3	69.62
4	68.65

5	67.67
6	66.69
7	65.71
8	64.73
9	63.74
10	62.75
11	61.76
12	60.78
13	59.79
14	58.82
15	57.85
16	56.91
17	55.97
18	55.05
19	54.13
20	53.21
21	52.29
22	51.38
23	50.46
24	49.55
25	48.63
26	47.72
27	46.80
28	45.88
29	44.97
30	44.06
31	43.15
32	42.24
33	41.33
34	40.23
35	39.52
36	38.62
37	37.73
38	36.83
39	35.94
40	35.05
41	34.15
42	33.26
43	32.37
44	31.49
45	30.61

46	29.74
47	28.88
48	28.02
49	27.17
50	26.32
51	25.48
52	24.65
53	23.82
54	23.01
55	22.21
56	21.43
57	20.66
58	19.90
59	19.15
60	18.42
61	17.70
62	16.99
63	16.30
64	15.62
65	14.96
66	14.32
67	13.70
68	13.09
69	12.50
70	11.92
71	11.35
72	10.80
73	10.27
74	9.27
75	9.24
76	8.76
77	8.29
78	7.83
79	7.40
80	6.98
81	6.59
82	6.21
83	5.58
84	5.51
85	5.19
86	4.89

87	4.61
88	4.34
89	4.09
90	3.86
91	3.64
92	3.43
93	3.24
94	3.06
95	2.90
96	2.74
97	2.60
98	2.47
99	2.34
100	2.22
101	2.11
102	1.99
103	1.89
104	1.78
105	1.68
106	1.59
107	1.50
108	1.41
109	1.33
110	1.25
111	1.17
112	1.10
113	1.02
114	0.96
115	0.89
116	0.83
117	0.77
118	0.71
119	0.66

Life Estate And Remainder Interest Table

Age	Life Estate	Remainder
0	.97188	.02812
1	.98988	.01012
2	.99017	.00983

3	.99008	.00992
4	.98981	.01019
5	.98938	.01062
6	.98884	.01116
7	.98822	.01178
8	.98748	.01252
9	.98663	.01337
10	.98565	.01435
11	.98453	.01547
12	.98329	.01671
13	.98198	.01802
14	.98066	.01934
15	.97937	.02063
16	.97815	.02185
17	.97700	.02300
18	.97590	.02410
19	.97480	.02520
20	.97365	.02635
21	.97245	.02755
22	.97120	.02880
23	.96986	.03014
24	.96841	.03014
25	.96678	.03322
26	.96495	.03505
27	.96290	.03710
28	.96062	.03938
29	.95813	.04187
30	.95543	.04457
31	.95254	.04746
32	.94942	.05058
33	.94608	.05392
34	.94250	.05750
35	.93868	.06132
36	.93460	.06540
37	.93026	.06974
38	.92567	.07433
39	.92083	.07917
40	.91571	.08429
41	.91030	.08970
42	.90457	.09543
43	.89855	.10145

44	.89221	.10779
45	.88558	.11442
46	.87863	.12137
47	.87137	.12863
48	.86374	.13626
49	.85578	.14422
50	.84743	.15257
51	.83674	.16126
52	.82969	.17031
53	.82028	.17972
54	.81054	.18946
55	.80046	.19954
56	.79006	.20994
57	.77931	.22069
58	.76822	.23178
59	.75675	.24325
60	.74491	.25509
61	.73267	.26733
62	.72002	.27998
63	.70696	.29304
64	.69352	.30648
65	.67970	.32030
66	.66551	.33449
67	.65098	.34902
68	.63610	.36390
69	.62086	.37914
70	.60522	.39478
71	.58914	.41086
72	.57261	.42739
73	.55571	.44429
74	.53862	.46138
75	.52149	.47851
76	.50441	.49559
77	.48742	.51258
78	.47049	.52951
79	.45357	.54643
80	.43659	.56341
81	.41967	.58033
82	.40295	.59705
83	.38642	.61358
84	.36998	.63002

85	.35359	.64641
86	.33764	.66236
87	.32262	.67738
88	.30859	.69141
89	.29526	.70474
90	.28221	.71779
91	.26955	.73045
92	.25771	.74229
93	.24692	.75308
94	.23728	.76272
95	.22887	.77113
96	.22181	.77819
97	.21550	.78450
98	.21000	.79000
99	.20486	.79514
100	.19975	.80025
101	.19532	.80468
102	.19054	.80946
103	.18437	.81563
104	.17856	.82144
105	.16962	.83038
106	.15488	.84512
107	.13409	.86591
108	.10068	.89932
109	.04545	.95455

20350.10 Exceptions to the Transfer of Assets

20350.10.1 Exceptions To Transfer Of Residence

20350.10.2 Exceptions To Transfer Of An Asset

20350.10.1 Exceptions To Transfer Of Residence

The transfer provision does not apply to the HOME and title to the home transferred to:

a. a spouse (as long as spouse does not then transfer property for less than fair market value);

b. a child under 21 years of age;

c. a child who is blind or disabled, as defined by the SSI program;

d. a sibling who has an equity interest in the home and who has resided in the home for at least one year immediately before the date the individual becomes institutionalized; or

e. a son or daughter of the individual (other than a child described above) who was residing in the home for at least 2 years immediately before the date the individual became institutionalized, and who provided care to that individual which permitted the individual to reside at home rather than in an institution.

In items d. and e. above the property cannot be excluded unless and until the assets are actually transferred. Also verification for this would consist of a written statement from the parent indicating that this situation existed. If the parent is not capable, a statement from an adult child or sibling and statements from two other adults indicating that the situation

existed would suffice. Statements must specify the number of years spent in the home and the exact nature of the care provided.

20350.10.2 Exceptions To Transfer Of An Asset

The transfer provision does not apply to ANY asset transferred:

a. to the individual's spouse, or to another for the sole benefit of the individual's spouse;

b. from the individual's spouse to another for the sole benefit of the individual's spouse (OBRA 93);

c. to the individual's child that is blind or totally and permanently disabled;

d. to a trust containing the assets of an individual under age 65 who is disabled as defined by the SSI program and which is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual or a court if the trust contains a provision that upon the death of the individual the State will receive all amounts remaining in the trust up to an amount equal to the total medical assistance paid on behalf of the individual (OBRA 93);

e. to a pooled trust containing the assets of an individual who is disabled as defined by the SSI program and that is established and managed by a non-profit association if the trust contains a provision that upon the death of the individual the State will receive all amounts remaining in the trust up to an amount equal to the total medical assistance paid on behalf of the individual (OBRA 93).

A transfer of assets or an establishment of a trust is considered to be for the sole benefit of a spouse, child with a disability, or individual under age 65, if the transfer is arranged in such a way that no individual except the spouse, child or individual can benefit from the assets in any way, either at the time of the transfer, or at any time in the future. If a beneficiary is named to receive the asset at the time of the individual's death, the transfer or trust will nevertheless be considered to have been made for the sole benefit of the individual if Medicaid is named as the primary beneficiary of the asset, up to the amount paid for services provided to the individual.

To determine whether an asset was transferred for the sole benefit of a spouse, child, or individual with a disability, obtain a legally binding, written document (such as a trust document). The document must clearly define the conditions under which the transfer was made, as well as who can benefit from the transfer. A transfer without such a document cannot be said to have been made for the sole benefit of the spouse, child, or individual with a disability, since there is no way to establish, without a document, that only the individual will benefit from the transfer.

Where it is alleged that an asset was transferred to or for the benefit of an individual who is blind or totally and permanently disabled, a determination must be made that the individual in fact meets the definition of blindness or disability used by the SSI program. If the individual is receiving either SSI or Title II benefits, accept the disability determination made for those programs. If the individual is not receiving those benefits, a separate disability determination must be made. The individual who is claiming the disability must submit acceptable medical evidence he has been determined disabled according to the standards used by the SSI program (Title XVI). The individual will be given a reasonable amount of time to provide the medical evidence.

10 DE Reg. 558 (09/01/06)

15 DE Reg. 202 (08/01/11)

20350.11 Undue Hardship

A transfer of assets is exempt from consideration if the penalty would cause undue hardship. Undue hardship exists when application of the transfer of assets provisions would deprive the individual of medical care such that his/her health or his/her life would be endangered. Undue hardship also exists when application of the transfer of assets provisions would deprive the individual of food, clothing, shelter or other necessities of life.

20 DE Reg. 117 (08/01/16)

20350.12 Transfer of Assets Procedures

If an individual and/or couple alleges selling, giving away or otherwise transferring any non-excluded assets within the 60 months preceding the date of application, take the following steps:

1. Ascertain and document the FMV of the asset.
2. Ascertain and document the amount of compensation received by the individual and/or couple for the transfer.

3. Calculate the uncompensated value, if any.

If the asset was transferred at FMV, process the application as usual.

If the asset was transferred at less than FMV, explain to the applicant that an amendment to the Social Security Act requires that DSS presume, when assets are sold or given away at less than FMV, that the transaction was made for the purpose of establishing Medicaid eligibility. The difference between the amount received for the transfer and the FMV is counted as being available to meet the needs of the individual for a period after the date of disposal.

Explain that the law requires that DSS presume the transfer to be for the purpose of establishing Medicaid eligibility unless the individual can demonstrate that:

1) the individual intended to dispose of the assets either at fair market value or for other valuable consideration; or

2) the assets were transferred exclusively for a purpose other than to qualify for Medicaid.

If the applicant does not wish to rebut the presumption, she/he will be ineligible for Medicaid for a specified period.

20350.13 Rebutting the Presumption

In all cases where any amount of uncompensated value is established, the applicant must be advised of the fact before the application is allowed or denied. The applicant should be given written notice that it was determined that she/he transferred an asset for less than fair market value and that this amount must be counted for eligibility purposes unless the individual wishes to rebut the presumption.

If an applicant wishes to rebut the presumption, the burden of proof rests with the applicant. The intent to rebut the presumption must be received in the DSS/Medicaid office within 15 days of the date of the notice. The following information should be obtained from the applicant and placed in the file:

1. the applicant's purpose for transferring the asset
2. the applicant's attempts to dispose of the asset at FMV
3. the applicant's reasons for accepting less than FMV
4. the applicant's means of, or plans for, supporting himself/herself after the transfer
5. the applicant's relationship, if any, to the person(s) to whom the asset was transferred
6. the file should also include any pertinent documentary evidence (e.g., legal documents, realtor agreements, relevant correspondence, etc.). Statements from other individuals may also be obtained if material to the decision to transfer.

Verbal statements that the individual intended to dispose of the asset at fair market value or that the individual transferred the asset for a purpose other than to qualify for Medicaid are not sufficient evidence. Convincing evidence must be presented as to the specific purpose for which the asset was transferred, as well as to the reason why the individual chose to transfer the asset. The validity of the individual's rebuttal must be determined on a case-by-case basis, based on the individual's specific circumstances.

The presence of one or more of the following factors, while not conclusive, may indicate that assets were transferred exclusively for some purpose other than establishing Medicaid eligibility. This list is not all-inclusive.

1. After transfer of assets, the occurrence of traumatic onset of disability.
2. After the transfer of assets, the occurrence of unexpected loss of other resources which would have precluded Medicaid eligibility.
3. After transfer of assets, the occurrence of unexpected loss of income which would have precluded Medicaid eligibility.

The presumption that an asset was transferred to establish Medicaid eligibility is successfully rebutted only if the applicant demonstrates that the asset was transferred exclusively for some other purpose. If the claimant had some other purpose for transferring the asset, and establishing Medicaid eligibility seems to have also been a factor in the decision to transfer, the presumption is not rebutted.

The decision should be documented in the case record. It should be signed by the social worker and countersigned by the supervisor. If the transfer has been proven to be exclusively for some purpose other than establishing

Medicaid eligibility, the transfer has no effect on eligibility. The uncompensated value is not counted toward the resource limit.

20360 Conditional Medicaid Coverage While Disposing of Resources

Effective September 1, 1987 "conditional" Medicaid coverage for nursing home care can be approved for applicants who need Medicaid services while they are disposing of non-liquid resources, e.g., property. There are strict limits on the amount of time allowed for sale of resources and the applicant must sign a statement agreeing to the conditions before an application can be approved. Under conditional eligibility, excess resources are treated as a "conditional exclusion" and are not counted during the conditional benefit period.

However, there is no “conditional exclusion for spousal impoverishment cases. These resources count because they meet the spousal definition of countable resources. They should be counted in the spousal resource calculation.

8 DE Reg. 1312 (3/1/05)

20360.1 Disposal/Exclusion Periods

1. Beginning Date of the Conditional Medicaid Coverage

A social worker can exclude the resource that causes someone to be ineligible for Medicaid and approve Medicaid coverage when:

a. all other eligibility criteria are met;

b. the applicant or authorized representative signs Form 412 "Agreement to Sell Property"; and

c. documentation of individual's effort to sell is obtained within 30 days of the date of the Agreement to Sell Property.

2. Length of Conditional Benefits Period

There is a 9-month time limit on the period for which Conditional Medicaid benefits are payable; however, this period may be extended.

3. Ending Date

The Conditional Benefit Period ends when the individual:

a. disposes of the excess non-liquid resources, i.e. property goes to settlement; or

b. stops making good faith efforts to dispose of them; or

c. requests cancellation of Medicaid coverage.

If an individual becomes ineligible for one or more months despite exclusion of the resources to be sold (due to income, other resources, failure to file for other benefits, etc.) conditional Medicaid benefits are not payable for such month(s). However, the 9 month disposal/exclusion period continues to run.

20360.2 Effective Date of Eligibility

Resources to be sold cannot be excluded until Form 412 "Agreement to Sell Property" has been signed and dated by the applicant or authorized representative. Medicaid eligibility cannot be effective prior to the date that Form 412 is signed and there can be no retroactive coverage.

Property listed with a realtor prior to or at time of application cannot be excluded until the agreement is signed and dated.

20360.3 Follow-Up Contacts During the Disposal/Exclusion Period

Contact the owner or his authorized representative (by phone, if possible) on the following schedule:

1) 30 days following the date conditional benefits were authorized.

2) every 90 days thereafter until the end of the 9 month period.

20360.3.1 Purpose of Contact

1) Remind the individual of the responsibility for selling the property;

2) Document the efforts being made to accomplish a sale;

3) Document whether there has been any offer to buy since the prior contact and, if such an offer has been made and refused, obtain the individual's explanation for refusal; and

4) Document (when there have not been continuing reasonable efforts to sell) whether there was good cause.

5) Document, when good faith efforts are not being made to sell the resources, whether circumstances beyond the individual's control are preventing such efforts.

20360.4 Documentation of Efforts to Sell

Record the individual's or responsible party's allegations regarding ads, listings, consignments and other efforts to sell the resources.

Obtain any supporting evidence the individual can provide (e.g.: copy of the listing agreement with the real estate agency in current use; dated advertisement(s) indicating the property is for sale; contracts with local media to advertise the property; a photograph of the "For Sale" sign on the property).

If the individual cannot provide evidence which is necessary to establish that good faith efforts to sell the resources are being made, verify the allegation with the appropriate third party, i.e., lawyer, banker, real estate broker. For example, the lawyer may verify that the guardianship is still pending and that the property cannot be offered for sale until the guardian is appointed.

It is not necessary to verify all allegations, only those necessary to establish that good faith efforts are being made. Verifying the duration of an ad, listing, or consignment at the outset will eliminate the need to verify its continuing existence at a subsequent follow-up contact.

20360.4.1 Reasonable Offer to Buy

Assume that an offer to buy property at a particular price is reasonable if it is at least two-thirds of the estimated current market value (CMV) unless the owner proves otherwise (e.g., provides convincing evidence of a different CMV).

20360.4.2 Good Faith Efforts

Good faith efforts to sell property consist of taking all necessary and reasonable steps to sell it in the geographic area covered by local radio, television, newspaper and other media serving the area where the person lives or, if different, where the property is located.

20360.4.3 Good Faith Efforts Not Being Made

1. Documentation of Reasons - If good faith efforts to sell the resources are not being made, record the individual's allegations as to why they are not being made.

If the allegations indicate circumstances beyond the individual's control obtain any evidence the individual has to support the allegations. To the extent necessary to establish that circumstances beyond the individual's control are preventing good faith efforts to sell the resources, verify any allegations the individual cannot support with evidence. Use the telephone whenever possible.

2. Make a determination regarding, as applicable, whether to continue or terminate the disposal period. Terminate the disposal period unless evidence establishes both that the individual cannot pursue good faith efforts to sell the resources on his/her own and cannot make arrangements for someone else to sell the resources on his/her behalf.

20360.4.4 Illustrations of Good Cause

Although other circumstances will arise which require careful judgment, the following situations illustrate the principle of good cause.

1. No Offer To Buy

The individual makes good faith efforts throughout the disposal period to sell an excess non-liquid resource, or is prevented from doing so by circumstances beyond his or her control, and receives no offer to buy them.

2. Reliance On Offer That Does Not Result In Sale

A legitimate or apparently legitimate offer to buy an excess non-liquid resource halts further efforts to sell it for a prolonged period of time, and the prospective buyer subsequently cannot or will not complete the purchase.

3. Escrow begins, but closing does not take place within disposal/exclusion period

The individual accepts an offer to buy real estate, escrow begins, the acceptance of another offer is precluded, and closing (at which full or partial payment and transfer of title are exchanged) does not take place within the disposal/ exclusion period.

4. Incapacitating illness or injury

The individual becomes homebound or hospitalized for a prolonged period, due to illness or injury, and cannot take the steps necessary to sell the resource or to arrange for someone to sell it on his or her behalf.

5. Co-owner dies

A co-owner of a resource dies, and administration of probation of the estate delays efforts to sell the resource (assuming that the property continues to be a resource).

20360.5 Resources Sold/Not Sold

Request documentation of the sale (i.e., settlement sheet, photocopy of the check) for the case record when resources are sold. The recipient is ineligible in the month proceeds are received. This information is important should the individual re-apply in the future claiming all resources have been depleted.

When an individual has received 9 months of conditional benefits but has not been able to sell real property despite reasonable efforts to do so, you may continue Medicaid coverage if the Medicaid recipient continues to make reasonable efforts to sell the resource and doesn't refuse a valid offer to buy the resource/property.

1. Notification to the Client

Inform the recipient or responsible party that:

a) Client or family member is responsible to inform Medicaid promptly of any sale of property.

b) Medicaid will continue to exclude the value of the property for so long as reasonable efforts to sell continue but are not successful;

c) Medicaid will continue to make periodic follow-up contacts and to request evidence of continued reasonable efforts to sell;

d) The individual is still responsible for informing Medicaid promptly of any offers to buy and for showing that any offer refused was not reasonable; and

e) Total resources, including the real property in question, do not fall within the applicable resource limit.

2. Follow up Contacts

Contact the owner or his representative (by phone, if possible) at 90 day intervals following the end of the conditional benefits period.

EXCEPTION - contact may be at 6 month intervals if:

The individual does not have a spouse and equity in the property to be sold is $2,000 or less; or

The individual has a spouse and equity in the property to be sold is $3,000 or less.

NOTE:This exception recognizes the possibility that an individual may have spent down other resources and become eligible without benefit of the real property exclusion.

Use these follow up contacts for the same purposes as described above.

Evaluate efforts to sell (and good cause, if appropriate) as above.

20370 LTC Retroactivity

Any individual or couple who applied for Medicaid may also be eligible for Medicaid coverage of any unpaid medical bills incurred in any of the three months prior to the month in which they applied. However, certain requirements must be met in order for these bills to be paid under Medicaid.

Applications for Medicaid, even if denied, qualify for a determination of retroactive eligibility.

a) Individual must document that for time period in which bill was incurred, all medical and financial conditions of the Long Term Care Program have been met. For individuals whose income is between the SSI standard and 250% of the SSI standard, retroactive payment is only possible if the individual has been institutionalized 30 consecutive days. The assumption used for initial nursing facility eligibility determination, that the applicant will remain institutionalized for 30 consecutive days, does not apply for retroactive coverage when it is obvious the 30 day criteria has not been met.

b) Individual must supply documentation of the unpaid bill. In some circumstances, bills may have been paid by someone other than the applicant and they have requested a refund. Documentation of provider reimbursement and unpaid balance must be provided. Acceptable documentation would be a copy of the provider reimbursement check written to someone other than the applicant. Credit to a patient's account is not acceptable. If part of the 30 day consecutive period was hospitalization no documentation of unpaid hospital bills are required.

20400 Trusts

BACKGROUND

The Delaware Department of Health and Social Services (DHSS), in order to comply with the Social Security Act Section 1917 (c) (1) as amended by the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) has established policies and procedures for treating trusts in eligibility determinations and Post eligibility treatment.

20400.1 Definitions of Terms Found in a Trust Document

Trust For the purpose of eligibility requirements, a trust is a legal document in which a person (grantor, trustor) transfers any item of value (property, money) to another person or organization (trustee) with the intention that it is held, managed, or administered by the trustee for the benefit of the grantor or certain named individuals (beneficiaries). The trust must be valid under State law and confirmed by a valid trust instrument or agreement. A trustee has a responsibility to hold or manage the trust and income for the benefit of the beneficiaries. The term "trust" also includes any legal instrument or device that is similar to a trust. It does not cover trusts established by wills.

Trustee An individual, individuals or entity (such as an insurance company or bank) that manages a trust or similar device and has absolute responsibilities for the trust.

Grantor (Trustor) A grantor is any individual who creates a trust. For eligibility requirements, the term "grantor" includes:

- The individual
- The individual's spouse
- A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual's or the individual's spouse
- A person, including a court or administrative body, acting at the direction or upon the request of the individual, or the individuals spouse

Individual For the purpose of Medicaid eligibility requirements, an individual is one who establishes a trust and who is an applicant for or receives Medicaid. An individual is considered to have established a trust if his or her assets were used to form part or all of the trust; and if the trust was not established by a will.

Income See Section 20200 for explanation of income and how income is treated in eligibility determinations

Resource Any cash or other liquid assets or any real or personal property that an individual owns and could convert to cash to be used for his/her support and maintenance.

Beneficiary A person who gains or has an advantage or profits from the existence of a trust. A beneficiary does not hold legal title to trust property but does have an equitable ownership interest in the trust.

Payment A payment from a trust is any disbursal (money, property) from the trust principal or from income generated by the trust that benefits the person receiving the disbursal.

Annuity The right to receive fixed periodic payments either for life or a term of years.

Assets Assets include all income and resources of the individual and of the individual's spouse. Income is considered assets that are current. Resources are assets that have accumulated.

20400.2 Effective Date

This section applies to all trusts established on or after August 11, 1993. It is based on the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) rules. Treatment of trusts established prior to August 11,1993 would use pre-OBRA rules.

20400.3 Application of Trust Eligibility Policy

These instructions apply to eligibility determination for all individuals including cash assistance recipients and others who are otherwise automatically eligible and whose income and resources are not ordinarily measured against an independent Medicaid eligibility standard.

Any trust that meets the basic definition of a trust can be considered in determining eligibility for Medicaid. The characteristic of each trust determines the eligibility of the trust under Medicaid rules. In order to be eligible, trusts must state that upon the death of the individual any funds remaining in the trust will be paid to the State agency, up to the amount of Medicaid benefits paid on the individual's behalf. If an individual has resided in more than one State and has received Medicaid benefits from each state, any funds remaining in the trust are distributed to each State based on the States proportionate share of the total amount of Medicaid benefits paid by all the states.

20400.4 Revocable Trusts

For the purpose of eligibility a trust is considered to be revocable if under State law it can be terminated by the grantor, if the trust states that it can be changed or terminated by a court, or if the trust states that it can be terminated if some action is taken by the grantor. For example, a trust may state that it is irrevocable but it may require a trustee to terminate the trust and give all funds to the grantor if the grantor leaves a nursing facility and returns home.

20400.4.1 Treatment of Revocable Trusts

The entire body of the trust is a resource to the individual. All payments from the trust to the individual are considered income to the individual if the payment benefits the individual. However, if payments are made from the trust which do not benefit the individual, those payments are considered a transfer of assets for less than market value. The look-back period is 60 months for revocable trusts from the current date that the individual applied for Medicaid.

20400.5 Irrevocable Trusts

An irrevocable trust is a trust that cannot in anyway, be legally revoked by the grantor.

20400.5.1 Treatment of Two Types of Irrevocable Trusts

Irrevocable trusts are treated differently based on whether payment can or cannot be made for the benefit of the individual.

20400.5.1.1 Irrevocable Trust States Payment Can Be Made To Or For The Benefit Of The Individual

When the terms of an irrevocable trust state that payment can be made to or for the benefit of the individual from any part or all of the trust, the payments made are considered income. Any part of the trust or payment that could be paid for the benefit of the individual is treated as an available resource.

When the terms of an irrevocable trust state that payment can be made to or for the benefit of the individual from any part or all of the trust, and the payment is not used for the benefit of the individual, the payment is treated as a transfer of assets. In this type of situation, the look-back period is 60 months.

10 DE Reg. 1613 (04/01/07)

20400.5.1.2 Irrevocable Trust States Payments Cannot Under Any Circumstances Be Made To Or For The Benefit Of The Individual

When all or a portion of the principal or income on the principal of the trust cannot be paid to the individual or for the benefit of the individual, all of these payments are treated as a transfer of assets for less than fair market value. The date of transfer is the date the trust was established or, if later, the date on which payment to the individual was actually barred.

When determining the value of the portion of the trust that cannot be paid to the individual, do not subtract from the trust the value of any payments made. If the trustee or the grantor adds funds to the trust after the date of transfer, these added funds are considered to be a new transfer of assets. The transfer date for these additional funds is the date that the new funds were placed in the trust. (Note, when determining the penalty period: if a previous penalty period is still in effect, the new penalty period cannot begin until the previous penalty period has expired.) Under this type of trust the look-back period is 60 months.

20400.6 Determination of Payment

To determine if payments can or cannot be made from a trust use the following guidelines.

20400.6.1 Payment From a Revocable or Irrevocable Trust is Paid to or for the Benefit of an Individual

Any payment from the trust principal or income produced by the trust that is paid directly to the individual, or to his/her guardian or legal representative is considered to be paid to the individual.

If an individual benefits from any payment from the trust principal or income produced by a trust that is paid to another person or entity, the payment is considered to be made for the benefit of the individual.

If a payment is counted as income under the SSI program, that payment would be counted as a benefit to the individual. Payments made on behalf of the individual for medical care are not counted in determining income eligibility under the SSI program; thus, such payments are not counted as income under the trust provision.

20400.6.2 Payments Can or Cannot Be Made From a Trust to or for an Individual

Review the trust to determine if the trust places limits or restrictions on payments or the trustee. Only the amount of money or the portion of the trust that can or could be paid out is treated as a payment. This information is then used to determine if the payment is a resource for the individual.

20400.7. Trusts With Excluded Assets

An asset that is excluded from being used in the determination of eligibility. An asset is all income or resources of the individual or eligible spouse. For asset exclusions see Section 20200 and Section 20310.

20400.7.1 Treatment of Excluded Assets Placed in Trust

The placement of an excluded asset (income or resource) in a trust does not change the excluded nature of the asset; it remains excluded. Note: For institutionalized individuals, the home is no longer an excluded resource if placed in a trust.

20400.8 Trusts With Non-Excluded Assets

All income and resources of the individual or the individual's spouse that are not excluded from being used in the determination of eligibility.

20400.8.1 Non-Excluded Assets Placed in a Trust

Non excluded assets placed in a trust are treated as one of the following:

- available income
- available resources
- transfer of assets for less than fair market value

NOTE: AVOID IMPOSING A PENALTY FOR BOTH THE TRANSFER OF ASSETS INTO A TRUST AND THE APPLICATION OF THE TRUST PROVISIONS. THIS COULD RESULT IN THE INDIVIDUAL BEING PENALIZED TWICE FOR ACTIONS INVOLVING THE SAME ASSET.

20400.9 Exceptions to the Trust Eligibility Policy

Two exceptions to the trust eligibility policy are Special Needs Trusts and Pooled Trusts for disabled individuals.

20400.9.1 Special Needs Trusts

A special needs trust contains the assets of an individual under age 65 who is disabled. It is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual or a court.

Special Needs Trusts created on or after December 13, 2016 by an individual with a disability under age 65 for his or her own benefit can qualify as a special needs trust, conferring the same benefits as a special needs trust set up by a parent, grandparent, legal guardian or court.

The trust may also contain the assets of other individuals.

21 DE Reg. 566 (01/01/18)

20400.9.1.1 Treatment of Special Needs Trusts

For individuals under age 65 the exceptions to the Medicaid eligibility rules continue even after the individual becomes age 65. No additional assets may be added to the trust after the individual reaches age 65. If assets are added they will not be exempted and are subject to penalties. To qualify as a special needs trust, the following conditions must exist:

The trust must be established solely for the needs of an individual with a disability who is under age 65.

The individual is disabled as defined by the SSI program in 1614(a)(3) of the Act.

The trust must be established by the parent(s), grandparent(s), legal guardian(s) of an individual with disabilities or a court.

For trusts created on or after 12/13/2016:

The trust must be established by the disabled individual under age 65 for his or her own benefit, the disabled individual's parent, grandparent, legal guardian or court.

In addition to the above criteria, the trust **must state** that upon the individual's death all remaining assets and funds should be paid to the State agency up to the amount paid in Medicaid benefits on the individual's behalf.

10 DE Reg. 1302 (02/01/07)

15 DE Reg. 202 (08/01/11)

21 DE Reg. 566 (01/01/18)

20400.9.2 Pooled Trusts for Individuals with Disabilities

A pooled trust contains the assets of an individual with disabilities as defined by the Supplemental Security Income (SSI) Program and meets the following conditions:

The trust is established and managed by a non-profit association

A separate account is maintained for each beneficiary of the trust; for purposes of investment and management of funds, the trust pools the funds in these accounts.

Accounts in the trust are established solely for the benefit of the individual with disabilities, by the parent, grandparent, legal guardian of the individual, or by the court.

To the extent that the amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State the amount remaining in the account up to an amount equal to the total amount of medical assistance paid on behalf of the beneficiary. The trust must include a provision specifically providing for such payment to the State.

15 DE Reg. 202 (08/01/11)

20400.9.2.1 Conditions to Qualify as Exempted Pooled Trust

a. The trust account must be established for an individual with disabilities.

b. The individual is receiving either Title II or SSI benefits as an individual with disabilities. (In this case we would accept the disability determination made for those programs.)

c. The Medical Review Team (See Section 20102.2.2) has determined that the individual is disabled using the State of Delaware's Determination of Disability for Medicaid procedure.

15 DE Reg. 202 (08/01/11)

20400.10 Treatment Of Funds Entering And Leaving An Exempted Trust For an Individual with Disabilities

While trusts for an individual with disabilities are exempt from treatment under the trust rules, funds entering and leaving them are not exempt from treatment under the rules of the appropriate cash assistance program. The following are rules applicable to funds entering and leaving both kinds of exempt trusts for an individual with disabilities. (see DSSM 20400.1.1, trusts established with income and DSSM 20400.10.2, trusts established with resources).

15 DE Reg. 202 (08/01/11)

20400.10.1 Exempted Trust For an Individual with Disabilities Established With The Individual's Own Income

- For eligibility purposes, do not count income before it is placed in the trust.
- If a transfer of assets into a trust for an individual with disabilities is not exempted under the exceptions to the transfer of assets' rules, a penalty must be enacted.
- Post-eligibility income rules may be applied to income placed in the trust.
- Funds paid out of the trust to or for the benefit of the individual would count as income
- Spousal impoverishment provisions are also applicable as they apply to exempted trusts.

Note: When the right to income placed in a trust actually belongs to the trust and not the individual, the income does not count under SSI rules as income received by the individual.

Most trusts for an individual with disabilities are created using the individual's resources; some may be created using the individual's income or a combination of income (Income as defined by the SSI program.) and resources. When income is placed in the trust see Section 20400.11.1- Income Trusts (Miller Trusts) for treatment of income.

15 DE Reg. 202 (08/01/11)

20400.10.2 Exempted Trust for an Individual with Disabilities Established in Part or in Whole With Resources

- Resources placed in an exempt irrevocable trust for an individual with disabilities are counted as resources only during the months in which they are in the possession of the individual. Beginning with the month the resources are placed in the trust, they are exempt from being counted as resources to the individual.
- Resources placed in an exempted trust for an individual with disabilities are subject to imposition of a penalty under the transfer of assets provisions unless:

the transfer is specifically exempt from penalty,

or unless the resources placed in the trust are used to benefit the individual,

and the trust purchases items and services for the individual at fair market value.

NOTE: These rules apply to both income and resources placed in an exempt trust.

15 DE Reg. 202 (08/01/11)

20400.11 Income Trusts (Miller Trusts)

This type of trust is composed only of Social Security, pension, and/or other income to the individual, including accumulated interest in the trusts.

20400.11.1 Medicaid Qualification of a Miller Trust or Income Trust

To qualify, the individual must receive the income and place it into a Miller trust. If an individual has transferred his/her right to receive the income, and the income is legally received by the trust, then this income is no longer considered to be the individual's income. In this situation the income does not meet the requirements for exemption.

A Miller Trust must be irrevocable.

The trust must be composed only of income. No resources may be used to establish or add to the trust. The inclusion of resources will void the Medicaid eligibility of the trust.

The trust must state that, upon the death of the individual, the State will receive all funds remaining in the trust, up to an amount equal to the total medical assistance paid on behalf of the individual under the State Medicaid plan.

20400.11.2 Treatment of a Miller Trust That Meets All Requirements

When a trust meets all requirements for exemption, and is irrevocable, the corpus of the trust is exempt from being counted as available to the individual. A revocable trust is counted under SSI rules as an available resource to the individual.

20400.11.3 Treatment of Income Placed in a Miller Trust

Income (Social Security benefits, VA pensions, private pensions, etc.) can be placed directly into a Miller trust by the recipient of those funds, without those funds adversely affecting the individual's eligibility for Medicaid. Income generated by the trust that remains in the trust is not income to the individual.

20400.11.4 Application Of Transfer Of Assets Penalties To Income Placed In A Miller Trust

Transfer of assets penalties do not apply to income placed in a Miller trust if the provisions of the trust state that income placed in the trust will be used for medical care provided to the individual (nursing facility or home care provided under a community-based waiver, etc.). When such payments are made, the individual is considered to have received fair market value for the income placed in the trust, up to the amount actually paid for medical care provided to the individual and to the extent that the payments purchased care at fair market value.

NOTE: PAYMENTS (e.g. patient pay) FOR MEDICAL CARE SHOULD BE MADE IN MONTHLY INTERVALS TO AVOID TRANSFER OF ASSETS PENALTIES.

Funds placed in a Miller trust can be transferred for the sole benefit of a spouse (medical care for the community spouse). Transfer penalties do not apply to assets transferred to a spouse.

Transfer of property penalties can be avoided if the trust states that the property can only be used for the benefit of the individual's spouse while the trust exists, and that the trust cannot be terminated and distributed to any other individuals or entities for any other purpose.

Funds placed in the trust that are used for the benefit of the individual,(administrative fees for the trust, income tax owed by the trust, attorney's fees, food, clothing, or mortgage payments) are exempt from transfer of assets penalties if they reflect fair payments for the items or services that were purchased.

NOTE: There is NO provision for the use of funds in this manner to be deducted in calculations for the Patient Pay Amount (PPA).

When income placed in the trust exceeds the amount paid out of the trust for medical services or other items or services that benefit the individual, the excess income is subject to penalties under the transfer of assets provisions.

20400.11.5 Treatment Of Payments Made From A Miller Trust

Payments from the trust may still count as income to the individual under the State Medicaid Plan. Payments made from a Miller Trust directly to the individual are counted as income to the individual, provided the individual could use the payments for food, clothing, or shelter. This rule applies whether or not the payments actually are used for these purposes, as long as there are no legal impediments that prevent the individual from using the payments this way.

Any payments made by the trustee to purchase something in kind for the individual also can count as income to the individual. In kind income include actual food, clothing, or shelter, or something the individual can use to obtain one of these. For example, if the trustee makes a mortgage payment for the individual, that payment is a shelter expense and counts as income. However, medical expenses paid on behalf of the individual are not counted as income to the individual.

20400.11.6 Post-Eligibility Treatment of Income Not Placed in a Miller Trust

Income that is retained by the individual is subject to post-eligibility rules. See post eligibility rules in Section 20600.

20400.11.7 Post-Eligibility Treatment of Income Placed in a Miller Trust

Although income placed in a Miller trust is not counted for Medicaid eligibility purposes, the income is counted for post-eligibility purposes. *Post-eligibility rules are applied to all income entering the trust.*

20400.11.8 Post-Eligibility Treatment of Payments Made From a Miller Trust

If not used for medical care costs, payments from the Miller trust may be counted for eligibility purposes. However, payments made from a Miller trust are not considered for post-eligibility purposes. Post-eligibility rules have already been applied to all income entering the trust through the patient pay calculation.

20400.11.9 Treatment of Miller Trust and Spousal Impoverishment

All funds placed in a Miller trust are subject to the post-eligibility treatment of income rules, including funds applicable to spousal impoverishment.

20400.12 When Application Of The Trust Provisions Would Cause Undue Hardship

20400.12.1 Undue Hardship

20400.12.2 Burial Trusts

20400.12.1 Undue Hardship

Undue hardship exists when application of the trust provisions would deprive the individual of medical care such that his/her life would be endangered. Undue hardship also exists when application of the trust provisions would deprive the individual of food, clothing, shelter or other necessities of life.

20 DE Reg. 117 (08/01/16)

20400.12.2 Burial Trusts

A burial trust is a trust established by an individual for the purpose of paying, at some point in the future, for the various expenses associated with the individual's funeral and burial. Irrevocable prepaid burial trusts that do not exceed $15,000 are exempted under the undue hardship policy.

11 DE Reg. 1051 (02/01/08)

20500 Estate Recovery and Liens

BACKGROUND

The Delaware Department of Health and Social Services (DHSS), in order to comply with Chapter 50, Title 25 of the Delaware Code and Section 1917 of the Social Security Act as amended by Section 13612 of the Omnibus Budget Reconciliation Act of 1993, and Delaware House Bill No. 437 as amended by House Amendment Nos. 1, 2, and 4, has established policies and procedures for filing liens against the real property, and recovering from estates of, individuals applying for or receiving DHSS long-term care services.

20500.1 Application

These policies and procedures shall apply to individuals age 55 and over who are applying for DHSS Long Term Care Services. This includes nursing facility services, home and community-based waiver services, and community-based long-term care services and supports.

Medicaid benefits paid for Medicare cost-sharing expenses, with a date of service on or after January 1, 2010, are exempted from estate recovery. These benefits include Part A and B premiums, deductibles, coinsurance, and co-payments. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid agency. The date of service for premiums is the date the State Medicaid Agency pays the premium.

16 DE Reg. 423 (10/01/12)

20500.2 Notification

All applicants will be informed of the Estate Recovery and Lien Policy and procedures at the time of application. Recipients who turn 55 after their cases are active will be informed of the policy and procedures at their first financial redetermination after their 55th birthday.

Notification of the policy will be via recovery forms and/or a letter, that will be provided to the applicant or the applicant's representative.

16 DE Reg. 423 (10/01/12)

20500.3 Definitions

The following definitions apply to this section:

Child means offspring or legally adopted child of the recipient or the applicant.

Civil Union Partner means an individual who enters into a legal union with another individual of the same sex.

Estate means all real property, as well as all personal property that constitutes assets of the individual's estate as described in Chapter 19 of Title 12 of the Delaware Code.

Family means legal spouse, dependent parents (claimed for income tax purposes), and children.

Lawfully residing in the home means residing in the home with the permission of the owner or, if under guardianship, the owner's legal guardian.

Legal representative means power of attorney over property or guardian of property.

Long-term care means a service provided in a long-term care facility or in the home as an alternative to institutionalization (known as Long-Term Care Community Services or home and community-based services (1915(c) waivers).

Real Property means land, including houses or immovable structures or objects attached permanently to the land. The terms "real estate," "realty," and "real property are used synonymously with one another and designate real property in which an individual has ownership rights and interests.

Residing in the home on a continuous basis means using the home as the principal place of residence.

Sibling means brother, sister, legally adopted brother or sister, half brother or half sister.

16 DE Reg. 423 (10/01/12)

20500.4 Recoveries

DHSS shall seek recovery after the individual's death or upon sale of the property subject to a lien, when long term care assistance has been paid on behalf of an individual.

20500.5 Recovery Exceptions

20500.5.1 Family Member Residing

20500.5.2 Lien Recovery Exceptions

20500.5.3 Undue Hardship

20500.5.1 Family Member Residing

DHSS shall **not** seek recovery as long as there is:

a surviving spouse;

surviving son or daughter who is blind or disabled as defined in accordance with the disability rule of the federally administered Supplemental Security Income (Title XVI of the Social Security Act) who was residing in the home on a continuous basis immediately prior to the death of the individual;

or

Child under age 21.

NOTE: If DHSS cannot seek recovery after the recipient's death due to the exceptions noted above and DHSS cannot recover from the estate due to Title 12 of the Delaware Code, Section 2102, no further action will be taken to recover.

20500.5.2 Lien Recovery Exceptions

DHSS shall not seek recovery in the case of a lien on an individual's home when there is:

a son or daughter over the age of 21 lawfully residing in the home of the recipient, who has resided there for a period of at least two years immediately prior to the date of the recipient's admission to a long-term care service, who has lawfully resided there on a continuous basis since that time, and who can establish to the Department's satisfaction that he or she provided the care that permitted the recipient to reside in the home rather than in a long-term care facility

or

Sibling lawfully residing in the home of the recipient for one (1) years (12 months) immediately prior to the recipient's admission for long term care services.

NOTE: DHSS can seek recovery from other assets in the estate.

20500.5.3 Undue Hardship

20500.5.3.1 Recovery Waiver

20500.5.3.2 Individuals Eligible for Recovery Waiver

20500.5.3.1 Recovery Waiver

In cases of undue hardship, recovery may be waived for the period of the hardship. Undue hardship exists for certain individuals who have resided in the home of the DHSS long term care recipient on a continuous basis for a period of at least two (2) years (24 consecutive months) immediately prior to the date of the DHSS long-term care recipient's admission to DHSS long term care services.

20500.5.3.2 Individuals Eligible for Recovery Waiver

These individuals are limited to a civil union partner, children, grandchildren, parents, or siblings of the DHSS long-term care recipient who meet 1 of the following conditions:

Receive any Federal or State funded assistance for living expenses (examples: SSI, AFDC, VA Aid and Attendance) and have no other home to which they can return.

Or

Have total family income less than or equal to 200% of the current monthly Federal Poverty limit, and have total family resources that can be converted to cash less than or equal to $3,000, including any real property that they own.

Or

DHSS will also not recover if the real property that is held in ownership with a civil union partner, children, grandchildren, siblings or parents constitutes a business that contributes to the livelihood of that other individual or his/her dependents or heirs.

NOTE. The waiver for recovery will exist as long as one of the above conditions continues to be met and as long as the above described individuals reside in the DHSS long-term care recipient's home on a continuous basis.

The maximum amount to be recovered will be the total of funds disbursed or incurred by DHSS with any Federal matching dollars during the time an individual receives long-term care services from DHSS.

16 DE Reg. 423 (10/01/12)

20500.6 Liens

DHSS will place a lien against the real property of recipients who are inpatients in a nursing facility, intermediate care facility for individuals with developmental disabilities or other medical institution whose property does not meet the exemption or undue hardship conditions.

NOTE: The lien policy does not apply to recipients of Long Term Care Community Services or Division of Developmental Disabilities Services Waiver unless they become institutionalized.

16 DE Reg. 423 (10/01/12)

20500.6.1 Exceptions to the Lien Policy

1. Clients intending to return home within sixty (60) days of their admission date to a facility.
   a) If the stay in the facility is sixty (60) days or more, DHSS will place a lien on the property.

b) The lien on the property will be released if the patient is discharged after sixty (60) days and returns to live in the home.

2. DHSS will not file a lien as long as the following individuals lawfully resided in the home before the date of application for long term care services and continue to reside in the home while the applicant receives long term care services:

a) Husband or wife of the applicant or recipient (NOTE: Common law marriages are not recognized by the Courts of Delaware).

b) A Civil Union Partner;

c) Son or daughter who is blind or disabled as defined in accordance with the disability rule of the federally administered Supplemental Security Income (Title XVI of the Social Security Act).

d) Child under age 21 who is lawfully residing in the home.

e) Sibling lawfully residing in the home for 1 year (12 months) immediately prior to admission to a long term care facility and who has equity in the property.

3. DHSS will also not file a lien if the real property that is held in ownership with a civil union partner, children, grandchildren, siblings or parents constitutes a business which contributes to the livelihood of that other individual or his/her dependents or heirs.

9 DE Reg. 1076 (01/01/06)
16 DE Reg. 423 (10/01/12)

20500.7 Undue Hardship

In cases of undue hardship, liens against the real property of DHSS long-term care recipients shall be filed, but a moratorium established on the lien.

20500.7.1 Residency

This means DHSS will not force the sale of the property. Undue hardship exists for certain individuals who have resided in the home of the DHSS long term care recipient on a continuous basis for a period of at least two (2) years (24 consecutive months) immediately prior to the date of the DHSS long-term care recipient's admission to DHSS long-term care services.

20500.7.2 Eligible Individuals

These individuals are limited to children, grandchildren, parents, or siblings of the DHSS long-term care recipient who meet 1 of the following conditions:

a. Receive any Federal or State funded assistance for living expenses (examples: SSI, AFDC, VA Aid and Attendance) **and** have no other home to which they can return.

OR

b. have total family income less than or equal to 200% of the current monthly Federal Poverty limit, and have total family resources that can be converted to cash less than or equal to $3,000, including any real property that they own.

20500.7.3 Moratorium

The moratorium on imposing the lien on the home will exist as long as the hardship condition continues to be met and as long as the above described individuals reside in the DHSS long-term care recipient’s home on a continuous basis.

20600 Post-Eligibility Definitions/Procedures

20610 Definitions

20610.1 Gross Unearned Income

20610.2 Gross Earned Income

20610.3 Regularly Employed or Regularly Attends

20610.4 Income Protection

20610.1 Gross Unearned Income

Total amount of benefit before deductions. Examples of deductions are:

Medicare premiums,

health insurance premiums,

life insurance premiums, etc.

Gross income is always used in determining eligibility.

20610.2 Gross Earned Income

Income before taxes or other deductions such as insurance premiums, savings, union dues, etc. Gross wages are used to determine eligibility.

20610.3 Regularly Employed or Regularly Attends

To be considered regularly employed or regularly attending, the recipient must be working or attending at least 3 1/2 hours per day and 4 days a week.

20610.4 Income Protection

Nursing facility recipients who are eligible for Medicaid are entitled to retain some of their available income for personal needs.

20620 Patient Pay Amount Deductions

42 CFR §435.725; 42 CFR §435.733; 42 CFR §435.832

The total income to be used in the post-eligibility process will include all amounts that meet the definition of income. This includes income that is counted for eligibility, as well as income that is excluded for eligibility.

The following amounts are deducted from the gross income when computing the application of an individual or couples income to the cost of institutionalized care:

20620.1 Personal Needs Allowance;

20620.2 Necessary Medical Care Expenses;

20620.3 Community Spouse Income Allowance/Home Maintenance Disregard (if applicable); and

20620.4 Family Allowance (if applicable).

19 DE Reg. 1095 (06/01/16)

20620.1 Personal Needs Allowance

20620.1.1 $50.00 per month of available income is to be protected for the Medicaid recipients recipient's direct personal needs; or

20620.1.2 If the recipient regularly attends a rehab/educational program off the grounds of his or her long-term care facility, including employment for the purpose of rehabilitation in a sheltered workshop, $50.00 per month will be protected; or

20620.1.3 For long-term care facility residents who are participating in substantial gainful activity (SGA) (20 CFR 416.971), the following amounts, not to exceed the Adult Foster Care rate will be deducted from gross earned income:

20620.1.3.1 Mandatory payroll deductions that are a condition of employment including, but not limited to:

- Federal, State and Local Taxes
- FICA
- Union Dues
- Insurance premiums

- Pension contributions
- Transportation costs as paid to & from work
- Clothing and personal needs allowance of $75/month.

20620.1.3.2 If monthly earnings average more than the current SGA amount in a calendar year, this is considered SGA and the Division of Medical Assistance (DMMA) can allow a personal needs allowance of up to the AFC rate.

20620.1.3.3 If earnings average less than $300 a month in a calendar year, this is not ordinarily considered SGA and DMMA can allow the $50 personal needs allowance.

20620.1.3.4 If average earnings are between $300 and the current SGA amount, DMMA must consider other factors to determine whether or not the work constitutes SGA. Other factors include considering if the work is comparable to persons without disabilities in the community performing similar jobs.

20620.1.4 For nursing facility residents requiring a court appointed guardian, the following amounts will be deducted from the gross income:

i. Monthly guardianship fees not to exceed $100

ii. Initial establishment of a guardianship (to include attorney's fees) not to exceed $750

19 DE Reg. 1095 (06/01/16)
26 DE Reg. 108 (08/01/22)
26 DE Reg. 694 (02/01/23)

20620.2 Necessary Medical Care Expenses

20620.2.1 Medical Insurance Premiums

20620.2.2 Necessary Medical Care

20620.2.3 Prior Medical Costs

20620.2.1 Medical Insurance Premiums

Cost of medical insurance premiums carried by the recipient shall be set aside from his/her income. A medical insurance premium which is payable less often than monthly (for example, quarterly) may be averaged out so that a consistent amount of the recipient's income is protected for this purpose each month. The recipient, or other person responsible for his financial affairs, will be responsible for handling this money and assuring that is available for paying the premium when due.

20620.2.2 Necessary Medical Care

Cost of necessary medical care not covered under the recipient's medical insurance, Medicaid or Medicare but recognized under state law may be set aside from his/her income. The care must be ordered by a professional, such as a physician, dentist, optometrist, physical therapist, etc. For items such as dentures and hearing aids to be approved a medical professional will have to state, in writing that the patient will benefit medically (as opposed to cosmetically only). Other approved medical care items which might occur frequently are eye exams, eyeglasses, dental care, prostheses and appliances.

When in doubt as to whether the care is recognized under state law or is appropriate to be charged to the patient under this policy, consult the Long Term Care Operation’s Administrator. The recipient and the provider must understand that these are not Medicaid payments but are an arrangement between recipient and provider, and that it is the responsibility of the recipient, or his representative to see that payments are made. If both parties are agreeable, payments may be spread out over a period of months.

10 DE Reg. 703 (10/01/06)

20620.2.3 Prior Medical Costs

Medical costs incurred in a prior period of ineligibility (if approved by Medicaid) may be protected from his/her income. Costs incurred in a period of ineligibility must be approved by the Medicaid State Office prior to being protected and will only be considered if incurred within three (3) months of the beginning date of Medicaid eligibility.

The recipient's reimbursement level and patient pay amount must be identified. Medicaid will protect at the Medicaid reimbursement rate, not the private pay rate.

The period of ineligibility may be caused by excess resources or excess income.

Protections for which the individual is seeking coverage will not be granted if the ineligible period occurred during a transfer of assets penalty phase.

10 DE Reg. 703 (10/01/06)

21 DE Reg. 435 (11/01/17)

20620.3 Community Spouse Income Allowance/Home Maintenance Disregard

Temporary Institutionalization - If the attending physician has certified that a recipient is likely to return to his own home within a definite period (not to exceed 2 months) up to $75.00 per month may be protected for maintenance of the home. This allowance may be used for mortgage payments, rent, insurance, utility bills, repairs, etc. Copies of receipts, contracts or other types of verification shall be obtained and kept in the DSS record.

The $75 home maintenance disregard may not be allowed if the community spouse is receiving the spousal income allowance.

9 DE Reg. 1076 (01/01/06)

20620.4 Family Allowance

To determine community spouse income allowance and family allowance for recipients institutionalized after 9/30/89 see section on Spousal Impoverishment. For recipients institutionalized prior to 9/30/89, an additional amount must be protected for the maintenance needs of the recipient's needy spouse and/or dependents in accordance with TANF standards.

If the family has earned and/or unearned income, work expense and dependent care costs should be deducted to determine monthly net income. Use standard TANF deductions. The monthly net income should then be deducted from allowances given above to determine the amount to be protected.

Standard TANF deductions:

$90 per each employed person

$30 and 1/3 disregard

up to $200/month/child under two

up to $175/month/child age two and older and incapacitated adult

PLEASE NOTE: spouses with income less than the SSI standard should be referred to the Social Security Administration for benefits.

20630 Cost Of Care In The Facility

After taking all of the above appropriate income disregards, any remaining income will be applied toward the cost of care in the facility. The cost of care computation is totally distinct from the eligibility computation. For instance, the $20.00 that is disregarded from income when determining if an applicant is eligible is not disregarded when budgeting for patient pay amount.

Another example is that any "infrequent and inconsequential income" (gifts, contributions and interest amounting to less than $20.00 per month and received less than quarterly) that is disregarded for the eligibility determination would be counted as available income when computing the budget for the nursing facility recipient.

20630.1 Accumulation of Personal Needs Monies

In some cases, the amount protected for the recipient's direct personal needs may accumulate in a savings account. Even when the individual has no immediate use for such income, personal needs monies are not to be applied towards medical care costs. However, should the amount accumulated exceed the resource limit, the recipient becomes temporarily ineligible for Medicaid. At that time, any amount above the resource limit may be applied to medical cost.

20640 Patient Pay Calculation

The patient pay amount equals total gross income minus all protected amounts and disregards.

The fiscal agent will compute the payment to the Nursing Facility for each recipient by multiplying the established per diem rate by the number of days of nursing facility care received in a month and deducting the patient pay amount.

The per diem rate is established by DSS through an evaluation of nursing facilities' cost reports.

20640.1 Partial Months

If vendor payment is made to the nursing facility for part of the month, a Patient Pay Calculation must be done to prorate the patient pay amount for that month.

For example: If a patient normally would be expected to pay $120.00 toward his care in a nursing facility for a full month, but enters the home on the 21st day of June, (10 days remaining in the month), his patient pay amount for that month would be $40.00 (see calculation below).

Patient pay divided by # of days in month = per diem

$120.00 divided by 30 = $4.00

Per Diem x # of days in facility = prorated patient pay

$4.00 x 10 = $40.00

20650 Temporary Absence from a Long-Term Care Facility
42 CFR §447.40

Payment will be made for reserving beds in long-term care (LTC) facilities for Medicaid recipients during their temporary absence for the following purposes:

20650.1 Temporary Absence from a Long-Term Care Facility for Acute Hospitalization

20650.2 Temporary Absence from a Long-Term Care Facility for Reasons Other Than Hospitalization

7 DE Reg. 781 (12/1/03)

19 DE Reg. 1092 (06/01/16)

20650.1 Temporary Absence from a Long-Term Care Facility for Acute Hospitalization

20650.1.1 Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

If a recipient is hospitalized for a short period of time and is expected to return to the facility, payment to the facility may continue for a period of not more than fourteen (14) days provided the ICF/IID agrees to hold the bed for the resident. Medicaid reimbursement is available for no more than fourteen (14) days within any thirty-day period. The thirty-day count begins with the first day of hospitalization. If payments are suspended because recipient remains hospitalized more than fourteen (14) days and the thirty-day count expires, a new thirty-day count starts with readmission to the ICF/IID. In other words DMMA will not pay fourteen (14) days out of every thirty (30) days for people who remain in the hospital for weeks at a time.

20650.1.2 Other Long-Term Care Facilities

If a recipient is hospitalized for a short period of time and is expected to return to the facility, payment to the facility may continue for a period of not more than seven (7) days provided the LTC facility agrees to hold the bed for the resident. Medicaid reimbursement is available for no more than seven (7) days within any thirty-day period. The thirty-day count begins with the first day of hospitalization. If payments are suspended because recipient remains hospitalized more than seven (7) days and the thirty-day count expires, a new thirty-day count starts with readmission to the LTC facility. In other words DMMA will not pay seven (7) days out of every thirty (30) days for people who remain in the hospital for weeks at a time.

19 DE Reg. 1092 (06/01/16)

20650.2 Temporary Absence from a Long-Term Care Facility for Reasons Other Than Hospitalization

20650.2.1 A recipient may be absent from a long-term care facility for reasons other than hospitalization for a period of eighteen (18) days per year without interruption of payment to the long-term care facility, as long as such absences are provided for in the recipient's plan of care.

20650.2.2 If a recipient's physical condition is being negatively impacted by his or her emotional need to be in a family setting, prior approval may be obtained for a waiver of the eighteen-day leave of absence limitation (for other than acute care hospitalization) from the Title XIX Medical Consultant in order to allow the patient more time to visit with his or her family.

To obtain approval, a written request must be submitted by the long-term care facility to the Long-Term Care Coordinator and must include:

20650.2.2.1 Reason for the request;

20650.2.2.2 Medical summary;

20650.2.2.3 Statement from the LTC facility's medical director regarding the medical necessity of the patient being absent from the LTC facility in excess of eighteen (18) days per year;

20650.2.2.4 Anticipated frequency of absence; and

20650.2.2.5 Number of days the recipient was absent from the LTC facility during the previous six-month period.

If the approval is given, the eighteen-day restriction will be waived for six (6) months from the date of approval. Any request for a waiver after the six-month limit must be resubmitted and approved for payments to be continued.

19 DE Reg. 1092 (06/01/16)

20660 Interim Changes

Interim changes are any changes in circumstances which could result in a change in eligibility (i.e. discharge, income increases or decreases, death). Interim changes must be evaluated at the time they occur or at the time they are reported to determine the effect on eligibility. Unreported changes could cause loss of Medicaid and/or overpayment. Interim changes which do not affect eligibility may affect monthly patient pay amounts (i.e. health insurance premium change, increases or decreases in income, COLA). Unreported changes may also affect payment to providers such as nursing facilities, hospitals, doctors, etc.

20660.1 Interim Changes Procedures

If the nursing facility recipient's income changes anytime during the year, perform the following:

update the eligibility system, and

notify the recipient/representative and facility.

20660.2 Termination of Medicaid Vendor Payments

If a Medicaid nursing facility recipient becomes ineligible due to a change in income or resources and remains in the facility, give 30 days notice of termination to the recipient and the facility. For example, a Medicaid nursing facility resident is determined ineligible on May 10. DSS must give 30 days notice (i.e. June 10).

20660.3 Interim Changes Due to Transfer

If a Medicaid nursing facility recipient is transferred to another facility, the following steps are required:

1. compute the pro-rated patient pay amount for each facility
2. update DCIS
3. notify recipient's representative and the facility.

20660.4 Interim Changes Due to Discharge

When a Medicaid recipient leaves the nursing facility and is discharged by the facility, the following steps must be taken:

1. complete budget to determine pro-rated patient pay amount
2. update DCIS. The case would be closed effective the last day of discharge month if the client received 10 days notice. Vendor payment would stop the day prior to discharge.

3. notify the recipient's representative and facility.

20660.5 Interim Changes Due to Death

When a Medicaid nursing facility recipient expires the following steps must be taken:

1. complete budget to determine pro-rated patient pay amount
2. update DCIS. The case would be closed effective the date of death; vendor payment would stop the day prior to death.
3. notify the recipient's representative and facility.

20670 Redetermination

A redetermination is identical to an application. A new application form must be completed and all elements which have the potential for changing must be reverified.

A complete redetermination of eligibility must be done at least every 12 months. This must include:

1. a newly signed application form;
2. verification of current income and resources documented in the recipient's record

A redetermination of eligibility is not needed for those patients receiving an SSI payment of $30.00. It is SSA's responsibility to redetermine these cases for continued eligibility. However, it is the responsibility of the financial unit to monitor the patient accounts for this group of recipients and to verify their continued receipt of SSI payment once a year.

20680 Inappropriate Placement

If a recipient's condition changes and he requires a nursing facility level of care that the facility is not certified to provide or the recipient no longer needs nursing facility care, the vendor payment must be terminated. From the time it is determined that the recipient is inappropriately placed he or she will be given a 30 day planning period to secure alternate placement.

The Long Term Care Coordinator will determine the planning period and notify the recipient's facility in writing. She will contact the case worker who will notify the recipient's responsible party, first of the need to transfer the recipient and second, that failure to make the transfer will result in case closing. If the level of care reverts back to a level appropriate to the current facility before the 30 days expire, payments will not be terminated.

20690 Disposition of Deceased Nursing Facility Residents Effects

Nursing Facility Administrators must turn over the clothing, valuables and unexpended patient funds of a deceased recipient to the administrator of the estate.

If a recipient dies leaving no will and having no heirs, his property reverts to the State. The Secretary of Delaware's Department of Finance has the responsibility of handling the transfer of the property to the State.

20700 Home and Community Based Services

Federal Regulation - 42 CFR 435.217

1115 Social Security Act (42 U.S.C. 1315)

Effective April 1, 2012, all Home and Community Based Waiver programs, except for the Division of Developmental Disabilities Services Waiver, are incorporated into Diamond State Health Plan Plus, a managed care program. See section DSSM 14900 for additional information regarding this program.

15 DE Reg. 1718 (06/01/12)

20700.1 Division of Developmental Disabilities Services Lifespan Waiver

1. Only clients of the Division of Developmental Disabilities Services (DDDS) are eligible for the Lifespan Waiver.
2. Individuals must be medically eligible.

Initial and ongoing medical eligibility is determined by DDDS staff.

3. Individuals must be financially and technically eligible.

   If the client is not already Medicaid eligible as an SSI recipient, DDDS submits an application (individuals in residential placements) or referral packet (individuals residing in the family home) to the appropriate DMMA Operations Unit for the financial and technical eligibility determination. The financial and technical eligibility determination is made by using criteria applied to those institutionalized and receiving Long Term Care (LTC) Medicaid.

15 DE Reg. 1718 (06/01/12)

21 DE Reg. 574 (01/01/18)

20700.2 Home And Community Based Waiver For The Elderly And Disabled

Effective April 1, 2012, this waiver program is incorporated into the Diamond State Health Plan Plus and referred to as Long Term Care Community Services. See DSSM 20710.

15 DE Reg. 1718 (06/01/12)

20700.3 Home and Community Based Waiver for Individuals With AIDS/HIV

Effective April 1, 2012 this waiver program is incorporated into the Diamond State Health Plan Plus and referred to as Long Term Care Community Services. See DSSM 20710.

15 DE Reg. 1718 (06/01/12)

20700.4 Assisted Living Waiver

Effective April 1, 2012 this waiver program is incorporated into the Diamond State Health Plan Plus and referred to as Long Term Care Community Services. See DSSM 20710.

15 DE Reg. 1718 (06/01/12)

20700.5 Acquired Brain Injury Medicaid Waiver Program

Effective April 1, 2012 this waiver program is incorporated into the Diamond State Health Plan Plus and referred to as Long Term Care Community Services. See DSSM 20710.

11 DE Reg. 1054 (02/01/08)

15 DE Reg. 1718 (06/01/12)

20700.5.1 – 20700.5.8

8 DE Reg. 557

11 DE Reg. 1055 (02/01/08)

20700.6 - 20700.6.7 ATTENDANT SERVICES WAIVER PROGRAM

Repealed, Effective February 10, 2009.

8 DE Reg. 1625 (05/01/05)

12 DE Reg. 1088 (02/01/09)

20710 Long Term Care Community Services

1. Individuals must be medically eligible.

   The Division of Medicaid & Medical Assistance (DMMA) Pre-Admission Screening (PAS) Unit determines medical eligibility.

   The applicant must be in need of nursing facility level of care as defined by DMMA.

   See DSSM 20102 for additional information on Medical eligibility.

2. Individuals must be technically and financially eligible

   The DMMA Long Term Care Financial Unit determines eligibility using criteria in DSSM 20103.

3. Individuals must choose a managed care organization once eligibility has been determined.

15 DE Reg. 1718 (06/01/12)

20720 Patient Pay Calculation

This policy applies to all individuals receiving Medicaid through the Division of Developmental Disabilities Services (DDDS) Lifespan Waiver and the Long Term Care Community Services (LTCCS) Program.

1. The Medicaid recipient's total income will be used in the post eligibility treatment of income. This includes income that is counted for eligibility and income that is excluded for eligibility.
2. Allowable deductions are given based on an individual's circumstances. Not all deductions will apply to all individuals.
3. Any amount of income remaining after allowable deductions is the patient pay amount. This amount must be paid on a monthly basis as indicated below:
    - Individuals receiving Residential Habilitation funded by the DDDS waiver will submit their patient pay amount directly to the provider of Residential Habilitation.
    - Individuals residing in an Assisted Living Facility will submit their patient pay amount directly to the Assisted Living Facility.

The following deductions from the Medicaid recipient's total gross income should be taken in the following order:

15 DE Reg. 1718 (06/01/12)

20 DE Reg. 552 (01/01/17)

21 DE Reg. 574 (01/01/18)

20720.1 Daily Living Needs

Individuals receiving Medicaid under the Division of Developmental Disabilities Services (DDDS) Lifespan Waiver who receive Residential Habilitation services are allowed a deduction equal to the current Adult Foster Care (AFC) rate. The AFC rate is based on the current SSI income level plus the Optional State Supplement amount.

Individuals receiving Medicaid under the Long-Term Care Community Services (LTCCS) program and residing in an Assisted Living Facility are given a deduction based on the Adult Foster Care rate less an amount payable for room and board.

Individuals receiving Medicaid under the DDDS Lifespan Waiver who do not receive a residential habilitation service and individuals receiving Medicaid under the LTCCS program (excluding those residing in an Assisted Living Facility) are allowed a deduction equal to their total income, including income that is placed in a Miller Trust. All earned income in the form of wages shall be allowed to be protected.

15 DE Reg. 1718 (06/01/12)

21 DE Reg. 574 (01/01/18)

26 DE Reg. 957 (05/01/23)

20720.2 Support & Maintenance of Spouse and/or Children

In order to be considered a dependent, the spouse and/or children must be claimed on the applicant's income taxes as a dependent. A spouse is the husband or wife of the applicant who is living with the applicant or was living with the applicant prior to institutionalization.

If the applicant is responsible for the support and maintenance of the spouse and/or children, (i.e. provides them with food and shelter) the following calculations would be completed to determine the protected amount.

An amount up to the current SSI payment standard may be protected for the spouse. Monthly allowances for dependents other than the spouse are based on the current TANF standard of need.

If the spouse or other dependents have income their net income (gross income minus work expense and child care costs) should be deducted from the standards given above. Use standard SSI and TANF deductions. The amount remaining (if any) would then be protected for the dependent.

Please note, spouses with income less than the SSI standard should be encouraged to contact the Social Security Administration Office to apply for benefits.

20720.3 Additional Protected Amounts

Medical expenses not subject to payment by 3rd party, such as:

1. Health insurance premiums

2. Necessary medical or remedial care not covered under the Medicaid State Plan such as hearing aids, dentures, etc.

NOTE:Medicare deductibles and co-insurance charges are paid by Medicaid directly.

20760 Redetermination

A redetermination of eligibility must be performed annually.

Medical eligibility is redetermined by the Managed Care Organization.

Financial eligibility is redetermined by the Division of Medicaid & Medical Assistance (DMMA).

15 DE Reg. 1718 (06/01/12)

20775 Program Of All- Inclusive Care For The Elderly (Pace)

Program of All-Inclusive Care for the Elderly (PACE) is a benefit that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The PACE model was developed to address the needs of long-term care clients, providers, and payers. For most participants, the comprehensive service package permits them to continue living at home, while receiving services rather than be institutionalized. Through PACE, organizations are able to deliver all services covered by PACE which participants need rather than only those services reimbursable under the Medicare and Medicaid fee-for-service systems.

This policy applies to all individuals that elect to receive their long-term care services through the PACE and request Medicaid payment for these services.

1. Participation in PACE is voluntary.
2. A PACE participant's eligibility will be determined under rules applying to institutional groups.
   See DSSM 20000
3. Spousal Impoverishment rules apply if individual is married and spouse continues to reside in the community and does not receive long-term care Medicaid.
   See DSSM 20900
4. Post eligibility treatment of income does not apply to PACE participants.
   Participants will not be required to contribute to the cost of their care received from the PACE Organization.
5. To be initially eligible for enrollment in PACE the individual must:
   - Be at least 55 years old;
   - Meet the State's eligibility criteria for nursing home level of care;
   - Reside in the PACE approved service area;
   - Be living in the community;
   - Be able to be maintained safely in the community based setting at the time of enrollment with the assistance of the PACE;
   - Not be enrolled in a Medicaid/Medicare managed care program; and
   - Voluntarily agree to enroll in PACE and receive services exclusively through the PACE organization and their subcontractors.
6. The Pre-Admission Screening process will be followed when determining medical eligibility.
   See DSSM 20102
7. An individual's enrollment effective date is the first day of the month following the month the PACE Organization receives the signed enrollment form.
8. There is no retroactive coverage for PACE.
9. Nursing facility services are part of the PACE benefit package.
   Nursing facility admission that occurs post-PACE enrollment will not have a negative impact on the individual's continued eligibility.
   The PACE Organization must notify the Division of Medicaid and Medical Assistance (DMMA) eligibility worker of the individual's placement in the nursing facility.
   The PACE individual is not required to contribute to the cost of their care while in a nursing facility.
10. An individual's enrollment continues until the enrollee's death unless either of the following actions occurs:
    a. The enrollee voluntarily disenrolls for any reason.
    b. The enrollee is involuntarily disenrolled for any of the following reasons:
       - No longer meets the nursing facility level of care requirement and there is no indication that the participant is expected to need nursing facility level of care within the next 6 months;

- Moves out of the PACE service delivery area;
- Has decision making capacity and is consistently non-compliant with the individual plan of care and enrollment agreement, which may impact the participant's health and welfare in the community;
- Engages in disruptive, threatening or non-compliant behavior which jeopardizes his or her safety or the safety of others;
- Is out of the service area for more than 30 consecutive days (unless arrangements have been made in advance with the PACE Organization); or
- Is enrolled in a PACE Organization that cannot provide the required services due to loss of licensure or contracts with outside providers, and/or the PACE program agreement is not renewed.

11. An individual may be administratively disenrolled if the participant is admitted to a hospital prior to the effective date of PACE enrollment.
12. Medicaid appeal requirements apply to PACE cases. See DSSM 5000

16 DE Reg. 532 (11/01/12)

20800 Determining Eligibility for the Acute Care Program

LTC POL-

This policy applies to all applications received for Medicaid payment of Inpatient hospitalization or rehabilitation.

Thirty Consecutive Days of Hospitalization

Eligibility for this program will only be determined once the individual has been hospitalized for 30 consecutive days, unless:

the discharge plan is for nursing home placement; or

the individual is seeking out of state inpatient rehabilitation placement.

Licensed and Certified Hospital or Rehabilitation Facility

The medical facility must be licensed and certified as a Title XIX Acute Care or Rehabilitation Medical Facility.

The Acute Care facility must be engaged in providing diagnostic and therapeutic services for medical diagnosis, treatments, and care of injured, disabled, or sick persons. These services must be provided by or under the supervision of physicians. Continuous twenty–four (24) hour nursing services are provided.

The Rehabilitation facility may be a freestanding rehabilitation hospital or a rehabilitation unit in an Acute Care hospital.

Medical Eligibility Requirements For In State Hospitalization and/or Rehabilitation

Medical eligibility for Inpatient hospitalization/rehabilitation services received within the state is determined by the Division of Medicaid and Medical Assistance Pre-Admission Screening (PAS) units. The individual must have required the level of care provided by a hospital during the time of his/her hospitalization, as determined by the PAS units.

Anyone 65 years of age or older, or statutorily blind would meet the medical eligibility criteria if they were in need of acute care services during the time of their hospitalization.

Medical Eligibility Requirements For Out of State Rehabilitation

Medical eligibility for Inpatient Rehabilitation services to be received out of state is determined by the Division of Medicaid and Medical Assistance Medical Director. The individual must require:

- close medical supervision by a rehabilitation physician;
- twenty-four (24) hour nursing supervision;
- an intensive level of physical, occupational or speech therapy; or
- psychological services; or
- prosthetic-orthotic services.

The individual must be able to tolerate and participate in all required therapies or services.

Medical eligibility must be reviewed on a bi-weekly basis.

Prior authorization must be requested and approved before out of state placement is made.

Financial Eligibility Requirements

Financial eligibility is determined by the Division of Medicaid and Medical Assistance Financial units. An individual must meet income and resource guidelines.

Income Guidelines

The income limit is equal to 100% of the Federal SSI Standard. However, if the individual is going to a nursing home directly from a hospital or rehabilitation facility, the higher income limit of 250% of the Federal SSI standard will be applied.

For out of state rehabilitation the income limit is 250% of the Federal SSI standard.

Refer to DSSM sections 20200, 20210, and 20240 for additional guidelines regarding income.

Resource Guidelines

The resource limit is $2,000.00. Refer to DSSM sections 20300 – 20360, and 20400 for additional information on determining countable resources.

Spousal

If applicable, Spousal Impoverishment rules should be followed. (DSSM 20900)

Financial Redetermination

A redetermination of the individual's financial eligibility should be completed at six month intervals.

Post Eligibility Budgeting

There is a patient pay requirement for these individuals. The patient pay amount is determined in accordance with DSSM section 20600 - (Post-Eligibility Definitions/Procedures). Notification of patient pay amount and approval must be sent to the appropriate hospital/rehabilitation social worker.

Medicaid Eligibility Effective Date

In no case shall the effective date of eligibility be earlier than the first day of hospitalization.

13 DE Reg. 263 (08/01/09)

20810 Treatment of Income and Resources of Couples

This policy applies to all legally married couples when determining and redetermining Long Term Care Medicaid eligibility for both husband and wife.

Treatment of Home and Community Based Services (HCBS) Couples

The income and resource standards for a HCBS couple will be applicable if:

Both are requesting HCBS AND reside at the same address; OR

One is currently receiving HCBS and the spouse is requesting HCBS AND they reside at the same address.

Treatment of Couples Residing in an Institution

The income and resource standards for couples residing in an institution will be applicable if:

- Both are requesting institutional services AND they will be residing in the same facility;

  OR

- One is currently receiving institutional services and the spouse is requesting institutional services at the same facility.

After a husband and wife have resided in the same facility for 6 months they have the option of being budgeted as a couple or as two individuals. This decision should be based on the couple's best interests in regard to the income and resource limits.

See DSSM 20100.2.2 (income standards) and 20300 (resource standards).

9 DE Reg. 142 (7/1/05)

12 DE Reg. 224 (08/01/08)

20900 Spousal Impoverishment

Section 303 of the Medicare Catastrophic Act contains provisions that significantly change the way in which income and resources of a couple are calculated when one spouse is institutionalized or likely to be institutionalized for continuous periods in a nursing facility, and who has a spouse residing in the community. The revisions are intended to prevent the spouse who remains in the community from becoming impoverished either before or after the institutionalized spouse becomes eligible for Medicaid.

Effective July 1, 1993, Delaware elected the option to apply the Spousal Impoverishment rules to persons who are likely to receive services under Section 1915(c) the Home and Community Based Waivers. All references to institutionalized spouses and continuous periods of institutionalization include spouses receiving Home and Community Based Waiver services in lieu of institutional services. Individuals receiving a combination of institutional and waiver services are subject to these rules.

Generally, the Bill counts income as Medicaid policy has always counted income (i.e., income owned by only one spouse is considered available solely to that spouse). One change is that income in both their names is divided evenly between the two spouses. The most drastic change occurs in the calculation of resources. Medicaid has always viewed the resources held solely by the non-institutionalized spouse as not available to the institutionalized spouse.

Under the Spousal Impoverishment provisions, all assets/resources held by either or both spouses are considered available equally to both spouses as of the beginning of the first continuous period of institutionalization (beginning on or after 9/30/89). The couple's house, car, and personal goods are excluded from countable resources.

Resource rules described in this section apply only to persons first institutionalized for continuous periods on or after September 30, 1989. Persons first institutionalized before that date are subject to prior Medicaid plan policies as long as they remain in an institution.

The spousal impoverishment regulations must be applied to any couple who is legally married unless the couple is separated and maintains two separate residences for at least 12 months prior to admission to a medical institution (hospital, nursing facility, etc.) AND the community spouse is uncooperative or his/her whereabouts are unknown.

These rules apply regardless of State laws relating to community property or to the division of marital property. For example, resources listed in a prenuptial agreement are not excluded.

The income eligibility and post-eligibility provisions in the instruction are effective September 30, 1989, and the resources provisions are effective October 1, 1989 for persons first institutionalized for continuous periods of institutionalization beginning on or after September 30, 1989.

20900.1 Undue Hardship

Spousal Impoverishment rules may be waived if the application of the rules would cause an undue hardship. Undue hardship exists when application of the spousal impoverishment provisions would deprive the individual of medical care such that his/her life would be endangered. Undue hardship also exists when application of the spousal impoverishment provisions would deprive the individual of food, clothing, shelter or other necessities of life.

20 DE Reg. 52 (07/01/16)

20910 Definitions

20910.1 Institutionalized Spouse

20910.2 Community Spouse

20910.3 Family Member

20910.4 Minimum Monthly Maintenance Needs Allowance

20910.1 Institutionalized Spouse

An individual who is in a medical institution or nursing facility and is married to a spouse who is not in a medical institution or nursing facility.

9 DE Reg. 1187 (02/01/06)
9 DE Reg. 1565 (04/01/06)
10 DE Reg. 701 (10/01/06)
10 DE Reg. 1619 (04/01/07)

20910.2 Community Spouse

An individual who is married to an institutionalized spouse.

9 DE Reg. 1187 (2/1/06)
9 DE Reg. 1565 (04/01/06)
23 DE Reg. 871 (04/01/20)

20910.3 Family Member

A minor or dependent child, dependent parent, or dependent sibling (including half-brothers and half-sisters) of either spouse and who is living with the community spouse. A dependent is a family member who may be claimed as a dependent by either spouse for tax purposes under the Internal Revenue Code.

20910.4 Minimum Monthly Maintenance Needs Allowance

An allowance for the community spouse which, effective 7/1/92, equals 150% of Federal Poverty Level for two plus an excess shelter allowance. (Prior to 7/1/92 the allowance was 133% of the FPL for two plus excess shelter.)

The minimum maintenance needs allowance will change annually (every July) based on the FPL and the cap on the maintenance allowance will change annually (every January) based on the consumer price index. See Allowances Chart.

20910.5 Excess Shelter Allowance

The amount by which the spouse's expenses for rent or mortgage payment, property taxes, and homeowner's insurance plus the Food Stamp standard utility allowance (SUA) exceeds 30% of the applicable percent of the FPL for two.

20910.6 Community Spouse Monthly Income Allowance

The amount of income needed to bring the monthly income of the community spouse up to the minimum maintenance needs allowance.

20910.7 Monthly Income of the Community Spouse

Income that is "otherwise available" to the community spouse. "Otherwise available income" includes income that would be used if eligibility was being determined for the community spouse, i.e. gross income.

Exception: Do not count as income to the community spouse the amount that the institutionalized spouse who is a veteran pays for the medical needs of the community spouse.

20910.8 Family Allowance

The amount of income needed to bring a family member's monthly income up to 1/3 of the applicable percent of the FPL for two. Each family member is entitled to a family allowance.

20910.9 State Spousal Share

The state spousal share is the minimum amount of the couples' combined countable resources necessary to maintain the community spouse.

20910.10 Community Spouse Resource Allowance

The community spouse resource allowance is the amount of resources equal to whichever is greater:

$25,000.00 (current state spousal share)

OR

1/2 of the value of the couple's combined countable resources as of the beginning of the first continuous period of institutionalization on or after 9/30/89, but no more than current maximum resource allowance determined by Federal law.

The minimum and maximum resource allowances increase on January 1 of each year by Federal law. Delaware Senate Bill 99 increased the minimum resource allowance from $14,148 to $25,000 for applications filed on or after 10/1/93.

If the share belonging to the spouse in the community is less than $25,000, the institutionalized spouse's resources are deemed available to the community spouse to bring the community spouse's resources up to $25,000 for initial eligibility determinations. Any amount above the Maximum Resource Allowance determined by Federal law is considered available to the institutionalized spouse for the purpose of Medicaid eligibility determination.

20930 Resource Assessment and Eligibility

The State must promptly assess and document the couples' combined countable resources as of the beginning of the first continuous period of institutionalization on or after 9/30/89. The community spouse resource allowance is equal to 1/2 of a couples' combined countable resources as of the beginning of the first continuous period of institutionalization (but not to exceed the maximum permitted). The community spouse resource allowance is a set figure used to determine the amount of resources that will be used to determine institutionalized spouses' initial Medicaid eligibility for the current application period.

If the couple cannot adequately verify what their resources were at the beginning of the first continuous period of institutionalization, the eligibility worker may calculate the community spouse resource allowance based on the resources that can be adequately documented. This may be any point in time between date of admission and date of application. If the couple cannot document their resources, DSS will advise them that it cannot calculate the community spouse resource allowance.

20950 Initial Eligibility Determinations

Determine couples' combined countable resources for the month of application. Deduct from the couples' countable resources owned at the time of application a protected amount which is the greater of the following amounts:

the community spouse resource allowance (provided it does not exceed the maximum)

OR

the current State spousal share ($25,000)

Compare the remaining resources to the Medicaid resource limit of $2,000. If the remaining resources are over $2,000, the institutionalized spouse is ineligible until the combined countable resources are reduced to the greater of the following:

the community spouse resource allowance plus $2000

OR

the current State spousal share ($25,000) plus $2,000

An institutionalized spouse who (or whose spouse) has excess resources shall not be found ineligible per Section 1924 (c)(3)(C) of the Social Security Act where the state determines that denial of eligibility on the basis of having excess

resources would work an undue hardship. Resources may be depleted in whatever manner the client/spouse wishes as long as there is no transfer for less than fair market value. See Section 20350.6 Transfer of Assets.

Once eligibility has been established, resources not used to determine eligibility for institutionalized spouses (i.e., the amount of spousal resource allowances) may be transferred to community spouses to assist such spouses in meeting their needs in the community. Thus, resources are not merely deemed available (or attributed) to community spouses in initial eligibility periods, but are actively made available to meet their needs in the community. Spouses who intend to transfer resources for this purpose are encouraged to do so as soon as is practicable before the first regularly scheduled redetermination of eligibility under.

Resources transferred to community spouses as well as other specified parties, without receiving fair market value for the property transferred, do not adversely affect continuing eligibility of institutionalized spouses. See Section 20350.6 Transfer of Assets

NOTE:Although the revised transfer of assets provisions allow the institutionalized spouse to transfer all of his or her resources to the community spouse without regard to the resource allowance, the initial eligibility determination will still attribute resources in excess of the community spouse allowance to the institutionalized spouse.

After eligibility has been determined the eligibility worker must provide a written notice to both spouses including the following information as appropriate:

the amount of combined countable resources at the beginning of the first continuous period of institutionalization;

the method used to compute the community spouse resource allowance, and

institutionalized spouses' right to rebut through a fair hearing ownership or availability of income and resources.

20950.1 Application of "Income First" Rule in Applying Community Spouse's Income Before Assets in Providing Support of Community Spouse

This policy relates to the procedure described in §1924(d) of the Social Security Act (42 U.S.C. §1396r-5) for increasing the amount of the married couple's resources that are not counted in determining the institutionalized spouse's eligibility for Medicaid, in order to protect income for the spouse who is remaining in the community (community spouse).

Section 6013 of the Deficit Reduction Act of 2005 (Public Law 109-171), enacted on February 8, 2006, mandates the State must consider all income of the institutionalized spouse that can be allocated to the community spouse, in order to bring the community spouse's income up to the minimum monthly maintenance needs allowance (MMMNA), before raising the community spouse's resource allowance to adequately provide for that income.

The income first methodology requires that an institutionalized spouse who applies for Medicaid must first divert income to his or her community spouse (who is not applying for Medicaid) before the institutionalized spouse may increase the amount of the couple's resources that would be protected from consideration in evaluating the institutionalized spouse's Medicaid eligibility. This is referred to as the "income first" methodology for determining the extent of protection of the couple's assets and applies to transfers and allocations of income and resources made on or after the date of enactment by individuals who become institutionalized spouses on or after such date.

10 DE Reg. 283 (10/01/06)

20960 Exemptions to Minimum Resource Allowance

If there is a court order against an institutionalized spouse for the support of the community spouse which requires a greater resource allowance than that determined above, that amount shall be used for determining initial and ongoing eligibility. This would not be considered a transfer.

20970 Fair Hearings

Either spouse can appeal the computation of the 1/2 spousal share, how resources are calculated for initial eligibility purposes, or the amount of the community spouse resource allowance. In addition, if either spouse establishes that the resource allowance is inadequate to bring the community spouse's income up to the minimum income allowance level + excess shelter, the resource allowance can be increased so that this level is reached.

This would likely occur in instances in which the spouses' combined income falls below the minimum income allowance level. The community spouse may need income generated from resources to supplement existing income. Hearings requested on the basis of these computations must be conducted within 30 days from the date of request.

20970.1 Income First Policy for Increasing the Spousal Resource Allowance to Compensate for Insufficient Income

In nursing facility cases with a community spouse, the institutionalized spouse can make a request or file an appeal to increase the community spouse resource allowance (CSRA) to produce additional income for the community spouse. The hearing officer, as appropriate, may then increase the CSRA to an amount that is adequate to produce income that equals, but does not exceed, the MMMNA.

For Home and Community Based Services Waiver applicants/recipients see DSSM 20720.2.

10 DE Reg. 283 (10/01/06)

20980 Continuing Eligibility

Beginning in the month following the month in which the institutionalized spouse is determined to be eligible, no resources solely owned by the community spouse shall be deemed available to the institutional spouse. Thus, to benefit from the community spouse resource allowance, the institutionalized spouse will need to actually transfer sufficient resources to equal the amount of the allowance to the community spouse so that those resources will not cause ineligibility at redetermination.

20990 Income Rules

Income eligibility is determined by considering the income of the institutionalized spouse only. The sole deduction taken from the gross income before comparing to the income limit is the $20 disregard. Neither the community spouse income allowance nor the family allowance may be deducted to bring the income below the income limit. Income in both spouses names is considered to be equally available to both spouses within the following guidelines.

20990.1 Income From Non-Trust Property

1) If payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse.

2) If payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

3) If payment of income is made in the names of the institutionalized spouse or the community spouse or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

4) Consider available to each spouse one-half of any income which has no instrument establishing ownership.

20990.2 Income From Trust Property

In the case of a trust, income shall be considered available to each spouse as provided in the trust, or, in the absence of a specific provision in the trust, use the guidelines specified for non-trust property.

20995 Continuing Eligibility

After an institutionalized individual has established eligibility for Medicaid, the state must protect part of the individual's income for the community spouse. Protect enough income to equal the community spouse income allowance.

After eligibility has been determined, income paid solely to one spouse is attributed only to that named spouse. If income is paid to both it is attributed to both in equal parts.

20995.1 Post - Eligibility Deductions

42 CFR §435.725; 42 CFR §435.733; 42 CFR §435.832

Post-eligibility determination is revised to allow the following deductions from the income of the institutional spouse. The deductions must be taken in the following order:

20995.1.1 Personal Needs Allowance for the institutional spouse

The personal needs allowance amount is $30 per month for SSI recipients, and $50 per month for all others. If the institutionalized spouse is employed, personal needs may range from $50 up to the Adult Foster Care rate per month.

20995.1.2 Community Spouse Income Allowance

20995.1.2.1 The community spouse monthly income allowance is the amount of income necessary to bring the spouse's monthly otherwise available income up to the applicable percent of the FPL for two, plus an additional amount for excess shelter.

20995.1.2.2 The total amount available to the community spouse may not exceed "Cap for Minimum Monthly Maintenance Standard. This standard usually changes each January based on the Consumer Price Index for Urban Consumers.

20995.1.3 Family Allowance

20995.1.4 Items for which protection of income has been approved by the Long-Term Care Operation's Administrator and/or incurred medical expenses of the institutionalized spouse.

10 DE Reg. 703 (10/01/06)

19 DE Reg. 1095 (06/01/16)

20995.2 Amount for Incurred Medical Expenses

The financial eligibility worker must take into account amounts for incurred medical expenses of the institutionalized spouse within reasonable limits as defined by the State. These are expenses that are not covered by any third party payor and for which the couple is responsible. Questions regarding what constitutes necessary medical or remedial care and what constitutes reasonable limits should be referred to and resolved by the Medical Review Team.

Incurred expenses for medical or remedial care that are not subject to payment by a third party, include--

1) Medicare and other health insurance premiums, deductibles or coinsurance, and

2) necessary medical or remedial care recognized under State law but not covered under the state plan under this title, subject to reasonable limits the State may establish on the amount of these expenses.

20995.3 Exemptions to Allowance Determination

20995.3.1 Treatment of Court-ordered Support

If court-ordered support for the community spouse is greater than the calculated community spouse income allowance, the amount of the support is to be recognized as the income allowance. For example, if the institutionalized spouse was ordered to pay $200/month to the community spouse, that amount would be allowed and deducted even if it exceeded the calculated income allowance.

20995.3.2 Fair Hearings

Either spouse can appeal the amount of the monthly income allowance or how the income otherwise available to the community spouse was determined. In addition, the allowance can be adjusted higher than that allowed above if they can show that additional income is necessary due to "exceptional circumstances resulting in significant financial duress."