DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Roberts	9-26-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 13088	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Mr. Keck, Singleton Cleared 10/2/12, response attached	[X] Prepare reply for appropriate signature DATE DUE 10-15-12 [ ] FOIA DATE DUE _____ Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION V
233 NORTH MICHIGAN, SUITE 1360
CHICAGO, IL 60601

September 21, 2012

Report Number: A-05-12-00027

Mr. Anthony Keck
Director
South Carolina Department Health and Human Services
1801 Main Street
P.O. Box 8206
Columbia, SC 29201

Dear Mr. Keck:

This is to notify you of our intention to conduct a review of the South Carolina Department Health and Human Services' (the State agency) implementation of certain provisions of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) and the Deficit Reduction Act of 2005 (DRA '05). The objectives of our review are to determine the State agency's: (1) progress in implementing eligibility and estate recovery provisions of the OBRA '93 and the DRA '05; (2) efforts with regard to estate recovery, including the amount of resources put into estate recoveries; and (3) estate recovery amounts and medical assistance expenditure amounts for nursing home care during the fiscal years 2005 through 2011. This review is in response to a congressional request to report on States' progress in implementing the provisions of the OBRA '93 and DRA '05.

As a recipient of U.S. Department of Health and Human Services (HHS) grant funds, the State Medicaid agency is subject to Office of Inspector General (OIG) audits and other reviews. Pursuant to 45 CFR § 92.42(e), OIG has the right to timely and unrestricted access to all books, documents, papers, or other records that are pertinent to the Federal grant award.

OIG performs independent reviews of HHS programs and operations pursuant to the Inspector General Act of 1978, 5 U.S.C. App. § 4(a)(1).

Under the health information privacy regulation that implements the Health Insurance Portability and Accountability Act of 1996, providing the information requested by this letter is a permitted disclosure because it will be used for "health oversight" activities by OIG, which meets the definition of a "health oversight agency" (45 CFR §§ 164.512(d) and 164.501).

To expedite completion of our work, we request that you provide responses to the questions and requests listed in the enclosure and its appendix within 30 days from the date of this letter.

During our review, we may also need access to additional documents, records, and information. We appreciate your cooperation in this matter and will make every effort to minimize any disruption to the work of your office.

When transmitting any audit information to the Office of Audit Services over the Internet, please properly safeguard the information. We request that you use the HHS/OIG Delivery Server, not email or attachments to email. Information transmitted through the HHS/OIG Delivery Server complies with Federal Information Processing Standard (FIPS) 140-2, *Security Requirements for Cryptographic Module*. Please contact Mr. George Ampalathumkal at (312) 353-1788 or George.Ampalathumkal@oig.hhs.gov or Ms. Olga Gesell at (312) 353-7907 or Olga.Gesell@oig.hhs.gov of my staff, to provide the requested information.

We are required to report as a security breach any audit information sent to us that does not meet FIPS 140-2 requirements.

This review will be performed under my direction. If you have any questions or concerns about our review, please contact Mr. Stephen Slamar, Audit Manager at (312) 353-7905 or Mr. George Ampalathumkal at (312) 353-1788 or George.Ampalathumkal@oig.hhs.gov, or Ms. Olga Gesell at (312) 353-7907 or Olga.Gesell@oig.hhs.gov. Please refer to report number A-05-12-00027 in all correspondence. Thank you for your attention to this matter.

Sincerely,

Sheri L. Fulcher

Sheri L. Fulcher
Regional Inspector General
for Audit Services

Enclosure

Department of Health and Human Services
Office of Inspector General, Office of Audit Services
233 North Michigan Ave, Suite 1360, Chicago, IL 60601

States' Progress in Implementing the Provisions of the OBRA '93 and DRA '05

A-05-12-00027

QUESTIONNAIRE AND INFORMATION REQUEST

ELIGIBILITY

Look-back and Penalty Periods

1. Section 6011(a) of the Deficit Reduction Act of 2005 (DRA'05) amended section 1917(c)(1)(B)(i) of the Social Security Act (the Act) to extend the look back period to 60-months for any transfer of assets made on or after February 8, 2006.

    a. Did your State agency implement the DRA '05 provision of 60-month look back period?

    b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

    c. If no, what was the reason for not implementing this provision?

    d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation.

2. Section 6011(b) of DRA '05 amended section 1917(c)(1)(D) of the Act to require that the penalty period start date be the later of either: (1) the first date of the month during or (at State option) after which assets have been transferred for less than fair market value; or (2) 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.
    a. Did your State agency implement the DRA '05 penalty period start date provision?

    b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

    c. If no, what was the reason for not implementing this provision?

    d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation.

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3. Section 6016(a) of DRA '05 amended section 1917(c)(1)(E) of the Act to prohibit a State from rounding down or otherwise disregarding any fractional period of ineligibility. States must impose a penalty period even where the period of ineligibility would be less than a full month.
    a. Did your State agency implement the DRA '05 provision related to partial months of ineligibility?

    b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

    c. If no, what was the reason for not implementing this provision?

    d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation.

4. Section 6016(b) of DRA '05 amended section 1917(c)(1) of the Act to give States the option to accumulate multiple transfers into a single period of ineligibility, rather than imposing multiple penalty periods.

    a. Did your State agency opt to permit accumulation of multiple transfers in computing the penalty period?

    b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

    c. If no, what was the reason for not implementing this provision?

    d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation.

5. Section 13611 of OBRA 93 amended section 1917 of the Act to include in the definition of "assets" any income or resources which the individual or spouse is entitled to but does not receive because of their own action. Such actions may include disclaiming an inheritance, waiving pension income or refusing to accept an injury settlement. Disclaiming an inheritance could cause a person to lose his or her eligibility for Medicaid for a penalty period.

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a. Did your State agency implement the OBRA '93 provision that required treating such actions as disclaimer of inheritance as an asset transfer?

b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

c. If no, what was the reason for not implementing this provision?

d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation.

Annuities – Medicaid Application Requirement

6. Section 6012(a) of DRA '05, which amended sections 1917 of the Act by adding a new section 1917(e), provides that the States shall require, as a condition for an individual's eligibility for medical assistance related to long-term care services, that the individual's application for such assistance (including any subsequent recertification) shall disclose any interest the individual or community spouse has in an annuity or similar financial instrument, regardless of whether the annuity is irrevocable or is treated as an asset.

    a. Did your State agency implement the DRA '05 provision related to disclosure and treatment of annuities?

    b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan, procedure manuals and example copies of Medicaid application.

    c. If no, what was the reason for not implementing this provision?

    d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation.

    e. If the Social Security Administration is making Medicaid eligibility determinations for your State, who is responsible for collecting and analyzing the annuity disclosures and remainder beneficiary statements?

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Annuities – When State is Not the Remainder Beneficiary

7. Section 6012(b) of the DRA '05, which amended section 1917(c)(1) by adding new sub-paragraph (F). The newly added subparagraph (F), provides that the purchase of an annuity on or after February 8, 2006 shall be treated as transfer of assets for less than fair market value unless the State is named as the remainder beneficiary in the correct position for amounts paid by Medicaid. Under 1917(e)(2)(A) (added by section 6012(a) of the DRA), the State must notify the issuer of the annuity of the State's rights as a preferred remainder beneficiary. The State may also require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn.

    a. Did your State agency implement the DRA '05 provision of treating the purchase of annuity as asset transfer for less than fair market value unless the State is named as the remainder beneficiary of the annuity?

    b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

    c. If no, what was the reason for not implementing these provisions?

    d. If your State agency could not have implemented this provision without State legislation, when did the State legislation occur? Provide relevant pages of such State legislation.

    e. For each of the Federal fiscal years ended since February 2006:

        i. How many notifications regarding your State's right as a preferred remainder beneficiary were submitted to issuers of annuities?

        ii. How many remainder beneficiary collections were received from issuers of annuities?

Annuities – Purchases and Other Transactions

8. Section 6012(c) of the DRA'05, which amended section 1917(c)(1) by adding a new sub-paragraph (G), provides that the purchase of an annuity on or after February 8, 2006, by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility

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services or other long-term care services, shall be treated as a transfer of assets for less than fair market value unless the annuity meets the criteria listed in the section.

a. Did your State agency implement the DRA '05 provision of treating the purchase of certain annuities as asset transfer for less than fair market value?

b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

c. If no, what was the reason for not implementing these provisions? and

d. If your State agency could not have implemented this provision without State legislation, when did the State legislation occur? Provide relevant pages of such State legislation.

9. Section 6012(d) of the DRA '05 specifies that the provisions of the DRA apply to annuity-related transactions, including purchases, which occur on or after February 6, 2008. In its State Medicaid Directors Letter number 06-018 dated, July 2006, Centers for Medicare and Medicaid Services stated that such transactions include any action taken by the individual that changes the course of payments to be made by the annuity or the treatment of the income or principal of the annuity. Such actions include additions of principal, elections to annuitize the contract and similar actions. Routine changes, automatic events, and changes beyond the control of the individual are not considered transactions that would subject the annuity to treatment under the provisions of the DRA. .

a. Did your State agency implement the DRA '05 provision that would make an annuity, regardless of its purchase date, subject to asset transfer rules if certain transactions occur?

b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

c. If no, what was the reason for not implementing this provision? and

d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation.

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Annuities – Income

10. The Act, as amended by DRA '05, prevents the State agency from treating certain transactions related to annuities as transfer for less than fair market value. However, under CMS's SMD letter 06-018, the annuity must still be considered in determining Medicaid eligibility, including spousal income and resources, and post-eligibility calculation, as appropriate. Even if an annuity is not subject to penalty under the provisions of the DRA, this does not mean it is excluded as income or resource.

    a. Is your State agency considering income derived from annuities when determining Medicaid eligibility for long-term care?

Promissory Notes, Loans or Mortgages

11. Section 6016(c) of DRA '05, which added section 1917(c)(1)(I) of the Act, provided that, with respect to the transfer of assets, the term 'assets' includes funds to purchase a promissory note, loan, or mortgage unless such instruments have a repayment term that is actuarially sound, provide for payments to be made in equal amounts during the term of the loan with no deferral and no balloon payments, and prohibit cancellation of the balance upon the death of the lender. If the instruments do not satisfy such requirements, their value shall be the outstanding balance as of date of the individual's application for medical assistance for long term care services.

    a. Does the definition of assets in your State include funds used to purchase certain promissory note, loan, or mortgage as specified in Section 6016(c) of DRA '05?

    b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

    c. If no, what is the reason for not implementing this provision? and

    d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation.

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Life Estates

12. Section 6016(d) of DRA '05, which amended section 1917(c)(1) of the Act by adding a new subparagraph (J), provides that the term assets includes the purchase of life estate interest in another individual's home unless the purchaser resides in the home for a period of at least 1 year after the date of purchase. If the purchaser resides in the home for less than a year, CMS's SMD letter states that the transaction should be treated as a transfer of assets. The amount of the transfer is the entire amount used to purchase the life estate. This amount should not be reduced or prorated to reflect an individuals' residency for a period of time less than a year.

    a. Does the definition of assets in your State include a life estate interest in another individual's home as specified in Section 6016(d) of DRA '05?

    b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

    c. If no, what was the reason for not implementing this provision?

    d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation.

13. Do any of the provisions of your State law or State agency policies specify conditions that would result in a presumption that undue hardship exists (or does not exists)? If yes, list such conditions and provide relevant pages of the State laws, regulations, or policies.

Income First Rule

14. Section 6013 of the DRA '05, which amended section 1924 of the Act, required all States to follow the "income first" method in calculating revisions to the community spouse resource allowance. All States are required to attribute or allocate the maximum available income of the institutionalized spouse to the community spouse before granting an increase in the CSRA under section 1924(e)(2)(C).

    a. Did your State agency implement the DRA '05 provision of income first rule.

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b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

c. If no, what was the reason for not implementing this provision?

d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation.

Entrance Fee

15. Section 6015 of the DRA '05 added subsection (g) to Section 1917 of the Act to set forth conditions under which an entrance fee paid to a continuing care retirement community or life care community would be treated as a resource to an individual for purposes of determining Medicaid eligibility.

    a. Did your State agency implement the DRA '05 provision of treating, in certain circumstances, entrance fee deposits as resources of the applicant for determining Medicaid eligibility?

    b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

    c. If no, what was the reason for not implementing this provision?

    d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation.

Home Equity Limit

16. Section 6014(a) of the DRA '05, which amended section 1917 (f) of the Act, provided that in determining the eligibility of an individual to receive medical assistance payment for nursing facility services or other long-term care services, States must deny eligibility if the individual's equity interest in his or her home exceeds $500,000 (disqualification rule). States may elect a home equity limit greater than $500,000 , as adjusted by inflation beginning in 2011, but that does not exceed $750,000, adjusted by inflation. This restriction applies only to applicants who do not have a spouse or a child under age 21, or who is blind or disabled, lawfully residing in the individual's home.

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a. Did your State agency implement the DRA '05 home equity limit rule?

b. If yes, when were the effective date, and how the State agency determines the dollar value of equity interest? Provide any relevant pages of the CMS approved State plan and procedure manuals.

c. If no, what was the reason for not implementing this provision?

d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation.

17. Section 6014(a) of DRA '05, which amended section 1917(f)(3) of the Act, provided that nothing in the provision shall prevent an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

    a. Does your State plan or State regulation contain any provisions that would prevent a Medicaid applicant from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home?

    b. If yes, please provide related pages of CMS approved State plan, state legislation and procedure manuals.

Trusts – Establishment of a Trust

18. Section 13611(b) of OBRA '93, which added section 1917(d) (2) to the Act, addresses the availability to the individual of assets held in trusts that were established on August 11, 1993 or later, for purposes of determining Medicaid eligibility. This section provides that an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if such trust was established (other than by will) by: (i) the individual; or (ii) the individual's spouse; or (iii) a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or (iv) a person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

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a. Did your State agency implement OBRA '93 provision related to when an individual shall be considered to have established a trust?

b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

c. If no, what was the reason for not implementing this provision?

d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation.

Trusts – Legal Instrument or Device Similar to Trust

19. Section 13611(b) of OBRA '93, which added section 1917(d)(6) to the Act, provides that the term 'trust' includes any legal instrument or device that is similar to a trust. Section 3259.1 of the CMS' State Medicaid Manual provides that, " legal instrument or device similar to a trust" is any legal instrument, device, or arrangement which may not be called a trust under State law but it involves a grantor who transfers property to an individual or entity with fiduciary obligations (trustee). The grantor makes the transfer with the intention that it be held, managed, or administered by the individual or entity for the benefit of the grantor or others. This can include (but is not limited to) escrow accounts, investment accounts, pension funds, and other similar devices managed by a trustee, but includes an annuity only to the extent CMS specifies in guidance.

    a. Did your State agency implement OBRA '93 provision that treats "legal instruments or device similar to a trust" as a trusts for purpose of determining Medicaid eligibility?

    b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

    c. If no, what was the reason for not implementing this provision?

    d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation.

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Trusts - Revocable

20. Section 13611(b) of the OBRA '93, which added section 1917(d)(3)(A) to the Act, provides guidelines for the treatment of assets held in revocable trusts (trusts which can under State law be revoked by the grantor or which provide that the trust can only be modified or terminated by a court), that were established on August 11, 1993 or later, for purposes of determining Medicaid eligibility. This section provides that: (i) the principal of a revocable trust is considered a resource to the individual; (ii) payments from the revocable trust to or for the benefit of the individual are considered income to the individual; and (iii) any other payments from the trust that are not made to or for the benefit of the individual are considered assets disposed of by the individual.

    a. Did your State agency implement OBRA '93 provision related to the principal of a revocable trust and payments from the revocable trust for determining Medicaid eligibility?

    b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

    c. If no, what was the reason for not implementing this provision?

    d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation.

Trusts - Irrevocable

21. Section 13611(b) of the OBRA '93, which added section 1917(d)(3)(B) to the Act, provides guidelines for the treatment of assets held in irrevocable trusts (trusts which cannot, in any way, be revoked by the grantor), that were established on August 11, 1993 or later, for purposes of determining Medicaid eligibility. Under this section: (i) if there are any circumstances under which payment from an irrevocable trust could be made to or for the benefit of the individual, the portion of the principal from which (or income on that principal from which) payment to the individual could be made is considered resources available to the individual; (ii) payments from that portion of the principle or income on the principle to or for the benefit of the individual are considered income of the individual: (iii) payments for any other purpose are considered a transfer of assets by the individual; and (iv) any portion of the irrevocable trust or income on the principle from which no payment could be made under

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any circumstances to the individual is considered assets disposed by the individual on the date the irrevocable trust was/is established (If, however, the access by the individual was blocked later, the date of the transferred assets will be the date that access was blocked (foreclosed)).

a. Did your State agency implement OBRA '93 provision related to the principal of, payments from, and income of the irrevocable trust for determining Medicaid eligibility?

b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

c. If no, what was the reason for not implementing this provision?

d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation.

Lien

22. Under §1917(a), The Tax Equity and Responsibility Act of 1982 (TEFRA) allows States to file liens, known as TEFRA liens, on the real property of permanently institutionalized nursing home residents.

a. Did your State agency elect to use TEFRA liens? Provide relevant pages of the CMS approved State plan

If yes:

b. How does your State agency determine whether a Medicaid recipient is permanently institutionalized?

c. Do any of the provisions of your State law or State agency policies specify conditions that would result in a presumption that a Medicaid recipient is permanently institutionalized? If yes, list such conditions and provide relevant pages of the State laws, regulations, or policies

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d. Are the TEFRA liens in your State limited to the homestead of the Medicaid recipient or does your State agency impose TEFRA liens on real property other than home, such as income-producing property? If yes, provide relevant pages of the CMS approved State plan

ESTATE RECOVERY

23. Section 13612(a) of OBRA'93 which amended Section 1917(b)(1) of the Act required each State to seek adjustment or recovery from the individual's estate of amounts correctly paid by the State on behalf of an individual who was 55 years or older when the individual received medical assistance for nursing facility services, home and community-based services, and related hospital and prescription drug services. Section 1917(b)(2) permits such recovery only after the death of any surviving spouse, when there is no surviving child under 21 or blind or disabled child.

    a. Did your State agency implement the estate recovery provision as required in section 13612(a) of OBRA'93?

    b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

    c. If no, what is the reason for not implementing this provision?

    d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation, and

    e. Do any State laws or regulations limit your State agency's ability to enforce the estate recovery mandated under Section 13612(a) of OBRA'93?

    f. How does your State agency obtain the information about the death of the Medicaid beneficiaries?

24. Section 13612(a) of OBRA'93, which amended section 1917(b)(1) of the Act, provided States the option of recovering payments from the individual's estate for all Medicaid services provided to beneficiaries who were 55 or older and received nursing facility services, home and community-based services, and related hospital and prescription drug services.

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a. Did your State opt to recover payments for all Medicaid services as provided in section 13612(a) of OBRA'93?

b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

c. Do any State laws or regulations limit the State agency's ability to recover additional Medicaid payments?

25. Section 13612(c) of OBRA'93, which amended section 1917(b) of the Act, provided that [in addition to the assets in the individual's estate as defined under the State probate law] the term "estate" may include, at the option of the State, any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest) such as assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

    a. In addition to recoveries from the probate estate, of an individual Medicaid recipient, did your State opt to recover from the individual's other real and personal property that transferred outside of probate?

    b. If yes: (i) when was the effective date? (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

26. Section 13611(b) of OBRA'93, which amended section 1917(d)(4) of the Act, allowed a Medicaid applicant to transfer assets to OBRA'93 special needs irrevocable trust for the benefit of a person with disability under the age of 65 to qualify for Medicaid without incurring any penalty. Also, an individual with disabilities and under the age of 65 who had assets in his or her own name (as well as the parent or guardian of such individual or the court on behalf of such individual) can create an OBRA'93 special needs irrevocable trust. When the disabled individual dies, the State is entitled to reimbursements from such trusts to the extent of Medicaid expenses incurred by the Medicaid recipient.

    a. Does your State plan provide for recovering Medicaid expenses from the special needs trusts?

DHHS/OIG/OAS contact information: George Ampalathumkal, Senior Auditor (312) 353-1788 or George.Ampalathumkal@oig.hhs.gov; Olga Gesell, Auditor (312) 353-7907 or Olga.Gesell@oig.hhs.gov

b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

27. Does your State agency use third party contractors for conducting estate recoveries?

    a. If yes, who are the contractors? Provide copies of contracts/agreements.

    b. How the contractors are compensated?

    c. How long have you been using the contractors for conducting estate recoveries?

28. What was the cost of operating your State agency's estate recovery program for each of the last seven Federal fiscal years? How many individuals are employed in your estate recovery unit?

29. Provide a break-down of the estate recoveries and long-term care expenditures for each of the Federal fiscal years 2005 through 2011 as requested in the table in the Appendix. For estate recovery items, indicate the CMS-64 page numbers and line description under which the item was reported to CMS. (Please provide the contact information of your designated staff to whom we can forward an electronic copy of the table seen in the Appendix).

OTHER

30. Are there any OBRA '93 provisions or DRA '05 provisions that your State agency has not implemented?

    If yes, provide reason for not implementing and a listing of such provisions.

31. Have any reviews or studies been conducted [by your State or outside contractors] on State's potential cost savings resulting from the implementation of penalty periods and estate recovery provisions? If yes, what were the results of such reviews or studies? Provide copies of such reviews, study results, and budget estimates.

32. What changes to the Act would you propose to ensure that Medicaid covered long-term care services are provided to the needy while preventing the individuals with substantial assets from qualifying for Medicaid coverage through circumventing the Medicaid regulations?

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33. In your opinion, what loopholes in the current Act allow individuals with substantial assets to transfer their assets to others to qualify for Medicaid covered long-term care?

34. What barriers within the Act has your State encountered relative to filing TEFRA liens on residential property? and

35. What barriers within the Act has your State encountered relative to recovering from the estate of the deceased spouse of a deceased institutionalized beneficiary?

* * * * *

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APPENDIX

State_____
Calendar Quarter_____ Year_____

Estate Recoveries and Long Term Care Expenditures	Number of recoveries	Amount	Line number on CMS-64	Item Description on CMS-64
Estate Recoveries From -				
1. Probate Courts				
2. Small Estate Affidavits				
3. Deceased's Funds from nursing homes				
4. Deceased's bank and investment accounts				
5. Funeral Trusts				
6. Other Special need trust balances				
7. Annuity issuers				
8. Life insurance policies				
9. Real property, homestead - Enforcement of TEFRA liens				
10. Real property, non homestead-Enforcement of TEFRA liens				
11. Real property – post death liens				
12. Unclaimed Funds				
13. Others – Please list (insert more lines as necessary)				
–				
Total Estate Recoveries (Sum of 1 through 13)				
Long-Term Care Expenditures For -				
Nursing Home				
Intermediate Care - Mentally Retarded: Public Providers				
Intermediate Care - Mentally Retarded: Private Providers				
Total Long-Term Care Expenditures				

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Marie Brown

Log #88

From:	Bruce Carter
Sent:	Friday, November 02, 2012 5:07 PM
To:	George.Ampalathumkal@oig.hhs.gov; Gesell, Olga (OIG/OAS)
Cc:	Byron Roberts; Marie Brown
Subject:	SC Response to OIG Questionnaire A-05-12-00027 - SC re OBRA & DRA Implementation - Internal Log 88
Attachments:	OIG DRA Questionnaire to States - South Carolina Response.docx; Copy of Copy of Estate Recovery OBRA93 and DRA Compliance final CMS 64 expenditures.xlsx; SCDHHS Policy Information for OIG Response.docx

Attached please find the SC Response to OIG Questionnaire A-05-12-00027 – SC related to implementation of OBRA and DRA. There are 3 files, 2 word files and 1 excel file. If you have difficulty opening or reading the files, please contact me. We can make them available through our portal or we can provide hard copies if necessary. Call me if there are concerns or you need additional information. Thank you.

Bruce D. Carter

Assistant General Counsel
P.O. Box 8206
Columbia, SC 29202-8206
T: 803.898.2793
F: 803.255.8210

Department of Health and Human Services
Office of Inspector General, Office of Audit Services
233 North Michigan Ave, Suite 1360, Chicago, IL 60601

States' Progress in Implementing the Provisions of the OBRA '93 and DRA '05

A-05-12-00027 - SC

QUESTIONNAIRE AND INFORMATION REQUEST

ELIGIBILITY

Look-back and Penalty Periods

1. Section 6011(a) of the Deficit Reduction Act of 2005 (DRA'05) amended section 1917(c)(1)(B)(i) of the Social Security Act (the Act) to extend the look back period to 60-months for any transfer of assets made on or after February 8, 2006.

    a. Did your State agency implement the DRA '05 provision of 60-month look back period?
    Yes

    b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.
    Effective 10/1/06 and implemented 6/1/06. State Plan and Medicaid Policy and Procedures (MPPM) attached.

    c. If no, what was the reason for not implementing this provision?

    d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation. **N/A**

2. Section 6011(b) of DRA '05 amended section 1917(c)(1)(D) of the Act to require that the penalty period start date be the later of either: (1) the first date of the month during or (at State option) after which assets have been transferred for less than fair market value; or (2) 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.
    a. Did your State agency implement the DRA '05 penalty period start date provision?
    Yes
    b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.
    Effective 10/01/06 and implemented 6/1/06. State Plan and MPPM attached

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c. If no, what was the reason for not implementing this provision?

d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation. **N/A**

3. Section 6016(a) of DRA '05 amended section 1917(c)(1)(E) of the Act to prohibit a State from rounding down or otherwise disregarding any fractional period of ineligibility. States must impose a penalty period even where the period of ineligibility would be less than a full month.

a. Did your State agency implement the DRA '05 provision related to partial months of ineligibility?
Yes

b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.
Effective 10/1/06 and implemented 6/1/06. State Plan and MPPM attached

c. If no, what was the reason for not implementing this provision?

d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation. **N/A**

4. Section 6016(b) of DRA '05 amended section 1917(c)(1) of the Act to give States the option to accumulate multiple transfers into a single period of ineligibility, rather than imposing multiple penalty periods.

a. Did your State agency opt to permit accumulation of multiple transfers in computing the penalty period?
Yes

b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.
Effective 10/1/06 and implemented 06/01/06 State Plan and MPPM attached

c. If no, what was the reason for not implementing this provision?

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d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation. **N/A**

5. Section 13611 of OBRA 93 amended section 1917 of the Act to include in the definition of "assets" any income or resources which the individual or spouse is entitled to but does not receive because of their own action. Such actions may include disclaiming an inheritance, waiving pension income or refusing to accept an injury settlement. Disclaiming an inheritance could cause a person to lose his or her eligibility for Medicaid for a penalty period.

   a. Did your State agency implement the OBRA '93 provision that required treating such actions as disclaimer of inheritance as an asset transfer?
   Yes

   b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.
   Effective 10/01/06 and implemented 6/01/06. State Plan and MPPM attached

   c. If no, what was the reason for not implementing this provision?

   d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation. **N/A**

Annuities – Medicaid Application Requirement

6. Section 6012(a) of DRA '05, which amended sections 1917 of the Act by adding a new section 1917(e), provides that the States shall require, as a condition for an individual's eligibility for medical assistance related to long-term care services, that the individual's application for such assistance (including any subsequent recertification) shall disclose any interest the individual or community spouse has in an annuity or similar financial instrument, regardless of whether the annuity is irrevocable or is treated as an asset.

   a. Did your State agency implement the DRA '05 provision related to disclosure and treatment of annuities?
   Yes

b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan, procedure manuals and example copies of Medicaid application.
Implemented 6/01/06. MPPM attached

c. If no, what was the reason for not implementing this provision?

d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation. **N/A**

e. If the Social Security Administration is making Medicaid eligibility determinations for your State, who is responsible for collecting and analyzing the annuity disclosures and remainder beneficiary statements?
The DHHS Casualty Division.

Annuities – When State is Not the Remainder Beneficiary

7. Section 6012(b) of the DRA '05, which amended section 1917(c)(1) by adding new sub-paragraph (F). The newly added subparagraph (F), provides that the purchase of an annuity on or after February 8, 2006 shall be treated as transfer of assets for less than fair market value unless the State is named as the remainder beneficiary in the correct position for amounts paid by Medicaid. Under 1917(e)(2)(A) (added by section 6012(a) of the DRA), the State must notify the issuer of the annuity of the State's rights as a preferred remainder beneficiary. The State may also require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn.

   a. Did your State agency implement the DRA '05 provision of treating the purchase of annuity as asset transfer for less than fair market value unless the State is named as the remainder beneficiary of the annuity?
   Yes

   b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.
   Effective 10/01/06 and implemented on 6/1/06. MPPM attached

   c. If no, what was the reason for not implementing these provisions?

d. If your State agency could not have implemented this provision without State legislation, when did the State legislation occur? Provide relevant pages of such State legislation. **N/A**

e. For each of the Federal fiscal years ended since February 2006:

i. How many notifications regarding your State's right as a preferred remainder beneficiary were submitted to issuers of annuities? **Approximately 600**

ii. How many remainder beneficiary collections were received from issuers of annuities? **1(one)**

Annuities – Purchases and Other Transactions

8. Section 6012(c) of the DRA'05, which amended section 1917(c)(1) by adding a new sub-paragraph (G), provides that the purchase of an annuity on or after February 8, 2006, by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services, shall be treated as a transfer of assets for less than fair market value unless the annuity meets the criteria listed in the section.

   a. Did your State agency implement the DRA '05 provision of treating the purchase of certain annuities as asset transfer for less than fair market value?
   Yes

   b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.
   Effective 10/01/06 and implemented 6/01/06. MPPM attached

   c. If no, what was the reason for not implementing these provisions? and

   d. If your State agency could not have implemented this provision without State legislation, when did the State legislation occur? Provide relevant pages of such State legislation. **N/A**

9. Section 6012(d) of the DRA '05 specifies that the provisions of the DRA apply to annuity-related transactions, including purchases, which occur on or after February 6, 2008. In its State Medicaid Directors Letter number 06-018 dated, July 2006, Centers for Medicare and

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Medicaid Services stated that such transactions include any action taken by the individual that changes the course of payments to be made by the annuity or the treatment of the income or principal of the annuity. Such actions include additions of principal, elections to annuitize the contract and similar actions. Routine changes, automatic events, and changes beyond the control of the individual are not considered transactions that would subject the annuity to treatment under the provisions of the DRA.

a. Did your State agency implement the DRA '05 provision that would make an annuity, regardless of its purchase date, subject to asset transfer rules if certain transactions occur?
Yes

b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.
Effective 10/01/06 and implemented 6/1/06 Please note that subsequent changes in the procedures for the annuities changed this, and the transactions that can occur are listed in MPPM, section 304.12.02 "Annuities after 2/8/06."

c. If no, what was the reason for not implementing this provision? and

d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation. **N/A**

Annuities – Income

10. The Act, as amended by DRA '05, prevents the State agency from treating certain transactions related to annuities as transfer for less than fair market value. However, under CMS's SMD letter 06-018, the annuity must still be considered in determining Medicaid eligibility, including spousal income and resources, and post-eligibility calculation, as appropriate. Even if an annuity is not subject to penalty under the provisions of the DRA, this does not mean it is excluded as income or resource.

a. Is your State agency considering income derived from annuities when determining Medicaid eligibility for long-term care? **Yes**

Promissory Notes, Loans or Mortgages

11. Section 6016(c) of DRA '05, which added section 1917(c)(1)(I) of the Act, provided that, with respect to the transfer of assets, the term 'assets' includes funds to purchase a promissory note, loan, or mortgage unless such instruments have a repayment term that is actuarially sound, provide for payments to be made in equal amounts during the term of the loan with no deferral and no balloon payments, and prohibit cancellation of the balance upon the death of the lender. If the instruments do not satisfy such requirements, their value shall be the outstanding balance as of date of the individual's application for medical assistance for long term care services.

    a. Does the definition of assets in your State include funds used to purchase certain promissory note, loan, or mortgage as specified in Section 6016(c) of DRA '05? **Yes**

    b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals. **Effective 10/1/06 and implemented 6/01/06; MPPM attached**

    c. If no, what is the reason for not implementing this provision? and

    d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation. **N/A**

Life Estates

12. Section 6016(d) of DRA '05, which amended section 1917(c)(1) of the Act by adding a new subparagraph (J), provides that the term assets includes the purchase of life estate interest in another individual's home unless the purchaser resides in the home for a period of at least 1 year after the date of purchase. If the purchaser resides in the home for less than a year, CMS's SMD letter states that the transaction should be treated as a transfer of assets. The amount of the transfer is the entire amount used to purchase the life estate. This amount should not be reduced or prorated to reflect an individuals' residency for a period of time less than a year.

    a. Does the definition of assets in your State include a life estate interest in another individual's home as specified in Section 6016(d) of DRA '05?

Yes

b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.
Effective 10/01/06 and implemented 6/01/06

c. If no, what was the reason for not implementing this provision?

d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation. **N/A**

13. Do any of the provisions of your State law or State agency policies specify conditions that would result in a presumption that undue hardship exists (or does not exists)? If yes, list such conditions and provide relevant pages of the State laws, regulations, or policies.
Undue hardship exists if the application of a transfer of penalty would deprive the individual of (a) of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life.
See Section 304.09.03 of MPPM policy attached.

Income First Rule

14. Section 6013 of the DRA '05, which amended section 1924 of the Act, required all States to follow the "income first" method in calculating revisions to the community spouse resource allowance. All States are required to attribute or allocate the maximum available income of the institutionalized spouse to the community spouse before granting an increase in the CSRA under section 1924(e)(2)(C).

a. Did your State agency implement the DRA '05 provision of income first rule.
SC was following this rule prior to the DRA '05

b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.
Was implemented under MCCA (Medicare Catastrophic Coverage Act of 1988) effective 10/1989. MPPM attached.

c. If no, what was the reason for not implementing this provision?

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d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation. **N/A**

Entrance Fee

15. Section 6015 of the DRA '05 added subsection (g) to Section 1917 of the Act to set forth conditions under which an entrance fee paid to a continuing care retirement community or life care community would be treated as a resource to an individual for purposes of determining Medicaid eligibility.

    a. Did your State agency implement the DRA '05 provision of treating, in certain circumstances, entrance fee deposits as resources of the applicant for determining Medicaid eligibility?
    Yes

    b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.
    Effective 10/01/06 implemented 6/01/06. MPPM attached

    c. If no, what was the reason for not implementing this provision?

    d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation. **N/A**

Home Equity Limit

16. Section 6014(a) of the DRA '05, which amended section 1917 (f) of the Act, provided that in determining the eligibility of an individual to receive medical assistance payment for nursing facility services or other long-term care services, States must deny eligibility if the individual's equity interest in his or her home exceeds $500,000 (disqualification rule). States may elect a home equity limit greater than $500,000 , as adjusted by inflation beginning in 2011, but that does not exceed $750,000, adjusted by inflation. This restriction applies only to applicants who do not have a spouse or a child under age 21, or who is blind or disabled, lawfully residing in the individual's home.

    a. Did your State agency implement the DRA '05 home equity limit rule?
    Yes

b. If yes, when were the effective date, and how the State agency determines the dollar value of equity interest? Provide any relevant pages of the CMS approved State plan and procedure manuals.
Effective 10/01/06 and implemented 6/01/06. The dollar value is determined by researching the assessed value of the property; asking the individual to provide proof of the equity value. State Plan and MPPM attached.

c. If no, what was the reason for not implementing this provision?

d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation. **N/A**

17. Section 6014(a) of DRA '05, which amended section 1917(f)(3) of the Act, provided that nothing in the provision shall prevent an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

a. Does your State plan or State regulation contain any provisions that would prevent a Medicaid applicant from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home?
No

b. If yes, please provide related pages of CMS approved State plan, state legislation and procedure manuals.

Trusts – Establishment of a Trust

18. Section 13611(b) of OBRA '93, which added section 1917(d) (2) to the Act, addresses the availability to the individual of assets held in trusts that were established on August 11, 1993 or later, for purposes of determining Medicaid eligibility. This section provides that an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if such trust was established (other than by will) by: (i) the individual; or (ii) the individual's spouse; or (iii) a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or (iv) a person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

a. Did your State agency implement OBRA '93 provision related to when an individual shall be considered to have established a trust? **Yes**

b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals. **Effective 7/93 and implemented 8/1/93- MPPM attached**

c. If no, what was the reason for not implementing this provision?

d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation. **NA**

Trusts – Legal Instrument or Device Similar to Trust

19. Section 13611(b) of OBRA '93, which added section 1917(d)(6) to the Act, provides that the term 'trust' includes any legal instrument or device that is similar to a trust. Section 3259.1 of the CMS' State Medicaid Manual provides that, " legal instrument or device similar to a trust" is any legal instrument, device, or arrangement which may not be called a trust under State law but it involves a grantor who transfers property to an individual or entity with fiduciary obligations (trustee). The grantor makes the transfer with the intention that it be held, managed, or administered by the individual or entity for the benefit of the grantor or others. This can include (but is not limited to) escrow accounts, investment accounts, pension funds, and other similar devices managed by a trustee, but includes an annuity only to the extent CMS specifies in guidance.

    a. Did your State agency implement OBRA '93 provision that treats "legal instruments or device similar to a trust" as a trusts for purpose of determining Medicaid eligibility? **Yes**

    b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals. **Effective 7/1/93 and implemented 8/1/93**

    c. If no, what was the reason for not implementing this provision?

    d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation. N/A

Trusts - Revocable

20. Section 13611(b) of the OBRA '93, which added section 1917(d)(3)(A) to the Act, provides guidelines for the treatment of assets held in revocable trusts (trusts which can under State law be revoked by the grantor or which provide that the trust can only be modified or terminated by a court), that were established on August 11, 1993 or later, for purposes of determining Medicaid eligibility. This section provides that: (i) the principal of a revocable trust is considered a resource to the individual; (ii) payments from the revocable trust to or for the benefit of the individual are considered income to the individual; and (iii) any other payments from the trust that are not made to or for the benefit of the individual are considered assets disposed of by the individual.

    a. Did your State agency implement OBRA '93 provision related to the principal of a revocable trust and payments from the revocable trust for determining Medicaid eligibility? **Yes**

    b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals. **Effective 7/1/93 and implemented 8/1/93- MPPM attached**

    c. If no, what was the reason for not implementing this provision?

    d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation. **N/A**

Trusts - Irrevocable

21. Section 13611(b) of the OBRA '93, which added section 1917(d)(3)(B) to the Act, provides guidelines for the treatment of assets held in irrevocable trusts (trusts which cannot, in any way, be revoked by the grantor), that were established on August 11, 1993 or later, for purposes of determining Medicaid eligibility. Under this section: (i) if there are any circumstances under which payment from an irrevocable trust could be made to or for the benefit of the individual, the portion of the principal from which (or income on that principal from which) payment to the individual could be made is considered resources available to the individual; (ii) payments from that portion of the principle or income on the principle to or for the benefit of the individual are considered income of the individual: (iii) payments for any other purpose are considered a transfer of assets by the individual; and (iv) any portion of

the irrevocable trust or income on the principle from which no payment could be made under any circumstances to the individual is considered assets disposed by the individual on the date the irrevocable trust was/is established (If, however, the access by the individual was blocked later, the date of the transferred assets will be the date that access was blocked (foreclosed)).

a. Did your State agency implement OBRA '93 provision related to the principal of, payments from, and income of the irrevocable trust for determining Medicaid eligibility? **Yes**

b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals. **Effective 7/1/93 and implemented 8/1/93- MPPM attached**

c. If no, what was the reason for not implementing this provision?

d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation. **N/A**

Lien

22. Under §1917(a), The Tax Equity and Responsibility Act of 1982 (TEFRA) allows States to file liens, known as TEFRA liens, on the real property of permanently institutionalized nursing home residents.

a. Did your State agency elect to use TEFRA liens? Provide relevant pages of the CMS approved State plan **No**

If yes:

b. How does your State agency determine whether a Medicaid recipient is permanently institutionalized?

c. Do any of the provisions of your State law or State agency policies specify conditions that would result in a presumption that a Medicaid recipient is permanently institutionalized? If yes, list such conditions and provide relevant pages of the State laws, regulations, or policies

d. Are the TEFRA liens in your State limited to the homestead of the Medicaid recipient or does your State agency impose TEFRA liens on real property other than home, such as income-producing property? If yes, provide relevant pages of the CMS approved State plan

ESTATE RECOVERY

23. Section 13612(a) of OBRA'93 which amended Section 1917(b)(1) of the Act required each State to seek adjustment or recovery from the individual's estate of amounts correctly paid by the State on behalf of an individual who was 55 years or older when the individual received medical assistance for nursing facility services, home and community-based services, and related hospital and prescription drug services. Section 1917(b)(2) permits such recovery only after the death of any surviving spouse, when there is no surviving child under 21 or blind or disabled child.

    a. Did your State agency implement the estate recovery provision as required in section 13612(a) of OBRA'93?
    Yes

    b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.
    July 1, 1994 - http://www.scdhhs.gov/internet/pdf/SC%2043-7-460.pdf
    http://www.scdhhs.gov/internet/pdf/SPA%204.17%20Estate%20Recovery.pdf

    c. If no, what is the reason for not implementing this provision?

    d. If this provision needed State legislative approval, was the approval obtained and when? Provide relevant pages of such State legislation, and
    The law was passed July 1, 1994 which was the end of the first legislative session after OBRA '93. http://www.scdhhs.gov/internet/pdf/SC%2043-7-460.pdf
    http://www.scdhhs.gov/internet/pdf/SPA%204.17%20Estate%20Recovery.pdf

    e. Do any State laws or regulations limit your State agency's ability to enforce the estate recovery mandated under Section 13612(a) of OBRA'93? **No**

DHHS/OIG/OAS contact information: George Ampalathumkal, Senior Auditor (312) 353-1788 or George.Ampalathumkal@oig.hhs.gov; Olga Gesell, Auditor (312) 353-7907 or Olga.Gesell@oig.hhs.gov

f. How does your State agency obtain the information about the death of the Medicaid beneficiaries? **The department receives notification of recipient's death from a variety of sources. These include, but are not limited to, the following: data match with vital statistics records at DHEC, Nursing Home billing process, Eligibility Case workers, DHHS Division of Eligibility, family members, providers, attorneys and probate courts..**

24. Section 13612(a) of OBRA'93, which amended section 1917(b)(1) of the Act, provided States the option of recovering payments from the individual's estate for all Medicaid services provided to beneficiaries who were 55 or older and received nursing facility services, home and community-based services, and related hospital and prescription drug services.

    a. Did your State opt to recover payments for all Medicaid services as provided in section 13612(a) of OBRA'93?
    No

    b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

    c. Do any State laws or regulations limit the State agency's ability to recover additional Medicaid payments?
    d. No

25. Section 13612(c) of OBRA'93, which amended section 1917(b) of the Act, provided that [in addition to the assets in the individual's estate as defined under the State probate law] the term "estate" may include, at the option of the State, any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest) such as assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

    a. In addition to recoveries from the probate estate, of an individual Medicaid recipient, did your State opt to recover from the individual's other real and personal property that transferred outside of probate?
    No

b. If yes: (i) when was the effective date? (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

26. Section 13611(b) of OBRA'93, which amended section 1917(d)(4) of the Act, allowed a Medicaid applicant to transfer assets to OBRA'93 special needs irrevocable trust for the benefit of a person with disability under the age of 65 to qualify for Medicaid without incurring any penalty. Also, an individual with disabilities and under the age of 65 who had assets in his or her own name (as well as the parent or guardian of such individual or the court on behalf of such individual) can create an OBRA'93 special needs irrevocable trust. When the disabled individual dies, the State is entitled to reimbursements from such trusts to the extent of Medicaid expenses incurred by the Medicaid recipient.

a. Does your State plan provide for recovering Medicaid expenses from the special needs trusts? **Yes**

b. If yes: (i) when was the effective date? and (ii) when was the implementation date? Provide any relevant pages of the CMS approved State plan and procedure manuals.

Effective 7/1/93 and implemented 8/1/93 MPPM attached

Based upon our historical data retrieved, the Casualty Department implemented the SNT process in fiscal year 2002-2003. The first special needs trust case was opened in our database on 03/31/2002. To date, we have received a total of $2,583,481.14 in reimbursements related to Special Needs Trusts.

27. Does your State agency use third party contractors for conducting estate recoveries?

a. If yes, who are the contractors? Provide copies of contracts/agreements.
The department has a limited contract with attorney, Palmer Freeman to collect on estates that are not being probated.

b. How the contractors are compensated?
The contract reimburses him for costs and 25% of the recoverable portion of our claim; not to exceed $8000

c. How long have you been using the contractors for conducting estate recoveries?
Since 2004.

28. What was the cost of operating your State agency's estate recovery program for each of the last seven Federal fiscal years? How many individuals are employed in your estate recovery unit?
Attached are the estimated costs for operating SCDHHS' estate recovery program for the past three Federal fiscal years (FY 2010, 2011, 2012). This estimation is based on staff salaries, benefits, and an indirect component for other operating and agency overhead costs. Because of a statewide changeover to a new accounting system in 2010, data for operating costs prior to FFY 2010 are not readily available and will have to be manually reconstructed. Please let us know if this information is critical to the audit. We can provide this information but will need more time.

29. Provide a break-down of the estate recoveries and long-term care expenditures for each of the Federal fiscal years 2005 through 2011 as requested in the table in the Appendix. For estate recovery items, indicate the CMS-64 page numbers and line description under which the item was reported to CMS. (Please provide the contact information of your designated staff to whom we can forward an electronic copy of the table seen in the Appendix).
See attached excel table.

OTHER

30. Are there any OBRA '93 provisions or DRA '05 provisions that your State agency has not implemented? **No**

    If yes, provide reason for not implementing and a listing of such provisions.

31. Have any reviews or studies been conducted [by your State or outside contractors] on State's potential cost savings resulting from the implementation of penalty periods and estate recovery provisions? If yes, what were the results of such reviews or studies? Provide copies of such reviews, study results, and budget estimates. **We are unaware at this time of any cost-savings studies of this type.**

32. What changes to the Act would you propose to ensure that Medicaid covered long-term care services are provided to the needy while preventing the individuals with substantial assets from qualifying for Medicaid coverage through circumventing the Medicaid regulations?
None

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33. In your opinion, what loopholes in the current Act allow individuals with substantial assets to transfer their assets to others to qualify for Medicaid covered long-term care?
One loophole- when we allow couples that are substantially over the resource limit to transfer funds from an institutionalized spouse to the community spouse and the community spouse can create an actuarially sound annuity (in any amount) thus bringing them under the resource limit and allowing us to grant Medicaid for LTC.

34. What barriers within the Act has your State encountered relative to filing TEFRA liens on residential property? **NA** and

35. What barriers within the Act has your State encountered relative to recovering from the estate of the deceased spouse of a deceased institutionalized beneficiary?
None

* * * * *

Attachments
1. Excel Spreadsheet for Appendix
2. SCDHHS Medicaid Policy Manual Sections cited in response
3. Excerpts from South Carolina Medicaid Plan

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States' Progress in Implementing the Provisions of the OBRA '93 and DRA '05
A-05-12-00027

APPENDIX

State_____
Calendar Quarter_____ Year_____

Estate Recoveries and Long Term Care Expenditures	Number of recoveries	Amount	Line number on CMS-64	Item Description on CMS-64
Estate Recoveries From -				
1. Probate Courts				
2. Small Estate Affidavits				
3. Deceased's Funds from nursing homes				
4. Deceased's bank and investment accounts				
5. Funeral Trusts				
6. Other Special need trust balances				
7. Annuity issuers				
8. Life insurance policies				
9. Real property, homestead - Enforcement of TEFRA liens				
10. Real property, no n homestead-Enforcement of TEFRA liens				
11. Real property – post death liens				
12. Unclaimed Funds				
13. Others – Please list (insert more lines as necessary)				
–				
Total Estate Recoveries (Sum of 1 through 13)				
Long-Term Care Expenditures For -				
Nursing Home				
Intermediate Care - Mentally Retarded: Public Providers				
Intermediate Care - Mentally Retarded: Private Providers				
Others - Please list (insert more lines as necessary)				
Total Long-Term Care Expenditures				

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APPENDIX

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LOOK BACK and PENALTY PERIODS

304.09.02C Look-Back Date/Period

When an individual applies for Medicaid coverage for nursing home or HCBS, a look-back must be conducted to determine if there has been a transfer of assets. If a transfer has occurred, the eligibility worker must determine if a penalty applies.

Note: For any SSI recipients entering a nursing facility or a Home and Community Based Services waiver program, a look-back is NOT required. A modified look-back must be conducted for those individuals applying for institutional coverage who do not currently receive SSI but were SSI eligible in the past. The modified look-back period would begin the month the SSI was terminated.

The look-back period is 60 months prior to the date:

- An institutionalized individual was institutionalized, and has applied for medical assistance for long term care coverage, or
- A non-institutionalized individual applies for medical assistance for long-term care coverage.

The look-back date is the earliest date on which a penalty can be assessed.

Transfers of assets for less than Fair Market Value are:

- Subject to penalty if the transfer took place on or after the look-back date, or
- Not subject to penalty if the transfer took place prior to the look-back date.

Procedure – Conducting a Look-back

Property Check

- Must be done to verify no real property was transferred in the look-back period.
- May be done online or by sending a DHHS Form 1255 ME, Verification of Real and personal property
- The property check must be done for:
  - County of residence, and
  - Other counties where the individual and/or spouse:
    - In-state
      - Alleges current or previous property ownership, and/or
      - Resided for long periods in their adulthood.
    - Out-of-state
      - Alleges current ownership of property, and/or
      - Alleges ownership of property within the past five years.
- If an applicant's spouse and/or parents have deceased, Probate must be checked in the counties where they lived.

Bank/Financial Accounts

- Request statements for the month of application, the month prior to the month of application, and for the 12th, 24th, 36th, 48th, and 60th months. For example, if an application is placed in April 2012, a worker would request the following statements: April 2012, March 2012, April 2011, April 2010, April 2009, April 2008, and April 2007. If these exact months are not available, but the information provided is reasonably close (within a couple of months), the information should be accepted.
- If the above statements cannot be secured from the applicant/authorized representative, send a DHHS Form 1253 ME, Request for Financial Investigation, to the financial institution requesting the balances for the above months, and a balance for the month with the highest balance within the look-back period.
- Once the information is obtained, the eligibility worker must examine the statements for evidence a transfer may have occurred. For instance:
  - The interest paid to date shows a substantial amount, but the current balance does not support payment of that amount of interest
  - The balances in the past show substantially higher amounts than is currently in the account
  - If a DHHS 1253 has been obtained from the bank, and it shows a substantial balance that is not currently in the account
  - If the account shows a substantial withdrawal or withdrawals over a period of time
- If the eligibility worker finds evidence to suspect a transfer may have occurred, the applicant or authorized representative must be questioned to secure an explanation and be asked to provide additional information and documentary evidence as needed.

304.09.02D Penalty Period – Important Points

Maximum Penalty Period – There is no maximum penalty period. (Refer to MPPM 304.09.05 for computation of penalty period.)

Beginning Date of Penalty Period – For transfers occurring on or after February 8, 2006, the beginning date of the penalty period is the later of:

- The first day of the month in which the asset was transferred, or
- The date on which the individual is eligible for medical assistance for long term care and would otherwise be receiving a vendor payment if not for the application of the penalty period.

PARTIAL MONTHS

304.09.05 Calculating the Penalty Period

To calculate the penalty period, the eligibility worker must follow the procedure listed below. The result is the period during which the individual would be ineligible for certain Medicaid services. (Refer to MPPM 304.09.07.)

Procedure to Calculate the Penalty Period

- Determine the uncompensated value of the transferred asset(s).
  - Fair Market Value – amount received = amount transferred
  - Amount transferred – amount of legal encumbrance (such as a mortgage or lien) = uncompensated value
- Total the uncompensated value of all assets transferred by the individual and/or his or her community spouse.
- Divide by the state's most current average private pay nursing home rate (Refer to MPPM 103.07A). **Do not** use the average pay rate that was in effect at the time the transfer occurred.
- **Do Not** round answer down to the nearest whole number.
- Multiply the fractional amount of the month by 30 days to determine the partial month penalty period.

$$\frac{\text{Uncompensated Amount}}{\text{Current Average Nursing Home Private Pay Rate}} = \text{Length of Penalty Period}$$

The result is the period the individual would be ineligible for certain Medicaid services.

Example: Alton Gray transferred $10,000. The penalty period is calculated as follows:

$10,000 ÷ $5,644.12 = 1.77 (round to two places)
.77 x 30 = 23.1 (round down to whole day)
Length of penalty period is 1 month, 23 days

The penalty period is assessed the later of:

- The first day of the month in which the asset was transferred, or
- The date on which the individual is eligible for medical assistance for long term care and would otherwise be receiving a vendor payment if not for the application of the penalty period.

If a beneficiary in a Nursing Home or receiving HCBS transfers an asset, the penalty period will begin the first day of the month in which the transfer occurred. An overpayment summary must be completed to recover any vendor payments made for a beneficiary is residing in a Nursing Home during the penalty period. If the beneficiary is

receiving waiver services, the case must be closed (if the penalty period is still in effect) and an overpayment summary completed for all Medicaid services received during the penalty period.

Transfers that take place on or after February 8, 2006 during the look-back period are added together to determine the total uncompensated value subject to the penalty.

Multiple Transfers

- If the individual made multiple transfers for less than Fair Market Value during the look-back period, and the transfers occurred in the same or different months, the transferred amounts are added together.

Life Estates

The purchase of a life estate in another individual's home on or after February 8, 2006 is a transfer of asset unless the purchaser resides in the home for at least 12 consecutive months after the date of purchase. Do not deduct vacations, overnight visits, and hospital stays from the one-year period as long as the home continued to be the individual's legal residence. Count the entire purchase price as an uncompensated transfer if the purchaser resides in the home for any period less than one year. Determine the sanction period based on the purchase price.

In addition to the above requirement, the purchaser must not pay more than fair market value for the life estate. Any amount paid above fair market value is considered a transfer and should be penalized according to the transfer policy.

Procedure

- Verify the life estate purchase
  - Copy of deed
  - County tax records
- Verify the Fair Market Value (FMV) of the property. The county tax assessed value may be used
- Verify the purchase price and calculate the fair market price of the life estate. Any amount over the fair market value of the life estate is considered a transfer
- Verify that the individual purchasing the life estate lived in the home for at least 12 consecutive months after the date of purchase. Acceptable forms of verification include:
  - Old postmarked mail received at the address
  - Bills such as electric or telephone in her name
  - Statements from at least two persons who indicate the individual lived in the home for at least 12 consecutive months after the date of purchase

304.09.02H Transfer of Assets in Month of Receipt

Assets transferred in the month of receipt are subject to penalty under the transfer of assets provision, even though the asset may not be a countable resource in the month of receipt.

Examples:

- Cash proceeds of a loan, home equity loan, or reverse mortgage
- An inheritance

If the transfer was a stream of income, determine the value of the stream of income by multiplying the life expectancy of the individual at the time of the transfer by the annual amount of income that would have otherwise been received.

304.09.03 Exceptions to the Penalty (Rev. 04/01/07)

Resources excluded under SSI policy (except for the home) are not subject to the transfer of assets penalty. However, assets, which are excluded by Medicaid, but not by SSI, are subject to the transfer of assets penalty.

If there has been a transfer of assets, no penalty is imposed if:

1. The asset transferred was a home, and title to the home was transferred to:

   - The spouse of the institutionalized individual;

   - A child who:
     - Is under age 21, or
     - Meets the Supplemental Security Income (SSI) definition of blindness or disability (may be at any age); or
     - Was residing in the home:
       - For at least two years immediately before the individual became institutionalized; **and**
       - Who provided care which delayed institutionalization.

   - A sibling of the individual who:
     - Has an equity interest in the home; **and**
     - Was residing in the home for at least one year immediately before the date the individual became institutionalized.

Procedure – Home is Transferred to a Child

The following must be verified:

- Relationship (Examples of verification: birth certificate, adoption papers, family Bible)
- Criteria for not imposing penalty
  - Age, if under 21
  - Blindness or disability
  - Length of residence
  - Doctor's statement verifying the child's care delayed the need for institutionalization.

Procedure – Home is Transferred to a Sibling

The following must be verified:

- Relationship
- Sibling's equitable interest
- Length of time sibling has resided in the home

Example: Mr. Brownlee applied for Medicaid through the Nursing Home program. It was discovered that he transferred his home to his daughter one year before he applied for Medicaid. The home was valued at $250,000. The daughter explained that Mr. Brownlee wanted her to have the home because she had lived with him and cared for him since he had a stroke six years ago so that he would not have to be placed into a nursing home. She said she had occasionally hired a sitter to stay with him while she ran errands; but, for the most part, she had cared for him herself for the past six years. Now that his health had deteriorated to the point that she was no longer able to provide the care he needed, she has placed him in a nursing home.

Treatment: No penalty is imposed for this transfer of assets if the daughter can provide the following sources of verification:

- Verification of her relationship to Mr. Brownlee
  - Birth certificate
  - Family Bible
- Verification that she lived at the same address as her father for at least two years immediately before he was institutionalized. Acceptable forms of verification include:
  - Old postmarked mail received at the address
  - Bills such as electric or telephone in her name
  - Statements from at least two persons who know she stayed at the same address and provided for her father's care.
- Verification from her father's doctor stating that the care she provided delayed institutionalization.

2. The assets were transferred:

- To the individual's spouse or to another person for the sole benefit of the spouse; or
- From the individual's spouse to another person for the sole benefit of the individual's spouse;

- To an individual's child or to a trust established solely for the benefit of the individual's child. The child MUST be blind or totally and permanently disabled as defined by SSI.
- To a trust established solely for the benefit of an individual under age 65 who is disabled as defined by SSI.

A transfer is considered to be "for the sole benefit of" a spouse, disabled child or individual under age 65 under the following circumstances:

- The transfer is arranged in such a way that no individual except the spouse, child or individual under age 65 can benefit from the assets transferred in any way at the time of transfer or in the future.
- The trust may provide for reasonable compensation for a trustee to manage the trust.
- If a secondary beneficiary is named to receive the asset, or whatever is left, at the individual's death as long as:
    - The state Medicaid agency is:
        - Named as the primary beneficiary of the asset, and
        - Receives up to the amount paid by Medicaid; and
    - The other designated beneficiary is only to receive any remaining amounts after the obligation to Medicaid is satisfied.

3. The individual can show that he/she intended to dispose of the assets either at Fair Market Value or for other valuable consideration.

4. The individual can show that he/she transferred the assets exclusively for a purpose other than to qualify for Medicaid.

Procedure

If the individual indicates the transfer was made for a reason other than to qualify for Medicaid:

- Request a written statement from the individual outlining the circumstances of the transfer. The statement should at least include the following:
    - A listing of all transferred assets;
    - The reason(s) for the asset transfer;
    - To whom the assets were transferred;
    - Compensation received for the asset;
    - The financial condition of the applicant at the time of the transfer;
- A statement from the individual's physician detailing the health status of the applicant at the time of the transfer.
- Request the names and addresses of all principles involved including attorneys, realtors, or any individuals having knowledge of the circumstances surrounding the transaction;
- Request collaborative statements from anyone having supporting evidence that the transfer occurred exclusively for reasons other than to qualify for services; and
- After the county has reviewed the information, forward all material to the Division of Policy and Planning for a decision.

5. All assets transferred for less than Fair Market Value have been returned to the individual.

6. The individual can show that the transfer occurred because of exploitation.

Procedure – Verification of Exploitation

Refer the applicant or authorized representative to DSS Adult Protective Services. Require verification that the exploitation has been reported to the Solicitor for prosecution.

7. A transfer that does not meet one of the above six exceptions and for which a denial of vendor payment or Home and Community Based Services has occurred may have the penalty waived if it is determined that the denial of eligibility would cause an *undue hardship*. Undue hardship is defined as depriving the applicant/beneficiary of medical care that would result in the individual's health or life being endangered, or that would result in the individual being deprived of food, clothing, shelter, or other necessities of life. The applicant/beneficiary, an authorized representative, or a nursing facility with the consent of the applicant/beneficiary or his authorized representative may make a request for a waiver of the penalty. Refer to MPPM 304.09.04 for the waiver of transfer penalty procedure.

304.09.04 Waiver of Transfer Penalty Procedure and 30 Day Hold (Eff. 04/01/07)

Within thirty (30) days of an applicant/beneficiary receiving the DHHS Form 932, Notice of Denial of Waiver Services or Nursing Home Care, indicating that a vendor payment or eligibility for HCBS services has been denied due to the imposition of a transfer penalty, the individual, the individual's spouse or authorized representative, or the institution where the individual resides (with the individual's consent) may submit a written request for a waiver of the penalty period based on a claim of undue hardship.

It must be demonstrated that all other possible exceptions to the imposition of the transfer penalty has been explored, including return of the asset to the applicant/ beneficiary.

The eligibility worker must obtain the following verifications:

- Letter from a physician certifying that the applicant/beneficiary is at risk of death or permanent disability without the institutional care; AND
- Letter from CLTC either denying or terminating services; OR
- Letter from the nursing home either:
  - Refusing to admit the patient, or
  - Threatening discharge of the patient.

Send the letters, a copy of the DHHS Form 932, and other documentation to the DHHS Division of Policy and Planning in the Bureau of Eligibility Administration for evaluation.

While an application for waiver of the penalty period is pending for an individual currently residing in a nursing facility, a payment may be made to the facility for up to 30 days from the date the request is made if the individual meets all other eligibility criteria. The nursing facility may request an earlier date, but in no event will the start date occur after the date of the request.

The DHHS Form 3229-C, Request for Waiver of Transfer Penalty, is used by the Medicaid eligibility worker to:

- Notify applicants/beneficiaries the dates that have been approved for the bed hold and any recurring income to be paid to the facility, and/or
- Notify the applicant/beneficiary if the request for the waiver of transfer penalty has been approved or denied.

If a request for a waiver of the penalty period is denied, the applicant/beneficiary may request a fair hearing. Refer to MPPM 101.13.04.

DISCLAIMER OF INHERITANCE

304.10 Obtaining Other Assets/Elective Share (Eff. 06/01/06)

If a benefit is available to an applicant/beneficiary, he/she must make an effort to obtain the benefit or asset. Failure to do so may result in a transfer of assets.

One such asset relates to the claiming of an **elective share** from a spouse's estate. The South Carolina Probate Code gives a surviving spouse the right to claim an "elective share" of the deceased spouse's estate.

The Elective Share is one-third of the estate remaining after deductions for:

- Funeral expenses,
- Administrative expenses, and
- Enforceable claims (SC Code Ann.62-2-201 and –202).

The right to an Elective Share usually becomes an issue when:

- The surviving spouse inherits nothing, or
- The surviving spouse receives only a small inheritance.

In these types of cases, the surviving spouse can demand his/her elective share of 1/3 of the estate. The surviving spouse must claim the elective share on the latter of these two dates:

- Within 8 months of the decedent's death; or
- Within 6 months of the time the decedent's will is probated.

An individual applying for Medicaid sponsorship of nursing facility services or Home and

Community Based Services **must** claim the elective share. Failure to do so will be considered a transfer of assets if the surviving spouse:

- Received no inheritance and did not claim the elective share; or,
- Inherited an amount less than the elective share.

Note: In the first situation, the value of the transfer is 1/3 of the estate, after expenses.
In the second situation, the value of the transfer is 1/3 of the estate, after deductions for expenses, minus the amount actually received.

Procedure – Elective Share and Calculating the Penalty Period

1. **Determine the Elective Share Value**
   - Determine the total value of the decedent's estate.
   - Deduct the following expenses:
     - Funeral expenses
     - Administrative expenses
     - Enforceable claims filed against the estate
   - Divide the remainder by 3; this amount represents the value of the elective share to which the surviving spouse is entitled.

2. **Determine the Amount Transferred**
   - Take the value of the elective share.
   - Subtract the value of any of the decedent's property passing to the surviving spouse.
   - The difference is the amount transferred.

3. **Determine the Penalty Period**
   - The amount transferred is then divided by the monthly average private pay rate to determine the number of months to which the penalty applies.

For purposes of the transfer penalty, the transfer is deemed to have occurred on the last day that the surviving spouse could have claimed the elective share.

Example: The husband is in a nursing facility as a Medicaid beneficiary. His wife dies on January 1, leaving him nothing in her will. Her will is probated on February 1, but the husband fails to make a claim against her estate. The estate consists of real property and certificates of deposit with a total value of $105,000. Expenses and claims against the estate total $27,000, leaving a "net" estate subject to the elective share provisions of $78,000.

Treatment: The husband is entitled to receive 1/3 of this net estate as his elective share ($26,000.) The last day on which he could have claimed the elective share was August 31 (that is, within 8 months from the date of her death, since this date is later than 6 months from the date the will was probated.) His failure to claim the $26,000 to which he is entitled is treated as a transfer of resources on August 31.

Note: If the cost of obtaining the asset is greater than the value of the asset, the individual is not required to pursue it.

ANNUITIES

304.12 Annuities

(Eff. 06/01/06)

Annuities are generally purchased from a financial institution such as a bank or insurance company. The purchaser/annuitant is promised regular payments of income in certain amounts in exchange for the money paid to the financial institution.

304.12.01 Periodic Payments

(Eff. 06/01/06)

Payments from an annuity usually continue for a fixed period (such as 10 years) or as long as the annuitant or other designated beneficiary lives. These payments create an ongoing income stream for the individual.

The annuity may or may not include a remainder clause under which the financial institution converts and pays the remainder of the annuity in a lump sum to a designated beneficiary in the event the annuitant dies before the payout is completed.

304.12.02 Purpose of Annuity

(Rev. 10/01/07)

Policy for Annuities before February 8, 2006:

Annuities are generally purchased to provide a source of income for retirement. However, they are occasionally used as a mechanism to shelter assets. The following determinations must be made to decide if the transfer of assets penalty applies to an individual who has purchased an annuity:

Procedure to Determine Purpose of Annuity

It is considered to be a creation of a stream of income if:

- It was purchased as part of a retirement plan and regular payments were made while employed; or
- It was purchased with a lump sum and is actuarially sound.

It is considered a transfer of assets for less than Fair Market Value if it is not actuarially sound.

The ultimate purpose of an annuity must be determined to in order to distinguish an annuity purchased as part of a retirement plan from those used to shelter assets. To be considered valid, the annuity must be actuarially sound.

If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive fair market value for the annuity based on the projected return; in this case, the annuity is not "actuarially sound" and a transfer of assets for less than fair market value has taken place.

Procedure – Determining if Annuity is Actuarially Sound

To make this determination, use the Life Expectancy Table found in Appendix A of this chapter.

Example: A 65-year-old male purchases a $10,000 annuity to be paid over the course of 10 years. According to the tables, his life expectancy is 15.52 years. Therefore, the annuity is actuarially sound.

The average remaining life expectancy for the individual must coincide with the life of the annuity. If the individual is not reasonably expected to live longer than the guaranteed period of the annuity, the individual is not considered to receive Fair Market Value for the annuity based on the projected return and the penalty is applied.

Policy for Annuities on or after February 8, 2006

The Deficit Reduction Act of 2005 made many changes concerning annuities created on or after February 8, 2006.

- At application and review, applicants/beneficiaries must disclose to the agency the existence of any annuities held by the applicant/beneficiary or the community spouse;
- The purchase of an annuity may be treated as a disposal of an asset for less than fair market value unless the SC Department of Health and Human Services (SCDHHS) is named as the primary remainder beneficiary for at least the total amount paid by Medicaid for long-term care services, or is named as such a beneficiary after the community spouse and/or minor or disabled child;
- SCDHHS must inform the issuer of the annuity of the requirement that the agency be named as the primary remainder beneficiary, and the responsibility of the issuer to inform the agency of any change in the amount of income or principal withdrawn from the annuity; and
- An annuity may be treated as a disposal of assets for less than fair market value unless it is irrevocable and non-assignable, actuarially sound, and provide for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments.
- An annuity that is revocable and assignable must be considered as a countable resource, and not a transfer of assets. If the annuity is revocable, the resource value is the amount that the purchaser would receive if the annuity is canceled. If the annuity is assignable, the resource value is the amount the annuity can be sold for on the secondary market. A secondary market is an informal market where existing financial instruments, such as mortgages and annuities, are bought and sold.

Procedure to Determine Purpose of Annuity

An annuity purchased by an applicant/beneficiary or a community spouse is not considered a transfer if it is:

- Purchased with the proceeds from certain retirement accounts, such as a Roth IRA
- The annuity is:
  - Irrevocable and non-assignable;
  - Is actuarially sound; and
  - Provides for equal payments during the term of the annuity, with no deferred or balloon payments

An annuity is now considered part of an estate that is subject to estate recovery unless the annuity is issued by a financial institution or other business that sells annuities in the state as part of its regular business.

A copy of the annuity must be sent to the Division of Policy and Planning for evaluation.

Changes in payments or withdrawals from the annuity must be reported to the Division of Policy and Planning.

PROMISSORY NOTES, LOANS OR MORTGAGES

304.11 Promissory Notes

(Rev. 10/01/06)

A promissory note is a written, unconditional promise by one party to pay a specified sum of money to another party. It may be:

- Payable:
  - At a specified time
  - On a specified schedule
  - On demand
- Given in return for goods, money loaned, or services rendered
- Negotiable or non-negotiable

Negotiable Notes

- May be sold or transferred, and
- Value is a countable resource.

Non-Negotiable Notes

- May not be sold or transferred under any circumstances.
- May not be considered a transfer of an asset for less than Fair Market Value if:
  - It is actuarially sound – that is, expected to be paid back during the holder's lifetime (refer to MPPM 304.11.01)
  - It requires monthly payments that fully amortize it over the life of the loan
    - Equal payments with no balloon payment at the end
    - Payments include both interest and principle
    - Reasonable rate or interest

- May NOT be self-canceling or conditional

Procedure – Promissory Notes

All Promissory Notes must be forwarded to the Division of Policy and Planning for approval using the DHHS Form 3275 ME, Medicaid Transmittal for Income Trust; Promissory Note/Annuity; Special Needs Trust.

304.11.01 Actuarially Sound Notes

(Eff. 06/01/06)

Like an annuity, the non-negotiable note must be actuarially sound. The expected return on the note must be proportionate with a reasonable estimate of the life expectancy of the owner of the note (that is, it is expected to be paid off within the owner's lifetime). If the note is NOT actuarially sound, it is considered a transfer of assets for less than Fair Market Value and the transfer of assets penalty applies. (Refer to MPPM 304.11.03.)

Procedure – Determining if Non-Negotiable Note is Actuarially Sound

- Use the Life Expectancy Table found in MPPM Chapter Appendix A. Life expectancy is based on the individual's age at the time the promissory note was executed (the date signed), NOT the date of the Medicaid application.
- The average number of years of expected life remaining on the table for the owner's age must be equal to or less than the number of years stated in the note to be paid.
- If the individual is not expected to live long enough to receive full payment on the note:
  - Fair market value was not received, and
  - The transfer penalty is applied.

304.11.02 Transfer of Assets Related to Promissory Notes

(Eff. 03/01/12)

For notes created on or after February 8, 2006, the transfer penalty begins the later of the first day of the month in which the asset was transferred, or the date on which the individual is eligible for medical assistance for long term care and would otherwise be receiving institutional level care (vendor payment) if not for the application of the penalty period (Refer to MPPM 304.09.02D.)

Procedure – Promissory Notes and Calculating Transfer of Assets Penalty Period for notes created on or after February 8, 2006

- If the promissory note, loan, or mortgage does not meet the criteria listed in MPPM 304.11, determine the outstanding balance due as of the date of application.
- Divide the uncompensated value by the average private pay nursing facility rate in the state. (Refer to MPPM Chapter 304 Appendix D.) Follow the procedure for calculating a transfer penalty as shown in MPPM 304.09.04.

Example #1: Mr. Jones is 89 years old. He applies for assistance on March 1, 2012. He sold

his home and surrounding property for $150,000. He holds the note, which is to be paid off in 30 years at 4% interest. The note is non-negotiable; therefore, it must be determined if the note meets the test of being actuarially sound. The note was signed and payments began March 1, 2011, when he was age 88. The note is not actuarially sound because the length of time for payments through the note is 30 years, and Mr. Jones' life expectancy at the time the note was executed was 4.26 years. Therefore, Mr. Jones is not considered to have received Fair Market Value based on the projected return and the transfer of assets penalty is applied.

To calculate the transfer of assets penalty:

- Determine the balance due on the note on the date of application, March 1, 2012: $147,358.45.
- Divide the balance due by the current average cost of nursing home care.

$$\frac{\$147,358.45}{\$5,644.12 \text{ per month (Current Average Nursing Home Rate)}} = \begin{matrix}26.11 \text{ months} \\ 26 \text{ months } 26 \text{ days}\end{matrix}$$

Treatment: The penalty period is 26 months and 3 days: March 1, 2012 through May 3, 2014. The vendor payment may not be authorized earlier than May 4, 2014. Medicaid may be approved if otherwise eligible.

Example #2: Mr. Smith is 50 years old. He sells a piece of property valued at $10,000. On September 1, 2007, he signs the mortgage and payments begin that day. The mortgage is non-negotiable and will be paid off in 25 years. According to the Life Expectancy Table, Mr. Smith is expected to live 27.13 years.

Treatment: Since the mortgage will be paid off in 25 years, the note is considered actuarially sound.

Note: If it is determined that a transfer of assets did not occur and the mortgage is actuarially sound, the scheduled loan payments, including the interest, are counted as income in the month received in the eligibility and post-eligibility steps. The loan payments will be counted as income according to the schedule stated in the mortgage.

304.11.03 Default on Payments

(Eff. 06/01/06)

As long as the requirements in MPPM 304.11.01 are met and payments are made, no transfer has occurred. Should the borrower default on his/her payments, the owner of the note must take legal action to foreclose on the note. The owner must provide documentation of the action being taken. If the owner fails to take any action to foreclose on the note, he/she is considered to have transferred assets equal to the remaining value of the note. The effective date of this transfer is the date the payments stopped.

304.11.04 Forgiving Principle Portions of Promissory Notes

Forgiving Principle Portions of Promissory Notes

If a promissory note was approved by the Bureau of Eligibility Administration, it has been determined the note:

- Is actuarially sound; AND
- Was established to create a steam of income; AND
- Is fully amortized over the life of the note.

If the owner of the note later gifts a portion of the principle balance of the note, Medicaid cannot forgive the owner of the note for gifting the principle balance of the note. The monthly payments he/she gifted would still be counted as income to the beneficiary. This means the gift will not change the final payment or principle balance of the note.

Example: Mrs. Smith is a Medicaid beneficiary. She established an actuarially sound non-negotiable promissory note prior to becoming eligible. The terms of the note state she is to receive $325 per month for a period of 5 years (60 months running from November 2004 through October 2009). At annual review, it is discovered that she "gifted" $5,000 of the principle balance to her daughter.

Treatment: The $325 remains countable income each month for the term of the original note ($325 per month through October 2009).

Income First Rule

304.15.01 Eligibility

The first step is to determine if the institutionalized individual is income eligible. Only the institutionalized spouse's income is considered in this step. However, the resources of both the institutionalized and the community spouse must be considered.

Procedure – Step One - Eligibility
Income — Consider only the income of the institutionalized spouse in this step.

Resources — Consider the resources of both the institutionalized spouse and the community spouse at these times: (1) initial eligibility determination, and (2) at the beginning of the first continuous period of institutionalization.

304.15.02 Post-Eligibility

(Rev. 05/01/07)

If the institutionalized individual is eligible, the post-eligibility step is next. In this step, the eligibility worker must determine:

Procedure – Step Two – Post-Eligibility

The eligibility worker must determine:

- How much income and resources the institutionalized individual keeps,
- How much income and resources are allocated to the community spouse, and
- How much the institutionalized individual must contribute toward the cost of his/her care after allowable deductions (that is, recurring income).

Note: Only the income and resources that the institutionalized individual actually makes available to the community spouse will be allowed as a deduction from his/her income or resources.

304.15.02A Income Allocation

In the post-eligibility step, the deductions from gross income are made in the following order:

- Personal Needs Allowance
  - $100 – Work Therapy Allowance – if the institutionalized individual participates in a work therapy program as a part of the plan of care; or
  - $30 – Standard Allowance – if the institutionalized individual does not participate in a work therapy program.
  - $2,094 – Waiver Allowance – for individuals participating in a HCBS waiver

Note: Individuals receiving any VA benefits receive the $30 personal needs allowance. For example:

- $114 per month – all of which is Aid and Attendance (excluded income)
- $35 per month – insurance benefit resulting from the death of a veteran (countable unearned income)
- $90 per month – reduced VA pension (excluded income)

- The lesser of 10% or $25 for court ordered guardianship fees
- Community Spouse Income Allowance:
  - Institutionalized spouse **must** choose to give; and
  - The amount must not exceed $2,841 per month.

Procedure to Determine the Amount of the Community Spouse Income Allowance

- Determine the community spouse's gross income.
- Subtract this amount from $2,841.
- The difference is the maximum allocation amount.

Note: A lower amount may be allocated if the community spouse wishes to maintain or establish eligibility for SSI benefits or Medicaid under another payment category such as ABD. The institutionalized individual must actually make the income available to the community spouse in order for it to be deducted. The spouse of a nursing home patient who receives Home and Community Based Services is considered a community spouse for the purposes of the income provisions of spousal impoverishment.

Procedure – Amount of Community Spouse Allocation Questioned

If the community spouse disagrees with the amount allocated or needs a higher amount to maintain him/her, the eligibility worker should inform the spouse of his/her right to appeal (Fair Hearing).

The community spouse must justify the need for the additional amount due to exceptional circumstances or significant financial duress. A higher amount can only be allowed if it is ordered through an appeal.

- Allowance for Other Dependent Family Members – may include children, dependent adults, etc. A dependent adult is an adult family member (such as a mother, father, grandmother, grandfather, child, brother, sister, aunt, uncle) living in the home who depends on the applicant/beneficiary or community spouse for meeting physical, medical, or financial needs. A signed statement completed by the applicant/beneficiary or authorized representative indicating the relationship of the dependent adult and the nature of the dependency is acceptable verification to provide the allowance.

Procedure to Determine the Amount of Income Allowances for Other Dependent Family Members

Dependent(s) residing with Community Spouse

- Determine the gross income of each family member.
- Subtract the total gross income of each family member from $2,841.
- One-third of the remaining amount is each family member's income allowance.
- Add each family member's income allowance together to determine the total family income allowance.
- This is the amount allowed for allocation to family members.

Dependent(s) residing with someone other than the Community Spouse

- Determine the gross monthly income of all dependents living together
- Compare the gross income of all dependents living together to the TANF/FI Need Standard (LIF Net Income Limit, refer to MPPM 103.03) for a family of the appropriate

size. For example, 3 dependents would use LIF Net Income Limit for 3.

- If gross monthly income is equal to or greater than the standard, no allocation is made.
- If gross monthly income is less than the standard, subtract the income from the standard. The resulting figure is the allocation to the dependents.
  NOTE: The institutionalized individual must actually make the income available to the family in order for it to be deducted.

ENTRANCE FEE

304.26.05 Continuing Care Retirement Communities (CCRCs)

Continuing Care Retirement Community (CCRC): sometimes referred to as a "life care community," the service is the provision of multiple residential options all in one location. Residential options typically include independent living arrangements, assisted living, and skilled nursing care. Usually, a contract is required that obtains a financial commitment from the aging person in return for assurances that the appropriate level of care will be provided when needed. The SC Department of Consumer Affairs licenses CCRC's in this state. A list of licensed facilities can be found at www.scconsumer.gov.

Treatment of Entrance Fees of Individuals Residing in Continuing Care Retirement Communities (CCRCs) and applies for Long-term Care:

Entrance fees for CCRCs or life care communities are considered to be countable resources to the applicant, to the extent that:

- The individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient.
- The individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the CCRC or life care community contract and leaves the community; and
- The entrance fee does not confer an ownership interest in the CCRC or life care community.

HOME EQUITY

304.05.03 Homestead Property

For applications filed before January 1, 2006, homestead property is excluded regardless of value with intent to return home and is not subject to the home equity requirement as long as there is no break in institutionalization (Refer to MPPM 302.14.01.) No break in institutionalization occurs if a beneficiary remains in an institutional setting and does not have to file a new application for long-term care services to re-establish eligibility.

The Deficit Reduction Act of 2005 changes the way homestead property is evaluated for individuals applying for long-term care services effective with applications received on or after January 1, 2006. Homestead property for applicants whose spouse, child under age 21, or a child who is blind or disabled lawfully resides in the home is excluded regardless of equity value. The statement of the applicant/beneficiary or authorized representative is adequate verification of an individual lawfully residing in the home. Otherwise, individuals with an equity interest in their home over $525,000 are not eligible for vendor payment or other long-term care services, but may be eligible for MAO-NH, Payment Category 10, or other Medicaid category if all other eligibility criteria are met. (Refer to MPPM 101.04.01.) An applicant may seek to reduce his or her equity value by taking out a loan on the home including reverse mortgage arrangements. Verify the arrangements and the amount of funds the individual receives. The equity value does not decrease until the client actually receives the money from the loan. Any amount of funds received from a loan is an available resource when received. Any such arrangements must be done under a written contractual agreement. Chapter 104, Appendix HH contains additional information about reverse mortgages.

Procedure for Applications Received After January 1, 2006

1. If an applicant indicates homestead property, complete a DHHS Form 1255 ME, Verification of Real and Personal Property, and obtain the current assessed value of the property.
2. If the applicant has a spouse, a child under age 21, or a child who is blind or disabled that lawfully lives in the home, exclude the value of the home regardless of value, and continue with the eligibility determination.
3. If the applicant does not meet the criteria in step 2, and the assessed value is equal to or less than $525,000, exclude the property, and continue with the eligibility determination.
4. If the applicant does not meet the criteria in step 2, and the assessed value exceeds $525,000, request verification of any mortgages, liens, judgments, or other encumbrances that may reduce the equity value of the property.

5. Subtract the reductions from the assessed value of the property. If the remaining equity value is equal to or less than $525,000, continue with the eligibility determination. If the remaining equity value exceeds $525,000, deny for long-term care services.
6. Determine Medicaid eligibility.

TRUST

302.30 Trust Property

The policy in this section applies to the treatment of trusts as related to SSI determinations. For information on the treatment of trusts for Medicaid purposes, refer to Chapter 304, Nursing Home, Waivered Services, and General Hospital.

A trust is a legal arrangement involving property and ownership interests. Property held in a trust may or may not be considered a resource for SSI purposes. The general rules concerning resources apply to evaluating the resource status of property held in a trust.

Trusts are often complex legal arrangements involving State law and legal principles. All trusts **must be sent** to the Office of Eligibility Enrollment and Member Services the State Department of Health and Human Services for review and a determination of the appropriate treatment of the trust.

302.30.02 Instruments Similar to Trusts

The following accounts and instruments are similar to trusts and may be titled as trusts but may or may not be considered a resource.

Instrument	Definition	Difference from a Trust
Conservator Account	• Established by a court • Court appointed conservator uses the account for the individual.	Beneficiary is the owner even when the assets are not available.

Procedure

Verification:

- Copy of court order appointing conservator
- Copy of bank statements for the conservator account

Treatment: Generally, counted as a resource. (Refer to MPPM 302.10.01.)

Instrument	Definition	Difference from a Trust
Patient Trust Account	• Held and maintained by institution • Used for things such as toiletries, cigarettes, candy.	Patient is the owner.

Procedure:

Obtain verification from the nursing home or institution verifying the amount in the fund and any interest from the past 3 months. Acceptable verification includes:

- DHHS Form 1272 ME, Request for Financial Verification from Medical Facility
- Written statement from the facility
- Eligibility worker's documentation of a telephone statement by a member of the nursing facility's staff

Instrument	Definition	Difference from a Trust
Representative Payee Account	• "In trust for" account • Improperly titled • Best titled in both the individual and the payee's names.	Beneficiary is the owner.

Procedure

Verification:

- DHHS Form 1253 ME, Request for Financial Investigation
- Bank statements
- Other verification from the bank

Treatment: Count as resource.

Instrument	Definition	Difference from a Trust
Totten Trust	• Individual deposits his own funds into an account and holds the account as owner for the benefit of another individual.	

Procedure

Verification:

- DHHS Form 1253 ME, Request for Financial Investigation
- Bank statements

- Written statement from bank

Treatment:

Any funds "held for" an individual are considered that individual's resource.

302.30.03 Use of Trust Funds

If an individual (claimant, recipient or deemor) has legal authority to **revoke** the trust and then use the funds to meet his food, clothing or shelter needs, or if the individual can direct the use of the trust principal for his support and maintenance under the terms of the trust, the trust principal is a resource for SSI purposes.

The following individuals usually have the authority to revoke a trust and its assets.

- **Grantor**
  - Sometimes, the grantor has the authority to revoke a trust.
  - Even if the power to revoke is not specifically retained, the trust may be revocable in certain situations.
  - State law may contain presumptions as to revocability of trusts.
  - If the principle reverts to the grantor at revocation and can be used for support and maintenance, the principle is a resource.

- **Beneficiary**
  - Generally, does not have the power to revoke a trust.
  - Trust may be a resource if he has the authority to direct the use of the principle:
    - Under specific trust provisions
    - By order of the trustee
  - The trustee should not be considered an agent of the beneficiary unless the trust specifically states this. The opposite is true in the case of a Power of Attorney who acts as an agent.

- **Trustee**
  - Trustees occasionally have the right to revoke a trust.
  - Trust is not a resource to the trustee on these occasions **unless** the trustee:
    - Becomes the owner at revocation.
    - Can withdraw and use the principle for his own support.
  - The trustee is considered a third party.

- **Totten Trust**

  The creator of a Totten trust has the authority to revoke the financial account trust at any time. Therefore, the funds in the account are his resource.

302.30.04 Trust Revocability and Its Effect on the Status as a Resource

The following is used to determine when a trust is not a resource.

- Individual does not have:
  - Legal authority to revoke the trust
  - Legal authority to use the assets for his own support and maintenance

- The Trust is IRREVOCABLE:
  - By its terms AND
  - Under State law

- Grantor Trust
  - If Grantor is sole beneficiary, it is generally considered revocable regardless of the Trust's language.
  - If there is a residual beneficiary, it is generally considered irrevocable.
  -

302.30.05 Disbursements from Trusts

Trust Principal is NOT a Resource

If the trust principle is not a resource, disbursements from the trust **may be** income depending on the nature of the disbursements. Regular rules to determine when income is available apply. (Refer to MPPM Chapter 301 on Income.)

Trust Principal IS a Resource

If the trust principal is a resource to the individual, disbursements from the trust principle received by the individual are not income, but conversion of a resource. (However, trust earnings, such as interest, are income.)

- **Trust Earnings**

  Trust earnings are NOT income to:

  - The trustee unless designated under the terms of the trust (for example, fees)
  - The beneficiary unless payment is made to the beneficiary
    - Under the terms of the trust or
    - By the trustee

  Trust earnings are income to the individual for whom trust principle is a resource, unless the terms of the trust make the earnings the property of another.

Additions to Principle

Additions to trust principle made directly to the trust are not income to the grantor, trustee or beneficiary.

Additions to principle may be income or conversion of a resource, depending on the source of the funds. If funds from a third party are deposited into the trust, the funds are income to the beneficiary. If funds are transferred from an account owned by the individual to the trust, the funds are not income, but conversion of a resource from one account to another.

- **Assignment of Income**

A legally assignable payment that is assigned to a trust is income for SSI purposes **unless the assignment is irrevocable**. If the assignment is revocable, the payment is income to the individual legally entitled to receive it.

Note: Certain payments are non-assignable by law and, therefore, are income to the individual entitled to receive the payment under regular income rules. They may not be paid directly into a trust, but individuals may attempt to structure trusts so that it appears that they are so paid. **Exception:** Institutional Income Trusts and Special Needs Trusts allow for placing income in a trust after receipt without the right to the payment being irrevocably assigned. Refer to MPPM 304.19 for Income Trusts and MPPM 302.30.06 for Special Needs Trusts.

Non-assignable payments include:

- Family Independence (FI or TANF) payment (formerly known as Aid to Families with Dependent Children-AFDC)
- Railroad Retirement Board-administered pensions
- Veterans Administration pensions and assistance
- Federal employee retirement payments (CSRS, FERS) administered by the Office of Personnel Management
- Social Security Title II and SSI payments
- Private pensions under the Employee Retirement Income Security Act (ERISA) [29 U.S.C.A. section 1056(d)]

302.30.06 Special Needs Trusts

This type of trust is designed especially for individuals under the age of 65 who meet the SSI definition of disability. Special Needs Trusts established for a disabled individual age 64 or younger are exempt from the application of the transfer of assets penalty provision. Therefore, funds placed in a Special Needs Trust established for an individual age 65 or older will be subject to a penalty for a transfer of assets for less than fair marker value. Further, once an

individual reaches age 65, any funds or assets placed into the trust will be considered a transfer, even if the trust was properly established by a disabled individual age 64 or younger.

Criteria

- Established for the sole benefit of the disabled individual by:
  - Parent
  - Grandparent
  - Legal Guardian
  - Court
- Must be funded initially with the income and/or resources of the disabled individual
  Note: Assets from any individual may be placed in the trust after the initial funding.

- Must contain a provision stating that at the individual's death, the state will receive all amounts remaining in the trust up to the amount expended by Medicaid on the individual's behalf.
- Some Special Needs Trusts have a provision allowing the trustee to make loans from the trust. On or after September 1, 2003, any loan provision must be accompanied by a requirement that the trustee furnish SCDHHS with documentation of the following:
  - Source of the payback funds
  - An amortization schedule (schedule of the monthly payments of principal and interest)
    - Must have a reasonable rate of interest
    - Must be actuarially sound (that is, expected to be paid back during the person's life expectancy).
  - Documentation must be provided prior to funds being disbursed for the loan.
  - Loans made that do not meet the above requirements are counted as income in the month received.
- May be established with the individual's income.
  - The income must belong to the individual and be placed in the trust after he or she has received it.
  - Income that is placed in the trust is not counted when determining the individual's Medicaid eligibility. Any income, including Social Security Benefits, VA pensions, private pensions, can be placed directly in the trust by the applicant/beneficiary without it affecting the individual's Medicaid eligibility. Also any income generated by the trust, which remains in the trust, is not counted as income.
  - Any payments paid by the trust directly to the individual are counted as income for eligibility purposes.
  - Any payments made by the trust to purchase food or shelter for the individual is considered as in-kind income for eligibility purposes.

Procedure

When Trust is Established: The eligibility worker must forward copies of the trust to the Bureau of Eligibility Administration for review and approval using a DHHS 3275 ME, Income Trust transmittal. The relationship of the individual establishing the trust to the disabled individual must be documented.

At Annual Review: The eligibility worker must verify whether any money has been paid to the beneficiary to determine countable income. Request copies of bank statements or an accounting of any disbursements for the beneficiary.

At the time of case closure, including death of a beneficiary: The eligibility worker must forward a copy of the trust with identifying information to:

Department of Health and Human Services
Division of Third Party Liability
1801 Main Street
Columbia, SC 29202

302.30.07 Pooled Trusts

Pooled trusts contain the assets of individuals who meet the SSI definition of disability. Although a pooled trust may be established for beneficiaries of any age, only trusts established for a disabled individual age 64 or younger are exempt from the application of the transfer of assets penalty provision. Therefore, funds placed in a pooled trust established for an individual age 65 or older will be subject to a penalty for a transfer of assets for less than fair market value. Further, once an individual reaches age 65, any funds or assets placed into the trust will be considered a transfer, even if the trust was properly established by a disabled individual age 64 or younger.

Criteria

In order for such a trust to be exempt from the transfer of assets penalty, the trust must:

- Be established and managed by a non-profit association
  Example: Babcock Center

- Have a separate account maintained for each beneficiary
- Contain an account in the trust solely for the benefit of the disabled individual which is funded by the disabled individual, parent, grandparent, legal guardian or court; and
- Contain a provision stating that at the individual's death, the state will receive all amounts remaining in the individual's account up to the amount expended by Medicaid on the individual's behalf.

Although an account is established for each member of the pooled trust, funds in the trust are pooled for investment and management purposes.

States' Progress in Implementing the Provisions of the OBRA
A-05-12-00027
SC

State_____
Calendar Quarter____**10/01/2005 - 12/31/2005**_____ **Year**_____2

	Number of recoveries	Amount
Estate Recoveries From -		
1. Probate Estates		
2. Small Estate Affidavits		
3. Deceased's Funds from nursing homes		
4. Deceased's bank and investment accounts		
5. Funeral Trusts		
6. Other Special need trust balances		
7. Annuity issuers		
8. Life insurance policies		
9. Real property, homestead - Enforcement of TEFRA liens		
10. Real property, non homestead-Enforcement of TEFRA liens		
11. Real property – post death liens		
12. Unclaimed Funds		
13. Others – Please list (insert more lines as necessary)		1,884,977.00
–		
Total Estate Recoveries (Sum of 1 through 13)		
Long-Term Care Expenditures For -		
Nursing Home		114,687,710.00
Intermediate Care - Mentally Retarded: Public Providers		39,571,719.00
Intermediate Care - Mentally Retarded: Private Providers		0.00
Others - Please list (insert more lines as necessary)		0.00
Total Long-Term Care Expenditures		

APPENDIX

2006_____

Line number on CMS-64	Item Description on CMS-64
9B	PROBATE
3A	
4A	
4B	