

**ALABAMA MEDICAID AGENCY
ADMINISTRATIVE CODE**

**CHAPTER 560-X-25
MEDICAID ELIGIBILITY**

560-X-25-.09 Transfer Of Assets Affecting Eligibility.

(1) An individual, or the spouse of such individual, who is an applicant or recipient of either institutional Medicaid or home and community-based waiver services, who transfers an asset at any time on or after the "look-back date", as defined in paragraph (9) (j), for less than fair market value for the purpose of establishing or maintaining eligibility will cause the individual to be charged with the difference between the fair market value of the asset and the amount of any compensation received. The difference is referred to as uncompensated value and is counted toward the resource limit of the individual for a period of time determined in accordance with paragraph (5).

(a) When there is an institutionalized married couple and only one applies for Medicaid, any transfers of assets for less than fair market value within the "look-back date" made by the applicant and /or non-applying spouse affects the applicant's eligibility. In these situations, the applying spouse will incur the entire penalty period.

(b) If at a later time the applicant's spouse, who initially did not apply, makes an application, the remaining penalty period would be apportioned between them. Any fractional remainder will be served by either spouse.

(2) When a stream of income or the right to a stream of income, such as an annuity, is transferred, Medicaid shall make a determination of the total amount of income expected to be transferred during the owner's life, based on an actuarial projection of the owner's life expectancy as established by federal life expectancy tables, and calculate a penalty period based on the projected total income.

(3) A transfer of an asset for less than fair market value is presumed to have been for the purpose of establishing or maintaining Medicaid eligibility unless the individual presents convincing evidence that the transfer was exclusively for some other purpose, in accordance with paragraph (7).

(4) Any individual who fails to disclose in an application a transfer of assets which occurred on or after the "look-back date" or who fails to report a transfer which occurs after eligibility is awarded, or who receives Medicaid benefits prior to discovery of a transfer of assets in violation of this rule shall be subject

to recoupment action and suspension of benefits pursuant to Code of Ala 1975, §22-6-8 and Chapters 4 and 33 of this Administrative Code. Such individual and/or his representative may also be subject to criminal prosecution under Code of Ala. 1975, §22-1-11 and §1128B of the Social Security Act (42 U.S.C. §1320a-7b).

(5) Penalty Period for Transfers of Assets Occurring Within the "Look-Back Date."

(a) This period is applicable to nursing facility services as defined in the State Plan, a level of care in any institution equivalent to that of nursing facility services as defined in the State Plan, and home and community-based waiver services.

(b) The total, cumulative uncompensated value of the assets transferred on or after the "look-back date" will be divided by the average monthly cost to a private patient for nursing facility services in the state (at the time of application) as determined by Medicaid. This quotient, minus the fractional remainder, shall be the number of months the uncompensated value is counted. The fractional remainder shall be converted to a dollar figure and added to the individual's liability. This penalty period shall begin the month of transfer, or the first month in which the individual is eligible for medical assistance under the State Plan and would otherwise be receiving institutional level care based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this Rule.

(6) Transfers Not Considered. An individual shall not be ineligible for medical assistance to the extent that:

(a) The assets transferred were a home and title to the home was transferred to:

1. the individual's spouse;
2. the individual's child who is under age 21, or who is blind or permanently and totally disabled;
3. the individual's sibling who has an equity interest in such home and who has been residing in such individual's home for a period of at least one year immediately before the date such individual becomes an institutionalized individual; or
4. the individual's son or daughter (other than a child described in paragraph (6)(a)2. above) who was residing in such individual's home for a period of at least two years immediately before the date such individual becomes an institutionalized individual, and who (as determined by Medicaid) provided care to such individual which

permitted such individual to reside at home rather than in such an institution or facility.

(b) The assets—

1. were transferred:

(i) to the individual's spouse or to another for the sole benefit of the individual's spouse;

(ii) from the individual's spouse to another for the sole benefit of the individual's spouse; or

(iii) to the individual's child who is blind or permanently and totally disabled or to another for the sole benefit of the individual's child who is blind or permanently and totally disabled.

2. All assets transferred must be spent only for the sole benefit of the individual's spouse or the individual's child who is blind or permanently and totally disabled within a time frame actuarially commensurate with the life expectancy of the beneficiary of the transferred assets.

(c) A satisfactory showing is made to Medicaid that the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, or the assets were transferred exclusively for a purpose other than to qualify for Medicaid.

(d) Medicaid determines that denial of eligibility would work an undue hardship.

(e) The assets were transferred to a trust which is determined to be exempt from consideration under § 1917(d) of the Social Security Act.

(f) All assets transferred on or after the "look-back date" for less than fair market value have been returned to the individual. A return of the assets may cause ineligibility based on excess resources.

(7) Rebuttal. The burden is upon the individual to rebut the presumption that a transfer of an asset was made for the purpose of establishing or maintaining Medicaid eligibility by furnishing Medicaid with convincing evidence that the asset was transferred exclusively for some other purpose. Convincing evidence may be pertinent documentary or non-documentary evidence which shows, for example, that the transfer was ordered by a court, or that at the time of transfer the individual could not have anticipated becoming eligible due to the existence of other circumstances which would have precluded eligibility. A subjective statement of

intent or ignorance of the provisions of this Rule is not sufficient, by itself, to rebut the presumption raised.

(8) Undue Hardship

(a) In situations where an individual has admitted that an asset has been transferred for less than fair market value for the purpose of obtaining Medicaid benefits, the Agency may still grant an exemption from the penalty period where the individual demonstrates by clear and convincing evidence that the imposition of such a penalty will cause the individual to suffer undue hardship. Undue hardship will only be considered in extreme cases where the individual has been denied admission to or discharged from an institutional facility or denied home and community-based waiver services under circumstances which would deprive the individual of medical care such that the individual's health or life would be endangered, or of food, clothing, shelter, or other necessities of life. Undue hardship does not exist where a transfer penalty causes an individual or the individual's family to experience inconvenience or would cause an individual to restrict his/her lifestyle.

(b) In determining the existence of "undue hardship" Medicaid will consider all circumstances involving the transfer and the situation of the individual, including but not limited to, the following:

1. Whether the individual has been determined to be a person in need of care and protection pursuant to the Adult Protective Services Act, Code of Alabama 1975, § 38-9-1, et seq.;
2. Whether the individual or his representative has exhausted all reasonable efforts to obtain a return of, or compensation for, the transferred asset, including voiding the transfer pursuant to Code of Alabama 1975, § 35-1-2 or § 8-9-12, or diligently prosecuting other criminal or civil action available to recover the asset;
3. Whether the individual was deprived of an asset by fraud or misrepresentation. Such claims must be documented by official police reports or civil and/or criminal legal actions against the perpetrator;
4. Whether the individual or his representative has exhausted all reasonable efforts to meet the individual's needs from other available sources.

(c) When a penalty period is imposed, the Notice of Action will include notice that the individual or authorized representative may, as part of the review process, request an undue hardship exemption. The written request for an undue

hardship exemption must be received be Medicaid within 60 days from the date the notice of action is mailed. A denied request may be appealed in accordance with Chapter 3 of this Code.

(9) Definitions. As used in this rule:

(a) "Transfer" is, and occurs at the time, when an individual or spouse (or a parent, guardian, court or administrative body, or anyone acting in place of or on behalf of or at the request or direction of the individual or spouse), by either affirmative act or failure to act, loses or relinquishes all rights of legal access to an asset or interest therein.

(b) "Compensation" is all money, real or personal property, food, shelter or services received by the individual or spouse at or after the time of transfer in exchange for the asset in question. Money, real or personal property, food, shelter or services received prior to the transfer are compensation only if they were provided pursuant to a legally enforceable agreement (i.e., personal service agreement, etc.) to provide such items in exchange for the asset in question. Services provided pursuant to a personal service agreement are compensation only if all the criteria set forth in paragraph (9)(k) of this rule are met. Payment or assumption of a legal debt owed by the individual or spouse in exchange for the asset is also compensation.

(c) "Fair market value" is the current market value of an asset at the time of the transfer or contract of sale, if earlier. Current market value shall be determined in accordance with Rule 560-X-25-.06(3), except that if a remainder interest in property is transferred, whether or not a life estate is retained, the uncompensated value will be based on the fair market value of the entire property at the time of the transfer or contract of sale, if earlier.

(d) "Uncompensated value" is the fair market value of the asset minus the amount of any compensation received by the individual or eligible spouse in exchange for the asset.

(e) A "home" is any shelter in which the individual (and spouse, if any) has an ownership interest and which is used by the individual (and spouse, if any) as his principal place of residence. The home includes any land that appertains thereto and any related outbuildings necessary to the operation of the home.

(f) The "month of application" is the month in which the original, initial application of an individual is received and accepted by the Medicaid Agency.

(g) "Assets" are all income or resources of the individual or the individual's spouse. This term includes income or

resources which the individual or individual's spouse is or was entitled to but does not receive. With respect to transfer of assets, the term "assets" also includes the following:

1. An annuity purchased by or on behalf of the individual and will be treated as a disposal of assets for less than fair market value unless:

(i) the annuity is—

(I) an annuity described in subsection (b) or (q) of § 408 of the Internal Revenue Code of 1986; or

(II) purchased with proceeds from—

A. an account or trust described in subsection (a), (c), (p) of §408 of such Code;

B. a simplified employee pension (within the meaning of §408(k) of such Code); or

III. a Roth IRA described in § 408A of such Code; or

(ii) the annuity—

(I) is irrevocable and non-assignable;

(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made; and,

(iii) in the annuity—

(I) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant; or

(II) the State is named as such beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value

2. The purchase of a life estate interest in another individual's home will be treated as a disposal of assets for less than fair market value unless:

(i) the purchase—

(I) was made by the individual who resides in the home continuously for a period of at least one (1) year after the date of the purchase; and

(II) price is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration).

(ii) Any purchase price less than the actuarially sound purchase price will be treated as a transfer of assets for less than fair market value under the provisions of this Rule.

3. Funds used to purchase a promissory note, loan, or mortgage will be treated as disposal of assets for less than fair market value unless:

(i) such promissory note, loan, or mortgage—

(I) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

(II) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(III) prohibits the cancellation of the balance upon the death of the lender.

(ii) In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (I) through (III), the value of such promissory note, loan, or mortgage shall be the outstanding balance due as of the date of the individual's application for institutional or home and community-based waiver services.

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

(i) "Institutionalized individual" is an individual who is:

1. An inpatient in a nursing facility;
2. An inpatient in a medical institution (including an intermediate care facility for individuals with intellectual disabilities (ICF/IID), as defined in 42 C.F.R. § 435.1009) for whom payment is based on a level of care provided in a nursing facility; or
3. Determined eligible for home and community-based services and who would otherwise require the level of care provided in a nursing facility or medical institution.

(j) "Look-back date" for an institutionalized individual is the date that is 60 months immediately prior to the later of the first day of the month of the original, initial application. For individuals receiving home and community-based waiver services, the "look-back date" is the date that is 60 months immediately prior to the later of the first day of the month of the original, initial application or the first day of the month in which the individual disposes of assets for less than fair market value. For transfers relating to trusts, annuities, or similar legal instruments, the "look-back date" is 60 months.

(k) "Personal Service Agreement" is a legally enforceable written agreement for personal care services to be provided in exchange for anything of value. A transfer of assets is presumed to have occurred at the time of the exchange and a transfer penalty shall be imposed unless all of the following are met:

1. At the time of the receipt of the services, the services were recommended in writing and signed by the applicant's physician, as necessary to prevent the admission of the applicant to a nursing facility. Such services may not include the providing of companionship and related services;
2. At the time of the receipt of the services, the applicant was not residing in a nursing facility;
3. At the time of the receipt of the services, the transfer of the consideration (money and/or property) to the provider/relative occurred; and
4. At the time of the receipt of the services there already existed a written and signed agreement executed between the applicant and provider for the specific service(s) rendered.

(i) The agreement executed between the applicant and provider/relative must fully describe the type, frequency and duration of the services being provided to the applicant in such a way that they can be documented when provided; and the amount of consideration (money and/or property) being received by the provider/relative.

(ii) The agreement executed between the applicant and provider/relative must provide that the amount of consideration (money and/or property) cannot exceed the fair market value for that rendered service(s). Rates for these services must be shown to be comparable to the usual and customary rates in the local area. The fair market value of the services may be determined by consultation with an area business which provides such services.

(iii) Services that are provided pursuant to a valid personal services agreement must be documented with time sheets and attendance logs for each hour of services provided. Contracts cannot provide for a "lump sum" payment regardless of the services that are to be provided, as each service must be individually documented to be justified.

(iv) Payment must only be for actual services rendered. Any reimbursement for out-of-pocket expenses incurred by the caregiver must be documented by a receipt.

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