REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

HB 2601 (2005)
Medicaid Asset Transfer Allowances

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT NO. 93

COMMONWEALTH OF VIRGINIA
RICHMOND
2006

JOINT COMMISSION ON HEALTH CARE: 2005

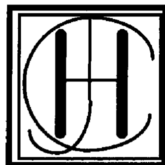
Chairman
The Honorable Harvey B. Morgan

Vice Chairman
The Honorable William C. Mims

The Honorable Harry B. Blevins
The Honorable R. Edward Houck
The Honorable Benjamin J. Lambert, III
The Honorable Stephen H. Martin
The Honorable Linda T. Puller
The Honorable Nick Rerras
The Honorable William C. Wampler, Jr.
The Honorable Clifford L. Athey, Jr.
The Honorable Robert H. Brink
The Honorable Benjamin L. Cline
The Honorable Franklin P. Hall
The Honorable Phillip A. Hamilton
The Honorable R. Steven Landes
The Honorable Kenneth R. Melvin
The Honorable John M. O'Bannon
The Honorable John J. Welch, III

Secretary of Health and Human Resources
The Honorable Jane H. Woods

Executive Director
Kim Snead



PREFACE

In 1965, Title XIX of the Social Security Act created the federal-state program Medicaid, to provide health insurance to primarily low-income children, parents meeting specific income thresholds, pregnant women, the elderly, and individuals with disabilities. Participation in Medicaid is not mandatory. However, if a state establishes a Medicaid program, the state is required to provide certain basic services such as nursing facility care.

Medicaid has become the nations' primary payer for nursing facility services. In 2003, Medicaid provided $51 billion in nursing facility care in the United States. During the same year, Virginia's Medicaid payments to nursing facilities totaled $547,287,699.

The improper transfer of assets to qualify for Medicaid payment for long-term care services has received national attention as growing Medicaid budgets have placed additional strains on state finances. Several initiatives, that have been promoted as methods for curtailing Medicaid long-term care costs, are addressed in this report including: additional restrictions on Medicaid asset transfers, estate recovery programs, reverse mortgages, long-term care insurance tax incentives, and long-term care partnerships. In response to study findings, JCHC introduced legislation that: (1) amends Title 58.1 of the *Code of Virginia* to provide a one-time tax credit (of 15 percent of the insurance premiums paid within the tax year) for individuals who purchase long-term care insurance; and (2) requests (by joint resolution) that the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission monitor changes in Medicaid restrictions on sheltering assets.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the numerous individuals, agencies, and associations that assisted in the completion of this study, including the Department of Medical Assistance Services and numerous advocacy groups.

Kim Snead
Executive Director

May 2006

TABLE OF CONTENTS

	Executive Summary	*i-vi*
I.	Authority for Study/Organization of Report	1
II.	Overview of Medicaid Long-Term Care	3
III.	Medicaid Long-Term Care Eligibility	9
IV.	Current Issues Involving Medicaid Asset Transfers	23
V.	Strategies to Discourage the Use of Asset Transfers	31
VI.	Policy Options	45

APPENDICES

Appendix A:	House Bill 2601 (2005 General Assembly Session)
Appendix B:	Virginia's Home and Community Based Services Waivers (Source: Department of Medical Assistance Services)
Appendix C:	Virginia Administrative Code 12VAC30-60-303
Appendix D:	Senate Bill 266 (2004 General Assembly Session)

MEDICAID ASSET TRANSFERS
EXECUTIVE SUMMARY

Authority for Study

House Bill 2601 (2005) would have permitted the Department of Medical Assistance Services, when appropriate and practicable, to seek a waiver of the Social Security Act under Section 1115 to create more restrictive asset transfer limits than those currently allowed under federal law or regulations. Ultimately, the bill was left in the Senate Finance Committee. However, upon the request of members of the Joint Commission on Health Care, a study was conducted to review a variety of the issues raised by HB 2601.

Medicaid Long-Term Care

Nationally, Medicaid is the largest purchaser of nursing facility services with $51 billion covered by this federal-state program in 2003. According to the Virginia Department of Medical Assistance Services' (DMAS) Statistical Record, annual expenditures for nursing facility services reached $547,287,699 in 2003. Just over 76% of these expenditures were for individuals classified as aged.

The improper transfer of assets to gain access to Medicaid payment for long-term care services is an issue that has received national attention. Beginning in 1980 with the Boren-Long Amendments, the federal government enacted legislation designed to curb abuse of the Medicaid system. National studies have come to varying conclusions about the prevalence of inappropriate asset transfers.

Current Issues Involving Sheltering Assets in Virginia

Interviews with State personnel revealed three major methods that Medicaid applicants are using to shelter assets in Virginia including: increased use of annuities, life estates, and savings bonds. Although the exact number of inappropriate asset transfers is not readily available, anecdotal evidence suggests they are becoming a more pervasive issue. DMAS is currently going through the regulatory process to strengthen regulations regarding the use of annuities to shelter assets. Options for curbing the use of life estates and savings bonds to shelter assets are currently being reviewed.

A number of proposals have been discussed at the national and state levels to help curb the abuse of Medicaid asset transfers. One proposal involves placing additional restrictions on Medicaid asset transfers. A second proposal is to expand estate recovery programs. Proposals for imposing additional restrictions on Medicaid asset transfers have focused most often on increasing

the look-back period, changing the start date of the penalty period, or altering the formula used to determine the length of the penalty period.

Look-Back Period. Currently, states have a look-back period of 36 months (60 months for trusts) in which to examine a Medicaid applicant's financial transactions to determine if unallowable asset transfers have occurred. Several organizations, including the Medicaid Commission and the National Governor's Association, have proposed increasing the length of the look-back period from three to five years. The CMS Office of the Actuary estimates that this change would save less than $100 million over five years.

Penalty Period. If an individual makes an improper transfer during the look-back period, they are assessed a penalty period in which they do not qualify for Medicaid payment of long-term care services. The penalty period is calculated by dividing the uncompensated value of assets transferred during the look-back period by the average monthly cost of private pay nursing facility services at the time of application for Medicaid. At the present time, the first day of the month in which the asset transfer occurred (provided that the date does not occur during an existing penalty period) is the start date for the penalty period. Proposals have been made to change that start date from the date of the asset transfer to either the date of application for Medicaid long-term care services or the nursing home admission date. In addition, it has been suggested that the formula used to determine the penalty period be altered by using the average monthly cost of Medicaid nursing facility services instead of the average monthly cost of private pay nursing facility services. This change would dramatically increase the length of the penalty period.

Estate Recovery Programs. Since the inception of the Medicaid program, states have been allowed to recover assets from the estates of deceased Medicaid recipients who were over the age of 65 when they received benefits and who had no surviving spouse, minor child, or adult disabled child. The passage of the *Omnibus Reconciliation Act of 1993* required states to implement estate recovery programs.

Under Virginia's Medicaid estate recovery program, adjustments or recoveries for services Medicaid has covered may be recovered from the estate of a permanently institutionalized individual or from a recipient age 55 or older for payments covering nursing facility services, home and community-based services, and related hospital and prescription drug services.

Methods for reducing the cost of Medicaid long-term care services for the federal and state governments have received attention also. Two methods

include encouraging individuals to use reverse mortgages and to purchase long-term care insurance.

Reverse Mortgages. Home Equity Conversion Mortgages (HECM) are the most common type of reverse mortgage. With an HECM, a lender advances money to a homeowner who must be age 62 or older. The money may be provided in a series of fixed monthly payments, a line of credit from which the borrower may draw from, or a combination of these methods. Payments do not need to be made on the loan as long as the individual remains living in the home. The loan balance collected by the lender includes any accrued interest, other charges, and the amounts paid out. Funds from reverse mortgages can be used to pay for long-term care services. However, restrictions regarding eligibility for reverse mortgages, including maximum initial loan amounts, mean that reverse mortgages are not a viable option for some individuals.

Long-Term Care Insurance Tax Incentives. Governments on both the federal and state level recognize the potential for savings if individuals purchase adequate long-term care coverage. As a result, numerous pieces of legislation across the country have been proposed to encourage the purchase of these plans. According to the National Conference of State Legislators, 26 states have long-term care insurance tax incentives in place. Maine offers both a tax credit and a deduction. Sixteen states, including Virginia, offer a tax deduction. Another nine states offer a tax credit.

Long-Term Care Partnerships. The Long-Term Care Partnership program allows individuals to access state Medicaid long-term care programs and not deplete their assets if they have purchased certain approved long-term care insurance policies. California, Connecticut, Indiana, and New York are the only states that have LTC Partnerships in operation. Nineteen states, including Virginia, have enacted some form of enabling legislation to create the program in their state, but the *Omnibus Reconciliation Act (OBRA) of 1993* has restricted the ability of states to create LTC Partnerships.

In response to positive outcomes from the four states with Partnership programs and growing concerns over Medicaid long-term care budgets, a variety of stakeholders have expressed strong support for removing the restrictions imposed by OBRA 1993. The National Governor's Association and the National Conference of State Legislators have called for the repeal of federal restrictions. In addition, the President included language in his 2006 budget that would provide authority for states to implement LTC Partnership programs; and, several bills have been introduced in Congress that would lift federal restrictions.

Options and Public Comments

The following options were proposed and public comments received regarding those options. The Options that were approved by JCHC are shown in bold text.

Option I: Take no action.
No comments were received addressing Option I.

Option II: Introduce legislation to provide a tax credit for employers who offer long-term care insurance to their employees.
Six comments in support of Option II were received. Jill Hanken, in explaining the Virginia Poverty Law Center's support of Option II, stated:

> *I support this option as a way to encourage broader use of long term care insurance. Long term care insurance remains a relatively new product that has not reached a broad enough audience. Tax incentives are an important mechanism for encouraging more employers to offer and more consumers to purchase coverage.*

Option III: Introduce legislation to provide a tax credit rather than a tax deduction for long-term care insurance.
This issue was addressed during the Long-Term Care Subcommittee meeting and resulted in the introduction of legislation to provide a one-time tax credit (of 15 percent of the insurance premiums paid within the tax year) for individuals who purchase long-term care insurance.
Option III received six supportive comments. Christopher McCarthy, on behalf of the Elder Law Section of the Virginia Bar Association, commented in support of Option III stating:

> *We support this option. A taxpayer will be more motivated to purchase a policy if an immediate benefit will be available.*

Option IV: Introduce a budget amendment (language and funding) to create a grant program for individuals purchasing long-term care insurance to be administered through the Virginia Department for the Aging. VDA would work with stakeholders to develop eligibility criteria for participation in the program. Concerns over the ability and applicability of VDA administering this potential program were raised by VDA. Another six comments in support of Option IV were received. Eldon James commented for the VAAAA in support of Option IV and in opposition to Option V:

> *We support this option. Cost is a deterrent, especially for those of low and moderate income. A grant program, similar to what was intended when the*

Caregivers' Grant Program was created, would make it more financially possible foe lower or middle income households to purchase this coverage. We see this as consistent with the recommendation in Option VI.

Option V: Introduce legislation authorizing DMAS to apply for a waiver to implement more restrictive asset transfer restrictions.
Six comments in opposition to Option V were received. Mary Lynne Bailey, representing the Virginia Health Care Association, stated in opposition to Option V:

As you are aware, there is considerable interest among national organizations and in Congress for the federal government to address additional restrictions on asset transfers to make it more difficult for individuals to transfer assets in order to qualify for Medicaid long term care services. Because of this federal interest, VHCA believes the Joint Commission should not pursue Option V (Introduce legislation authorizing the Department of Medical Assistance Services to apply for a waiver to implement more restrictive asset transfer restriction.)

Option VI: Introduce a resolution or send a letter from the JCHC encouraging members of Congress to pass legislation authorizing the further implementation of Long-Term Care Partnership programs in other states.
Option VI solicited seven supportive comments. Dana Steger commented on behalf of the Virginia Association of Non-Profit Homes for the Aging (VANHA) to support Option VI:

VANHA supports option VI, introducing a resolution or sending a letter from the JCHC to encourage members of Congress to pass legislation authorizing the further implementation of Long-Term Care Partnership programs in other states.

Option VII: Continue to monitor the actions of Congress regarding additional asset transfer restrictions, reverse mortgages, and Long-Term Care Partnership programs, in addition to monitoring the activities in Virginia involving annuities, life estates, and bonds by including the issues on the JCHC workplan for 2006.
Seven comments in support of Option VII were received. Susan Ward commented in support of Option VII on behalf of the Virginia Hospital and Healthcare Association (VHHA) and stated:

The VHHA supports Option VII, suggesting that the commission continue to monitor the actions of Congress regarding additional asset transfer restrictions, reverse mortgages and Long-Term Care Partnership programs in addition to monitoring Virginia activities regarding annuities, life estates and bonds.

The Medicaid program is a necessary but an expensive program, requiring a growing level of resources to serve those in need. Given its cost and importance,

we believe that Medicaid eligibility and transfer-of-asset policies should be examined to ensure that they incorporate the concept of recipient personal responsibility and that they direct Medicaid resources to those who truly qualify for benefits. This is best done in the context of federal Medicaid reform to ensure that policies uniformly address difficult issues such as long-term care providers' exposure when individuals whom they are serving lose benefits for illegally transferring assets but have no resources to pay for needed nursing home care.

Option VIII: Introduce a resolution requesting JLARC to conduct a study to determine the extent of the use of asset transfers to shelter assets in order to qualify for Medicaid long-term care.

Five comments were received in support of Option VIII. Cynthia Pritchard explained the Multiple Sclerosis Virginia Consumer Action Network's (MSVACAN) support for Option VIII by stating:

We support this option. The information in the 1993 JLARC report is dated and does not reflect the current environment in Virginia because of policy and programmatic changes that have occurred over the past 12 years.

JCHC Staff for this Report

Catherine W. Harrison
Senior Health Policy Analyst

I. Authority for the Study/Organization of Report

During the 2005 General Assembly Session, House Bill 2601 was introduced (Appendix A). The bill allows the Department of Medical Assistance Services, when appropriate and practicable, to seek a waiver of the Social Security Act under Section 1115 to create more restrictive asset transfer limits than those currently allowed under federal law or regulations. Amendments proposed by the Committee on Health, Welfare and Institutions and the patron were agreed upon, and HB 2601 passed the House of Delegates. However, after being reported with a substitute from the Senate Education and Health Committee, the bill was left in the Senate Finance Committee. Upon the request of members of the Joint Commission on Health Care, this study will review a variety of the issues raised by HB 2601.

The final version of HB 2601, which was left in Senate Finance, included five enactment clauses. The first enactment clause allowed the Department of Medical Assistance Services to seek a §1115 waiver from the Centers for Medicare and Medicaid Services, which would allow the use of more restrictive asset transfer limits than those currently allowed under federal Medicaid law or regulations. Authorization to recover Medicaid payments provided on behalf of an individual during a period of Medicaid ineligibility was included in the first enactment clause. Medical assistance payments could be retrieved from the individual determined to be ineligible for Medicaid due to the improper transfer of assets, the individual's estate, or the person to whom the improper transfer was made.

The second enactment clause of HB 2601 granted emergency regulatory authority to the Department of Medical Assistance Services upon the approval of the §1115 waiver by the Centers for Medicare and Medicaid Services. The third enactment clause further addressed regulatory issues by directing the Department of Medical Assistance Services to use electronic media whenever possible and in keeping with the Administrative Process Act during the regulatory process.

Included in the fourth enactment clause was a requirement that the Director of the Department of Medical Assistance Services report on asset transfer limits established in the proposed waiver to the Chairmen of the House Committees on Appropriations and Health, Welfare and Institutions and the Senate Committees on Finance and on Education and Health. The fifth and final

enactment clause established that provisions of HB 2601 would not become effective unless reenacted by the General Assembly in 2006.

ORGANIZATION OF THE REPORT

This report includes six sections. The initial section, which was just discussed, covers the authority for this study. Section II will provide an overview of Medicaid long-term care followed by a description of Medicaid long-term care eligibility in Section III. Current issues involving Medicaid asset transfers are discussed in Section IV. The fifth section contains strategies to discourage the use of asset transfers. Section VI contains policy options presented to the Joint Commission on Health Care.

II. Overview of Medicaid Long-Term Care

In 1965, Title XIX of the Social Security Act created the federal-state program Medicaid, to provide health insurance primarily to low-income children, parents meeting specific income thresholds, pregnant women, the elderly, and individuals with disabilities. States are not required to participate in Medicaid, but if a Medicaid program is established, the state must operate within certain parameters established by the federal government. In exchange, the federal government provides a monetary match for state expenditures. In Virginia, this match is 50 percent.

According to Title 42, Section 440.210 of the *Code of Federal Regulations*, mandatory services a state Medicaid program must provide to categorically needy individuals include:

- Inpatient hospital;
- Outpatient hospital including Federally Qualified Health Centers and rural health clinic services;
- Other laboratory and x-ray;
- Nurse practitioner services (when licensed to practice under state law);
- Nursing facility services for beneficiaries age 21 and older;
- Early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21;
- Family planning services and supplies;
- Physician's services;
- Medical and surgical services of a dentist;
- Home health services (which at a minimum includes intermittent or part-time nursing services, home health aides, and medical supplies and appliances for use in the home);
- Nurse mid-wife services (to they extent they are authorized to practice under state law or regulations);
- Pregnancy related services and service for other conditions that might complicate pregnancy; and
- 60 days postpartum pregnancy related services.

Among the services states are required to provide to categorically needy Medicaid recipients, nursing facility and sometimes home health services are classified as long-term care services. Long-term care involves providing a range of services that typically assist an individual in the performance of activities of

daily living (ADLs) and instrumental activities of daily living (IADLs). These functions range from basic activities such as bathing to food preparation.

MEDICAID LONG-TERM CARE

According to the Kaiser Commission on Medicaid and the Uninsured, Medicaid ranks as the country's primary payer of long-term care services. As a mandatory covered service for Medicaid categorically-needy recipients, nursing facility services for individuals age 21 or over form an important component of the long-term care system. Although nursing facility services are often seen as the principal component of Medicaid long-term care, there are many other services in both institutional and home and community-based settings that states may choose to provide.

In addition to mandatory nursing facility services for the categorically needy, states may also choose to offer institutional care through intermediate care facility services for the mentally retarded (ICF/MR), inpatient/nursing facility services for individuals 65 and over in an institution for mental diseases (IMD), and inpatient psychiatric hospital services for individuals under age 21. Virginia's Medicaid program provides care in all of the institutional settings listed above, with inpatient psychiatric hospital services for individuals under age 21 being provided through EPSDT.

Many individuals prefer to receive long-term care services in home and community-based settings. The only mandated Medicaid service states are required to provide to categorically needy individuals is home health. However, home health services require that the recipient require a certain level of care and are only provided on a part-time intermittent basis. States have the option of providing the following additional services in the community:

- Private duty nursing;
- Other home health care;
- Personal care;
- Case management;
- Respiratory care for ventilator-dependent individuals;
- Hospice;
- Services furnished under the Program of All Inclusive Care for the Elderly (PACE); and
- Home and community based waiver services.

Virginia has chosen to implement several of these programs. Through the Medicaid home health benefit, individuals may receive physical therapy, occupational therapy, speech pathology services and audiology services. These additional services exceed the service requirements established by federal

regulations for the standard home health benefit. Hospice services are also available in a community or institutional setting. The Program of All Inclusive Care for the Elderly (PACE) is another community-based option the Commonwealth offers for elderly Medicaid recipients. (For a capitated payment from Medicare and Medicaid, PACE providers provide an array of services to PACE enrollees including such services as adult day health care, personal care, physician services, and other services.) Case management services are also available to targeted populations in the community.

Currently, the Commonwealth provides private duty nursing services through EPSDT and home and community-based waivers. Personal care is not offered through Virginia's Medicaid state plan, but it is available through home and community-based waivers. Although respiratory care for ventilator dependent individuals is not a service the Commonwealth covers under the Medicaid state plan, individuals who may have qualified for this service could be eligible for the Technology Assisted Waiver. Home and community-based service waivers are a common method states employ to provide needed services to specific Medicaid populations in their homes and communities.

Typically, Medicaid services must be provided with the same amount, duration, and scope to all Medicaid recipients. However, the federal government allows the states to change some of these requirements by granting them a "waiver." All Medicaid waivers must be approved by the federal government. There are several different categories of Medicaid waivers. Most states operating waivers that provide services specifically to enable individuals to live in the community operate under the authority of section 1915(c) of the Social Security Act (SSA). These waivers are frequently referred to as Home and Community-Based Services (HCBS) Waivers or 1915(c) waivers.

Under the authority of §1915(c), states may waive Medicaid State Plan requirements such as statewideness, comparability of services, and community income and resource rules. Unlike the Medicaid State Plan, services provided through 1915(c) waivers do not have to be equal in amount, duration, and scope. With this flexibility, states have the option of providing a variety of different services to best meet the needs of the waiver population. In addition, states may target specific populations or geographic areas.

Virginia currently has five operational home and community-based services waivers including the:

1. AIDS Waiver;
2. Elderly or Disabled with Consumer Direction (EDCD) Waiver;
3. Mental Retardation (MR) Waiver;
4. Technology Assisted Waiver; and

5. Individual and Family Developmental Disabilities Support (DD) Waiver.

Appendix B contains additional information on each of Virginia's HCBS Waivers.

Waiver programs provide the opportunity for individuals who may otherwise have been institutionalized to live in their homes and community. In recognition of this level of care, individuals enrolled in a waiver must meet the criteria for admission to an institution, such as a nursing home, hospital, or ICF/MR. Each waiver has an alternate institutional placement.

A 1915(c) waiver must be cost-effective, meaning that the total costs of individuals on the waiver cannot exceed total costs of individuals in the institution. Various factors are taken into consideration when determining cost-effectiveness, including services provided in addition to waiver or institutional services such as acute hospital care.

LONG-TERM CARE COSTS

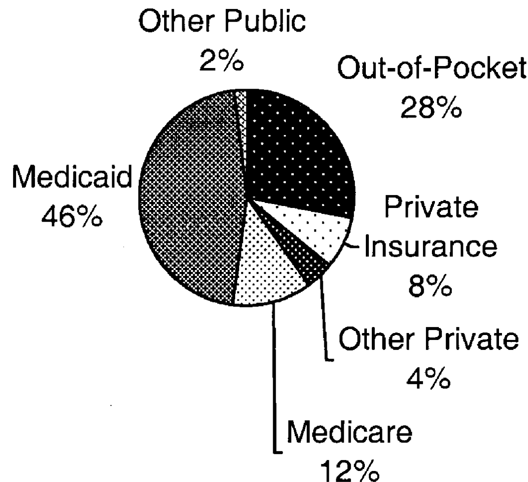
According to the Centers for Medicare and Medicaid Services, in 1980, $20.1 billion in public and private funding was spent nationally on long-term care services (nursing home and home health services), with nursing home care costs amounting to $17.7 billion. By 2003, nursing home and home health services accounted for $150.8 billion or 8.98 percent of the nation's $1,678.9 billion in health expenditures. Nursing home care was responsible for $110.8 billion in health care expenditures or 73 percent of nursing home and home health costs. Figure 1 displays the distribution of nursing home financing by payer across the nation; with Medicaid being the largest funding source at 46 percent. By contrast in Virginia, 48.4 percent of net revenues for nursing facilities were attributed to Medicaid in 2003, according to a summary of net revenues reported by the Virginia Health Information (VHI) Efficiency and Productivity Information Collection System (EPICS). In Virginia, Medicare was the next largest contributor to nursing home revenues at 29.2 percent.

Long-Term Care Spending by Medicaid

The National Conference of State Legislatures (NCSL) reported that in 2001, long-term care spending by Medicaid topped $75 billion which comprised approximately one-third of total Medicaid expenditures. (This was despite the fact that less than 10 percent of Medicaid beneficiaries access long-term care services.) Only 29 percent or $22 billion of this Medicaid long-term care

Figure 1

2003 Nursing Home Expenditure Distribution by Source of Funds



Source: Centers for Medicare and Medicaid Services, National Health Accounts, 2005

spending was used to provide services in the community to individuals who would otherwise be in an institution.

Institutional Care Funded by Medicaid. NCSL calculates that in 2001, 71 percent of Medicaid long-term care spending or $53 billion funded long-term institutional care in facilities such as nursing homes and intermediate care facilities for the mentally retarded (ICF/MRs). The Kaiser Commission on Medicaid and the Uninsured estimated that by 2002 long-term care spending in these institutional settings had dropped to 68 percent (consisting of 12 percent ICF/MR and 56 percent nursing home placement). By contrast in Virginia, a higher percentage (80 percent) of Medicaid long-term care costs was spent on care in ICF/MRs (13 percent) and nursing facilities (67 percent including spending involving mental health institutions) in 2002.

In 2003, Medicaid payments of $547,287,699 (approximately 50 percent of which was state general funds) were made to nursing facilities in Virginia. These payments represent 49 percent of the revenue received by nursing facilities. Just over 76 percent of these Medicaid payments were for individuals classified as

"aged." (Data provided by the *Virginia Department of Medical Assistance Services' Statistical Record* and the Virginia Health Information Efficiency and Productivity Information Collection System.)

Non-Institutionalized Care Funded by Medicaid. Most long-term care spending for non-institutionalized care involves services provided through home and community-based services (HCBS) waivers. The Kaiser Commission on Medicaid and the Uninsured estimates that, in 2002, optional HCBS waivers accounted for 66 percent of long-term care community services spending by Medicaid. Personal care, an optional benefit accounted for 22 percent of community-based costs and home health care, a mandatory Medicaid state plan service, contributed to 10 percent of the costs. In Virginia, the Kaiser Commission on Medicaid and the Uninsured calculated that spending on long-term care services in 2002 consumed 48 percent of the state's Medicaid dollars (with 20 percent of long-term care expenditures going to home care services).

III. Medicaid Long-Term Care Eligibility

As the largest purchaser of nursing facility services, Medicaid plays an integral role in the provision of long-term care services. A general explanation of Medicaid eligibility will be presented in this chapter. This explanation is not meant to be used as specific guidelines or requirements related to eligibility for Medicaid.

GENERAL MEDICAID ELIGIBILITY

As mentioned previously, there are certain services that must be provided by a state that participates in the Medicaid program while there are additional services that states may choose to provide. These mandatory and optional groups apply to Medicaid eligibility as well. Therefore, the number and types of individuals a state covers with its Medicaid program can vary dramatically.

To qualify for Medicaid, an individual must meet the qualifications to belong to a particular group or category. If an applicant does not meet the criteria for a particular group, they will not qualify for Medicaid no matter how low their income or resources may be. The Medicaid statute defines over 50 potential groups for Medicaid eligibility. However, in the Statistical Record of the Virginia State Medicaid Program, DMAS was able to breakdown most of the coverage classifications into six basic groups:

1. **Low income families with children** who meet the eligibility requirements of the State's July 16, 1996 AFDC Plan.
2. **Aged, Blind, or Disabled** individuals with income below a state specified percentage of poverty. Supplemental Security Income (SSI) recipients received Medicaid automatically, in all but a few states.
3. **Low-income pregnant women and children** who do not qualify for AFDC, either because their income is too high or because they fail to meet the program's categorical restrictions. Expansion of mandatory and optional coverage for non-AFDC pregnant women and children was a major theme of federal Medicaid legislation in the 1980s.
4. **The medically needy**, persons who no not meet the financial standards for cash assistance programs but meet the categorical standards and have income and resources within special medically needy limits established by the states. Persons whose incomes or resources are above the standards may qualify by "spending down," incurring medical bills that reduce their income and /or resources to the necessary levels. Coverage of the medically needy is optional:

41 states and other jurisdictions cover at least some groups of the medically needy.

5. **Persons requiring institutional care.** Special eligibility rules apply to persons receiving care in skilled nursing facilities (SNFs) or intermediate care facilities for the mentally retarded (ICF/MRs) or who are participating in alternative community care programs for the aged and disabled. Many of these persons may have incomes well above the poverty level but qualify for Medicaid because of the very high cost of their care.
6. **Low-income Medicare beneficiaries.** Medicaid pays required Medicare premiums, deductibles, and coinsurance on behalf of low-income aged and disabled Medicare beneficiaries. (Coverage is restricted to Medicare cost-sharing unless the beneficiary also qualifies for Medicaid in some other way.) Source: The Statistical Record of the Virginia Medicaid Program, State Fiscal Year 2003.

Examples of mandatory and optional coverage groups are included in Figure 2. (This list is not all inclusive.)

Figure 2
Examples of Medicaid Eligibility Groups

Mandatory Populations
- Children age 6 and older below 100% FPL.
- Children under age 6 below 133% FPL.
- Parents below state's AFDC cutoffs from July 1996 (median=42%FPL).
- Pregnant women ≤133% FPL.
- Elderly and disabled SSI beneficiaries with income ≤74% FPL.
- Certain working disabled.
- Medicare Buy-In groups (QMB, SLMB, etc.)

Optional Populations
- Low-income children above 100% FPL who are not mandatory by age.
- Low-income parents with income above state's 1996 AFDC level.
- Pregnant women >133%FPL.
- Disabled and elderly below 100% FPL, but above SSI level.
- Nursing home residents above SSI levels, but below 300% SSI.
- Individuals at risk of needing nursing facility or ICF/MR care (under HCBS waiver).
- Certain working disabled (>SSI levels).

Section 209(b) of Public Law 92-603 Allows for More Restrictive Criteria

Supplemental Security Income (SSI) recipients are a mandatory coverage group. In most states, SSI beneficiaries automatically receive Medicaid benefits. However, this is not the case in states, such as Virginia, that have elected to exercise the 209(b) option.

Section 209(b) of P.L. 92-603 allows states to use more restrictive criteria when determining Medicaid eligibility of the aged, blind, and disabled than what is allowed under the SSI program. Eligibility criteria established by the states may not be any more restrictive than what was included in the state's approved Medicaid plan as of January 1, 1972. Twelve states, including Virginia, currently employ the 209(b) option.

By exercising the 209(b) option, Virginia has been able to control the number of individuals who qualify for certain Medicaid groups and, therefore, contain certain Medicaid expenditures. If the Commonwealth did not employ the 209(b) option, changes in SSI eligibility would have resulted in large expenditures for Virginia. Each 209(b) state differs in their more stringent eligibility requirements. Virginia focuses primarily on resource evaluation. The most commonly discussed resource evaluation method concerns property contiguous to an applicant's home. When determining eligibility under SSI, the home and all contiguous property, regardless of the value, is exempt. However, Virginia Medicaid only exempts the home, the lot on which it sits, and up to $5,000 in additional contiguous property. Some of the other more stringent resource evaluation methodologies used by the state include counting the value of interests in undivided estates and limiting the time in which a home is exempt to six months from admission for individuals in nursing facilities.

ELIGIBILITY FOR MEDICAID LONG-TERM CARE

Pre-Admission Screening

With few exceptions, any individual seeking Medicaid payment for long-term care services must undergo the pre-admission screening process. In 1977, the Nursing Home Pre-admission Screening Program was established to ensure that Medicaid-eligible individuals accessing nursing facility services actually required the level of care provided in these facilities. By 1982, the program had expanded to include individuals seeking care in institutions and HCBS waivers.

To meet the criteria for nursing home admission, an individual cannot merely need assistance with ADLs. Nursing facility admission can only occur when an individual's functional capacity and medical or nursing needs meet specific requirements set forth in 12VAC30-60-303 (Appendix C). It is important to note that the individual must have a medical or nursing need.

Long-Term Care Financial Eligibility

To qualify for Medicaid long-term care services, an individual must fall into at least one Medicaid-covered group. Long-term care services are provided to individuals within the following Virginia Medicaid covered groups:

- All categorically needy covered groups which includes:
  - Aged, Blind and Disabled (ABD) groups such as:
    - Former Old Age Assistance (OAA), Aid to the Blind (AB), or Aid to the Permanently and Totally Disabled (APTD) money payment recipients who currently receive SSI or Auxiliary Grants (AG);
    - SSI recipients who meet the more restrictive resource eligibility requirements; and
    - AG cash assistance recipients.
  - As well as certain Family and Children (F&C) groups such as:
    - Foster care children receiving IV-E money payments; and
    - Adoption assistance children receiving IV-E money payments.
- All categorically needy non-money payment covered groups including:
  - ABD:
    - Individuals who are institutionalized in a medical institution, who meet all Medicaid eligibility requirements and have income before exclusions that is less than 300% of the SSI individual payment limit;
    - Individuals who receive or are applying for Medicaid HCBS waiver services, who meet all Medicaid eligibility requirements and have income before exclusions that is less than 300% of the SSI individual payment limit;
    - ABD individuals who have protected status; and
    - Hospice.
  - F&C groups:
    - Low-income families and children (LIFC) eligible children, parents, non-parent caretaker-relatives, and EWBs;
    - Children under age 1 born to certain mothers who were eligible for and receiving Medicaid under a particular category;
    - Non-IV-E foster care or Juvenile Justice Department children, or non-IV-E adoption assistance children;
    - Individuals under age 21 in an ICF or ICF/MR;
    - F&C individuals who are institutionalized in a medical institution, who meet all Medicaid eligibility requirements and have income before exclusions that is less than 300% of the SSI individual payment limit; and

    - F&C individuals who receive or are applying for Medicaid HCBS waiver services, who meet all Medicaid eligibility requirements and who have income before exclusions that is less than 300% of the SSI individual payment limit.
- ABD with income • 80% FPL.
- F&C group pregnant women and newborns under age one year.
- F&C group children under age 19.
- All medically needy covered groups which includes:
  - Aged, blind or disabled (ABD) individuals; and
  - F&C groups:
    - Children under 18;
    - Children under age one;
    - Pregnant women;
    - Non-IV-E foster Care/Adoption Assistance children and Juvenile Justice Department children; and
    - Individuals under age 21 in an ICF or ICF/MR).

It is important to note that ICF/MR, institution for mental disease, MR waiver, and DD waiver services are not provided to the medically needy.

It must be determined which Medicaid-covered group an applicant falls into before income and assets can be assessed. The Medicaid-covered group determines the income and resource levels that will apply.

Resource Limits

The Medicaid-covered group also determines the level of resources the individual is allowed to possess and still qualify for Medicaid. Figure 3 displays the current resource limits for groups eligible for Medicaid payment of long-term care services. It is important to note that the resource limits discussed in this section only apply to an unmarried individual or an individual without a spouse living in the community. Separate rules apply for institutionalized individuals with a community spouse.

Figure 3
Resource Limits for Medicaid Long-Term Care Eligibility Groups

	Resource Limit
All aged, blind, and disabled (ABD) covered groups	*$2,000* per individual
Family &Children (F&C) 300% SSI and Hospice groups	*$1,000* regardless of the number of individuals in the assistance unit
F&C Medically Needy groups	*$2,000* for individual, $3,000 for 2 persons (for pregnant woman with unborn child, add $100 for each additional unborn child)
All other F&C covered groups	*No resource requirements*

Source: Virginia Department of Medical Assistance Services Medicaid Eligibility Manual

ABD Resources. Special resource rules apply for individuals qualifying in an ABD group. According to the DMAS Statistical Record in 2004, 99 percent of nursing facility annual expenditures was for individuals who were classified as aged, blind or disabled. When determining Medicaid eligibility for ABD groups, some available resources are not counted. For example, the value of one automobile would not be considered when determining eligibility. Figure 4 provides an abbreviated overview of resources that are excluded when determining ABD Medicaid eligibility.

Figure 4
Resource Limits for Medicaid ABD Covered Eligibility Groups
(This list is not all inclusive.)

Exclusion	No Limit on Value and/or Length of Time	Limit on Value and/or Length of Time
Home serving as the principal place of residence, including the land on which the home stands, plus up to $5,000 worth of contiguous property (*contiguous property is exempt for QDWI, QMB, SLMB, QI and ABD 80%FPL; institutionalized individuals w/out community spouse have home excluded for 6 months)	* ✓	✓
Funds from sale of a home if reinvested timely in a replacement home		✓
Jointly-owned real property which cannot be sold without undue hardship (due to loss of housing) to the other owner(s) – for QMB, QDWI, SLMB, QI and ABD 80% FPL only	✓	
Real property for as long as the owner's reasonable efforts to sell it are unsuccessful.	✓	
One automobile (Exception – QDWI)	✓	
Life insurance, depending upon its face value		✓
Burial space or plot held for an eligible individual, hi/her spouse, or member of his/her immediate family	✓	
Burial funds for an individual an/or his/her spouse		✓
Certain prepaid burial contracts		✓
Household goods and personal effects	✓	
Property essential to self-support		✓

Source: Virginia Department of Medical Assistance Services Medicaid Eligibility Manual

Married Institutionalized Individuals with Community Spouses. The Medicare Catastrophic Coverage Act (MCCA) of 1988 implemented significant changes to Medicaid by providing protections to community spouses of individuals who receive Medicaid funded institutional care. Prior to enactment of this legislation, states had been able to implement strict guidelines when determining how resources held by married couples would be treated in determining eligibility and patient pay requirements for Medicaid institutionalized recipients. The MCCA provided a minimum and maximum amount of countable resources that a community spouse may keep. These rules were designed to keep the spouse who still lived within the community from becoming financially destitute.

When determining initial eligibility, the institutionalized spouse meets Medicaid eligibility requirements if in the month of application, the difference between the couple's total countable resources at the time of application and the amount of resources that are protected for the community spouse is equal to or less than $2,000. The spousal protected resource amount (PRA) is determined by looking at during the time of Medicaid application as an institutionalized spouse, the greater of:

- The spousal resource standard in effect at the time of application;
- The spousal share, which is calculated by taking half of the couple's combined countable resources at the beginning of the first continuous period of institutionalization and does not exceed the maximum spousal resource standard;
- The amount transferred to the community spouse by the institutionalized spouse by a court spousal support order; or
- The amount of resources designated by a DMAS Hearing Officer.

Spousal resource standards establish minimum and maximum resource levels that are necessary for the noninstitutionalized spouse to maintain himself in the community. The spousal resource standards have been increased each year since 1989 in concert with increases in the Consumer Price Index. The minimum spousal resource standard was set at $12,000 in 1989. As of January 1, 2005, the minimum spousal resource standard was $19,020. The maximum spousal resource standard was $60,000 in 1989. As of January 1, 2005, the maximum spousal resource standard was set at $95,100.

The community spouse resource allowance (CSRA) is a tool used to ensure that the community spouse is not left living in poverty by protecting resources that are in the institutionalized spouse's name for the support of the community spouse. The CSRA is the amount of resources in the institutionalized spouse's name, including their share of jointly-owned resources that may be transferred to the community spouse to ensure the community spouse's resources meet the PRA. During a protected period, which does not exceed 90 days after an initial determination of Medicaid eligibility, the CSRA amount is excluded from the institutionalized spouse's countable resources if the institutionalized spouse expressly indicates his intention of transferring resources in his name to the community spouse. The protected period of eligibility provides a time frame in which the institutionalized spouse may transfer resources to the community spouse.

MEDICAID ASSET TRANSFERS

During Medicaid's first 16 years in operation, there were no federal laws or regulations preventing recipients from disposing of assets in order to qualify

for Medicaid funded nursing home care. In 1980, as part of the *Omnibus Reconciliation Act*, the Boren-Long Amendments sought to address the issue of improper asset transfers. Under the amendments, states could deny SSI benefits to an individual who transferred assets for less than their fair market value. Since states based some of their eligibility on SSI, this rule could be used to withhold services for up to 24 months. However, serious asset transfer issues persisted. The Boren-Long amendment only restricted the transfer of non-exempt assets, which in many states would not include the home. Therefore, individuals could still transfer their homes and not incur a penalty.

The *Tax Equity and Fiscal Responsibility Act* (*TEFRA*) of 1982 sought to close additional loopholes. States were allowed to deny Medicaid to individuals that transferred assets that had been previously excluded from eligibility consideration, including the inappropriate transfer of a home. A second important component of *TEFRA* was the imposition of a two-year restriction on asset transfers made prior to the application for Medicaid. If an improper transaction occurred during those two years, the state could deny Medicaid eligibility. The length of the period of ineligibility was based on the value of the assets for which the applicant did not receive compensation. Congress allowed states to choose whether or not they wished to implement these additional safeguards against improper asset transfers.

The *Medicare Catastrophic Coverage Act* (MCCA), enacted on July 1, 1988, changed the federal law regarding property transfers. Unlike *TEFRA, MCCA* mandated that all states implement asset transfer restrictions. In addition, it extended the period of time in which improper asset transfers could not be made to 30 months prior to eligibility.

Public Law 103-66 (*Omnibus Budget Reconciliation Act*), enacted August 10, 1993, provided additional revisions to Medicaid asset transfer provisions. Section 1917 of the Social Security Act was amended to include additional provisions related to Medicaid asset transfers and trusts. In particular, it increased the period of time in which Medicaid may look back to determine if an individual has made an improper transfer to 36 months or 60 months for trusts.

Assets

For the purpose of Medicaid eligibility, assets are viewed as income and resources of an individual and his spouse. Any action that reduces or eliminates an individual's ownership or control of an asset is viewed as an asset transfer. According to the Virginia Medicaid Eligibility Manual, transfers may occur in many different forms including:

- *Giving away or selling property;*
- *Disclaiming an inheritance or not asserting inheritance rights in court;*

- *Clauses in trusts that stop payments to the individual;*
- *Putting money in a trust;*
- *Payments from a trust for a purpose other than benefit of the individual;*
- *Irrevocably waiving pension income;*
- *Not accepting or accessing injury settlements;*
- *Giving away income during the month it is received;*
- *Refusing to take legal action to obtain a court-ordered payment that is not being paid, such as alimony or child support;*
- *Placement of lien or judgment against individual's property when not an "arm's length" transaction; and*
- *Other similar actions.*

(Note: An arm's length transaction occurs when a transaction is negotiated by unrelated parties, with each acting in his own self-interest.)

Look-Back Period. Currently in Virginia, if an institutionalized person or his spouse disposes of assets for less than fair market value during the look-back period, they are ineligible for Medicaid long-term care services. This does not mean that they are ineligible for other Medicaid services. The look-back period varies depending upon the type of asset involved. For asset transfers that do not involve trusts, the look-back period includes 36 months prior to the first day that the individual was both institutionalized and a Medicaid applicant or recipient. If a transfer involves a trust, the look-back period includes 60 months prior to the first day in which an individual was both institutionalized and a Medicaid applicant or recipient.

Assets that Are Not Considered Resources. In Virginia, when determining if an improper asset transfer has occurred, there are a number of assets that are not considered resources for asset transfer purposes. As such, the transfer of these items does not affect an individual's eligibility for Medicaid long-term care services. The following items are not considered resources for asset transfer purposes:

- Personal effects and household items including:
  - An engagement ring;
  - A wedding ring;
  - Items needed for an individual's medical condition; and
  - Household goods and personal effects that are not items of unusual value.
- Certain vehicles meeting specific use requirements:
  - If the vehicle does not meet the specific use requirements at the time it was transferred, $4,500 of the trade-in value of the vehicle is excluded. Any value the vehicle had over $4,500 will be considered an asset transfer.

- Property which is essential to self-support.
- Transfer of resources under a disabled or blind SSI recipient's Plan of Self-Support (PASS).
- Certain life insurance:
  - If the total of all face values totals $1,500 or less.
- Certain cash and in-kind items to replace or repair, lost, damaged, or stolen exempt resources.
- Burial spaces or plots for the use of the individual, their spouse, or immediate family.
- Burial fund transfer of up to $1,500.
- Cash to purchase medical or social services if the cash was transferred in the receipt month or the month following the receipt month.
- Alaskan Natives' stock.
- Certain other assets that are not resources if they have been kept separate from other resources. (Retained disaster assistance is an example.)

Asset Transfers that Do Not Affect Eligibility. Virginia allows the transfer of certain resources in particular circumstances. The transfer of these resources will not affect an individual's eligibility for Medicaid covered long-term care services.

An individual may transfer their home to a spouse, children under age 21, or children of any age who are blind or disabled. Homes may also be transferred to a sibling when the sibling has an equity interest in the home and has resided in the home for at least one year prior to the date the individual became institutionalized. Homes may also be transferred to an adult child who is not blind or disabled if they resided in the home for a minimum of two years before the individual became institutionalized. The individual's child must also have provided care to the individual during that two-year period which allowed the individual to reside in the community instead of an institution. In addition, a physician's statement, a statement of services provided by the adult child, and a third party statement must be provided.

Transfers to certain individuals or trusts do not affect eligibility for Medicaid long-term care services. Asset transfers can be made to the individual's spouse or to another individual for the sole benefit of the individual's spouse. Transfers can also be made by the spouse to another individual for the sole benefit of the spouse. Any asset may also be transferred to the individual's child if he is under 21 or if is blind or disabled. Also, trusts may be established that are solely for the benefit of the individual's blind or disabled child or a child under the age of 21 or for the benefit of an individual under 65 who is disabled, when the trust meets certain conditions. (Generally

the asset transfer or trust must be arranged in a manner in which only the spouse, minor child, blind or disabled child, or disabled individual may benefit from the transferred assets or assets in the trust; both at the time of transfer as well as any time in the future.)

If an individual can prove that they intended or did receive adequate compensation for an asset transfer to cover long-term care services' payment, it does not affect their eligibility for Medicaid. An individual must show that they made a reasonable effort to sell real property as it is set forth in the Virginia Administrative Code. Evidence of a legally binding contract is needed to show that adequate compensation was received for the transferred asset. For burial trusts of more than $2,500 such evidence as a contract with the funeral home listing all items and services and their price must also be provided.

If an asset was transferred for a reason exclusive of becoming or remaining eligible for Medicaid long-term care, the transfer of assets does not affect eligibility. To prove their case, an individual must provide objective evidence that the transfer was not made with the intent of qualifying for Medicaid. A statement of the individual's lack of knowledge of the asset transfer provisions is not sufficient evidence.

The community spouse of an institutionalized individual may make post-eligibility transfers of resources owned by the community spouse when the institutionalized spouse has no ownership interest. These transfers do not affect the institutionalized spouse's eligibility for long-term care services provided by Medicaid.

Assets that have been transferred for less than fair market value may be returned to the individual. If the asset is returned, it does not affect the eligibility of the individual for Medicaid's payment of long-term care services.

Virginia Medicaid also has an undue hardship policy. Under this provision, eligibility for Medicaid payment of long-term care services is not affected, despite the fact that the individual has transferred an asset for less than fair market value, if ineligibility for Medicaid long-term care would provide an undue hardship for the individual.

Asset Transfers that Affect Medicaid Long-Term Care Eligibility. Asset transfers that do not meet the requirements for an allowable transfer or involve non-excluded resources can affect an individual's eligibility for Medicaid payment of long-term care services. According to DMAS' Medicaid Eligibility Manual, asset transfers that may affect eligibility for Medicaid long-term care services include:

- *Cash, bank accounts, and savings certificates;*
- *Stocks or bonds;*
- *Personal effects or household items of unusual value;*
- *Resources over $1,500 that are excluded under the burial fund exclusion policy;*
- *Cash value of life insurance when the total face value of all policies owned on an individual exceeds $1,500;*
- *Interests in real property, including mineral rights; and*
- *Rights to inherited real or personal property or income.*

Penalty Period

If an individual conducts a transfer of assets that does not meet requirements set forth by the state, Medicaid will not fund their long-term care services for a calculated period of time. This is known as a penalty period and it is calculated when an individual makes an improper transfer of assets during the look-back period. For asset transfers that do not involve trusts, the look-back period includes 36 months prior to the first day that the individual was both institutionalized and a Medicaid applicant or recipient. If a transfer involves a trust, the look-back period includes 60 months prior to the first day in which an individual was both institutionalized and a Medicaid applicant or recipient.

The penalty period is determined by dividing the uncompensated value of assets transferred during the look-back period by the average monthly cost of private pay nursing facility services at the time of application for Medicaid. The uncompensated value of an asset is determined by taking the asset's fair market value at the time of transfer (less any outstanding encumbrances, such as mortgages) and subtracting the amount the individual received for the asset.

The penalty period begins on the penalty date. When an individual applies for Medicaid, the first day of the month in which the asset transfer occurred, provided that the date does not occur during an existing penalty period, is the penalty date. The first day of the month following the month in which the asset transfer occurred, provided that the date does not occur during an existing penalty period, is the penalty date for Medicaid recipients who transfer assets while receiving Medicaid. The penalty period ends on the last day of the last month of the penalty period.

IV. Current Issues Involving Medicaid Asset Transfers

The improper transfer of assets to qualify for Medicaid payment for long-term care services is an issue that has received national attention. It has been a concern for many years with the enactment of the *Omnibus Reconciliation Act of 1980* and the Boren-Long Amendments as the first attempt to curtail abuse of the system. Since that time, several pieces of federal legislation have been enacted to curtail the practice of improper Medicaid asset transfers.

It is unclear how pervasive the practice of making improper asset transfers is. Georgetown University's Long-Term Care Financing Project published the issue brief *Medicaid's Coverage of Nursing Home Costs: Asset Shelter for the Wealthy or Essential Safety Net?* in May of 2005. The issue brief states there is little evidence that nursing home residents or the elderly in general transfer assets in order to qualify for Medicaid. The brief suggests that additional reforms designed to curb the transfer of assets would produce minimal Medicaid savings. However, a study entitled *Medicaid's Nursing Home Coverage and Asset Transfers,* conducted by William F. Bassett for the Board of Governors of the Federal Reserve System in March 2004, concluded that many individuals expect to need nursing care in the future and are likely to make asset transfers in order to comply with current Medicaid rules. As a result of these transfers, he concludes that there is at least a modest increase in Medicaid expenditures.

MEDICAID ASSET TRANSFERS IN VIRGINIA

In response to Senate Joint Resolution 91, which was passed during the 1991 General Assembly Session, the Joint Legislative Audit and Review Commission (JLARC) reviewed asset transfers in Virginia. The JLARC study, *Medicaid Asset Transfers and Estate Recovery*, SD 10 (1993) reported that more than $14 million in assets were sheltered using loopholes in the federal law in fiscal year 1991. The abuse of federal law in order to gain access to Medicaid eligibility only occurred in a small proportion of Virginia's Medicaid applicants. JLARC determined: "If federal and State laws are not adopted to discourage these practices, the number of persons who transfer assets with the intent of qualifying for Medicaid nursing home benefits could grow significantly, especially with the State's growing elderly population."

The JLARC report included a number of recommendations for curbing the improper transfer of assets. Figure 5 displays each JLARC recommendation related to asset transfers and any actions taken.

Figure 5
Recommendations Related to Asset Transfers from the 1993 JLARC Study on Medicaid Asset Transfers and Estate Recovery with Corresponding Actions

JLARC Recommendation	Action Taken
The General Assembly may wish to consider requiring the Clerks of the Court to conduct property checks for all persons applying for Medicaid benefits. These property checks should cover the 3 year period prior to the date that the application for benefits was submitted. To facilitate these checks, DSS should require each local office to send to the Clerks of Court, on a monthly basis, the names of new Medicaid applicants.	No action taken.
DMAS should use the authority recently provided by HCFA (now CMS) to adopt a state regulation permitting eligibility workers to count multiple transfers as a single transaction.	Current eligibility policy counts multiple transfers as a single transaction when there are overlapping penalty periods.
The General Assembly may wish to adopt legislation giving DMAS the authority to count the resources used by Medicaid applicants to purchase term life insurance policies which have benefit to premium ratios that are lower than an established threshold. The time period in which these transfers can be regarded as inadequate compensation should be 30 months prior to the date that the person applies for Medicaid nursing home benefits. The State Bureau of Insurance should assist in the development of an appropriate benefit to cost ratio standard.	Section 32.1-325.01 of the Code of Virginia addresses certain term life insurance. Current policy contends that the purchase of any term life insurance after 4/7/93 (except those that meet requirements under §54.1-2820) is an uncompensated transfer if the benefits payable at death do not equal or exceed twice the sum of all premiums paid for the policy.
The General Assembly may wish to amend the *Code of Virginia* by specifically prohibiting the courts from issuing orders which allow individuals the right to claim the assets of other institutionalized persons w/out their legal consent for purposes of avoiding payment of medical expenses.	Under federal spousal impoverishment law, resources owned in the name of one or both spouses are considered available in determining financial eligibility of an institutionalized individual who has a community spouse.
The General Assembly may wish to memorialize the United States Congress through joint resolution to place tighter restrictions on Medicaid asset transfers. This petition should request that the limit on transfers be extended to five years prior to eligibility and require states to calculate the period of ineligibility for illegal transfers beginning with the date that the applicant applies for and meets the level-of-care criteria for nursing home care.	OBRA 1993 established new requirements related to asset transfers and trusts.
The General Assembly may wish to pass legislation which clarifies whether §55-19(D) of the *Code of Virginia* gives the courts the authority to reform "spendthrift" trusts established for persons who are receiving Medicaid nursing home benefits.	No action taken.
DSS should limit the IEVS data which eligibility workers are required to check for long-term care cases to the financial information reported by the IRS. All other types of verification for data that are not current should be let to the discretion of the eligibility workers. DSS should also explore the possibility of establishing a liaison position with the IRS.	No action taken.

Source: Senate Document No. 10, 1993 and staff interviews

Current Issues Involving Sheltering Assets in Virginia

Interviews with state personnel revealed three major methods that Medicaid applicants are using to shelter assets in Virginia. State staff are seeing the increased use of annuities, life estates, and savings bonds to shelter assets from long-term care expenditures. Although the exact number of these asset transfers is not readily available, anecdotal evidence suggests they are becoming a more pervasive issue.

Use of Annuities. An analysis conducted by the CNA Corporation for the Centers for Medicare and Medicaid Services in 2005 revealed that the use of annuities to shelter assets could be costing the Medicaid program $200 million annually. In concurrence with this estimate, DMAS has begun to see the increased use of annuities to shelter assets. In an economic impact analysis conducted by the Virginia Department of Planning and Budget (DPB), it is noted that 15 cases with questionable annuity activity were reported by eligibility workers within the last year. DPB estimates that this number underestimates the number of annuity transactions that are actually occurring since annuities are currently allowed under DMAS' regulations. Based strictly on the 15 cases reported by eligibility workers, DPB estimates the cost to Medicaid to be around $2.3 million to $3.4 million. However, DPB believes that this is an underestimate due to the number of unknown cases of annuity transactions.

Federal law allows state Medicaid programs to disregard the value of an annuity as a countable resource if the expected return on the annuity is actuarially sound or is commensurate with a reasonable estimate of the life expectancy of the beneficiary. To be actuarially sound, the annuity must pay out its full principal plus interest during an individual's life expectancy. DMAS uses the actuarially sound life expectancies used in the SSI program. Regardless of the size of the payments received from an annuity, if the return on the annuity is commensurate with the annuitant's statistical life expectancy, it is considered a fair market value transaction and as such any annuity payments are viewed as income and not assets for determining Medicaid eligibility.

As long as the institutionalized annuitant lives to the full life expectancy or does not have a balloon payment at the annuities maturity, a patient pay amount may be collected and thus reduce DMAS' payment to the long-term care provider. When an annuitant dies before his statistical life expectancy projection, DMAS, under current regulations is unable to recoup the full purchase price of the annuity. In effect, this allows the deceased annuitant to transfer assets without a penalty. The amount that heirs may receive, and thus shelter from long-term care expenses, may be even greater if the annuity contains a balloon payment upon maturity. Even if an annuitant lives for the duration of the

balloon payment annuity, he may still shelter his assets by taking funds from the annuity balloon payment and rolling them into another annuity.

DMAS has discovered other practices individuals are using to shelter assets in annuities. One of the practices is to establish a "private annuity." This is typically an agreement between two individuals where assets other than cash are involved. Private annuities are often actuarially sound based on life expectancy tables, with small payments made over the life of the annuity and a large balloon payment due upon the maturity of the annuity. In a situation such as this, the institutionalized annuitant would have a decreased patient pay, thus increasing the financial burden on the Commonwealth. In addition, if the annuitant dies before the annuity matures, then the annuitant has successfully sheltered additional funds from the state.

The *Omnibus Budget Reconciliation Act of 1993* set out rules requiring the transfer of assets and trusts to be considered by states in determining Medicaid eligibility. When DMAS established regulations in response to *OBRA 1993*, the regulations did not specifically address annuities. This led to ambiguity in the consideration of annuities in the eligibility determination process. As a result of seeing the increased use of annuities to shelter assets, DMAS issued a regulatory package seeking to close the annuity loophole.

DMAS' proposed regulatory changes to the *Virginia Administrative Code* seek to amend 12VAC30-40-290 and 12VAC30-40-300. Within the proposed changes, DMAS defines annuities for the purposes of Medicaid eligibility, as a contract with an insurance company, bank, or other registered or licensed entity in which an individual has made a payment to the entity in exchange for fixed, non-variable payments, with no balloon-end-point payments for a lifetime or a specified number of years. Annuities will be evaluated as a Medicaid asset or resource in the following manner, as set forth by DMAS in the Virginia Register:

- *An annuity containing a balloon payment will be considered an available resource.*
- *A commercial (non-employment related) annuity purchased by or for an individual using that individual's assets will be considered an available resource unless it meets all of the following criteria. The annuity: (1) is irrevocable; (2) pays out principal and interest in equal monthly installments (no balloon payment) to the individual over the total number of months that equals the actuarial life expectancy of the annuitant; (3) names the Commonwealth of Virginia as the residual beneficiary of funds remaining in the annuity, not to exceed the amount of any Medicaid funds expended for the individual during his lifetime for Medicaid covered services and, (4) is issued by an insurance company, bank, or other registered or licensed entity approved to do business in the Commonwealth of Virginia, or if issued in a jurisdiction other than the*

Commonwealth, is licensed to do business in the jurisdiction in which the annuity is established. Payments from the annuity to the Commonwealth cannot exceed the total amount of funds for long-term care services expended on behalf of the Medicaid recipient.

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

In an attempt to expeditiously close existing annuity loopholes, DMAS introduced the proposed regulations as a fast-track action. If 10 or more individuals object to the use of the fast-track promulgation process during the 60-day public comment period, the agency must proceed with the normal promulgation process as outlined in the Virginia Administrative Process Act.

During the 60-day public comment period, DMAS received objections to the use of the fast-track process from more than 10 individuals. As a result, the initial publication of the fast-track regulation package served as the agency's Notice of Intended Regulatory Action (NOIRA). After the NOIRA phase is complete, the public will have a 60-day period to comment on the proposed regulations. DMAS will consider public comments as the final regulations are drafted. Once the Governor approves DMAS' draft of the final regulations, the regulations will be published in the Virginia Register and the 30-day final adoption period will begin. The regulations will become effective at the end of the 30-day period.

Use of Life Estates. Life estates are typically viewed as an estate whose duration is limited to the life of an individual. This is usually the party holding the life estate. DMAS' regulations as set forth in 12VAC30-40-290 establish more liberal methods for treating resources including life estates. When determining Medicaid eligibility, DMAS does not consider the value of a life estate as a resource. As a result, some individuals use life estates as a method to shelter assets by purchasing or trading countable resources to obtain life estates. These individuals can then show that they received adequate compensation for the transfer since a monetary value can be placed on the life estate. The use of life estates effectively turns what could be a countable resource into an exempt resource. Since the resource is now exempt, it is no longer available to assist in the payment of long-term care services. The following is an example of how life estates may be used to shelter assets:

Mrs. Doe, a Medicaid applicant has a home worth $50,000. She goes into a nursing facility, transfers the remainder value of her home to her daughter and keeps a life estate in the property. In exchange for the remainder value of her home, she obtains a life estate in her daughter's home. Since the remainder value in her home is less than the life estate in her daughter's home, the Medicaid applicant receives adequate compensation for the remainder value of her home. Neither her interest in her home nor her interest in her daughter's home are countable resources in determining her eligibility for Medicaid payment of her long-term care costs.

Federal regulations allow states the freedom to determine if life estates are a countable resource. In Virginia, life estates are not counted as a resource. However, considering life estates as resources would not solve the problem of their abuse. A value can be attached to a life estate. Thus, if life estates were counted as a resource, there would be a cash value associated with the life estate. Therefore, if an individual transferred the life estate, he would have to receive just compensation equivalent to the fair market value. If the fair market value was not received and the individual applied for Medicaid, a penalty period could be imposed. However, as long as the individual proves that he made a reasonable effort to sell the life estate, it would not be counted as a resource. Additional problems may occur if the individual with life rights sells his life estate. If the life estate is not sold to the majority property owners but to a third party, that third party has a right to that property for as long as the original life estate owner is alive.

Use of Savings Bonds. DMAS has begun to see the increased use of U.S. Savings Bonds as a method to shelter assets. U.S. Savings Bonds are obligations to the federal government and as such they may only be sold back to the federal government. This is in contrast to other government bonds which may be transferable.

After purchasing U.S. Savings Bonds, there is a mandatory retention period. The Series type purchased effects the length of the retention period. For example:

- Series E, EE, and I bonds issued prior to February 1, 2003 must be retained for 6 months;
- Series EE and Series I bonds issued on or after February 1, 2003 must be retained for 12 months; and
- Series H and HH bonds must be retained for 6 months.

U.S. Savings Bonds are not counted as a resource during the required retention period. Thus, individuals can transfer large amounts of assets into these bonds which will not be counted as a resource for a minimum of six

months, effectively transforming countable resources into non-countable resources. Complicating this issue is the fact that if a co-owner of a bond has physical possession of the bond and will not relinquish it, the bond cannot be counted as a resource for the co-owner seeking Medicaid coverage. An example of how an individual may protect their assets using U.S. Savings Bonds is as follows:

> *Mr. Doe purchases $200,000 of Series H U.S. Savings Bonds in August 2005. He then applies for Medicaid in September 2005. With the Series H mandatory retention period of 6 months, Mr. Doe successfully converted $200,000 in countable resources into an uncountable resource, thereby possibly qualifying for Medicaid.*

Further compounding the issue is the ability to roll funds over into other bonds once the retention period is complete. This roll-over effectively shelters assets by transforming countable resources into uncountable resources. Virginia is not the only state that is seeing an increase in this type of asset transfer. Many states are trying to determine the most effective means for deterring this type of transfer.

V. Strategies to Discourage the Use of Asset Transfers

A number of proposals have been suggested to address the use of loopholes in Medicaid policy to transfer assets. This chapter will discuss five primary methods that have received attention including:

- Additional restrictions on Medicaid asset transfers;
- Estate recovery programs;
- Reverse mortgages;
- Long-term care insurance tax incentives; and
- Long-Term Care Partnerships.

RESTRICTIONS ON MEDICAID ASSET TRANSFERS

Proposed initiatives for tightening restrictions on asset transfers have focused on several changes including:

- Increasing the look back period;
- Changing the start date of the penalty period; and
- Altering the formula used to determine the length of the penalty period.

Currently, states have a 36-month look back period in which to examine a Medicaid applicant's financial transactions to determine if unallowable asset transfers have occurred. (The look back period is 60 months for trusts.) Originally, states did not have any mandate from the federal government to review an applicant's financial history to determine if he was divesting himself of assets. *TEFRA 1982* allowed states the option to examine an applicant's asset transfers for up to 24 months prior to application for Medicaid. The *Medicare Catastrophic Coverage Act (MCCA) of 1988* mandated that states implement a 30-month look back period. The look back period was extended to 36 months with a 60-month requirement for trusts with the passage of the *Omnibus Budget Reconciliation Act (OBRA) of 1993.*

Several organizations including the Medicaid Commission and the National Governors Association (NGA) have proposed increasing the length of the look back period. (Note that the Medicaid Commission was established by the Secretary of Health and Human Services under Public Law 92-263 to advise on short- and long-term reforms to Medicaid.) Proposals have been made to

extend the length of the look back period from three to five years. The CMS Office of the Actuary estimates that this change would save less than $100 million over five years.

Currently, if an individual makes an improper asset transfer during the 36-month look back period or 60-month look back period for trusts, they are assessed a penalty period in which they do not qualify for Medicaid payment of their long-term care services. The penalty period is determined by dividing the uncompensated value of assets transferred during the look-back period by the average monthly cost of private pay nursing facility services at the time of application for Medicaid. The penalty period then begins on the penalty date. At the present time, the first day of the month in which the asset transfer occurred, provided that the date does not occur during an existing penalty period, is the penalty date. Therefore, it is possible for an individual to improperly transfer their assets during the look-back period, and still have Medicaid cover their long-term care services. This can happen when the assessed penalty period is less than the time between the improper transfer and when the individual applies for Medicaid. Even if an individual must pay for some of their long-term care services before Medicaid provides coverage, it is still possible for Medicaid to pay the majority of the cost of their care.

A proposal to end this loophole includes changing the start date of the penalty period from the date of the asset transfer to either the date of application for Medicaid long-term care services or the nursing home admission date, whichever is later. The Congressional Budget Office estimates savings of $1.4 billion over five years.

The NGA supports moving the penalty period start date to the day that an individual applies for Medicaid. The Medicaid Commission also supports this position in addition to changing the start date of the penalty period to the date of admission into a nursing home. The Medicaid Commission proposes using the later of the two possible events to begin the penalty period. President Bush's budget includes changing the start date of the penalty period to the later of the date of nursing home admission or the date an individual qualifies for Medicaid.

There has also been discussion about changing the formula that is used to calculate the penalty period. Currently, the penalty period is determined by dividing the uncompensated value of assets transferred during the look-back period by the average monthly cost of private pay nursing facility services at the time of application for Medicaid. It has been proposed that instead of using the average monthly cost of private pay nursing facility services that the average monthly cost of Medicaid nursing facility services should be used. This change would dramatically increase the length of the penalty period, due to the lower reimbursement rate provided to nursing facilities from Medicaid.

Many organizations have been opposed to any change in Medicaid law that would restrict asset transfers. A recent study conducted by the Long-Term Care Financing Project at Georgetown University suggests, "There is little evidence that large numbers of the elderly are planning their estates for the purpose of gaining access to Medicaid in the event they need nursing home care." For this reason, the study contends there is no need to require further restrictions. Other groups have argued that while additional restrictions are intended to curb abuse in the system, they will actually harm the individuals that Medicaid was intended to serve.

State Waivers

Connecticut, Massachusetts, and Minnesota have applied for Medicaid Section 1115 Research and Demonstration Waivers from the Centers for Medicare and Medicaid Services. Section 1115 waivers allow states to try innovative programs that would not typically be allowed under the state's Medicaid plan. However, the waivers must be budget neutral.

Connecticut's Proposal. Connecticut was the first state to apply for a Section 1115 waiver. The application which was made on April 26, 2002 was withdrawn by Governor Jodi Rell on May 6, 2005. Governor Rell cited concerns that the additional restrictions would place an increased burden on the state's elderly and disabled populations. The Connecticut proposal included:

- Changing the start of the penalty period from the month in which the transfer was made to the month in which the beneficiary qualifies for Medicaid;
- Increasing the look-back period from 36 to 60 months; and
- Establishing thresholds for transfers based upon time of occurrence within the look back period;
    - $0 for transfers made less than one year preceding Medicaid application for long-term care.
    - $2,500 for transfers made between one and two years preceding Medicaid application for long-term care.
    - $5,000 for transfers made between years two and five preceding Medicaid application for long-term care.

Massachusetts' Proposal. Massachusetts officials submitted an 1115 waiver proposal to CMS on August 29, 2003. They have received questions from CMS regarding their proposal. The Massachusetts waiver calls for:

- Extending the look back period to 60 months for real estate and 120 months for irrevocable trusts;

- Unless Massachusetts is named the beneficiary, treating annuities purchased by the individual in a nursing home or their spouse as a transfer at less than fair market value, and thus subject to a penalty period;
- Restricting the expenditure of excess assets after application to;
  - Medical care.
  - Necessary living expenses.
  - Necessary home maintenance.
  - Annuities that provide income to the community spouse in an amount that does not exceed the permitted spousal allowance.
  - Long-term care insurance for the applicant or spouse.
- Prohibiting the practice of sequential transfers which involves the transfer of asset to an allowable person and from that individual to another person;
- If the fair market value of an asset that is currently considered un-countable is above $20,000, then the transfer of that asset would be considered a countable asset and therefore a transfer subject to a penalty period; and
- Exempting the transfer of homes valued at less than $300,000 from the provisions of the demonstration.

Minnesota's Proposal. Minnesota's 1115 waiver proposal to CMS on March 25, 2003 was relatively restrictive. Guidelines designed by the state include:

- Change the start date of the penalty period to the month in which the beneficiary qualifies for Medicaid;
- Extend the look back period from 36 months to 72 months;
- Recalculate the formula for the penalty period by using the statewide average nursing facility payment made by Medicaid, instead of the statewide average nursing facility payment rate;
- Apply transfer prohibitions to all assets, including those currently excluded during the look back period;
- Prohibit the reimbursement of all Medicaid services, not just long term care, during the individual's penalty period; and
- Institute additional provisions that would impact the transfer of the home property to relatives, transfers of trust, and transfers to spouses.

Estate Recovery Programs

Since the inception of the Medicaid program, states have been allowed to recover assets from the estates of deceased Medicaid recipients who were over the age of 65 when they received benefits and who had no surviving spouse, minor child, or adult disabled child. The passage of the *Omnibus Budget Reconciliation Act of 1993* (*OBRA 1993*) required states to implement Medicaid estate recovery programs.

As mandated by *OBRA 1993*, states must pursue recovering costs for certain forms of medical assistance including:

- Nursing home or other long-term institutional care;
- Home and community based services;
- Any hospital or prescription drug services received by the recipient while they were provided institutional care or home and community based services; and
- At the state's option, any other items covered by the Medicaid State Plan.

States have the option of waiving estate recovery when it is not cost effective to pursue incurred expenses. The interpretation of this federal rule varies from state to state. Some states look at each estate on a case by case basis whereas other states may waive the recovery of very small estates.

Only certain individuals are subject to estate recovery. Recipients must be deceased, have been 55 or older when they received Medicaid benefits or have been of any age but were permanently institutionalized for recoveries to be made on their estates.

Under federal law, the needs of certain family members for assets contained in an estate takes precedence over the state Medicaid program. Estate recovery is prohibited in the following instances:

- During the lifetime of the surviving spouse;
- When there is a surviving child who is blind or disabled;
- When there is a surviving child under the age of 21;
- When the former home of the recipient is involved and a sibling with an equity interest in the home lived in the home for at least one year immediately before the deceased Medicaid recipient was institutionalized and continually resided in the home since the recipient's institutionalization; and

- When the former home of the recipient is involved and an adult child: (1) lived in the home for at least two years prior to the deceased Medicaid recipient becoming institutionalized, (2) lived in the home continuously since the Medicaid recipient's institutionalization, and (3) provided care that delayed the recipient's admission to an institution.

States may recover from estates once the spouse dies, a child loses their protected status, or when a protected relative leaves the home. States have taken a variety of approaches to this option, with some choosing to waive their future right to recovery, others deferring it, and others taking a varied approach based on the specifics of each case.

States also have the option of imposing liens on the property of Medicaid beneficiaries to protect the state's interest in the property. A lien, according to the American Bar Association's Commission on Law and Aging's report *Medicaid Estate Recovery: A 2004 Survey of State Programs and Practices* (June 2005), constitutes "a security device that binds property to a debt and puts a party on notice that someone besides the owner of the property has an interest in that property." Therefore, a lien is a notice and not a claim on property. Further, action must typically be taken in court to make a formal claim on the property. However, the use of liens frequently reduces the need to go to court since clear title to property cannot be conveyed at the point of sale if a lien is attached. To remove the lien, the seller must either satisfy the lien as part of the sale or have the lien removed through the courts.

Typically, states employing liens as an estate recovery tool use either pre-death or post-death liens. Pre-death liens are often referred to as TEFRA liens since they must follow the rules set forth in the *Tax Equity and Fiscal Responsibility Act of 1982*. They are typically imposed on the homes of permanently institutionalized individuals. In a survey conducted by the American Bar Association's Commission on Law and Aging, 19 states reported using TEFRA liens with 26 responding that they do not. Post-death liens have certain notice requirements provided under federal law. Otherwise, post-death liens are largely controlled by state law and the probate process.

Proponents of aggressive estate recovery programs argue that it is a necessary tool in decreasing the burden of Medicaid costs. They maintain that it shifts the burden of cost from the taxpayer to the estate of the deceased recipient. Opponents of more aggressive estate recovery programs contend that it is an unfair process that typically affects individuals of modest means. Some argue that it even encourages some individuals to forgo Medicaid funded care even though the services may be needed.

Virginia's Estate Recovery Program. Section 32.1-326.1 of the *Code of Virginia* provides authority for DMAS to operate a Medicaid estate recovery program. Virginia's estate recovery program allows for adjustments or recoveries for Medicaid-provided services to be recovered:

- From the estate of a permanently institutionalized individual;
- From a recipient age 55 or older for payments covering nursing facility services, home and community based services, and related hospital and prescription drug services; or
- From the estate of an individual with long-term care insurance. (If assets or resources are disregarded, recovery is made for all Medicaid costs for nursing facility and other long-term care services.)

Certain conditions must be met for DMAS to initiate recovery of an estate. They include:

- The legal estate administrator or executor has been verified;
- It must be cost effective for the state to pursue recovery;
- The recipient must be deceased and if married the spouse must be deceased also;
- The deceased recipient must not have any children who are blind or disabled or under the age of 21;
- The deceased recipient must have been 55 years or older when the individual received services; and
- The deceased recipient must not have a surviving sibling who has an equity interest in the recipient's home and who has resided in the home for at least one year prior to the recipient entering a nursing facility.

Virginia does not impose liens on an individual's property in order to make recoveries from an estate. Hardship provisions also exist for certain cases in which recovery of a claim would result in substantial hardship for heirs or dependents. When the estate is the sole income-producing asset of survivors, a home of modest value, or under other compelling circumstances DMAS may choose not to pursue recovery of the estate. Alternate methods of recovery may be considered by the Commonwealth if heirs or dependents do not wish to sell a nonliquid asset which is subject to recovery.

Reverse Mortgages

The idea of using reverse mortgages to help finance long-term care expenses (including the purchase of long-term care insurance) has received increased attention recently. The U.S. Census Bureau reports that 73 percent of

seniors own their homes without any encumbrances. The National Governor's Association (NGA) has proposed using reverse mortgages as a tool to discourage individuals with considerable assets from accessing Medicaid.

A Home Equity Conversion Mortgage (HECM) is the most common type of reverse mortgage. With an HECM, a lender advances money to a homeowner. The money may be provided in a series of fixed monthly payments, a line of credit from which the borrower may draw, or a combination of these methods. The HECM is usually provided by a bank and insured by the Federal Housing Administration. Payments do not need to be made on the loan as long as the individual remains living in the home. Payment is collected by the lender once the borrower or their estate sells the home. The loan balance collected by the lender includes any accrued interest, other charges, and the amount of the loan that was paid out.

There are requirements placed on HECMs that restrict their utility. Homeowners must be age 62 or older, including any joint owners of the property. There are restrictions regarding maximum initial loan amounts. Maximum initial loan amounts are controlled by median local home values which determine the county level limit. The county level limit determines the amount of home equity an individual may borrow against. The homeowner can only borrow a fixed percentage of the allowed home equity. The fixed percentage of the home equity is calculated using the borrower's age and the expected interest rate for the loan. (When more than one individual owns the home, the younger individual's age is used.)

Compounding interest along with fees and other costs may increase the final loan balance well above the original amount borrowed. Closing costs are typically included in the upfront costs which increase the final loan balance. Loan proceeds must first go to pay off an existing mortgage and any needed repairs to the property. For some individuals, the sum of the loan costs and required expenses may reduce their available loan to zero.

Different approaches to encouraging the use of reverse mortgages are being proposed. One approach involves letting individuals shelter a specific amount of money in home equity without incurring a Medicaid penalty. For example, if an individual took out a reverse mortgage to pay for his long-term care costs, he would be allowed to shelter $50,000 from Medicaid consideration, even if the resources of the reverse mortgage were to be depleted. The NGA sees initial savings from this type of initiative as being limited. However, future cost-savings could accrue if reverse mortgages restrain the growth of Medicaid long-term care expenditures. A second approach involves allowing a HECM to be used to pay long-term care insurance premiums. A change in the federal HECM law in 2000, allowed the waiver of required upfront mortgage insurance if the

HECM is used only to pay for long-term care insurance. This increases the amount of available loan proceeds to the borrower by 6.7 percent. However, the Georgetown University Long-Term Care Financing Project contends that individuals with limited financial means are not likely to surrender their largest asset, their homes, to gain access to long-term care insurance.

Long-Term Care Insurance Tax Incentives

Federal and state-level governments have recognized the potential for significant Medicaid savings if individuals purchase adequate long-term care coverage. Numerous pieces of legislation across the country have been proposed to encourage the purchase of these plans. The Urban Institute indicates that providing tax incentives that help to defer the cost of long-term care insurance policies is one method to encourage the purchase of these policies. In concurrence with this theory, many of the legislative activities have involved tax incentives.

According to the National Conference of State Legislators, 26 states currently have long-term care insurance tax incentives in place. Maine offers both a tax credit and a deduction. Sixteen states, including Virginia, offer a tax deduction. Another nine states offer a tax credit.

Legislation in Virginia. During the 1999 General Assembly Session, House Bill 1546 created an individual income tax deduction for long-term care insurance premiums. Since the federal government also offers tax incentives, the premium cannot have been deducted under federal income taxes in order to be deducted in Virginia. Since the inception of the tax deduction in Virginia, the number of tax returns claiming the deduction has increased by over fifteen fold, from 3,102 in tax year 2000 to 46,968 in tax year 2003. The increase in deductions resulted in a decrease in taxes collected from $250,000 in tax year 2000 to $6,030,000 in tax year 2003.

Legislation was introduced in the General Assembly to provide a tax credit instead of a tax deduction. House Bill 2600, which was tabled in House Finance, provided an individual income tax credit for certain long-term care insurance premiums paid during the taxable year. The credit was restricted to individuals at least 70 years old or a person purchasing long-term care insurance for a Virginia resident at least 70 years old. The tax credit would be the lesser of the individual's income tax liability or the premiums paid in the taxable year. It was estimated that the reduction in tax collection could have exceeded $60 million in FY 2007.

Considering the cost concerns that have been raised about implementing a tax credit, other creative methods for encouraging the purchase of individual

long-term care insurance policies have been discussed. A grant program could be created to provide direct payments to individuals who purchase policies. A predetermined amount of funding could be allocated to limit the cost to the state. In addition, the grant program could target specific populations within the state. For example, the program could target individuals who would be at high risk for nursing home placement within 10 years. Alternately, the grant program could be a tool to encourage younger individuals to purchase policies while they are more affordable.

Tax Incentives for Employers. Another method for encouraging the purchase of long-term care insurance policies has been to provide tax incentives to employers. Currently, four states, including Maryland, Maine, New York, and Oregon, provide tax incentives for employers. The policies and amounts of the tax incentives vary from state to state.

During the 2005 General Assembly Session, House Bill 2513 and Senate Bill 1041 were introduced to provide an employer tax credit of 10 percent of the cost of qualifying, long-term care insurance provided to employees. Each employer's tax credit was limited to $5,000 or $100 per employee, whichever was less. The impact on Virginia's tax revenue was estimated at less than $50,000 annually. However, both bills were left in the Senate Finance Committee.

Long-Term Care Partnerships

Long-Term Care Partnerships are increasingly being touted as a method to encourage individuals to purchase long-term care coverage and control Medicaid spending. Long-Term Care Partnership programs began in 1988 when the Robert Wood Johnson Foundation began funding a public/private alliance between state governments and private long-term care insurance providers. The planning phase of the grants began with eight states including California, Connecticut, Indiana, Massachusetts, New Jersey, New York, Oregon, and Wisconsin. Only four states, California, Connecticut, Indiana, and New York, were awarded implementation grants.

The core goal of the LTC Partnership was to stimulate market development of long-term care insurance policies in the areas of quality, affordability, and coordination. The result was a hybrid combination of long-term care insurance coverage and special Medicaid eligibility standards. This new model allows individuals to access state Medicaid programs and not to deplete their assets if they have purchased certain long-term care insurance policies.

Two basic LTC Partnership models were created, including the Total Assets model and the Dollar for Dollar model. Both models set a minimum

standard on the amount of long-term care insurance coverage an individual must purchase. The Total Assets model requires that three years of coverage for the initial period of care must be purchased. However, once the policy holder's private plan benefits have been exhausted (three years for a nursing facility, six years of home care, or a combination of the two), the policy holder does not have to provide further contribution of their assets. Although the policy holder may have to contribute part of his income to cover Medicaid long-term care, none of his assets will be considered when determining Medicaid eligibility. New York adopted this model.

Under the Dollar for Dollar model, individuals may purchase coverage equal to the amount of assets they wish to protect. Generally, the policy purchased must cover one year in a nursing facility. When the individual applies for Medicaid coverage, the amount of private LTC insurance benefits paid out for services are disregarded in determining Medicaid eligibility. California, Connecticut, and Indiana initially adopted this model, but Indiana changed its model in 1998 to include the Total Assets model.

Indiana's creative approach of blending the two models allows consumers to purchase the coverage that best meets their needs. Individuals who purchase policies that have at least a state defined coverage amount ($196,994 in 2005) receive Total Asset protection. The minimum amount of required coverage is increased yearly. Policies purchased before March 1998 that had a policy value of at least $140,000, also receive Total Asset protection. For policies that have less than the state-defined coverage amount, individuals receive Dollar for Dollar protection.

California. The California Partnership for Long-Term Care targets modest and middle-income California residents between 55 and 74 years of age. As of March 2005, 70 percent or 45,131 enrollees fell into this target age group. Another 19,784 individuals of other ages also participate in the program for a total program participation of 64,915 individuals. Seventy percent of participants are married and 59 percent are female. At the time of the March quarterly report, 77,501 policies had been purchased and 64,915 were in force.

As noted previously, California uses the dollar-for-dollar model. In approved policies, home and community based care must be a benefit option. In addition, policies must have 5 percent yearly compounded inflation protection or 5 percent simple inflation protection if the policy holder is 70 years of age or older. Care management is a mandatory benefit and must be provided by someone other than the insurer. Other consumer protections such as a once in a lifetime deductible and the waiver of premiums while an individual is in a nursing home or residential care facility must be included in the policy. At the

end of March 2005, the California Partnership for Long-Term Care had five participating insurers.

The cumulative savings to California's Medicaid program, Medi-Cal, as of March 31, 2005, were estimated at $10,555,426. Only 25 of the 1,086 policy holders who had qualified to receive payments had exhausted their policy benefits and accessed Medicaid as of March 31, 2005. As a result, $1,232,013 in assets were protected by policy holders who had exhausted their policy benefits and accessed Medicaid.

Connecticut. As of its March 2005 quarterly report, the Connecticut Partnership for Long-Term Care reported that 38,144 policies had been purchased by individuals between the ages of 20 to 89. The average age of purchasers was 58 and 56 percent were female. Of the over 38,000 policies purchased, 30,834 were still active. Of the individuals who purchased policies through the program, 413 had received benefits through the program but only 23 had accessed Connecticut's Medicaid program.

Policies offered through the Connecticut Partnership for Long-Term Care must provide policy holders the option to purchase home and community based services. As a part of any in home services, case management must be included. Automatic compound inflation protection on an annual basis must also be provided. Minimum daily rates established for nursing facility and home and community based benefits, which increase 5 percent annually, must be followed. If a policy holder is about to discontinue his policy, the insurer must offer that individual the option of switching to a shorter benefit period, thus reducing the premium. In addition, a unique component to Connecticut's program is the 5 percent discount on private pay nursing facility rates that is guaranteed by law.

Private insurance only provided one percent of the reimbursement for nursing facility residents in Connecticut as of September 30, 2004. However, of this one percent, one-quarter was provided through Connecticut Partnership for Long-Term Care policies. For individuals who had been approved to receive Medicaid after exhausting their Partnership LTC insurance benefits, an estimated $2 million in assets would be protected.

Indiana. The Indiana Long-Term Care Insurance Program reports that currently 29,189 of its original 34,969 policies are still in force. Seventy-eight percent of the individuals who have purchased policies are married. Fifty-seven percent of policy holders are women. Policy purchasers range in age from 19 to 90 years old with the average being 62.

The 10 approved Indiana Partnership insurers must provide the following in offered policies:

- Inflation protection (compounded by 5 percent) in the form of benefits that increase annually;
- Standardized and simple requirements for benefit qualification;
- An adequate daily benefit that is determined by the state; and
- Additional consumer protections and disclosure features than non-Partnership policies.

At the time of their March 31, 2005 quarterly report, the Indiana program had 249 policy holders who had accessed their long-term care insurance policy benefits and only 16 had exhausted their policy benefits and accessed Medicaid. By participating in Indiana's program, these participants have protected $912,066.62 in assets.

New York. As of December 31, 2004, 61,358 policies had been purchased through the New York State Partnership for Long-Term Care and 47,539 policies were active. The age of policy holders ranged from 19 to 96 with an average of 63. Fifty-nine percent of the policy holders were female. Of the 1,248 policy holders who have accessed their long-term care insurance benefits, 53 have received Medicaid.

New York requires certain basic benefits to be included in an approved Partnership policy. As of 2005, insurers must provide the following benefits:

- At least three years of nursing facility coverage, six years of home care, or a combination of the two;
- $180/day benefit for nursing facility care and $90/day for home care benefits;
- Inflation protection equal to 5 percent annually;
- Care management provided for 2 days a year;
- 14 days of respite care to be renewed annually for the at home caregiver;
- A 30 day grace period to ensure premiums are paid if a policy holder designates someone to be notified if payment is not made;
- Coverage of alternate level of care status in a hospital while awaiting nursing home placement or at-home services;
- Special consideration for adjustments of premiums and benefits if a national long-term care program is implemented ; and
- Required review of denied benefit authorization requests.

OBRA 1993. A number of states have indicated interest in establishing TLC Partnership programs. However, provisions in the *Omnibus Reconciliation Act (OBRA) of 1993* restrict the ability of additional states to create programs that

provide some form of asset protection within the Medicaid program for individuals who purchase long-term care insurance. (The four original programs were grandfathered in.) Several requirements contained in *OBRA 1993* have made it difficult for states to implement new programs including:

- States operating a Partnership program must recover assets from the estates of all individuals receiving services under Medicaid (which effectively only protects the assets of the individual while they are alive);
- States are prohibited from waiving the estate recovery program requirement; and
- A separate definition of estate for Partnership participants would allow some states to impose more stringent estate standards than what they currently provide for in their Medicaid program.

Despite the inability of states to create new LTC Partnerships, 19 states have enacted legislation that would enable them to create a Partnership as soon as federal legislation allows. In Virginia, the General Assembly enacted Senate Bill 266 (Appendix D) during the 2004 session of the General Assembly. Senate Bill 266 amended the *Code of Virginia* to allow the creation of a Long-Term Care Partnership program once federal restrictions are removed.

State groups such as the National Governor's Association and the National Conference of State Legislators have called for the repeal of federal restrictions on the Partnership program. In response, the President included language in his 2006 budget that would provide authority for states to implement Long-Term Care Partnership programs. In addition, Senate Bills 1569 and 1602 and House Bill 3511 propose to lift the restrictions imposed on states by *OBRA 1993*.

VI. Policy Options

The following Policy Options are offered for consideration by the Joint Commission on Health Care. They do not represent all available actions that the Joint Commission may wish to recommend regarding Medicaid asset transfers.

Option I: Take no action.

Option II: Introduce legislation to provide a tax credit for employers who offer long-term care insurance to their employees.

Option III: Introduce legislation to provide a tax credit rather than a tax deduction for long-term care insurance.

Option IV: Introduce a budget amendment (language and funding) to create a grant program for individuals purchasing long-term care insurance to be administered through the Virginia Department for the Aging. VDA would work with stakeholders to develop eligibility criteria for participation in the program.

Option V: Introduce legislation authorizing the Department of Medical Assistance Services to apply for a waiver to implement more restrictive asset transfer restrictions.

Option VI: Introduce a resolution or send a letter from the JCHC encouraging members of Congress to pass legislation authorizing the further implementation of Long-Term Care Partnership programs in other states.

Option VII: Continue to monitor the actions of Congress regarding additional asset transfer restrictions, reverse mortgages, and Long-Term Care Partnership programs, in addition to monitoring the activities in Virginia involving annuities, life estates, and bonds by including the issues on the JCHC workplan for 2006.

Option VIII: Introduce a resolution directing JLARC to conduct a study to determine the extent of the use of asset transfers to shelter assets in order to qualify for Medicaid long-term care.

APPENDIX A

051560376

1 **HOUSE BILL NO. 2601**
2 AMENDMENT IN THE NATURE OF A SUBSTITUTE
3 (Proposed by the Senate Committee on Education and Health
4 on February 17, 2005)
5 (Patron Prior to Substitute—Delegate Landes)

6 *A BILL to permit the Department of Medical Assistance Services to seek a waiver regarding limits on*
7 *asset transfer, recovery of subsequent assets, and recovery from estates.*

8 Whereas, the Virginia Medicaid program is the largest of the Commonwealth's health care programs
9 for persons who are poor; and
10 Whereas, it is the policy of the Commonwealth that persons who participate in the Medicaid program
11 use their own assets to pay their share of the total cost of their care during or after their enrollment in
12 the program in accordance with state and federal law; and
13 Whereas, there is growing concern that a number of persons seeking Medicaid eligibility are using
14 provisions in federal and state laws or regulations to transfer assets in order to gain access to the
15 program's benefits, thus preserving resources for their heirs; and
16 Whereas, stricter rules governing the transfer of assets for less than fair market value will discourage
17 and deter voluntary impoverishment or, alternatively, result in payment penalties for these activities,
18 thereby reducing medical assistance expenditures, including those for long-term care; and
19 Whereas, more thorough pursuit of resources that become available subsequent to Medicaid eligibility
20 and more aggressive recovery from estates of deceased Medicaid recipients will also result in reduced
21 medical assistance expenditures; now therefore
22 **Be it enacted by the General Assembly of Virginia:**
23 **1.** *§ 1. Medical assistance services; asset transfer limit waiver.*
24 *The Department of Medical Assistance Services may, when appropriate and practicable, seek a*
25 *waiver pursuant to § 1115 of the Social Security Act (42 U.S.C. § 1315) from the Centers for Medicare*
26 *and Medicaid Services to establish asset transfer limits that are more restrictive than those currently*
27 *permitted under federal Medicaid law or regulations. This waiver application may provide, insofar as it*
28 *is not already included in the state plan for medical assistance services pursuant to § 32.1-325, that (i)*
29 *transfer prohibitions would affect the transfer of all assets, including certain excluded assets set forth in*
30 *§ 1613 of the Social Security Act (42 U.S.C. § 1382b), such as vehicles and valuable jewelry, excluding*
31 *any wedding and engagement rings and each personal item valued less than $100; (ii) eligibility for all*
32 *medical assistance services shall be subject to penalty periods for a calculated period for transfers of*
33 *assets for less than fair market value; (iii) all transfers of assets for less than fair market value be*
34 *subject to a 36-month look-back period; (iv) the transfer penalty period for applicants shall commence*
35 *at the beginning of the month in which a person applies for medical assistance services or is otherwise*
36 *eligible, or when the Department of Medical Assistance Services becomes aware of the transfer,*
37 *whichever is later; (v) the transfer penalty period for recipients shall commence at the beginning of the*
38 *month in which the Department of Medical Assistance Services becomes aware of the transfer and can*
39 *give proper notice, or the month following a period of ineligibility existing when the transfer was made;*
40 *(vi) the divisor used to calculate a penalty period shall be the statewide average nursing facility*
41 *payment made by the Department of Medical Assistance Services in effect at the time the penalty is*
42 *determined and the penalty period begins, a figure that takes into consideration the income that would*
43 *otherwise be applied to cost of care in the post-eligibility process; (vii) transfers to spouses for less than*
44 *fair market value after eligibility for medical assistance services is established will be permitted only to*
45 *an amount allowed under spousal impoverishment asset provisions, so that assets acquired by or made*
46 *available to the institutionalized spouse after medical assistance services are obtained would first be*
47 *spent on the institutionalized spouse's medical costs; (viii) permissible transfers of assets to a disabled*
48 *child would be limited to transfers into a trust for the child's sole benefit that reverts to the*
49 *Commonwealth after the death of the disabled child, to recover medical assistance services payments*
50 *made on behalf of either the grantor or the beneficiary of the trust, or both; (ix) the Commonwealth*
51 *would have discretion to designate some trust purposes as invalid under § 1917 (c) or (d) of the Social*
52 *Security Act, such as care for a pet; and (x) an exemption would be provided for any individual who*
53 *has exhausted a long-term care insurance policy for a minimum of three years. Such individuals would*
54 *automatically qualify for Medicaid.*
55 *The Commonwealth shall be authorized to recover medical assistance payments for covered services*
56 *provided on behalf of an individual during a period of ineligibility determined in accordance with this*
57 *section from the following persons: (i) the individual determined ineligible for medical assistance*
58 *benefits because of an improper asset transfer; (ii) such individual's estate; or (iii) the person to whom*
59 *the asset was transferred in violation of this section. In no case shall the Department of Medical*

SENATE SUBSTITUTE

HB2601S1

5/18/06 10:20

60 *Assistance Services withhold Medicaid reimbursement from a Medicaid-participating health care*
61 *provider for services provided to an individual found to have improperly transferred assets under this*
62 *section.*
63 **2. That, upon the approval by the Centers for Medicare and Medicaid Services of any application**
64 **for the asset transfer limit waiver submitted by the Department of Medical Assistance Services**
65 **pursuant to this act, expeditious implementation of any asset transfer limits shall be deemed to be**
66 **an emergency situation pursuant to § 2.2-4002 of the Administrative Process Act; therefore, to**
67 **meet this emergency situation, the Board shall adopt emergency regulations to implement the**
68 **provisions of this act.**
69 **3. That, in order to avoid the costs as much as possible during the regulatory process, the Board**
70 **of Medical Assistance Services shall, when in compliance with the Administrative Process Act**
71 **(§ 2.2-4000 et seq.), notify, distribute, and provide public access and opportunity for comment via**
72 **electronic media, including, but not limited to, posting documents to and receiving comments via**
73 **the Department's website, by e-mail and fax. The Board shall, however, continue to provide public**
74 **notice and participation to those persons who do not have access to the Internet or to other forms**
75 **of electronic media.**
76 **4. That, prior to submitting any application for the asset transfer limit waiver, the Director of the**
77 **Department of Medical Assistance Services shall report on the limits on asset transfers in the**
78 **proposed waiver to the Chairmen of the House Committees on Appropriations and Health,**
79 **Welfare and Institutions, and the Senate Committees on Finance and Education and Health.**
80 **5. That the provisions of this act shall not become effective unless reenacted by the 2006 Session**
81 **of the General Assembly.**

APPENDIX B

Medicaid Home and Community Based Services Waivers

Generally Medicaid services must be available in the same amount, duration, and scope to everyone on Medicaid, and individuals must be able to choose their own providers. Waivers allow states to "waive" some or all of those requirements.

Home and Community Based Services (HCBS) Waivers
(§ 1915 (c) of SSA)

- Can waive statewideness.
- Can waive comparability of services.
- Can waive community income and resource rules.
- Can waive rules that require States to provide services, on an equal basis, to all persons in the State.
- States have the flexibility to design each waiver and select the mix of services that best meets the needs of the population they wish to serve.
- May be provided statewide or may be limited to specific geographic subdivisions.
- Waivers can be targeted to specific groups or any subgroup thereof that the State may define: aged or disabled, or both; mentally retarded or developmentally disabled or both; and mentally ill. Cannot be targeted to people in an Institution for Mental Disease (IMD). States cannot get waivers with an alternate institutional placement of an Institution for Mental Disease (IMD). Medicaid does not pay for any services for people in IMDs who are between the ages of 21 through 64.
- Initially approved for 3 years and renewed every 5 years.
- Optional programs that afford States the flexibility to develop and implement alternatives to institutionalizing Medicaid eligible individuals.
- The program recognizes that many individuals who would otherwise be institutionalized can be cared for in their homes and communities at a cost no higher than that of institutional care when compared on an average basis. This does not mean that waivers are a cost-savings to States since many people who would not enter an institution will choose community care. The bottom line is that waivers can be costly to states.
- To receive approval to implement a waiver, a State Medicaid agency must assure the Centers for Medicare and Medicaid Services (CMS) that it will not cost more, on average, to provide home and community based services than providing institutional care would cost. Waiver recipients must be offered the choice of institutional or community placement. The average costs of individuals on the waiver are compared to the average costs of individuals in the institution.
- The State must also assure CMS that there are safeguards to protect the health and welfare of recipients.

- Waivers must be submitted by the single state Medicaid agency (DMAS). The single state agency must not delegate, to other that its own officials, authority to:

  ☑ exercise administrative discretion in the administration or supervision of the plan, or

  ☑ issue policies, rules, and regulations on program matters.

  ☑ The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.

  ☑ If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency. 42 C.F.R. 431.10.

The Commonwealth of Virginia Had Six HCBS Waivers in FY 2004:

1. AIDS Waiver

2. Consumer Directed Personal Attendant Services (CD-PAS) Waiver (In February, 2005 the CD-PAS and Elderly and Disabled Waivers were combined into the Elderly or Disabled with Consumer-Direction Waiver (EDCD))

3. Elderly and (or) Disabled (E&D) Waiver

4. Individual and Family Developmental Disabilities Support Waiver (DD Waiver).

5. Mental Retardation Waiver (MR)

6. Technology Assisted Waiver (Tech)

As of July 1, 2005, Virginia had six waivers, which included the AIDS, DD, EDCD, MR, and Tech Waivers, and a Day Support Waiver for people with Mental Retardation (300 slots), which became effective July 1, 2005. An additional waiver, the Alzheimer's Assisted Living Waiver (200 slots), was approved by CMS effective July 1, 2005, but was not yet operational since State regulations were not yet in place. This waiver is expected to be operational in the fall of 2005.

AIDS Waiver

Initiative	Purpose is to provide care in the community rather than in nursing facilities or hospitals.
Targeted Population:	Diagnosis of AIDS or AIDS Related Condition (ARC) and documentation that the individual is experiencing medical and functional symptoms associated with AIDS or ARC which would require nursing facility or hospital care
Eligibility Rules	Must be eligible for Medicaid and meet screening criteria; income limit is 300% of the SSI payment limit for one person ($1,737/month). No patient pay.
Services Available	• Case management • Nutritional supplements • Private duty nursing • Personal care (consumer or agency directed) • Respite care
Service Authorization	Local and hospital screening teams
Program Administration	Program administered by DMAS
Service Provision	Services are provided by case management providers or personal care and nursing agencies that have a provider agreement with DMAS.
Number of People Served	274 people were served in FY 2004.
Cost	Waiver costs were $608,497 in FY '04. Other costs for people on the Waiver were $6,117,320 ($4 million was for pharmacy)

Consumer Directed Personal Attendant Services Waiver

Initiative	Purpose is to provide care in the community rather than in a nursing facility.
Targeted Population:	Individuals 65 or older or who are disabled, who meet screening criteria and are at imminent risk of nursing facility placement. Individuals must be able to hire, train and fire, if necessary, their own attendants, or have a parent, spouse, legal guardian, or adult child who directs care on their behalf if they cannot do so.
Eligibility Rules	Must be eligible for Medicaid and meet screening criteria; income limit is 300% of the SSI payment limit for one person ($1,737 /month). Could have a patient pay if income is in excess of SSI income limit for one ($579). Due to expenses of employment, can keep additional amount of earned income if working more than 8 hours/ week.
Services Available	Personal attendant services
Service Authorization	Local and hospital screening teams
Program Administration	Program administered by DMAS
Service Provision	Personal attendants hired by the recipient. Service coordination is provided by registered nurses, social workers or case managers who have a provider agreement with DMAS. Service coordinators assess, develop and monitor the care plan.
Number of People Served	417 people were served in FY 2004
Cost	The cost of waiver services was $4,403,107 in FY '04; the cost of acute care services was an additional $2,334,535.

Elderly and (or) Disabled Waiver

Initiative	Purpose is to provide care in the community rather than in a nursing facility.
Targeted Population:	Individuals 65 or older or who are disabled and who meet screening criteria and are at imminent risk of nursing facility placement (42 CFR 441.302(c)(1).
Eligibility Rules	Must be eligible for Medicaid and meet screening criteria; income limit is 300% of the SSI payment limit for one person ($1,737 month). Could have patient pay if income is in excess of SSI income limit for one ($579).
Services Available	• Adult day health • Respite care • Personal care • Personal Emergency Response System
Service Authorization	Local and hospital screening teams
Program Administration	Program administered by DMAS
Service Provision	Services are provided by personal care and nursing agencies that have a provider agreement with DMAS.
Number of People Served	In FY 2004, 10,161 people were served.
Cost	Waiver expenditures for FY 2004 were $101,354,887 Other costs for Waiver recipients were $78,082,480

Individual and Family Developmental Disabilities (DD) Support Waiver

Revised 8/7/2005

Initiative

Home and Community Based (1915(c)) waiver whose purpose is to provide care in the community rather than in an Intermediate Care Facility for the Mental Retarded (ICF/MR).

Targeted Population:

Individuals who are 6 years of age and older who have a related condition and do not have a diagnosis of mental retardation who (1) meet the ICF/MR level of care criteria (i.e., they meet two out of seven levels of functioning in order to qualify); (2) are determined to be at imminent risk of ICF/MR placement, and (3) are determined that community-based care services under the waiver are the critical services that enable the individual to remain at home rather than begin placed in an ICF/MR.

Eligibility Rules

Individual Eligibility

An individual is deemed eligible for DD Waiver services based on three factors:

- **Diagnostic Eligibility**: Individuals age six and older must have a psychological or standardized developmental evaluation that states that the child does not have a diagnosis of mental retardation or is at developmental risk and reflects the child's current level of functioning.

- **Functional Eligibility**: All individuals receiving DD Waiver services must meet the ICF-MR (Intermediate Care Facility for Mental Retardation) level of care. This is established by meeting the indicated dependency level in two or more of the categories on the "Level of Functioning Survey."

- **Financial Eligibility**: An eligibility worker from the local Department of Social Services (DSS) determines an individual's financial eligibility for Medicaid. Some individuals who would not ordinarily qualify financially for Medicaid may be eligible by receipt of DD Waiver services.

Medicaid regulations specify that, once an individual has been determined eligible by the IFDDS screening team, he or she must be offered a choice between institutional and Waiver services.

Services Available

- **Case management**: is the assessment, planning, linking and monitoring for individuals referred for the DD Waiver. It also ensures the development, coordination, implementation, monitoring, and modification of consumer service plans; links individuals with appropriate community resources and supports;

coordinates service providers; and monitors quality care.

- **In– Home Residential Support Services**: training, assistance and specialized supervision, provided primarily in an individual's home to help the person learn or maintain skills in activities of daily living, safety in the use of community resources, and behavior appropriate for home and the community.

- **Day support**: training, assistance and specialized supervision to enable the individual to acquire, retain or improve his/her self-help, social and adaptive skills. These services typically take place away from the home in which the individual resides and may be located in a "center" or in community locations.

- **Supported employment**: supports to enable individuals with disabilities to work in settings in which persons without disabilities are typically employed. It may be provided to one person in one job (e.g., a person working to bus tables in a restaurant) or to several people at a time when those individuals are working together as a team to complete a job (e.g., such as a grounds maintenance crew).

- **Prevocational services**: training and assistance to prepare an individual for paid or unpaid employment. These services are not job task-oriented. These are for individuals who need to learn skills fundamental to employment such as accepting supervision, getting along with co-workers, using a time clock, etc.

- **Personal assistance**: direct support with activities of daily living (e.g., bathing, toileting, personal hygiene skills, dressing, transferring, etc.),

  instrumental activities of daily living (e.g.,

  assistance with housekeeping activities, preparation of meals, etc.), accessing the community, taking medication or other medical needs, and monitoring the individual's health status and physical condition. These services may be agency-directed or *consumer-directed.*

- **Respite**: services designed to provide temporary, substitute care for that which is normally provided by the family or other unpaid, primary caregiver of an individual. These short-term services may be provided because of the primary caregiver's absence in an emergency or on-going need for relief. These services may be agency-directed or *consumer-directed.*

- **Companion**: provide non-medical care, socialization or support to adults in an individual's home or at various locations in the community. These services may be agency-directed or *consumer-directed.*

- **Consumer-directed services:** offer the individual/family the option of hiring workers directly, rather than using traditional agency staff.

- **Assistive technology**: specialized medical equipment, supplies, devices, controls and appliances, which enable the individual to better perform activities of daily living, to perceive, control or communicate with his/her environment, or which are necessary to his/her proper functioning.

- **Environmental modifications**: physical adaptations to an individual's home or vehicle needed by the individual to ensure his/her health, welfare and safety or enable him/her to experience greater independence in the home and around the community.

- **Skilled nursing services**: nursing services ordered by a physician for individuals with serious medical conditions and complex health care needs. This service is available only for individuals for whom these services cannot be accessed through another means. These services may be provided in an individual's home, community setting, or both.

- **Therapeutic consultation**: expert training and technical assistance in any of the following specialty areas to enable family members, caregivers, and other service providers to better support the individual. The specialty areas are: Psychology, Social Work, Speech and Language Pathology, Occupational Therapy, Physical Therapy, Therapeutic Recreation, Psychiatric Clinical Nursing, and Rehabilitation.

- **Crisis stabilization**: direct intervention (and may include one-to-one supervision) to a person with developmental disabilities who is experiencing serious psychiatric or behavioral problems which jeopardize his/her current community living situation.

- **Personal emergency response systems** (PERS): an electronic device that enables the individual who is alone to access a centralized, staffed emergency center in the event of an emergency.

- **Family and Caregiver:** training will provide training and counseling services to families of individuals receiving services in the DD Waiver

Service Authorization

An individual or family/caregiver submits a "Request for Screening"

	form screening team . The screening request is taken to one of the 11 Child Development Clinics designated to serve as the screening team for the DD Waiver. If the screening team determines the individual meets criteria, a service plan is created and DMAS assigns a slot to the individual once a slot becomes available.
Program Administration	The program is administered by the Department of Medical Assistance Services (DMAS). DMAS also conducts preauthorization of DD Waiver services.
Number of People Served	FY2004 392

Waiting List

A waiting list does exist for the DD Waiver. The waiting list is maintained on a first-come, first served basis. Individuals are assigned waiting list numbers based on the date DMAS receives the Screening Packet from the screening.

If an individual is determined eligible, a case manager works with the individual to develop a Plan of Care (POC). The amount of the POC determines which level waiting list the individual is assigned. Individuals whose care plans are below $25,000 are assigned to Level I. Individuals whose care plans exceed $25,000 are assigned to Level II.

Emergency Criteria

Subject to available funding, individuals must meet at least one of the emergency criteria to be eligible for immediate access to waiver services without consideration to the length of time an individual has been waiting to access services. In the absence of waiver services, the individual would not be able to remain in his home.

A. The criteria are:

1. The primary caregiver has a serious illness, has been hospitalized, or has died; or
2. The individual has been determined by the DSS to have been abused or neglected and is in need of immediate Waiver services; or
3. The individual has behaviors which present risk to personal or public safety; or
4. The child presents extreme physical, emotional or financial burden at home and the family or caregiver is unable to continue to provide care.

Providers:

An institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by DMAS, and has a current, signed contract with DMAS to be a provider of DD Waiver services.

Accessing DD Waiver Services

- Individual, family or representative requests services from the Case Manager.

- The case manager determines the preferred services and necessary supports by meeting with the individual and family (or other caregivers) and confirms diagnostic and functional eligibility by obtaining a psychological evaluation and completing an ICF/MR Level of Functioning Survey (LOF).

- Once the individual is determined eligible (including financial eligibility through the Department of Social Services), the case manager informs the individual and family of the full array of DD Waiver services and documents the individual's choice of Waiver or institutional care.

- Once it is determined that a slot is available and the individual has been enrolled, the individual selects providers for needed services. The case manager coordinates the development of a Consumer Service Plan (CSP) with the individual, family or other caregivers and the service providers within 60 days of enrollment. The CSP includes all of the supporting documentation developed by this team and describes the services that will be rendered.

- Prior to the start of services, the case manager forwards appropriate documentation to DMAS staff for review and authorization of the requested DD Waiver services.

- Once approved, DMAS staff enters service data in the DMAS computer system. This generates a notification letter to the providers and permits them to bill for approved services. Service provision should commence within 60 days from enrollment.

For additional information, please contact Ms. Pat Arevalo, Supervisor, Behavioral Health and Developmental Disabilities Unit of DMAS, at (804) 786-1465 or by e-mail at Pat.arevalo@dmas.virginia.gov.

Mental Retardation Waiver

Initiative	Purpose is to provide care in the community rather than in an Intermediate Care Facility for the Mentally Retarded.
Targeted Population	Individuals with mental retardation or related conditions and individuals under the age of 6 at developmental risk who have been determined to require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).
Eligibility Rules	Must be eligible for Medicaid and meet screening criteria; income limit is 300% of the SSI payment limit for one person ($1,737/month). Could have a patient pay if income is in excess of SSI income limit for one ($579). Could have a patient pay if income is in excess of SSI income limit for one ($579). Due to expenses of employment, can keep additional amount of earned income if working more than 8 hours/ week.
Services Available	• Day support • Supported employment • Residential supports (Congregate and In-Home) • Therapeutic consultation • Personal assistance services (consumer or agency directed) • Respite care (consumer or agency directed) • Skilled nursing services • Crisis Stabilization • Environmental Modifications • Assistive Technology • Companion (consumer or agency directed)
Service Authorization	Community Mental Health Services Boards (CSB)
Program Administration	Program administered by DMAS and DMHMRSAS
Service Provision	Services are provided by providers who have an agreement with DMAS.
Number of People Served	5,622 people were served during FY 2004. There is a waiting list for services.
Cost	Waiver costs were $227,229,982 in FY '04. Other costs for people on the waiver were $78,821,941.

Technology Assisted Waiver

Initiative	Purpose is to provide care in the community rather than in a nursing facility (adults) or hospital (children).
Targeted Population:	Individuals who need both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care.
Eligibility Rules	Must be eligible for Medicaid and meet screening criteria; income limit is 300% of the SSI payment limit for one person ($1,737/month). Could have a patient pay if income is in excess of SSI income limit for one ($579).
Services Available	• Private duty nursing • Respite care • Durable medical equipment • Personal care • Environmental modification
Service Authorization	Health Care Coordinator who is either an employee of DMAS or a DMAS contractor
Program Administration	Program administered by DMAS
Service Provision	Case management is provided by DMAS staff. Nursing services are provided by nursing agencies that have a provider agreement with DMAS.
Number of People Served	339 served in FY 2004
Cost	The cost of waiver services was $19,648,061 in FY '04; the cost of acute care services was an additional $7,109,713.

APPENDIX C

12VAC30-60-303. Preadmission screening criteria for long-term care.

A. Functional dependency alone is not sufficient to demonstrate the need for nursing facility care or placement or authorization for community-based care.

B. An individual shall only be considered to meet the nursing facility criteria when both the functional capacity of the individual and his medical or nursing needs meet the following requirements. Even when an individual meets nursing facility criteria, placement in a non-institutional setting shall be evaluated before actual nursing facility placement is considered.

1. Functional capacity.

a. When documented on a completed state-designated preadmission screening assessment instrument which is completed in a manner consistent with the definitions of activities of daily living and directions provided by DMAS for the rating of those activities, individuals may be considered to meet the functional capacity requirements for nursing facility care when one of the following describes their functional capacity:

(1) Rated dependent in two to four of the Activities of Daily Living, and also rated semi-dependent or dependent in Behavior Pattern and Orientation, and semi-dependent in Joint Motion or dependent in Medication Administration.

(2) Rated dependent in five to seven of the Activities of Daily Living, and also rated dependent in Mobility.

(3) Rated semi-dependent in two to seven of the Activities of Daily Living, and also rated dependent in Mobility and Behavior Pattern and Orientation.

b. The rating of functional dependencies on the pre-admission screening assessment instrument must be based on the individual's ability to function in a community environment, not including any institutionally induced dependence. The following abbreviations shall mean: I = independent; d = semi-dependent; D = dependent; MH = mechanical help; HH = human help.

(1) Bathing

(a) Without help (I)

(b) MH only (d)

(c) HH only (D)

(d) MH and HH (D)

(e) Performed by Others (D)

(2) Dressing

(a) Without help (I)

(b) MH only (d)

(c) HH only (D)

(d) MH and HH (D)

(e) Performed by Others (D)

(f) Is not Performed (D)

(3) Toileting

(a) Without help day or night (I)

(b) MH only (d)

(c) HH only (D)

(d) MH and HH (D)

(e) Performed by Others (D)

(4) Transferring

(a) Without help (I)

(b) MH only (d)

(c) HH only (D)

(d) MH and HH (D)

(e) Performed by Others (D)

(f) Is not Performed (D)

(5) Bowel Function

(a) Continent (I)

(b) Incontinent less than weekly (d)

(c) External/Indwelling Device/Ostomy—self care (d)

(d) Incontinent weekly or more (D)

(e) Ostomy—not self care (D)

(6) Bladder Function

(a) Continent (I)

(b) Incontinent less than weekly (d)

(c) External device/Indwelling Catheter/Ostomy—self care (d)

(d) Incontinent weekly or more (D)

(e) External device—not self care (D)

(f) Indwelling catheter—not self care (D)

(g) Ostomy—not self care (D)

(7) Eating/Feeding

(a) Without help (I)

(b) MH only (d)

(c) HH only (D)

(d) MH and HH (D)

(e) Spoon fed (D)

(f) Syringe or tube fed (D)

(g) Fed by IV or clysis (D)

(8) Behavior Pattern and Orientation

(a) Appropriate or Wandering/Passive less than weekly + Oriented (I)

(b) Appropriate or Wandering/Passive less than weekly + Disoriented—Some Spheres (I)

(c) Wandering/Passive Weekly/or more + Oriented (I)

(d) Appropriate or Wandering/Passive less than weekly + Disoriented—All Spheres (d)

(e) Wandering/Passive Weekly/Some or more + Disoriented—All Spheres (d)

(f) Abusive/Aggressive/Disruptive less than weekly + Oriented or Disoriented (d)

(g) Abusive/Aggressive Disruptive weekly or more + Oriented (d)

(h) Abusive/Aggressive Disruptive + Disoriented—All Spheres (D)

(9) Mobility

(a) Goes outside without help (I)

(b) Goes outside MH only (d)

(c) Goes outside HH only (D)

(d) Goes outside MH and HH (D)

(e) Confined—moves about (D)

(f) Confined—does not move about (D)

(10) Medication Administration

(a) No medications (I)

(b) Self administered—monitored less than weekly (I)

(c) By lay persons, Administered/Monitored (D)

(d) By Licensed /Professional nurse Administered/Monitored (D)

(11) Joint Motion

(a) Within normal limits (I)

(b) Limited motion (d)

(c) Instability—uncorrected or Immobile (I)

c. An individual with medical or nursing needs is an individual whose health needs require medical or nursing supervision or care above the level which could be provided through assistance with Activities of Daily Living, Medication Administration and general supervision and is not primarily for the care and treatment of mental diseases. Medical or nursing supervision or care beyond this level is required when any one of the following describes the individual's need for medical or nursing supervision:

(1) The individual's medical condition requires observation and assessment to assure evaluation of the person's need for modification of treatment or additional medical procedures to prevent destabilization and the person has demonstrated an inability to self observe or evaluate the need to contact skilled medical professionals;

(2) Due to the complexity created by the person's multiple, interrelated medical conditions, the potential for the individual's medical instability is high or medical instability exists; or

(3) The individual requires at least one ongoing medical or nursing service. The following is a non-exclusive list of medical or nursing services which may, but need not necessarily, indicate a need for medical or nursing supervision or care:

(a) Application of aseptic dressings;

(b) Routine catheter care;

(c) Respiratory therapy

(d) Supervision for adequate nutrition and hydration for individuals who show clinical evidence of malnourishment or dehydration or have recent history of weight loss or inadequate hydration which, if not supervised would be expected to result in malnourishment or dehydration;

(e) Therapeutic exercise and positioning;

(f) Routine care of colostomy or ileostomy or management of neurogenic bowel and bladder;

(g) Use of physical (e.g., side rails, poseys, locked wards) and/or chemical restraints;

(h) Routine skin care to prevent pressure ulcers for individuals who are immobile;

(i) Care of small uncomplicated pressure ulcers, and local skin rashes;

(j) Management of those with sensory, metabolic, or circulatory impairment with denstrated clinical evidence of medical instability;

(k) Chemotherapy;

(l) Radiation;

(m) Dialysis;

(n) Suctioning;

(o) Tracheostomy care;

(p) Infusion Therapy;

(q) Oxygen.

d. Even when an individual meets nursing facility criteria, provision of services in a noninstitutional setting shall be considered before nursing facility placement is sought.

Statutory Authority

§32.1-325 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 18, Issue 18, eff. June 20, 2002.

Editor's Note

The June 20, 2002 amendment revised and reformatted former 12VAC30-60-300, designating its former §§1.0 through 1.5 as 12VAC30-60-300, 12VAC30-60-303, 12VAC30-60-307, 12VAC30-60-312, 12VAC30-60-316, and 12VAC30-60-318, respectively. See the Virginia Register for full text of the former version of 12VAC30-60-300.

APPENDIX D

VIRGINIA ACTS OF ASSEMBLY -- 2004 SESSION

CHAPTER 246

An Act to amend and reenact § 32.1-325 of the Code of Virginia, relating to the development of a long-term care partnership program.

[S 266]

Approved March 31, 2004

Be it enacted by the General Assembly of Virginia:
1. That § 32.1-325 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-325. Board to submit plan for medical assistance services to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time and submit to the Secretary of the United States Department of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of 21, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of $3,500 for the individual and an amount not in excess of $3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;

3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of 21, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;

6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

7. A provision for the payment for family planning services on behalf of women who were Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such family planning services shall begin with delivery and continue for a period of 24 months, if the woman continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the purposes of this section, family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage or make direct referrals for abortions;

8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast

cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

9. A provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance;

10. A provision for breast reconstructive surgery following the medically necessary removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

11. A provision for payment of medical assistance for annual pap smears;

12. A provision for payment of medical assistance services for prostheses following the medically necessary complete or partial removal of a breast for any medical reason;

13. A provision for payment of medical assistance which provides for payment for 48 hours of inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

14. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician and in the durable medical equipment provider's possession within 60 days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons age 40 and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

16. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast;

17. A provision, when in compliance with federal law and regulation and approved by the ~~Health Care Financing Administration~~ *Centers for Medicare & Medicaid Services (CMS)*, for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions;

18. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant center where the surgery is proposed to be performed have been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living;

19. A provision for payment of medical assistance for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations;

20. A provision for payment of medical assistance for custom ocular prostheses;

21. A provision for payment for medical assistance for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such provision shall include payment for medical assistance for follow-up audiological examinations as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss;

22. A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer

Prevention and Treatment Act of 2000 (P.L. 106-354), for certain women with breast or cervical cancer when such women (i) have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise eligible for medical assistance services under any mandatory categorically needy eligibility group; and (v) have not attained age 65. This provision shall include an expedited eligibility determination for such women; ~~and~~

23. A provision for the coordinated administration, including outreach, enrollment, re-enrollment and services delivery, of medical assistance services provided to medically indigent children pursuant to this chapter, which shall be called Family Access to Medical Insurance Security (FAMIS) Plus and the FAMIS Plan program in § 32.1-351. A single application form shall be used to determine eligibility for both programs*; and*

24. A provision, consistent with federal law, to establish a long-term care partnership program that shall encourage the private purchase of long-term care insurance as the primary source of funding the participant's long-term care. Such program shall provide protection from estate recovery as authorized by federal law.

B. In preparing the plan, the Board shall:

1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured.

2. Initiate such cost containment or other measures as are set forth in the appropriation act.

3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations pursuant to § 2.2-4007, the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities With Deficiencies."

6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each recipient of medical assistance services, and shall upon any changes in the required data elements set forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective information as may be required to electronically process a prescription claim.

C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services as may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments which are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

D. The Director of Medical Assistance Services is authorized to:

1. Administer such state plan and receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers as provided by law.

2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

3. Refuse to enter into or renew an agreement or contract with any provider which has been convicted of a felony.

4. Refuse to enter into or renew an agreement or contract with a provider who is or has been a principal in a professional or other corporation when such corporation has been convicted of a felony.

E. In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his interest in a convicted professional or other corporation, the Director shall, upon request, conduct a hearing in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) regarding the provider's participation in the conduct resulting in the conviction.

The Director's decision upon reconsideration shall be consistent with federal and state laws. The Director may consider the nature and extent of any adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients.

F. When the services provided for by such plan are services which a clinical psychologist or a clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render in Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical social worker or licensed professional counselor or licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which reimburse licensed clinical psychologists, licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria, including the professional credentials required for licensure.

G. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance services as may be permitted by federal law to establish a program of family assistance whereby children over the age of 18 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

H. The Department of Medical Assistance Services shall:

1. Include in its provider networks and all of its health maintenance organization contracts a provision for the payment of medical assistance on behalf of individuals up to the age of 21 who have special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

2. Amend the Medallion II waiver and its implementing regulations to develop and implement an exception, with procedural requirements, to mandatory enrollment for certain children between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible recipients with special needs. The Board shall promulgate regulations regarding these special needs patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special needs as defined by the Board.

J. Except as provided in ~~subsection~~ *subdivision* A 1 of § 2.2-4345, the provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law and regulation.

JOINT COMMISSION ON HEALTH CARE

Executive Director

Kim Snead

Principal Health Policy Analyst

April Kees

Senior Health Policy Analyst

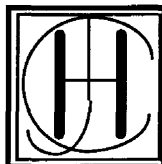
Catherine W. Harrison

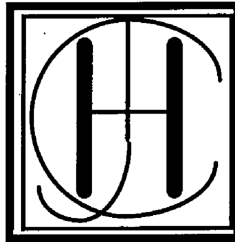
Intern

Ridgely Minter

Office Manager

Mamie White Jones





Joint Commission on Health Care
900 East Main Street, 1st Floor West
P.O. Box 1322
Richmond, Virginia 23218
(804) 786-5445
(804) 786-5538 (FAX)

E-Mail: jchc@leg.state.va.us

Internet Address:

http://legis.state.va.us/jchc/jchchome.htm