Medical Assistance and Divestment
THE RULES & THE HAZARDS

Fourth Edition
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PREFACE TO 4TH EDITION

Since the third edition of Medical Assistance and Divestment was published, a number of legislative, regulatory, and agency policy developments have occurred which continue to clarify how the Medical Assistance provisions of the Medicare Catastrophic Coverage Act of 1988 were implemented in Wisconsin.

Of particular interest to attorneys is the development of the use of multiple divestments to legally circumvent the intent of divestment prohibitions. As most of you know, we at the Center generally feel that divestment is a bad idea for the vast majority of seniors. However, because so many attorneys rely on this publication for their information on this subject and because the multiple divestment rule arises directly out of statutory language we felt we had to include discussion of it.

In addition, this edition has been substantially rewritten (again) in an effort to make it more readable. We hope this revised edition will prove as useful as the previous ones in explaining and demystifying this area of the law.

Mitchell Hagopian

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APPENDICES

WHAT IS MEDICAL ASSISTANCE (MA)?

Medical Assistance (also known as MA, Medicaid or Title XIX of the Social Security Act) is a joint federal-state public benefit program aimed at providing medical services to the poor and needy (e.g. the elderly, disabled, single parents and children).

It is a companion program to the Supplemental Security Income (SSI) program. Both SSI and MA are needs-based programs (welfare), as opposed to Medicare, where eligibility for Social Security benefits determines coverage. Medicare and Social Security are not needs-based programs.

MA is a "vendor" program; thus, eligible recipients must obtain medical care from MA participating and certified providers of health care services, who, in turn, submit claims directly to the Department of Health and Social Services (DHSS) for payment of their services. Payment is made directly to the provider of medical services or supplies. The recipient is never paid directly by the state. If the recipient pays for a MA covered service or supply, s/he must seek reimbursement from the provider, who, in turn, receives payment from the state.

Applicable federal statutes are codified at Title 42 U.S.C. §§1396 et seq., with federal regulations codified at 42. C.F.R. §§430.000-456.657.

In Wisconsin, the MA program is administered by the Wisconsin Department of Health and Social Services. Within the DHSS, responsibility is split between the Division of Health, Bureau of Health Care Financing (develops rules, makes determinations of coverage and formulates reimbursement procedures) and the Division of Community Services, Bureau of Economic Assistance (oversees determinations of eligibility).

Applicable state statutes are codified at §49.47, Wis. Stats., with state regulations codified at HSS §§101-107, particularly HSS §103, of the Wisconsin Administrative Code.

1: ELIGIBILITY FOR MA

A. Overview

1. Terms Used

Categorically needy - Persons with low income and resources, who meet all other eligibility criteria in order to receive SSI or AFDC (Aid to Families with Dependent Children). (§49.46, Wis. Stats.).

Medically needy - Persons with **income** too high for SSI or AFDC eligibility yet who are "categorically related" (aged, blind, disabled or AFDC-related), whose **resources** are within the SSI or AFDC limits, and whose **medical expenses**, if applied to their income, would reduce their income over a semi-annual period to the SSI or AFDC eligible levels. (§49.47, Wis. Stats.).

Medical expenses spend-down - The demonstration of sufficient medical expenses to be eligible for Medical Assistance under the "medically needy" category.

2. Wisconsin Participation in Federal Program

Wisconsin, mandated by federal law as a participating Medicaid state to provide Medical Assistance to the categorically needy (42 U.S.C. §1396a(a)(10)(A)), also chose the option of providing coverage to the medically needy (42 U.S.C. §1396a(a)(10)(C)).

Further, Wisconsin chose the option by signing a federal contract--a §1634 agreement--to have the federal government, through the Social Security Administration, make individual determinations of Medical Assistance eligibility for persons applying and eligible for SSI (42 U.S.C. §1383c). Signing of the §1634 agreement, in turn, bound Wisconsin to accept the federal eligibility criteria for its categorically needy. Wisconsin is thus known as a "§1634" state or a "SSI state." The §1634 contract saves states which sign it certain administrative expenses; states choosing not to sign are called §209(b) states and are allowed much more restrictive eligibility criteria in their state programs.

Signing of the §1634 agreement, in turn, bound Wisconsin to apply **eligibility** criteria to the **medically needy** which are no more restrictive than those of the federal **categorically needy** program (42. U.S.C. §§1396a(a)(10)(C)(i), 1383c and 42 C.F.R. §435.401(c)).

3. State Statutes

§49.46 Wis. Stats. governs eligibility and benefits for categorically needy applicants (also entitled "recipients of Social Security aids").

§49.47 Wis. Stats. defines application, eligibility criteria and benefits for medically needy applicants (also called "medically indigent").

4. State Administrative Rules

Chapters HSS §§101-108 Wis. Admin. Code codifies rules promulgated under the Wis. Administrative Procedure Act (Chap. 227, Wis. Stats.) by the DHSS to interpret and implement the federal statutes and regulations and state statutes.

5. Program Manuals

Categorically needy

The Program Operations Manual System ("POMS"), especially Part 5, is used as the major source of standards and procedures for all SSI claims handled at the Social Security Administration District Office level. POMS' provisions interpret federal law but have not been adopted as rules and, in instances where a decision based on them appears to conflict with federal law, it should be appealed. POMS' regulations are available for review at your Social Security Administration District Office.

Categorically and Medically needy

The Income Maintenance Manual and The Medical Assistance Handbook, issued by DHSS, are used by the county departments of social services or human services to operate the program. The provisions of the manuals implement the state statutes, DHSS regulations and federal statutes and regulations, but may not be legally binding. See County of Dane v. Department of Health and Social Services, 79 Wis. 2d 323, 255 N.W. 2d 539 (1973), where the Court held that manual provisions which fall within the definition of the term rule under Chap. 227, Stats. are also subject to the rulemaking provisions of that chapter. Absent compliance with those provisions the manual sections are invalid.

The I.M. Manual and especially the M.A Handbook are extremely useful for predicting how county workers will view the facts of your case.

The Medical Assistance Handbook is available from the Department of Health and Human Services, Division of Economic Support, Mailroom/ Benefits Distribution Unit, P.O. Box 7935, Madison, WI 53707-7935 (telephone: 608-266-8896). (See Appendix I.)

B. Citizenship and Residency

1. United States citizenship or residency requirements

United States citizenship, or

Alien lawfully admitted for permanent residence or permanently residing in the United States under color of law (42 C.F.R. §435.402).

2. Wisconsin resident requirement (42 C.F.R. §435.403; HSS §103.01, Wis. Admin. Code)

Wisconsin state residents will be eligible without considering length of residence or length of institutionalization.

Residents of other states placed by that state in a Wisconsin institution must receive coverage from that state, if eligible there, irrespective of intent.

Residents of Wisconsin can receive Wisconsin coverage for services received in certain border areas of neighboring states (HSS §105.48, Wis. Admin. Code).

C. Eligibility Groups: Categorically Needy, Medically Needy

1. Categorically Needy (§49.46, Wis. Stats.)

Non-financial requirements

AFDC- or SSI-related Medical Assistance serves as a companion program to the Supplemental Security Income and Aid to Families with Dependent Children programs. Thus, Medical Assistance applicants must first qualify as one of the individuals described in the non-financial eligibility requirements of those programs (§49.46, Wis. Stats.). Medical Assistance eligibility, under the Wisconsin Medicaid program, is established automatically for those individuals who are otherwise eligible as one of the following groups:

a. Persons receiving or eligible to receive AFDC (42 U.S.C. §1396a(a)(10)(A); §§49.19-49.41, Wis. Stats.), including pregnant women. Eligibility begins on the date pregnancy is verified or the date of application, whichever is later (§49.46(1)(a)1m, Wis. Stats.).

b. Persons receiving SSI (i.e., aged (65 or over), blind, or disabled, and with qualifying income and resources). NOTE: Criteria for determining blindness or disability are applied by the Social Security Administration

for SSI purposes. Wisconsin has chosen to provide Medical Assistance to all persons receiving either federal SSI payments or a state supplement (42 C.F.R. §§435.120-121; §49.46(1)(a)4, Wis. Stats.).

c. Persons eligible for but not receiving AFDC or SSI.

d. Persons made ineligible for SSI by Social Security cost-of-living increases ("Section 503" cases). (See C.3., below.)

e. Accommodated persons; institutionalized persons who would be AFDC- or SSI-eligible if not institutionalized and whose monthly income was less than $1,104 in 1989 and $1,158 in 1990 and $1,221 in 1991 (Medical Assistance Eligibility Handbook, Institutions Unit, p.4).

f. Patient in public medical institution.

Financial Requirements/SSI Financial Criteria

The Supplemental Security Income Program was established by Public Law 92-603, effective January 1, 1974, and replaced state welfare programs for aged, blind and disabled; funding contributed by the federal government (the federal Standard Payment Amount) per individual is supplemented by the State of Wisconsin.

Applicable law and regulations are codified at 42 U.S.C. §1381 et seq. and 20 C.F.R. §1100 et seq.

Financial eligibility for SSI depends on meeting two tests of need:

a. **Countable income**, computed monthly, must be less than the applicable grant standard, including both the federal benefit rate and the state supplement. If eligibility is established, SSI payments bring an individual's countable income up to the grant standard. SSI grant payment standards, effective January 1, 1991, for person(s) living in own household(s) are:

$509.72 (individual)

$745.86 (couple)

b. **Countable resources** must be less than applicable resource limits.

A resource is any cash, liquid asset or any real or personal property an individual owns and could convert to cash for support or maintenance (20 C.F.R. §416.1201(a)). Certain resources are excluded: they are discussed in detail at E. below.

2. Medically Needy Eligibility (§49.47, Wis. Stats.)

General

Medical Assistance eligibility under the Wisconsin Medically Needy program, is established for those individuals who are "categorically related" (i.e., who meet the non-financial and resource requirements of §49.49, Wis. Stats., and HSS §103, Wis. Admin. Code, which closely parallel those of AFDC and SSI) but who are not eligible for categorical aid because their income is too high. Medical expenses must be greater than excess income in order to be considered medically needed.

Spend-down

Achievement of spend-down eligibility is accomplished by deducting incurred medical expenses, which are not subject to payment by a third party, from the applicant's semi-annual income. These expenses are deducted in order as follows: 1) Medicare and health insurance; 2) necessary medical and remedial services that are recognized under state law but not included in the plan; and 3) medical expenses included within the plan (42 C.F.R. §435.831(c)).

The DHSS Medical Assistance Handbook Appendix 20 states that Medicare Part B premiums are not deducted because they are not counted when computing excess income.

HSS §103.04(3)(c), Wis. Admin. Code, provides that only the following medical expenses will be applied to meeting the spend-down amount required to gain eligibility:

- expenses incurred during the spend-down period, or
- expenses incurred prior to the spend-down period, but for which the applicant is still legally responsible and is consistently making payments, in which case the payments made during the spend-down period shall be applied. Note: This rule is impermissibly restrictive. DHSS itself no longer follows it. See Medical Assistance Handbook Appendix 20 for current interpretation. See also discussion related to income eligibility for medically needy program (4. below) for explanation.

Institutionalization

Income eligibility for persons in Medicaid-certified institutions is based on a different standard. Please refer to Chapter 3. below, "Considerations for Institutionalized Individuals."

Persons Requiring Treatment for Kidney Disease

See §49.48, Wis. Stats.

Eligibility; Persons Requiring Treatment for Hemophilia

See §49.485, Wis. Stats.

3. "Section 503" Cases

Title V, Section 503, 42 USC §1396(a), Public Law 94-566, 90 Stat. 2685 (1976), also known as the "Pickle Amendment," provides that categorically needy eligibility for Medical Assistance be preserved for individuals who lose SSI benefits because of an increased income caused solely by Social Security cost-of-living benefits and who would, except for that specific increase, continue to be eligible for SSI (42 C.F.R. §435.135). There is no applicable Wisconsin statute or administrative rule, but see M.A. Handbook Appendix 19.1.0. The First Circuit Court of Appeals decision, Ciampa v. Secy. of HHS, 687 F. 2d 518 (1982), holds that persons losing SSI (and Medicaid) for income other than Social Security cost-of-living increases can later regain eligibility if the later cost-of-living percentage increase for SSI and Social Security would render them eligible. (See an example of the Pickle Amendment in Appendix A. See also "Medicaid Eligibility in a Time Warp," Clearinghouse Review, June 1988, pp. 120-124).

Review for "Pickle" eligibility should also be conducted by the state whenever Medicaid coverage under another source of entitlement is being terminated. Unless such screening is done routinely, thousands of intended Pickle Amendment beneficiaries will be deprived of the Medical Assistance they so desperately need.

A person who loses SSI eligibility due to Social Security COLA's is given a three-month grace period (January-March) of M.A. eligibility following termination from the SSI program. During these three months this person should apply for M.A. at the local county department of human services. Such a person should be considered as categorically needy rather than medically needy, even though his income exceeds the categorically needy income standard. Because §503 persons are not considered medically needy, they do not have to meet a deductible.

4. Qualified Medicare Beneficiary (QMB)

Persons whose income are at or below 100% of the poverty line and whose resources are less than twice the allowable amount of liquid resources for the Medical Assistance program are eligible to receive a special Medical Assistance card which pays only for their Medicare deductibles, premiums

and co-insurance payments. This category of Medical Assistance recipients was created by the Medicare Catastrophic Coverage Act of 1988. For more information, contact your county human services agency.

D. Income

1. Income of Spouse (Deeming): Treatment as a couple

The first step in determining eligibility is to determine whose finances must be considered; the state must not consider the income and resources for any relative other than a spouse, or where an applicant is under 21, a parent (42 U.S.C. §1396a(17)D; 42 C.F.R. §435.821-23).

Federal law requires, in treating the eligibility of one or both members of a married couple or a child under 21, that the determination be made "...taking into account only such income and resources as are. ..**available** to the applicant ... and... would not be disregarded ... in determining his eligibility for [SSI or AFDC program.]" (42 U.S.C. §1396a(a)(17)(B)).

Wisconsin and all other "SSI States" have in the past been required to disregard a spouse's income when the applicant and spouse **cease to share the same household,** unless both are eligible for benefits, in which case the income of both is considered for six months, 42 C.F.R. §435.723(d), (c). Therefore, currently in Wisconsin,**where one member** of a couple **is eligible** and is separated by, e.g., institutionalization, that person is treated as an individual immediately. Income and resources of the non-applicant spouse are ignored unless actually contributed (HSS §103.07, Wis. Admin. Code).

2. Income of Parents (Deeming)

For disabled SSI-eligible minors who are hospitalized, or in a skilled nursing facility or intermediate care facility, §134 of T.E.F.R.A. of 1982 provided, at state option, that no parental income or resource deeming will take place (i.e., the child is treated as an individual) if the child could have appropriate care in the home and the Medicaid cost of that care would be less than in the institution (42 U.S.C. §1396a).

3. Standards: Categorically Needy

Countable income of categorically needy applicants is determined under the standard of the cash income program (AFDC or SSI) for which each applicant is eligible. For SSI criteria see 42 U.S.C. §§1382 et seq.; 20 C.F.R. §§416.1100-1182 et seq.

a. General

Eligibility is determined on the basis of individual's income and resources in the month of application (42 U.S.C. §1382(c)).

Income includes "...anything you receive in cash or in kind that you can use to meet your needs for food, clothing or shelter" (20 C.F.R. §416.1102).

Income does not include the value of third-party payments for medical care; Title XX in-home supportive services; receipts from the sale of a resource; income tax refunds; loan repayments; Food Stamps; weatherization assistance; fuel assistance, etc. (20 C.F.R. §416.1103).

b. Earned Income

Includes gross cash or in-kind wages (including income received from sheltered workshop) and net earnings from rents (20 C.F.R. §416.1110).

c. Unearned income

Includes all income, in cash or in kind, not considered earned income (20 C.F.R. §416.1121). Examples: Social Security, Black Lung, Veterans', Railroad Retirement, Worker's Compensation, and unemployment insurance benefits; pensions; sick pay; alimony; rents (less deduction for income production); dividends, interest and royalties; gifts and inheritances; "in-kind" support or maintenance; prizes and awards (20 C.F.R. §416.1121).

Income from a land contract is counted as unearned income (HSS §§103.07(2)(h) and 103.06(14), Wis. Admin. Code.)

d. Exclusions

The first $20 per month (one exclusion per couple).

The first $65 per month plus one-half of any additional earned income. (20 C.F.R. §416.1112).

Infrequent or irregular income: $20 per month: $60 per quarter (20 C.F.R. §416.1112(c)). NOTE: Income received more often than quarterly will not meet the requirement. Additionally, if income is greater than $20, the entire exclusion is lost.

Work expenses of blind and disabled (42 U.S.C. §1382a(b)(1)(B)).

Income needed to fulfill a plan for self-support (20 C.F.R. §416.1112).

4. Standards: Medically Needy

For persons applying for the medically needy program outside of a nursing home, the income standards are based on the principle of a deductible. The person or couple becomes eligible for the medically needy

program when the deductible has been met. The deductible is calculated as the amount of monthly income which exceeds the applicable threshhold income standard for the group size over a six month period. The current income standards for the medically needy program, compared to the categorically needy program, are as follows:

MA INCOME LIMITATIONS - 1991

	Categorically Needy	Medically Needy
Individual living in own home	$509.72	$509.72
Couple living in own home	$745.86	$591.67

(The current level for an SSI eligible couple is $745.86)

Using a prospective period of six months to compute income, the state must deduct any amount that would be deducted in determining eligibility for SSI or AFDC (42 CFR, § 435.831(a)).

In Wisconsin there are potentially two deductible periods available to an applicant. The current deductible period lasts for six months beginning with the month of application. The backdated deductible period may include any or all of the three months immediately preceding the month of application.

a. Calculating the deductible

Current

Add the applicant's expected countable income for six months beginning with the application month. Compare that number to the relevant monthly income standard multiplied by six. The difference between the two numbers is that person's current deductible.

Backdated

Decide which of the three months preceding application should be included in the calculation. Add the applicant's countable income for the desired months. Compare that number to the relevant monthly income standard multiplied by the number of months you want in the backdated period. The difference between the two numbers equals that person's backdated deductible.

Note: The effective use of the backdated eligibility period may save a person thousands of dollars in health care expenses. Because your medical expenses are already known, you can time your application for MA benefits to follow the month when expenses are incurred. Once a one-time deductible is met, eligibility is established. It is as if one was able to purchase

health insurance after an illness or injury, pay no premiums and only one small deductible and have retroactive coverage.

b. Meeting the deductible

A person meets the deductible when current medical and related expenses and/or unpaid past medical expenses exceed the deductible.

1) Expenses which may count toward the deductible

- current medical expenses (physicians, dentists, chiropractor, therapist, hospital, clinic, etc.)
- prescription drug expenses
- non-prescription drugs and supplies prescribed by a licensed medical practitioner
- transportation expenses associated with the provision of medical care
- health insurance premiums due within the deductible period
- past medical expenses which are still legally owed

Note: Under OBRA 90, states are permitted to allow MA deductible eligible persons to pay their deductible directly to the state, rather than incurring medical bills to meet it. Wisconsin has not yet incorporated this change in its MA plan.

2) Expenses which may not be used to meet the deductible

- medical bills which have been paid prior to the deductible period
- old medical expenses which are no longer legally owed (i.e., discharged in bankruptcy)
- over-the-counter drugs and/or supplies which have not been prescribed by a licensed medical practitioner
- medical expenses which have been or will be paid by a third party (i.e., Medicare or private insurance)

Once a deductible has been met, the person becomes eligible for the medically needy program for the time remaining in the deductible period. A new deductible period begins every six months.

Medically needy income eligibility for residents of MA certified nursing homes is calculated differently. Please refer to Chapter 3 below, "Considerations for Institutionalized Individuals."

E. Resources

This section discusses the basic resource requirements for both the categorically and medically needy programs. As a practical matter, the requirements are identical and county workers apply the same resource criteria to applicants for MA under either program. Categorically needy applicants are technically subject to the same resource requirements as SSI recipients. Thus, the citations in the discussion of the categorically needy program are to the United States Code and the Code of Federal Regulations. Where these provisions have been incorporated into the Wisconsin Administrative Code, those cites have also been included. The discussion of the medically needy resource requirements should be considered as complementary to the categorically needy section. Attorneys may assume all of the resource rules apply to nursing home cases. Special resource rules related to the Spousal Impoverishment program are discussed at Chapter 3, Considerations for Institutionalized Persons.

1. Resources for Categorically Needy: SSI criteria (20 C.F.R. §§416.1201-1266; 42 U.S.C. §§1382 et seq.).

a. Definition: any cash, liquid asset, or any real or personal property an individual owns and could convert to cash to be used for support and maintenance (20 C.F.R. §416.1201(a)).

Underlying principle: Is the property "available" to the recipient in cash or can it be converted into cash?

Examples: Checking and savings accounts; certificates of deposit; stocks; certain insurance; real and personal property which can be sold.

b. If an individual was unaware of his/her ownership of an asset, the asset is not counted as a resource during the period for which the individual was unaware of his/her ownership. The unknown asset is counted as of the first moment of the month following the month of discovery of the asset (POMS SI §01110.010B).

c. Valuation: Under 20 C.F.R. §416.1201, except for automobiles, equity valuation is used as the value for resources. "Equity value" is defined as the price for which the item can reasonably be expected to sell on the area's open market minus encumbrances (liens, etc).

d. Limit of countable liquid resources:

	1989 and Thereafter
Individual	$2,000
Couple	$3,000

2. Resource exclusions

a. **Home;** 42 USC §1382b(a)(1); 20 CFR §416.1212; HSS §103.06(1) and (4): The home, including all related outbuildings necessary to the home's operation and all contiguous land, regardless of value is exempt so long as it is the applicant's principal residence or the principal residence of the applicant's spouse or dependent relative.

Once a home becomes unoccupied, it becomes a countable resource. However, if the home is sold, the proceeds from the sale of the home may be excluded for up to 3 months if used to purchase another excludable home. NOTE: HSS §103.06 (4) provides for a one year exclusion for proceeds ultimately used to purchase another home.

b. Car; 20 CFR §416.1218; HSS §103.06(2): Generally, a vehicle with a current market value of $4500 or less is excluded. Where unexcluded market value exceeds $4500, only the excess value is counted toward the $2000 liquid asset limit. Exception: There is no value limit, however, if the car is necessary for employment or medical treatment or if it has been specially modified to accommodate a handicap. Note that market value, rather than equity value, is used to arrive at vehicle value. The distinction is that market value does not take into consideration any encumbrances on the vehicle. As a practical matter, however, counties appear to use equity value to determine vehicle value.

c. **Life Insurance;** 20 CFR §416.1230; HSS §103.06(10): Whole life policy with total face value of $1500 or less is excluded, regardless of its cash value. If face value exceeds $1500, then entire cash value counts towards liquid resource limit. Each spouse may possess an excluded whole life insurance policy. Because term insurance policies never have cash value, they never count as assets, regardless of their face value.

d. **Household Goods and Personal Effects;** 20 CFR §416.1216; HSS §103.06 (8): Household goods and personal effects are

excluded so long as their value does not exceed $2000. Wedding rings and personal medical equipment are excluded regardless of value. The Wis. Administrative Code contains no dollar value limitation, but limits the exclusion to goods and effects of "reasonable value." Unless the county has some reason to believe applicant has household goods and personal effects of highly unusual value, there will generally be no inquiry.

e. **Property Essential to Self-Support**; 20 CFR §416.1200-1224 HSS §103.06(5)(b): Income producing property used in a trade or business may be excluded if it produces a reasonable rate of return on its value. Traditionally, such property was excluded if its equity value did not exceed $6,000 and it produced at least 6% of income. OBRA '89 removed these limits if the items considered for exclusion were tools of trades-people, or the livestock or machinery of a farmer. Liquid resources cannot be excluded under this section. (20 CFR §416.1222).

Non-business property used to produce goods or services necessary to an individual's daily activities is excluded if its value does not exceed $6,000. This exclusion is typically applied to property used to produce one's own food such as land, tools, animals and crops. (20 CFR §416.1224.)

f. **Funds to Replace Lost, Damaged, or Stolen Excluded Resources**; 20 CFR §416.1232: Funds received from any source to replace lost, damaged, or stolen excluded resources are excluded for 9 months following their receipt. This exclusion would typically apply to insurance payments on houses and cars. Any funds not used to repair or replace the excluded resource begins counting as liquid resources after the 9 month period expires. The 9 month period may be extended if the failure to use the funds is due to circumstances beyond the individual's control or for other good causes.

g. **Burial Spaces**; 20 CFR §416.1231(a) as amended by Vol. 55 FR #133 p. 28373: Burial spaces, including burial plots, crypts, mausoleums, urns, niches and other traditional repositories for human remains are excluded regardless of value. The

exclusion also applies to contracts to purchase burial spaces so long as the contract creates a present right to utilize the space. Thus, an installment contract to purchase a burial space is not excluded until it is fully paid. The exclusion encompasses "improvements" to burial spaces including vaults, headstones, markers, plaques and arrangements for opening and closing grave sites. Applicants may also own burial spaces for spouse and immediate family (including children, step-children, siblings, and parents, as well as any spouses of these persons).

NOTE: Under §445.125(1)(a) Wis. Stats. Contracts to purchase burial spaces are considered revocable trusts. Thus, a significant amount of funds could be placed in an agreement to purchase burial spaces without technically relinquishing control of the funds, at least as long as the individual is alive. Funds returned from a funeral home burial space contract would count as resources as of the month returned, but there is no provision for using such returned resources as the basis for an overpayment of paid SSI or MA benefits. Attorneys using burial space contracts of unusual value as resource protection devices should be prepared to defend this tactic at a fair hearing.

h. **Irrevocable Burial Trusts:** 20 CFR §416.1231(b)(5): In Wisconsin, up to $1500 may be placed in an irrevocable burial trust. Interest earned on the principal may also be made irrevocable. See §445.125(1)(b) and (c) Wis. Stats. Funds held in an irrevocable burial trust reduce the amount, dollar for dollar, that may be held in a burial fund.

i. **Burial Funds;** 20 CFR §416.1231(b) as amended by vol. 55 FR #133 p. 28373: Up to $1500 may be excluded (in addition to funds invested in burial spaces) for use as a burial fund. The fund must be separately identifiable from other liquid resources. Co-mingling the burial fund with other liquid resources results in the loss of the exclusion. Interest earned on a burial fund is also excluded, even if it causes the fund to exceed $1500. Recent regulatory amendments have tightened the definition of "burial fund." Currently, burial funds must be in some form of a financial instrument which has a definite cash value. Previously, one could

designate virtually any property as a burial fund, no matter how tenuous the connection between the property and the ability to use it to meet burial expenses. Burial funds used for some other purpose cause an SSI overpayment equal to amount of the fund improperly utilized but do not create an overpayment problem for MA.

NOTE: The excludable amount in the burial fund is reduced by any amount held in an irrevocable burial trust and the face value of all whole life insurance policies. As a practical matter, this means an applicant may protect up to $3,000 by choosing to place funds in an irrevocable burial trust and a paid up whole life insurance policy with a face value of less than $1500. If the applicant elects to have a burial fund, he limits the total amount that may be placed in these three instruments to $1500.

j. **Non-Homestead Real Property;** 20 CFR §416.1245; HSS 103.06 (5): The value of non-homestead real property is counted as an available asset. However, it becomes temporarily excluded so long as it is listed for sale with a licensed real estate broker. The SSI rule has several technical requirements (including open houses, yard "for sale" signs and guidelines for accepting prices below the listing price). These technical requirements are not included in the Wisconsin rule. Once the property is sold, the proceeds from the sale count as liquid resources.

Under the SSI rule, when non-homestead real estate property is jointly owned with someone who refuses to sell the property and sale of the property would cause that person "undue hardship," the property is simply considered exempt and not subject to the listing requirement. "Undue hardship" is defined as meaning that the property is the sole place of residence for the joint owner and a forced sale of the property would cause that person to lose his or her home. Thus, if the joint owner has other residential real property to which a move is possible, the listing requirement remains.

The state rule is illogically restrictive and ignores the undue hardship requirement contained in federal law. Whether

jointly held non-homestead property would be subject to the listing requirement, depends on whether the property is held in joint tenancy or as a tenancy in common. According to the MA Handbook at Appendix 11.6.0, tenancies in common are transferrable with or without the joint owner's consent. Therefore, refusal to sell by the joint owner is irrelevant. Thus, the state generally requires that the interest in a tenancy in common be listed for sale. According to the state rule, joint tenancies can never be sold without the joint owner's permission. Therefore, the joint owner's refusal to sell makes the applicant's interest unsalable and therefore unavailable.

The Center has always taken the position that the distinction between joint tenancies and tenancies in common is nonsensical. The fact is that no real estate broker will list a tenancy in common for sale absent participation by remaining tenants. This fact may easily be established at fair hearing by providing statements from brokers. Once it is established that the interest is unsalable, it becomes unavailable.

3. Resources for Medically Needy: (§49.47(4)(b) Wis. Stats.; HSS §103.06 Wis. Admin. Code.)

The following section expands on the preceding one. Here, provisions relating to resources not enumerated in the SSI program are discussed.

The Wisconsin Administrative Code contains specific clarifying statements on how specific assets may be treated in the medically needy program.

a. Joint accounts; HSS §103.06(3)(a): Joint accounts are considered available to all persons whose names appear on the account. If the co-owners of the account are not MA recipients, the entire value of the account is considered available to the MA applicant or recipient. In other cases, each MA recipient is deemed an equal share of the account. Any joint account holder not applying for MA may legally withdraw the entire account balance, thereby wiping out the asset. As long as the MA recipient or his spouse does not instigate or participate in the wasting of the account, it will not be considered divestment. (See Appendix D). Since it is

not a divestment and the account is gone, it no longer counts as a resource to the applicant.

b. **Land contracts;** HSS §103.06(14): A vendor's interest in a land contract is counted toward the resource limit. The contract will be considered an unavailable resource if documentation of inability to sell is provided to the agency.

c. **Life estates;** HSS §103.06(8): Life estates in homestead property are exempt assets because they are considered homestead property. Life estates in non-homestead property are generally considered unavailable assets. This appears to be because of the absence of a market for such an interest. If a life estate is sold, the proceeds count towards the liquid resource limit.

d. **Loans;** HSS §103.06(9): Funds received as loans are exempt unless available to meet everyday living expenses. If they are available to meet living expenses, they are considered available even if a repayment schedule exists.

F. Deeming (20 CFR §416.1202):

Resources may be deemed to claimant from an ineligible spouse or parent or, if alien, from sponsor. Generally, the same exclusions apply to deemed resources as to actual resources of the individual. Deeming rules only apply to married couples when they share the same household. If separated by institutionalization of one spouse, the resource rules under the spousal impoverishment program become effective. (See Considerations for Institutionalized Individuals; Chapter 3 below).

Deeming rules may be waived under special circumstances (20 C.F.R. §416.1204(a)).

G. Conditional eligibility: (20 C.F.R. §§416.1240-1246)

Applicant with limited excess resources may still be eligible if s/he agrees to dispose of them within a restricted time period, and to return to SSA the amount of SSI benefits received from the amount realized from the property sale.

H. Problems of Excess Resources

1. Individuals with excess resources at the time medical care is given are not eligible for Medical Assistance regardless of the amount of medical expense incurred.

2. Accumulation of **income** by institutionalized recipients may result in exceeding **resource** limits if no one is available to assist in spending the personal needs allowance. The impact of Medical Assistance termination can be devastating and thus careful monitoring of institutionalized residents' accounts is necessary. Income may be treated as a resource in any month after the month it is received.

3. An individual may not, except under special circumstances, give away or transfer for less than fair market value any non-exempt resources in an attempt to become eligible for MA in a nursing home. This is called **divestment** and will result in denied eligibility. (See Chapter 2., below.) An individual may give away or transfer assets at less than fair market value for purposes of receiving MA card services (HSS §103.065(3)(d) and (4), Wis. Admin. Code) or SSI cash assistance outside an institution.

I. Trusts

1. Prior to June 1, 1986, an irrevocable intervivos trust could be used to protect assets by putting them beyond the reach of the grantor for any obligations which would otherwise be paid by Medical Assistance, so long as more than two years had passed from the establishment of the irrevocable trust to the date of application for benefits. The Will of Wright case, 12 Wis. 2d 375 (1961), established the principle that a testamentary trust could be established for the benefit of a recipient of state assistance to provide comforts, luxuries and necessities which would not otherwise be provided by the public assistance to which the beneficiary was otherwise entitled. Will of Wright trusts, both testamentary and intervivos, have been used to shelter assets and create eligibility for Medical Assistance.

2. On June 1, 1986, a provision of federal legislation contained in COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) codified at 42 U.S.C. §1396a(k) became effective.

   Trust assets are now considered available to a grantor and the grantor's spouse who are beneficiaries of the trust to the maximum extent of any discretion which the trustee is authorized to exercise. If the trustee had discretion to invade the corpus of the trust in case of a beneficiary's needs, then the whole corpus of the trust is considered to be an available asset for both the grantor and the grantor's spouse if both are beneficiaries of the trust.

   There is a hardship exception provided for the general rule on intervivos trusts.

   Testamentary trusts are not included within this legislation. This means the Will of Wright trusts established by will would be considered available assets only to the extent of the actual provisions of the trust, not to the maximum extent of the trustee's discretion.

3. **It is advisable** to exercise caution in establishing trusts as a mechanism for Medical Assistance qualification because of state administrative regulations.

   Section HSS §103.06(7), Wis. Admin. Code provides as a general rule that trust funds shall be considered available assets.

   Section HSS §103.06(7)(a), Wis. Admin. Code provides several exceptions to the general rule.

   Trust funds which are payable to a beneficiary only upon order of a court are not considered available assets if the trustee or other interested person has first applied to court for an order allowing use of funds and the court has denied the application.

- Funds held in a trust meeting the requirements of Wis. Stats. §701.06 are not considered available assets unless the grantor is legally obligated to support the beneficiary. Section 701.06 governs spendthrift trusts and includes many different sections. Section HSS §103.06(7)(a)2, Wis. Admin. Code is entirely unclear as to which of those sections are intended to be part of the

exception to the availability of trust funds. Arguably, any kind of trust with a spendthrift provision would qualify as an exception to the availability rule. This section has not been judicially construed or further explained by administrative rule.

- Federal standards apply as to trust funds considered available for recipients of SSI and AFDC.

- Pursuant to §701.13(2) Wis. Stats, unless the creating instrument provides to the contrary, a court may order payment of principal for the support or education of an income beneficiary of a trust if the beneficiary's other resources are not sufficient. Any trust established for a person who may need to apply for Medical Assistance in the future should be drafted with this provision in mind.

4. REMINDER: Under the Medicare Catastrophic Care Legislation, for a spouse who enters a nursing home after September 30, 1989, resources include all assets owned by both spouses in excess of community spouse's resource allowance. An institutionalized spouse is eligible when resources do not exceed the community spouse's resource allowance and exempt assets owned by each spouse. In order to start the clock running on the look-back period, the transfer of assets to the trust must be irrevocable. And, irrevocability prevents flexibility for future resources transfer planning.

2: DIVESTMENT

A. Introduction

It is extremely important for attorneys and their elderly clients to recognize that a person who transfers, or gives away, property to another for less than fair market value may face significant barriers to his or her eligibility and his or her spouse's eligibility for Medical Assistance in a nursing home. Such a transfer is called a divestment. It is also critical for attorneys to realize that Wisconsin currently has two separate divestment policies in place. The particular policy or policies which may be relevant to your client will depend totally on the date a transfer occurred. The date of application for Medical Assistance is not relevant for purposes of determining which set of divestment rules may apply.

The state's policy on divestment changed drastically with the promulgation of Department of Health and Social Services emergency rules on August 9, 1989. Transfers which occurred prior to August 9, 1989, continue to be subject to the rules which are located at HSS §103.063, Wis. Admin. Code. Transfers which occur on or after August 9, 1989, are subject to the rules located at HSS §103.065, Wis. Admin. Code. The rules have now been through the formal rulemaking process and may be found in the bound volume of the Wisconsin Administrative Code.

The new divestment rules were necessitated by the Medicare Catastrophic Coverage Act of 1988 which amended subsection (c) of §1917 (42 U.S.C. §1396p) of the Social Security Act. Wisconsin incorporated the federal changes by repealing and recreating §49.45(17), Wis. Stats. These legislative actions impose a bar to eligibility for MA when a transfer is made by an institutionalized person or his/her spouse of countable resources for less than fair market value within 30 months prior to or at any time after his/her application for MA. This is a change from the former law which contained only a 24 month prohibition. On October 13, 1988, President Reagan signed the Family Support Act of 1988, Public Law 100-485, which included technical amendments to the Catastrophic Coverage Act, including, most importantly, a provision which retained the inter-spousal transfer provisions in effect as of June 30, 1988, until October 1, 1989.

The changes in the law also repealed the SSI transfer of assets policy in effect prior to July 1, 1988, thereby arguably voiding all state plans using SSI guidelines for eligibility and divestment restrictions. However, states were allowed to request a "waiver" from the federal Department of Health and

Social Services which permitted them to delay implementation of the new federally mandated divestment provisions and retain existing divestment policies until conforming state legislation could be enacted. Wisconsin allegedly sought and received such a waiver. This explains why Wisconsin's new divestment rules did not go into effect prior to August 9, 1989. The post-August 9, 1989 divestment rules were altered significantly by the Omnibus Budget Reconciliation Act of 1989. The effects of the OBRA 89 provisions are discussed in detail below.

This section is organized as follows:

- the rules applying to transfers which occurred prior to August 9, 1989;
- the rules applying to transfers which occur on or after August 9, 1989;
- the multiple divestment rules;
- the hazards, problems and consequences of divestment for the divestor, as well as the ethical considerations for attorneys who represent elderly clients in these matters; and
- the special considerations for persons who divested on or after July 12, 1988, but before September 23, 1988. These are so-called Fedderly beneficiaries.

B. Divestment Rules applicable to transfers before August 9, 1989 (HSS §103.063 Wis. Admin. Code)

These rules apply to all transfers which occurred before August 9, 1989 regardless of when Medical Assistance is applied for.

1. General rule

In determining the resources of each applicant for Medical Assistance or in redetermining a recipient's eligibility, the department shall include any non-exempt (or the homestead, see 4., below) resource the person has disposed of for less than its fair market value, if the disposal occurred within 24 months preceding the application or redetermination (HSS §103.063, Wis. Admin. Code).

a. The Department of Health and Social Services will presume the transfer occurred for the purpose of establishing eligibility for MA, unless convincing evidence to the contrary is presented.

b. The amount of the divestment is the difference between the compensation received for the resource and the net market value (equity interest) of the resource.

c. If the divested amount, plus other non-exempt assets, is greater than the current asset limit ($2,000 for an individual, $3,000 for a couple), the excess over the limit will be the amount to be expended for maintenance needs and medical care before eligibility will be awarded.

2. Removing the Divestment for Non-homestead Transfers

a. If the divested amount is $12,000 or less, the person will be eligible for MA after spending the amount divested for maintenance needs and medical care or when 2 years have elapsed since the date of divestment, whichever occurs first.

b. If the divested amount exceeds $12,000, the person must expend the entire sum of the divestment on his/her maintenance needs and medical care before becoming eligible. NOTE: This means that the waiting period before MA eligibility begins could be longer than two years. Thus, where an individual was known to have divested a large amount (e.g., more than $50,000), it might be advisable to "simply" **wait** to apply for more than 24 months after the divestment.

c. What constitutes "maintenance needs and medical care"?

- For a non-institutionalized person, the actual expended amount of medical bills for the person, plus the current medically needy income limit for either AFDC or SSI, depending on the applicable program (currently $509.72 for SSI).
- For an institutionalized person, the total cost of the institutional care.

3. Divestment of a Homestead

a. Transferring the homestead is only a bar to eligibility if transferred for less than fair market value by an **institutionalized** person or a person who becomes

institutionalized within 2 years of application or redetermination of eligibility for MA.

EXCEPTIONS: (HSS §103.063(3)(d)3., Wis. Admin. Code)

- Transfer was to the person's spouse or child (child must be under 21 or blind or totally disabled).
- The person reasonably expected to be discharged and return to the homestead, as can be proven to the DHSS's satisfaction.
- It can be proven to the DHSS's satisfaction the transfer was intended to be for fair market value or other valuable consideration.
- It would work an undue hardship on the person to deny eligibility.

b. The divested amount is determined the same way as indicated above for non-homestead property.

4. Removing homestead divestment eligibility barrier (only institutionalized persons are affected).

a. If the amount of divestment to be expended for maintenance needs and medical care is less than the average MA expenditure for 24 months of care in an institution ($2,043/month in 1990), when the entire amount is expended for care, or 2 years have elapsed since the date of divestment, whichever occurs first.

b. If the amount of divestment is greater than the average MA expenditure for 24 months of institutional care ($49,032), when the entire amount of the divestment has been expended on care.

EXAMPLE: Tom Jackson owns a home that has a net market value of $64,500. He sells it to his son for $40,000. Shortly thereafter (before 2 years have elapsed), he takes up permanent residence in a nursing home and applies for MA.

Tom Jackson has divested because he is a resident of a skilled nursing facility (SNF) and he disposed of his homestead for less than fair market value within 2 years of his application. The divested amount is $24,500 ($64,500-$40,000). Since $24,500 is less than the average MA expenditure for 24 months in an SNF (24 x $2,043 = $49,032), Mr. Jackson has three ways of removing it.

- Spend it on his own maintenance needs and medical costs at the fixed rate of $2,043 a month. He may not deduct more than $2,043 a month from the divested amount, even if his actual SNF monthly costs are greater than $2,043. At this rate, he will have rid himself of the $24,500 in 12 months.
- Allow 2 years to go by from the date of divestment before applying.
- Return divested property to divestor; have the divestee transfer the divested resources back.

If the divested amount had been $49,032 or greater and Mr. Smith applied for MA within two years, he would have had no alternative but to expend the entire amount on his own maintenance needs and medical costs at the rate of $2,043 a month. For example, if he gave his home away, the divested amount would be $64,500 and he would not be able to remove the divestment by allowing 2 years to go by. The problem here is that he applied before the 2 years had expired. He could have simply waited 2 years to apply. Instead, he would have to rid himself of it at the rate of $2,043 a month. At this rate, it would take 31 months ($64,500 ÷ $2,043).

C. Divestment Rules Applicable to Transfers on or after August 9, 1989

Introduction

In December of 1989, the Congress again amended Section 1917 (c) of the Social Security Act [42 USC § 1396p (c)]. The amendment, which was included in the Omnibus Budget Reconciliation Act of 1989 (OBRA 89), expanded the prohibition on divestment to include transfers made by spouses of institutionalized persons. The intent of the legislation was to prevent the institutionalized spouse from transferring large amounts of resources to the community spouse and then having the community spouse retransfer all or a portion of the assets to a third party. Prior to this amendment, such retransfers could have been made without affecting the nursing home spouse's eligibility for MA. The amendment was supposed to be effective for all transfers which occurred after the effective date of OBRA 89, which was December 20, 1989.

Wisconsin did not incorporate this change into its state Medical Assistance plan until July 1, 1990. The department correctly recognized that Wisconsin's divestment statute as it existed in December of 1989 could not be construed to prohibit spousal retransfers in the manner prohibited by the

federal act. The statute was changed effective July 1, 1990. As of July 1, 1990, transfers by either spouse will be evaluated to determine if a divestment has occurred. It should be noted that the change did not affect the right of spouses to transfer assets to each other.

It should also be noted that Wisconsin's amendment to the Medical Assistance plan incorporating these divestment prohibitions as of July 1, 1990 has been disapproved by the Federal Health Care Financing Administration (HCFA). The Health Care Financing Administration has taken the position that these spousal divestment provisions were effective on the effective date of OBRA 89 regardless of state law. The state has requested reconsideration of HCFA's denial of their state plan amendment.

It is unlikely that this dispute will have any practical effect on Wisconsin Medical Assistance recipients. The state will probably not alter its Medical Assistance plan to conform to the December 20 effective date regardless of HCFA's ultimate decision. To do so, the Department would have to locate and re-evaluate all cases of divestment by spouses which may have occurred during the period between December 20, 1989 and July 1, 1990. It would involve potentially terminating Medical Assistance eligibility for persons who were not aware that the law did not permit spousal transfers of assets during this period. The Department has attempted this before and has been attacked for it.

The probable scenario is that even if the state plan amendment is not approved, the state program will simply accept any losses of federal financial participation it may experience by virtue of Medical Assistance payments made to persons whom HCFA believes should have been made ineligible based on the earlier effective date of the spousal transfer provisions. It is probably less expensive for the state to risk the small losses that might result from this reduced federal financial participation than to defend lawsuits from Medical Assistance recipients based on principles of equitable estoppel.

As this edition was going to press, the department was promulgating changes to HSS §103.065 Wis. Admin. Code incorporating the spousal divestment prohibitions. The department's proposed changes are reproduced in Appendix H of this volume. Note that the department's rules do not subject spousal transfers of homestead property to the divestment rules. Attorneys should be alert to the possibility that the final language may differ from the proposed language.

1. Effective Date-Generally

This provision (HSS §103.065 Wisconsin Admin. Code) is generally effective for all transfers made on or after August 9, 1989. The date Medical

Assistance is applied for is irrelevant for purposes of determining which divestment rule applies.

2. Specific Effective Dates

Because of nuances in the original law and the recent application of divestment prohibitions to spouses, there are other highly significant effective dates of which attorneys need to be aware. The following summary of all effective dates should be useful in analyzing a client's situation.

a. For transfers by the institutionalized spouses to third parties other than spouses: on or after August 9, 1989,

b. For transfers between spouses: on or after October 1, 1989,

c. For re-transfers by community spouses of non-homestead property received from a non-institutionalized spouse: on or after October 1, 1989 and before July 1, 1990,

d. For transfers by a spouse of a Medical Assistance applicant of non-homestead property: on or after July 1, 1990.

3. Penalties

All institutionalized persons shall be penalized for transfers of assets for less than fair market value within 30 months of applying for Medical Assistance, **unless** the transfers fall under the exceptions listed in sub-paragraphs 5. and 6. below.

4. Calculating ineligibility

The penalty for divestment shall be ineligibility for Medical Assistance in a nursing home for a period equal to the lesser of:

a. 30 months from the date of transfer, or

b. The number of months arrived at by dividing the divested amount by the average monthly cost of nursing home care to a private pay resident in Wisconsin. The resulting period of ineligibility begins in the month of transfer. As of October 1, 1989, the amount is $2,043. This monthly figure is supposed to be adjusted annually by DHSS. **Note: At publication this figure had not been updated.**

c. **If a divestment of non-homestead property is made by the spouse of an institutionalized Medical Assistance applicant or recipient, the period of ineligibility applies to the institutionalized person.** An unanswered question is how such a divestment would affect eligibility if the community spouse becomes institutionalized during the period of ineligibility that is being applied against the previously

institutionalized spouse. It would seem unfair that one divestment could be used against two persons, but the answer to that question is not resolved.

d. **WARNING:** Application of divestment principles to spouses of nursing home residences is likely to create a whole new class of unintentional divestors. Because Medical Assistance eligibility is determined without regard to Wisconsin's marital property rules, persons who make completely appropriate gifts of individual property may be unintentionally jeopardizing their spouse's potential eligibility for MA. An article outlining a potential legal strategy to challenge the application of the rule to these situations based on a technical reading of the language of 42 USC § 1396p is reproduced at Appendix G of this volume.

5. Transfers which are not divestments

Certain transfers are not considered divestments, even if they are for less than fair market value.

a. Transfer of the homestead is <u>not</u> a divestment if it is to:

- the spouse of the institutionalized individual (HSS §103.065(4)(b)1, Wis. Admin. Code).
- a child under the age of 21 or a disabled adult child (HSS §103.065(4)(b)2, Wis. Admin. Code).
- a sibling with an equity interest in the home who has resided in the home for at least one year prior to the institutionalization. DHSS considers "equity interest" to mean an ownership interest in the home by one or more persons who pay or have paid all or a portion of mortgage or land contract payments for the home (HSS §103.065(4)(b)3, Wis. Admin. Code).
- the son or daughter of the individual residing in the home for at least two years prior to the individual's admission to the institution, where such child was "providing care" to the individual, enabling the individual to reside in the home and thereby avoid institutionalization in a skilled nursing facility or an intermediate care facility (HSS §103.065(4)(b)4, Wis. Admin. Code).

b. Transfer of non-homestead property by either person is <u>not</u> a divestment if it is to:

- the community spouse (meaning that the transfer occurred after the transferring spouse entered the institution) (HSS §103.065(4)(c)1, Wis. Admin. Code);
- a minor or adult disabled child (HSS §103.065(4)(c)2, Wis. Admin. Code);
- the individual's spouse, other than a community spouse (meaning the transfer occurred while both spouses were outside a nursing home), as long as the receiving spouse does not re-transfer the property to a third party for less than fair market value. If the receiving spouse does make such a re-transfer, the transfer could be considered divestment applicable to the institutionalized spouse (HSS §103.065(4)(c)3, Wis. Admin. Code). **<u>Note</u>:** This section was subsumed by the OBRA 89 changes making all spousal transfers potential divestments. This section, however, does apply to some spousal transfers made between 9/30/89 and 7/1/90.

6. Divestments that do not bar eligibility

Prohibited divestments will also not be considered as barriers to eligibility if they were made:

a. as a result of a division of resources as part of a divorce or separation action, loss of resource due to foreclosure or the repossession of a resource due to failure to meet payments (HSS §103.065(5)(a), Wis. Admin. Code);

b. with the intent of receiving full market value or for other valuable consideration (HSS §103.065(5)(b)1, Wis. Admin. Code);

c. exclusively for a purpose other than to qualify for Medical Assistance in an institution (HSS §103.065(5)(b)2, Wis. Admin. Code); or

d. the state determines a denial would work an undue hardship on the institutionalized individual. For purposes of this exception, undue hardship means that an immediate life-threatening circumstance exists for the institutionalized individual (HSS §103.065(5)(b)3, Wis. Admin. Code).

The Department has concluded that an immediate life threatening circumstance exists if denial or termination of MA causes a subsequent lack of access to needed medical care.

D. Multiple Divestments

1. Introduction

A tool for accomplishing divestment of significant amounts of assets during the thirty months immediately prior to application for Medical Assistance is the so-called "multiple divestment rule". This is not a "rule" at all, but a creative manipulation of the timing of sequential divestments so as to maximize coincidental periods of ineligibility. It springs from the federal statutory language determining when periods of ineligibility begin and how their lengths are calculated.

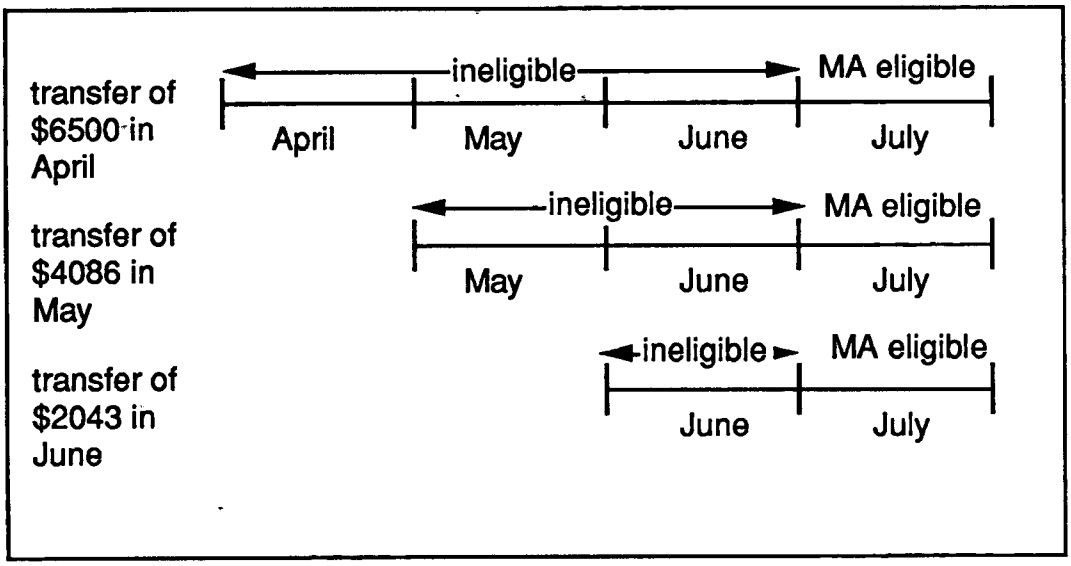
2. How it Works

a. As you will recall, a period of ineligibility begins in the month divestment occurs. The period of ineligibility lasts for the number of months arrived at by dividing the divested amount by the average monthly cost of nursing home care to a private pay patient. In 1990, that average cost was $2,043. Thus, if Rosie Greenhowe divested $6,500 on April 1, 1990, the period of ineligibility would be 3.18 months ($6500 ÷ $2,043). However, the department rounds fractional amounts down when determining actual ineligibility. Therefore, Rosie would be ineligible for Medical Assistance in a nursing home for three months beginning April 1, 1990 and ending on June 30, 1990.

b. The multiple divestment rule requires the divestor to make smaller divestments during an already known period of ineligibility. Subsequent divestments must occur in later months so that they trigger new periods of ineligibility. The divestments must be proportionately smaller so that they result in shorter periods of ineligibility. If divestments are planned correctly, they trigger periods of ineligibility that begin in different months, but end in the same month.

c. Using the example above, Rosie could divest up to $4,086 in May of 1990, thereby incurring a new two month period of

ineligibility ($4,086 ÷ $2,043 = 2) which begins in May of 1990 and ends in June of 1990. Rosie could then divest another $2,043 in June of 1990, incurring a new, one month, period of ineligibility ($2,043 ÷ $2,043 = 1). That period begins and ends in the month of June, 1990, the month of transfer. By using multiple divestments, Rosie can divest $12,629 between April 1 and June 30, and is eligible to receive Medical Assistance in a nursing home on July 1, 1990. This is because all periods of eligibility have ended by July 1 of 1990. Had Rosie divested all $12,629 on April 1, 1990, the period of ineligibility would have been 6.18 months ($12,629 ÷ $2,043). Because of rounding down the fraction, Rosie's actual period of ineligibility for Medical Assistance would have been six months, or from April 1, 1990 through September 30, 1990. She has successfully avoided three months of potential ineligibility. The following chart illustrates the concept:



3. Maximizing the Rule

a. To maximize a multiple divestment, the divestor should take into account the fact that the department does not count any fraction of a month in arriving at its actual period of ineligibility. For example, a person is ineligible for six months whether or not the period of ineligibility calculation

results in a figure of 6.0 or 6.99. In money terms, the difference is significant. For example, it means that a divestment of anywhere between $12,258 ($12,258 ÷ $2,043 = 6.0) and $14,300 ($14,300 ÷$2,043 = 6.99) results in six months of ineligibility for Medical Assistance. If divestors are bent on impoverishing themselves they should be aware of this nuance in the way the department calculates the period of ineligibility.

b. The upshot of the multiple divestment rule is that a person may divest up to $1,013,297 during the thirty months prior to application for Medical Assistance. The table which follows shows how one arrives at that figure. The table can also be used to plan any multiple divestment. If your client is already in a nursing home and has a specific amount of money which he or she wants to divest, columns 5 and 6 will show you based on that available dollar amount how many months in advance of Medical Assistance application you will have to begin the multiple divestment.

1 How to Calculate Maximum Allowable Divested Amount			2 Divested Amount	3 Average Private Pay Cost	4 Theoretical Period of Ineligibility	5 Actual Period of Ineligibility	6 Cumulative Divested Amount if Divestment Begins in this Month
2,043	x 30 = 61,290	(+ 2,042)	= 63,332	2,043 =	(30.99)	30	1,013,297
"	x 29 = 59,247	"	= 61,289	"	(29.99)	29	949,965
"	x 28 = 57,204	"	= 59,246	"	(28.99)	28	888,676
"	x 27 = 55,161	"	= 57,203	"	(27.99)	27	829,430
"	x 26 = 53,118	"	= 55,160	"	(26.99)	26	772,227
"	x 25 = 51,075	"	= 53,117	"	(25.99)	25	717,067
"	x 24 = 49,032	"	= 51,074	"	(24.99)	24	663,950
"	x 23 = 46,989	"	= 49,031	"	(23.99)	23	612,876
"	x 22 = 44,496	"	= 46,988	"	(22.99)	22	563,845
"	x 21 = 42,903	"	= 44,945	"	(21.99)	21	516,857
"	x 20 = 40,860	"	= 42,902	"	(20.99)	20	471,912
"	x 19 = 38,817	"	= 40,859	"	(19.99)	19	429,010
"	x 18 = 36,774	"	= 38,816	"	(18.99)	18	388,151
"	x 17 = 34,731	"	= 36,773	"	(17.99)	17	349,335
"	x 16 = 32,688	"	= 34,730	"	(16.99)	16	312,562
"	x 15 = 30,645	"	= 32,687	"	(15.99)	15	277,832
"	x 14 = 28,602	"	= 30,644	"	(14.99)	14	245,145
"	x 13 = 26,559	"	= 28,601	"	(13.99)	13	214,501
"	x 12 = 24,516	"	= 26,558	"	(12.99)	12	185,900
"	x 11 = 22,473	"	= 24,515	"	(11.99)	11	159,342
"	x 10 = 20,430	"	= 22,472	"	(10.99)	10	134,827
"	x 9 = 18,387	"	= 20,429	"	(9.99)	9	112,355
"	x 8 = 16,344	"	= 18,386	"	(8.99)	8	91,926
"	x 7 = 14,301	"	= 16,343	"	(7.99)	7	73,540
"	x 6 = 12,258	"	= 14,300	"	(6.99)	6	57,197
"	x 5 = 10,214	"	= 12,257	"	(5.99)	5	42,897
"	x 4 = 8,172	"	= 10,214	"	(4.99)	4	30,640
"	x 3 = 6,129	"	= 8,171	"	(3.99)	3	20,426
"	x 2 = 4,085	"	= 6,128	"	(2.99)	2	12,255
"	x 1 = 2,043	"	= 4,085	"	(1.99)	1	6,127
"	x 0 =	"	= 2,042	"	(.99)	0	2,042

4. Why Use Multiple Divestments

The question arises why a person would choose to divest in this manner rather than simply divesting all funds in excess of amount necessary to cover nursing home costs for 30 months. The primary reason is control. During the 30 months during which the multiple divestments are occurring, the divestor has considerably more income at his or her disposal to use for whatever purpose than does the person who has made a lump sum divestment and retained only enough to cover nursing home costs for 30 months.

The following example comparing the situations of two similarly situated persons who chose the different methods of divestment should illustrate the point.

Example: Winifred Hancock and Bobby Lee both have $1,074,587 . Both anticipate entering the local nursing home, the Star Chamber Home for the Aged and Infirm, on January 1, 1991. Bobby is convinced by his greedy son, Fitzhugh, to give him all of his funds except enough to pay his nursing home bill for 30 months. Bobby keeps $61,290 for himself ($2,043 x 30). He gives Fitzhugh $1,013,297 on January 1, 1991. He becomes eligible for Medical Assistance nursing home payments 30 months later on July 1, 1993.

Winifred doesn't trust her kids and dislikes parting with her life savings. She contacts you, Attorney I. M. Savvy, who explains the multiple divestment rule to her. She chooses it. During the 30 months that follow, she has much more money available to use for personal comfort and enjoyment. For example, six months after both Winifred and Bobby enter the nursing home, Bobby has $49,032 left. Winifred still has $712,982 . Yet both people will become eligible for Medical Assistance on the same date. If Winifred's health improves and she can live outside the nursing home, she has funds available. Bobby would be hard pressed to set up an independent household on the amount he has remaining.

5. Why <u>Not</u> Use Multiple Divestments

Of course the <u>most</u> effective way to maintain control over the potentially institutionalized person's situation is to retain all of his or her assets. A person who has $1,013,297 in assets has the ability to pay for potentially 495 months of nursing home care. That is approximately 41 years worth of nursing home care. The likelihood that all or even a large part of that million dollars would be spent on nursing home care prior to someone's death is extremely low. If attorneys are looking out for the best

interests of their client, the elderly person, they should probably recommend the person not engage in any sort of divestment. In addition, the use of multiple divestments may have significant professional responsibility consequences. The section which follows should be considered carefully before recommending the use of a multiple divestment. At the very least, clear disclosures about risks and consequences need to be made to the client.

E. Hazards, Problems and Consequences of Divestment

There are serious considerations that should be given attention and discussed before a divestment is made; being a Medicaid recipient is not without its potential problems and therefore the below-listed hazards should be carefully considered by a client.

1. The stigma attached to welfare, loss of self-worth and pride

2. Loss of privacy

a. Reports and accounting required by Social Service Departments.

b. Periodic reviews and evaluations intruding on private lives and information.

3. Loss of independence and control

a. If divestment is prior to a need for institutionalization, the divestor may run out of funds for living expenses outside an institution (including any needed home-based care).

b. If divestment is found and the person is ineligible for MA, **but in need of institutional care,** with no resources left, he or she will not have means to pay for nursing home care.

c. Loss of choice of particular nursing home since a person can only receive care in MA-certified facility.

4. Possible discrimination by care providers against MA patients. For example, reports of:

a. Discrimination in admission to nursing homes;

b. Differences in standards of care between private pay patients and MA patients; and

c. Undesirable assignments of locations and indiscriminate transfers within a nursing facility affecting access to the patient and level of care.

5. Nursing home MA certification could terminate; a home could choose to, or be forced to, decertify for MA patients

a. Since there is no legal right to remain in a certain nursing home, the patient would be transferred or evicted.

b. There is no implied contractual right to remain in a particular home.

c. A patient has minimal due process rights protected by law regarding transfer or decertification (HSS §§132.53 and 132.54, Wis. Admin. Code).

d. A transfer could cause inconvenience, "transfer trauma" (disorientation and physical debilitation) and new patient access problems.

Note: This is no longer merely a hypothetical possibility. In November of 1990, Middleton Village Nursing Home, a Dane County nursing home, decided to terminate its participation in the Medical Assistance program. Approximately one-third of its residents were told to relocate or risk eviction for non-payment once the Medical Assistance payments ended. Nursing homes consistently complain about their allegedly low reimbursement rates for their Medical Assistance residents. If a home believes there are sufficient numbers of private pay residents waiting for beds currently occupied by MA residents, it may follow Middleton Village's lead and decertify from the MA program.

6. **The level of care needed by an individual may change (i.e., condition could improve so that level of care needed is downgraded) causing ineligibility for coverage by MA.**

   RESULT: This individual would then be ineligible for MA in a nursing home and without resources to purchase services in the community.

7. **The MA program may change in the future -- either financial eligibility or level of care covered (as in 1981 when the Wisconsin MA program discontinued coverage for lower levels of intermediate care). See same RESULT as in 6., above.**

   NOTE: The person receiving the divestment is under no legal obligation to assist the divestor financially or care for the person who has divested. (Exception would be a spouse who may be forced to contribute to care.)

F. Ethical Considerations--Professional Responsibility

In addition to the hazards outlined in E., above, a lawyer or other adviser should consider the following before advising clients.

1. **Problems for attorneys planning the divestment.**

   a. Who is the client? The divestor? The child(ren)? The guardian or power of attorney? The relative?

   b. Is the divestor informed, competent and represented?

   c. Is it in the client's best interest and is it what the client wants (after being advised of hazards and consequences)?

   d. Will the divestment possibly be challenged, causing ineligibility for MA for the divestor, legal action against the client or disciplinary action against the attorney?

EXAMPLE: Disciplinary Proceedings Against Strasburg 154 Wis. 2d 90, 452 N.W. 2d 152 (1990):

In March of 1990, the Wisconsin Supreme Court suspended the license of Attorney John Strasburg. The suspension was largely due to the attorney's improper conduct in incidents relating to divestment and MA eligibility.

In one incident, before meeting with his client, the attorney advised his client's daughter to close her mother's $31,000 savings account in order to commence the "waiting period" for MA eligibility. After meeting with his client, but without her permission, he then created a trust funded by the divested $31,000 which made the daughter and son-in-law grantors and trustees. The daughter and son-in-law had sole discretionary authority to make payments for his client. He then billed his client, the elderly lady, $3,000 for his services. The attorney was found to have violated SCR 20:1.7 (formerly 20.30(2)) for permitting persons other than his client to direct his professional judgment and SCR 20:1.3 (formerly 20.32(3)) for failing to communicate with his client prior to taking actions on her behalf.

In the second incident, the attorney was retained by a daughter who paid him with her mother's funds. The daughter's goal was to make her mother eligible for Medical Assistance. The attorney billed the mother for the services he provided to the daughter. In the course of representation, he accomplished the divestment of some $100,000 of the mother's property. He failed to explain to the mother the effect of an irrevocable and complete divestment. His reason for this failure was that he did not make "house calls."

The Supreme Court found that the attorney violated three rules of professional conduct. First, he had violated SCR 20:1.7(a) and (b) (formerly SCR 20.28(2) and (3)) because he represented a conflicting interest without disclosing the conflict and obtaining his client's consent. Second, he neglected a legal matter in violation of SCR 20:1.3 (formerly 20.32(3)) by failing to meet or speak with his client concerning the legal effect of the documents he had prepared as well as by failing to supervise their execution. Finally, he was found to have overcharged his client for the services rendered.

The Supreme Court concluded with the following statement: "Attorney Strasburg violated his fundamental duty to protect and further the interest of his clients in those matters in which he took action on behalf of his clients which had been directed by those

client's relatives, not by the clients themselves, and without consulting his clients."

Obviously, the conduct involved in this case was particularly egregious. A point to be gleaned from the case, however, is that attorneys may be unintentionally engaging in the same or similar conduct. As a "family" attorney of many years, two or more generations may be relying on one attorney's advice in these matters. It is imperative that the conflicting interests and the consequences of action be identified early and carefully explained to all family members. To avoid problems, it may be in the attorney's interest to disengage from the situation and recommend that each party seek the advice of independent counsel, thus preserving the integrity of the established "family" attorney relationship for matters where it is appropriate.

2. Potential conflict of interest between family members and the person divesting.

a. Children of an elderly person often have their own interests in mind in seeking to have the parent divest property, such as:

- Receiving the parents' property without paying for it;
- Avoiding the burden of paying for long-term care for their parent by making the person eligible for MA;
- Ridding themselves of the burden of caring for the parent outside a nursing home (e.g., the parents' home or the child's home); or
- Preserving the assets of the parents' estate for themselves and avoiding possible inheritance tax (although there could be gift tax consequences).

b. Children or relatives of an elderly person have conflicts of interest between themselves when seeking to have the person divest such as:

- Receiving the "lion's share" of the property of the relative ahead of other siblings or possible heirs; or
- Receiving the property immediately without having to wait for the person to die or having to depend on

the person's wishes and intentions in the person's will.

c. Spouses of persons contemplating or needing long-term institutional care wish to save the couple's assets and avoid paying for the institutional care.

3. Is the person competent to divest?

a. If the person is not mentally competent, he/she cannot form the intent to make the transfer freely and voluntarily.

b. Even if not mentally and legally incompetent, persons must understand the hazards and consequences of making the transfer as set forth above. Are they knowingly divesting themselves?

c. A guardian cannot divest for a ward because of the fiduciary duty not to waste assets and to provide for the ward's needs (§880.19, Wis. Stats.).

d. There is a similar problem with the power of attorney, regardless of whether it is durable.

- Fiduciary duty.
- Does the power of attorney contain authority to gift?
- Conflict of interest by the power of attorney gifting to himself or herself.

G. Special Rules for People Who Divested On or After July 12, 1988, and Before October 1, 1988

(Note: This section remains for historical purposes. There should be no more Fedderly class members remaining after 9/23/90, since the look back period for those cases would no longer encompass a transfer made during the relvant time period.)

In the confusion following the passage of the Medicare Catastrophic Coverage Act, the Wisconsin Department of Health and Social Services prematurely revoked all of its divestment rules. This was accomplished through a Policy Memorandum dated July 12, 1988, which was circulated statewide to county social service agencies. Individuals were told that

divestment would no longer be a barrier to Medical Assistance eligibility. As a result, many people divested large amounts in order to become eligible for MA. On September 22, 1988, the Department rescinded its revocation and reinstated the divestment prohibitions retroactive to July 1, 1988. As a result, any individual who divested in reliance upon the July 12, 1988, memorandum lost or was denied Medical Assistance eligibility.

In June, 1989, the Center for Public Representation filed a class action lawsuit in Dane County, Fedderly, et al. v. Dept. of Health and Social Services, demanding relief for those who divested during the period beginning July 12 and ending September 22, 1988. The case has been settled. The Department has agreed the following groups of individuals can be eligible for Medical Assistance despite having divested:

1. Individuals who administratively appealed the denial or termination of MA benefits after the issuance of the September 22, 1988, Policy Memorandum and have not yet received a Department of Health and Social Services (DHSS) decision or have received a decision and have appealed that decision to the Circuit Court; and

2. Individuals who administratively appealed the denial or termination of MA benefits after the issuance of the September 22, 1988, Policy Memorandum and whose denial or termination was upheld at the administrative hearing level, but who did not appeal to the Circuit Court; and

3. Individuals who divested during the period beginning July 12, 1988, and ending September 22, 1988, received MA benefits and whose divestment may be discovered by routine future redetermination; and

4. Individuals who divested during the period beginning July 12, 1988, and ending September 22, 1988, but have not yet applied for MA benefits. This sub-group will be entitled to coverage three months prior to the month of application. This sub-group's eligibility for this treatment expires on September 22, 1990.

On December 22, 1989, the Department sent a letter to all beneficiaries of the Fedderly settlement and identified as members of sub-groups 1 and 2, above. A list of those beneficiaries was also sent to all nursing homes in the state, with instructions for the nursing home to contact the department if

one of those beneficiaries resided in their nursing home. The list was also sent to all county social service agencies.

Providers of services to Fedderly beneficiaries will be reimbursed by the state at the Medical Assistance rate for services provided to these beneficiaries during the entire period when they should have been eligible for MA. Beneficiaries or their representatives should notify providers of their reinstated or retroactive Medical Assistance eligibility and request that the providers submit bills to:

Department of Health and Social Services
Bureau of Health Care Financing
Attn: Gordon Soloway
Fedderly Claims
P.O. Box 309
Madison, WI 53701

All claims for reimbursement must be submitted by December 22, 1990.

Once the nursing home or other provider receives reimbursement from the Medical Assistance program, it is required to refund money which it received on behalf of the beneficiary to whoever originally paid the cost. If the provider was paid directly by the beneficiary, the beneficiary will receive a refund. If the beneficiary remains in a nursing home, that money will be counted as an asset during the month it is received. This could cause ineligibility for Medical Assistance in the month it is received and any subsequent month in which the liquid assets of the beneficiary remain over the $2,000 asset limit.

3: CONSIDERATIONS FOR INSTITUTIONALIZED INDIVIDUALS

A. Introduction

There are a number of important Medical Assistance program rules which are only relevant to persons who apply for Medical Assistance in a nursing home. Some of these rules have already been discussed in detail in the previous section on Divestment, Chapter 2. The remainder have been preserved for discussion in this separate section.

The specific income and resource rules which determine an individual's eligibility for Medical Assistance in a nursing home are at least as significant as the rules on divestment. These are different from the rules which are applied to determine eligibility for Medical Assistance in the community. This section is largely devoted to explaining those requirements.

Attorneys should pay particular attention to the resource rules. There are two separate sets of resource rules which must be clearly understood. The consequences for clients vary tremendously depending on which rule happens to apply to their situation. The resource rule which applies to an individual client's situation will depend wholly on the date the individual entered the nursing home.

With respect to income issues, attorneys should realize that separate calculations are made to determine initial eligibility for Medical Assistance and the resident's nursing home liability (the amount of income which the recipient will be expected to contribute toward the cost of the nursing home stay before Medical Assistance pays the remaining amount). Also, there are more potential deductions from the institutionalized individual's income for purposes of calculating his/her nursing home liability amount if s/he has a spouse in the community.

B. Non-financial Eligibility Requirements - Residency

1. The state of residence for an institutionalized person **over age 21** is the state where s/he is living **with the intent** to remain permanently or for an indefinite period.

2. The state of residence for an institutionalized adult who became incapable of expressing intent **before age 21** is: a) the state of residence for the parent/guardian who applies for Medicaid on the person's behalf, if the parents reside in separate states; b) the state of residence for the parent/guardian at the time the person is placed in an institution; c) the current state of residence for the parent/guardian who applies on the person's behalf, if the person is institutionalized in that state; or d) the state of residence for the party who applies on the person's behalf, when the person has been abandoned by his/her parents, has no legal guardian and is institutionalized in that state (42 C.F.R. §435.403(i)(2)).

3. The state of residence for an institutionalized adult who became incapable of expressing intent at **age 21 or older** is the state in which s/he is physically present (42 C.F.R. §435.403(i)(3); HSS §103.03(3)(e)2., Wis. Admin. Code). Furthermore, states may not deny MA eligibility to an institutionalized person who satisfied the residency requirements on grounds that the person did not establish state residence before entering the institution (42 C.F.R. §435.403(j)(2)). The regulations also provide for interstate agreements for use in resolving cases of disputed residency (42 C.F.R. §435.403(k)). Nonetheless, a person capable of expressing intent who comes to Wisconsin solely to obtain nursing home care must be considered a resident, provided that the stay is not temporary.

4. Residents of other states placed by that state in a Wisconsin institution must be covered for services from their home state, if they are eligible there, regardless of intent (42 C.F.R. §435.403(e)). In addition, Wisconsin residents can get other services covered in certain border areas of neighboring states (HSS §105.48, Wis. Admin. Code).

C. Income Requirements for Initial Eligibility for MA

1. Categorically Needy Income Limits

The categorically needy standard for an institutionalized person shall be an amount equal to 3 times the federal share of the SSI payment for one person living in his or her own home (HSS §103.04(4)(a), Wis. Admin. Code).

2. Medically Needy Income Limits

In Wisconsin, an institutionalized person will be determined medically needy if s/he meets all non-financial and resource requirements and the person's monthly need is greater than his/her gross monthly income. Monthly need is determined by adding the following together:

a. $40 personal needs allowance

b. Cost of care at an institution (using the private-pay rate)

c. Cost of any health care premium

d. Other medical costs

e. Court ordered support and/or other support obligation

f. Work related expenses

If these costs exceed the applicant's gross monthly income, s/he is considered medically needy.

D. Computing Institutionalized Individuals' Cost of Care Liability Once Eligibility is Established

1. Single individuals and married individuals without spouses in the community (HSS §103.07(1)(d) Wis. Admin. Code)

a. Federal regulations require some and permit other deductions to be made from the institutionalized person's income before calculating the resident's contribution to his/her care. Deductions are made from an individual's

total income (including income disregarded in determining eligibility). Wisconsin allows the following deductions:

- A personal needs allowance of at least $25 (Wisconsin allows $40 per month (§49.45(7)(a), Wis. Stats.). If actual income is below $40, the state will **not** make up the difference.
- Medicare and other health insurance premiums.
- Necessary medical or remedial care recognized by state law but not covered under the State's Medicaid plan.
- An amount for home maintenance for up to six months, if the institutionalized individual receives physician certification of the likelihood of returning to the home within that period (42 C.F.R. §435.832). Wisconsin allows a home maintenance cost deduction meeting the requirements for up to 1 year. The amount per month may not exceed the SSI payment level for one person living in their own home ($509.72 in 1991).

b. Any income remaining after these deductions is considered available for payment to the nursing home. Medical Assistance then pays the difference between the institutionalized individual's contribution and the MA reimbursement rate.

2. Married individuals with spouses in the community (42 USC §1396 r-5; §49.455, Wis. Stats)

The provisions creating these rules were included in the Medicare Catastrophic Coverage Act of 1988. They are commonly referred to as the income provisions of the spousal impoverishment program. They are designed to prevent the impoverishment of an at-home spouse once his or her spouse enters a nursing home. The provisions allow many married institutionalized nursing home residents to set aside monthly income for the benefit of their community spouses.

a. Effective date

The spousal impoverishment income protection program has been in effect since September 30, 1989. These provisions apply to all Medical

Assistance eligible nursing home residents who have spouses in the community. The date institutionalization began is irrelevant.

b. Attribution of income

Once a spouse becomes institutionalized, none of the community spouse's income may be deemed available to the institutionalized spouse. (§49.455(3)(a) Wis. Stats.)

c. Attribution of income once MA eligibility is established

IRRESPECTIVE OF WISCONSIN'S MARITAL PROPERTY PROVISIONS, income is considered available to and between married couples for medical assistance eligibility purposes subject to the following conditions:

1) Payment of income made solely to one spouse shall be considered available only to that spouse (§49.455(3)(b)1.a., Wis. Stats.).

2) Where payment of income is made in both spouses' names, one-half of the income is considered available to each of them (§49.455(3)(b)1.b., Wis. Stats.).

3) Where payment of income is made to either spouse or both, and to another person or persons, the income is considered available to each spouse in proportion to the spouse's interest (or, if payment is made to both spouses and no interest is specified, one-half is considered available to each spouse) (§49.455(3)(b)1.c., Wis. Stats.).

4) An institutionalized spouse may rebut the above presumed interest in income by a preponderance of the evidence to the contrary or by the provisions of a written instrument (§49.455(3), Wis. Stats.).

d. Protection of Income for the Community Spouse (§49.455(4), Wis. Stats.).

1) The institutionalized spouse may set aside an amount of his or her income sufficient to raise the community spouse's monthly income to the "minimum monthly maintenance needs allowance." (§49.455(4)(a) Wis. Stats.)

2) The minimum monthly maintenance needs allowance was established as $1500 in 1989. It is adjusted annually based on the cost of living. Thus, it has been increased since 1989 as follows:

$1565.00 effective 1/1/90

$1662.00 effective 1/1/91

It is important to note that cases do not get "locked in" at the minimum monthly maintenance needs level in effect at the time they first become eligible for MA. Rather, on January 1 of each year, a couple may utilize the benefit of the increased monthly allowance to the extent that there is income available from the nursing home spouse to increase the allocation to the community spouse.

3) The institutionalized spouse's income is considered a supplement to the community spouse's income. If the community spouse's income exceeds the monthly allowance, none of the institutionalized spouse's income may be given to the community spouse.

4) The state never supplements the community spouse's monthly income even if, together with all available income from the institutionalized spouse, the community spouse's monthly income is below the minimum monthly maintenance needs allowance.

e. Establishing a higher needs allowance in an individual case

1) If a court has entered a support order for a community spouse against an institutionalized spouse, the minimum monthly allowance shall not be less than the amount ordered by the court (§49.455(4)(b)2 Wis. Stats.).

2) A higher allowance may be established at a fair hearing upon proof of exceptional circumstances resulting in financial distress. Upon such proof the hearing examiner shall substitute a higher figure for the standard allowance sufficient to provide the needed additional income. (Sec. 49.455(8)(c), Wis. Stats.).

f. Calculating resident's liability for payment for married persons with community spouses (49.455(4) Wis. Stats.).

1) A personal needs allowance of at least $40 (§49.455(4)(a)1., Wis. Stats.).

2) The minimum monthly income allowance of the community spouse (see 2.d, above) (§49.455(4)(a)2., Wis. Stats.).

3) A family allowance for each family member equal to 1/3 of 122% of the Federal Poverty level for a household of 2 divided by 12

minus the household members' monthly income. "Family member" includes only minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse. Until June 30, 1991, the basic family allowance is $271.79 per family member minus that member's monthly income.

4) Amounts of the incurred expenses for medical or remedial care for the institutionalized spouse (§49.455(4)(a)4., Wis. Stats.).

These deductions apply only after the institutionalized spouse has been determined eligible for MA. Any income remaining after these deductions is considered available for payment to the nursing home. Medical Assistance then pays the difference between the institutionalized individual's contribution and the MA reimbursement rate.

E. Resource Requirements

1. Rules for All Persons Who Entered the Institution Prior to September 30, 1989 (effective date of new spousal impoverishment resource provisions).

a. These rules also apply to single persons no matter when they enter the nursing home. They apply to married persons with spouses in the community who enter a nursing home before 9/30/89 even if they do not apply for MA until after 9/30/89.

b. The institutionalized person is treated as an individual upon application for MA. Only resources actually available to the person are counted.

NOTE: When a non-institutionalized spouse is involved prior to September 30, 1989, general rules on assets discussed at Chapter 1, supra, will determine which spouse is the owner of a given marital asset or how much will be apportioned between them for purposes of assessing the amount of resources actually available to the institutionalized person. Therefore, how the particular resource is titled becomes of critical importance in determining whether a non-institutionalized spouse will be permitted to retain any of the couple's marital assets for his or her own support and not jeopardize his or her spouse's Medical Assistance eligibility.

c. Under Federal SSI regulations, if an individual is institutionalized, the individual's home continues to be an exempt asset if 1) spouse or dependent relative is residing there or 2) individual plans to return within six months (POMS SI §01130.425; 20 C.F.R. §416.1212(c)).

d. Under Wisconsin law (HSS §103.06, Wis. Admin. Code), the homestead of an institutionalized person is an exempt resource only if one of the following exceptions are met:

- The institutionalized person's home is currently occupied by the institutionalized person's spouse, child who is under age 18, or child who is 18 years or older and who is developmentally disabled.
- The institutionalized person intends to return to the home and the anticipated absence from the home, as verified by a physician, is less than 12 months.
- The anticipated absence of the institutionalized person from the home is for more than 12 months but there is a realistic expectation, as verified by a physician, that the person will return to the home. That expectation shall include a determination of the availability of home health care services which would enable the recipient to live at home.

e. If none of the conditions under c. (for SSI) or d. (for Wisconsin MA) above is met, the property is no longer the principal residence and becomes non-homestead property. Before qualifying for MA, the individual must attempt to sell the home and apply any proceeds towards the cost of his or her care, until resources fall below the limit.

f. When income of an institutionalized recipient accumulates to the point that the resource limit is exceeded, MA eligibility will terminate. Eligibility may not be reinstated until the assets are below limits ($2,000 for an individual and $3,000 for a couple) at which time a new application will be required.

g. Any other asset limitations for an institutionalized person are essentially the same as for a non-institutionalized person.

2. Rules for Persons Who Entered an Institution On or After September 30, 1989 (42 US Code § 1396r-5; §49.455(5),(6) Wis. Stats.)

Also created by the Medicare Catastrophic Coverage Act of 1988, the spousal impoverishment resource protections were designed to allow spouses of nursing home residents to retain a significant share of the couple's marital assets, regardless of title, for purposes of maintaining their financial independence in the community. The Medicare Catastrophic Coverage Act permitted states some flexibility in setting the amount of the community spouse resource allowance. After some hesitation, Wisconsin ultimately opted for a community spouse resource allowance base of $60,000, the maximum permitted by the federal law.

a. Effective Date

These resource rules were effective September 30, 1989. Any married person institutionalized on or after September 30, 1989, with a spouse in the community is subject to them. The date Medical Assistance is applied for is not relevant, at least in terms of their applicability. Therefore, persons who entered a nursing home before September 30, 1989, but who had not yet applied for Medical Assistance would be subject to the old, title based, resource assessment rules even if they apply for MA after these new spousal impoverishment resource rules have gone into effect.

b. Computing a Couple's Total Resources and the Community Spouse's Share

1) IRRESPECTIVE OF WISCONSIN'S MARITAL PROPERTY PROVISIONS, at the beginning of the first continuous period of institutionalization, the couple's total resources from all sources are determined regardless of title ownership. All the couple's non-exempt resources are considered available to the institutionalized spouse except the amount considered to be the community spouse's share. (§49.455(5)(a),(b) Wis. Stats.).

2) The community spouse's share is the first $60,000 of the couple's resources at time application for MA is made. The $60,000 figure is adjusted annually for inflation (§49.455(6)(b), Wis. Stats.). Therefore, the community spouse's share at the time of application for Medical Assistance is:

$60,000 if application is made on or after September 30, 1989 and before January 1, 1990

$62,580 if application is made in 1990

$66,480 if application is made in 1991.

3) Once Medical Assistance eligibility is established, none of the community spouse's resources are considered available to the institutionalized spouse. (§49.455(5)(d), Wis. Stats.).

4) The interplay of all these provisions leads to the following conclusions. Although the couple's resources are determined at the beginning of the institutionalization, the community spouse's share is calculated as of the date the MA application is made. Therefore, if application is made in a different year than the institutionalization began, the case should be evaluated using the resource allowance in effect at time of application. Similarly, any resource acquired by the community spouse after institutionalization but before Medical Assistance application is made, is considered available to the institutionalized spouse at the time Medical Assistance application is made. Only after MA eligibility is determined do increases in the community spouse's resources cease being considered available to the nursing home spouse.

5) In most cases, a couple's resources will never be greater than at the beginning of the institutionalization of one spouse. Therefore, it is important that an evaluation of resources be done at the time the nursing home stay begins, even if application for MA is not contemplated in the near future. Failure to evaluate assets could result in the couple spending more on nursing home care than was necessary to reduce the couple's resources to the community spouse resource share. The assessment of assets does not need to be completed by the state at the time institutionalization begins.

c. Getting the Community Spouse's Share to the Proper Person

Once the couple's resources are spent down to the community spouse resource allowance plus the institutionalized person's liquid asset limit, MA eligibility may commence.

1) It is not necessary to have all assets in the community spouse's name at the time application for Medical Assistance is made. The transfer to the community spouse must be made "as soon as practical" after MA eligibility is established. (49.455(6)(a), Wis. Stats.).

2) As a practical matter, the Department gives the nursing home resident until his/her next annual redetermination of Medical Assistance eligibility to transfer to the community spouse all assets in excess of the $2,000 liquid resource limit. If assets that should be in the community spouse's name are still in the MA recipient's name at the date of the

redetermination, eligibility may be terminated. (MA Handbook, Appendix 23.8.7).

d. Special Expanded Resource Exclusions for Spousal Impoverishment Cases

Two special expanded resource exemptions are available to people eligible for MA and the Spousal Impoverishment Program. These expanded exemptions spring from language in the Medicare Catastrophic Coverage Act defining "resources" (42 US Code Sec. 1396 r-5(c)(5)(B)).

1) One vehicle is exempt as a resource regardless of its value. This provision overrides HSS §103.06(2)(c) and 20 CFR sec. 416.1218.

2) Personal property: personal property is exempt as a resource regardless of value. This provision overrides the "reasonable value" standard established under HSS §103.06(8) and the $2,000 exemption under 20 CFR §416.1216.

3. Notice and Fair Hearing Rights (§49.455(8), Wis. Stats.)

a. This subsection should be read in conjunction with Chapter 6., below.

b. Upon determination of eligibility (or redetermination for purposes noted below) for MA of an institutionalized spouse, if requested by either spouse or their representative, the State, presumably by the Department of Health and Social Services, shall notify one or both spouses, depending on the circumstance, of:

- The amount of the community spouse's monthly income allowance; (Note: the department correctly interprets this to include the circumstance where a community spouse refuses to accept an income allowance from the nursing home spouse. Such a refusal usually occurs for two reasons. First, the community spouse may believe that taking part of his or her spouse's income will negatively affect the quality of care provided by the nursing home. Second, the county worker may have discouraged the spouse from accepting income because of the administrative burden it places on the worker. The refusal is considered a negative decision and is appealable.
- The amount of the family allowance;

- The method used to compute the community spouse's resources allowance; and
- The right to a fair hearing.

NOTE: In order to receive the option of a Fair Hearing, the institutionalized spouse must apply for MA. In some cases, this may mean applying before one actually expects to be eligible. The purpose of the application and subsequent Fair Hearing request would be to contest the amount of the community spouse's resource allowance. The goal would be to establish a higher resource allowance before the assets were spent on nursing home and other bills. (See e. below.)

c. At hearing one or both spouses may contest the determination of:

- The community spouse's monthly income allowance (§49.455(8)(a)1., Wis. Stats.);
- The amount of monthly income otherwise available to the community spouse (§49.455(8)(a)2., Wis. Stats.);
- The computation of the spousal share of resources [at time of institutionalization] (§49.455(8)(a)3., Wis. Stats.);
- The attribution of resources at time of application (§49.455(8)(a)4., Wis. Stats.); and
- The determination of the community spouse's resource allowance (§49.455(8)(a), Wis. Stats.). If the hearing involves this issue the hearing must be held within 30 days of the request (§49.455(8)(b), Wis. Stats.).

d. If either spouse establishes that the community spouse needs **INCOME above the level** otherwise provided by the **minimum** monthly maintenance needs allowance ($1,662 in 1991), "due to exceptional circumstances resulting in financial duress," there **shall** be substituted an amount adequate to provide the necessary additional income (§49.455(8)(c), Wis. Stats.). Thus, even the $1,662 monthly maintenance needs allowance may be exceeded in individual cases.

e. If either spouse establishes that the income generated by the community spouse's **resource allowance** ($66,480 in 1991) is inadequate to raise that spouse's income to the minimum monthly maintenance needs allowance, there **shall** be

substituted a resource allowance that will accomplish that purpose (§49.455(8)(d), Wis. Stats.). Thus, the $66,480 asset limit may also be exceeded if more than $66,480 in assets are required to generate $1,662 in monthly income.

4: DURATION AND EXTENT OF BENEFITS

A. Duration of Benefits

1. Medical Assistance applicants may become eligible to receive benefits to cover services retroactive to the first day of the third month prior to the month of application, **provided** a) claimant met all eligibility requirements and b) if medically needy, incurred medical expenses reaching the required spend-down amount, regardless of whether applicant may be subsequently ineligible or deceased at time of application (42 C.F.R. §435.914; §49.49, Wis. Stats.; HSS §103.08(1), Wis. Admin. Code).

2. Eligibility redetermination takes place at least annually, subject to 15 days notice, except where certification is for less than 60 days (HSS §103.09, Wis. Admin. Code).

B. Access to Services

1. Covered services may be obtained only from a Medicaid-certified provider, DHSS maintains a list of providers so certified (HSS §104.01(4), Wis. Admin. Code), except in case of emergency services (HSS §107.05, Wis. Admin. Code). Free choice of a provider is limited by §49.45(9), Wis. Stats., if "department's alternate arrangements are economical" and recipient has "reasonable access to health care of adequate quality."

2. Provider certification is regulated in Wisconsin under HSS §105, Wis. Admin. Code.

3. Providers are not required to participate in the Medical Assistance program or to accept individual Medical Assistance patients if they do participate, but may not discriminate on grounds of race, color, national origin or handicap (HSS §106.02(10), Wis. Admin. Code; Title VI, Civil Rights Act, 42 U.S.C. §2000d).

4. Providers may not charge recipients for covered services beyond levels of co-payments imposed.

5. Where services are not covered, provider must advise recipients prior to receipt of service (§49.45(18), Wis. Stats.).

6. Providers may terminate participation, but failure to provide sufficient notice may constitute malpractice; skilled nursing and intermediate care facilities appear to be subject to a different standard (see E.4., below).

C. Second Surgical Opinion Program

Under §49.45(3)(i), Wis. Stats., a mandatory second opinion program is imposed, requiring Medical Assistance recipients to obtain a second opinion on the medical necessity of certain elective procedures prior to approval of payment.

D. Prior Authorization

1. Certain services (e.g., dental services beyond basic maintenance) require prior authorization by DHSS to be covered (HSS §107.02(3), Wis. Admin. Code).

2. Procedure: Provider submits prior authorization request; DHSS must act on requests within 10 days of receipt of "all information necessary to make the determination." Standard criteria for decision making must be used (HSS §107.02(3), Wis. Admin. Code). Adverse decisions are appealable by recipient.

E. Skilled Nursing and Intermediate Care Facilities

1. This area of service is extremely important since Medical Assistance, unlike Medicare, covers custodial care (subject to limitations imposed under COBRA 1981, particularly non-coverage of Levels 3 and 4 in Intermediate Care Facilities, see below).

2. Provider participation is conditioned on meeting extensive federal regulations (42 C.F.R. Part 442), in addition to Wisconsin state licensing standards (HSS §132.31 Wis. Admin. Code).

3. Residents' rights are protected under federal rules (42 C.F.R. §483.10-.25), and state administrative rules (HSS §104.01, Wis. Admin. Code). Under 42 C.F.R. §483.12 and HSS 132.53,.54 Wis. Admin. Code, residents may be transferred or discharged from a facility only for a) medical reasons; b) for his/her welfare; c) for the welfare of other patients; and d) for nonpayment. The recipient must be given reasonable advance notice.

4. Skilled nursing and intermediate care facilities must give 30 days prior notice to DHSS, resident recipients and/or their legal guardians prior to voluntary withdrawal from the Medical Assistance program; services received during the 30 day period are reimbursable only if a) the recipient was not admitted to the facility after the date on which written notice of termination was given DHSS and b) the facility can demonstrate "to the satisfaction of the department" it has made reasonable efforts to facilitate orderly transfer (§50.03(14) Wis. Stats., HSS §106.05, Wis. Admin. Code).

F. Home Health and Personal Care Services

1. Skilled and custodial home health services are provided under Medical Assistance.

2. Personal care services (provided in the home by a certified home health or social service agency to assist recipient with daily living activities, household tasks, purchase of food, and meal preparation) are authorized for payment under §49.46(2)(a)4.d, Wis. Stats.

G. Other Services Covered by MA

1. The list of benefits payable under MA are set forth in §49.46(2), Wis. Stats. and §49.47(6), Wis. Stats. for the categorically needy and medically needy respectively. HSS Chap. 107, Wis. Admin. Code provides detailed regulations on covered services.

2. §49.45(18), Wis. Stats., establishes a recipient's cost-sharing plan requiring recipients to pay certain amounts as deductibles or co-payments for certain medical services, supplies or drugs. These

co-payments are collected directly from the recipient by the provider. The regulations are located at HSS §107.02(4), Wis. Admin. Code.

3. Effective July 1, 1990 covered service distinctions between the categorically and medically needy programs were eliminated.

H. Out-of-State Services

1. Certain out-of-state "border-status" providers, other than skilled or intermediate care facilities, can be certified to provide covered Medical Assistance services to Wisconsin residents (HSS §105.48, Wis. Admin. Code).

2. Wisconsin must also provide coverage to residents when in other states: a) in case of medical emergency; b) where the individual's health would be endangered if required to return to Wisconsin; c) where the state determines the service to be more readily available in another state; and d) where it is general practice to use "border-status" providers.

3. Prior authorization must be obtained for non-emergency out-of-state services obtained from non-"border-status" providers (HSS §107.04, Wis. Admin. Code).

I. Reimbursement

1. Generally

a. Providers, who are paid directly under the program, may not hold recipients liable for covered services delivered during recipient's eligibility (except for co-payments) or charge recipients for the difference between the reimbursement rate and the provider's usual service charge (HSS §§104.01(12)(a),(c) and (d) and 106.04(3) Wis. Admin. Code except, see §49.49(3m)(a)2., Wis. Admin. Code, discussed in 4., below).

b. Providers may charge recipients for non-covered services if they inform recipients of recipients' liability prior to rendering service (HSS §106.04(3), Wis. Admin. Code).

2. Third-Party Liability

a. Providers must seek reimbursement from any third party liable for all or part of recipient's expenses before billing the Medical Assistance program.

b. The state may not withhold payment if 1) the amount of third-party liability cannot be determined; 2) payments will not be available within reasonable time; or 3) the cost of administration is greater than the amount to be recovered (42 C.F.R. §433.139).

3. Relationship to Medicare Part B

a. As part of Medical Assistance coverage, the State pays the Medicare Part B premium for all Medicare-eligible SSI recipients (§49.46(2)(c), Wis. Stats.).

b. For Medical Assistance recipients who do have Medicare Part B coverage, providers are required to "accept assignment" thus, they must bill Medicare directly and accept as full payment the Medicare determination of "reasonable charge" (HSS §106.03(6), Wis. Admin. Code).

4. Retroactive Eligibility

If an individual receives and pays a provider directly for a Medical Assistance-covered service, and later has Medical Assistance eligibility retroactively established for that period, the provider must bill the program and return to the recipient the lesser of the amount paid or the Medical Assistance reimbursement (HSS §§104.01(11) and 106.04(2), Wis. Admin. Code; §49.49(3.m)(a)2., Wis. Stats).

5: APPLICATION PROCESS

A. Place of Application Depends on Eligibility Status

1. SSI eligibles: Apply at Social Security Administration District office.

2. All others: Apply at County Department of Social Services or Human Services.

B. Application Rights are Codified at §49.47(3), Wis. Stats. and HSS §102.01, Wis. Admin. Code.

1. Any person has the right to apply for Medical Assistance at the county agency in the county in which the person resides, regardless of whether or not it appears the person will be found eligible (HSS §102.01(1), Wis. Admin. Code).

2. Persons inquiring or applying must be given information concerning coverage, conditions of eligibility, scope of the program and related services, and applicant and recipient rights and responsibilities; where a substantial non- or limited English-speaking population exists, county must "communicate fully and effectively."

3. Application may be made by any person or, on a person's behalf, by a responsible relative, legal guardian, authorized representative, or (where incompetent or incapacitated) by any responsible person. Applications must be signed under oath.

4. The county agency must hold an interview and make an eligibility determination within 30 days of receipt of a signed application.

5. If an application processing delay occurs, the agency must so notify the applicant in writing that delay exists, specifying the

delay reason and informing the applicant of the right to appeal the delay.

6. Adequate written notice of authorization for assistance, or denial or termination, including statement of action, reasons, specific regulations supporting action, and right to request hearing must be given.

C. Recovery of Incorrect Payments (§49.497, Wis. Stats.)

The department may recover from the recipient any payment made incorrectly for benefits if the incorrect payment results from any misstatement or omission of fact by a person supplying information in an application, or if the recipient or responsible person fails to report the receipt of income or assets in an amount which would affect eligibility. The extent of recovery is limited to the amount of the benefits incorrectly granted.

D. Absence of "Lien Law" in Wisconsin

1. Federal law and regulations permit states to adopt so-called lien laws as means of recovering correct M.A. payments to recipients. (42 USC §1396p, 42 CFR §433.36)

2. Wisconsin has not yet adopted a lien law. However, DHSS's 1991-1992 budget request included a request for a lien law. A copy of the summary of their proposal is included at Appendix J of this volume.

6: HOW AND WHEN TO APPEAL

A. General Introduction

Recipient rights of due process to notice and an opportunity for hearing prior to reduction or termination of a public benefit are derived from the Supreme Court's decision in Goldberg v. Kelly, 397 U.S. 254 (1970). Goldberg entitles the right to notice and hearing, together with the continuation of benefits during pendency of a hearing, in any situation where benefits are essential to basic human needs or where there is a significant potential for human error.

B. Sources of Law

1. Federal

   Title VI, Civil Rights Act

   Section 504, Rehabilitation Act of 1973; and

   42 C.F.R. §§431.200 et seq.

2. State

   HSS §104.01, Wis. Admin. Code (Recipients' Rights and Duties);

   PW-PQ §20.18, Wis. Admin. Code (Fair Hearing Procedure); and

   §§49.45(5), 49.50(8) and Chapter 227, Wis. Stats.

C. Current Federal and State Law

1. Right to Prompt Decision

Eligibility decisions are required to be made within 30 days of signature by the applicant, except 90 days are allowed for a disability application; the DHSS is affirmatively required to furnish care "without any delay attributable to the department's administrative process" (HSS §104.01(10), Wis. Admin. Code).

2. Right to Notice

a. Medical Assistance recipients are entitled to ten days written notice prior to action by the DHSS which would discontinue, terminate, suspend or reduce an individual benefit or coverage of services to a general class of recipients (HSS §104.01(9)(b), Wis. Admin. Code).

b. Notice, in writing, is required to inform the recipient of:

- Nature of intended action;
- Reasons for intended action;
- Specific regulations supporting action;
- Explanation of recipient's right to request a fair hearing;
- Circumstances under which assistance is continued if hearing is requested (42 C.F.R. §431.213).
- The recipient has been admitted to an institution where he or she is ineligible under the State plan for further services; or change in level of medical care is prescribed by the recipient's physician (42 C.F.R. §431.213).
- Changes in state or federal law require automatic grant adjustments for recipients (HSS §104.01(5)(a)4, Wis. Admin. Code).

3. Right to Hearing

a. At the time of application or any action affecting a claim (e.g., whenever assistance is denied, unreasonably delayed, suspended, reduced, or terminated or when aggrieved by state or county action), every applicant or recipient must be informed in writing of 1) the right to a fair hearing; 2) the manner by which a fair hearing may be obtained; and 3) the right to representation by self or by another on one's behalf (42 C.F.R. §431.206(b); HSS §104.01(5)(a), Wis. Admin. Code).

b. Recipients may also request a fair hearing for alleged denial or impairment of the recipient's freedom of choice of provider (HSS §104.01(4)(c), Wis. Admin. Code).

c. Exception: Federal regulations do **not** provide for a hearing where 1) the action in question is due to any changes in federal or state law affecting a class of recipients **and** 2)

where the recipient does not allege an error in applying law to the individual case (42 C.F.R §431.220).

4. How and When to Request a Hearing

a. Either applicant or authorized representative may request hearing within 45 days of the effective date of Department's action (HSS §104.01(5)(a)3, Wis. Admin. Code).

b. Request may be made orally or in writing (but oral request should immediately be followed by written request). Request for Fair Hearing (Form FS-SS-203) may be used, or any clear expression of desire to present case to higher authority, specifying:

- Statement of request for hearing;
- Statement that applicant/recipient disagrees with agency's proposed action or failure to act;
- Statement of the date notice was received (if different from date of notice);
- Statement of request for interpreter, if necessary;
- Statement of request for hearing to be held in hospital, home, etc., if claimant would be burdened by attending at county agency office.

c. Department must take "prompt, definitive and final administrative action" within 90 days of date of receipt of hearing request (HSS §104(5)(a)3, Wis. Admin. Code).

d. Continuation of Benefits: If recipient requests hearing within prior notice period (which must be at least 10 days), state may not suspend, reduce, discontinue or terminate benefits until the hearing decision is rendered, unless the hearing examiner determines the sole issue is one of law or unless the recipient has lost benefits due to separate changes (20 C.F.R. §431.230). If there is ultimately a denial, any benefits paid pending appeal are considered overpayments and are subject to recovery.

5. Hearing Procedure

a. Hearing Examiner, DHSS Office of Administrative Hearings and Rules, conducts hearing according to procedures of PW-PA §20.18, Wis. Admin. Code and §227.44-.46, Wis. Stats.

b. Aspects of Hearing
   1) Procedure is generally informal; the hearing examiner takes an active role in questioning witnesses.
   2) The hearing examiner is not bound by common law or statutory rules of evidence (§227.45(1), Wis. Stats.).
   3) Written evidence from persons not present is accepted, with opportunity to rebut (§227.45(2), Wis. Stats.).
   4) The right to representation (attorney, benefit specialist, relative, friend, spokesperson) is guaranteed.

c. Decision: Must be in writing accompanied by findings of fact and conclusions of law (§227.47, Wis. Stats.)

d. Rehearing (§227.49, Wis. Stats.)
   1) Any person aggrieved by final order may, within 20 days after service of the order, file a written petition for rehearing specifying grounds for relief and supporting authorities.
   2) Filing of petition for rehearing does not suspend effective date of order; order shall take effect and continue a) unless petition is granted or b) until order is superceded, modified, or set aside.
   3) Rehearing will only be granted on basis of a) material error of law; b) material error of fact; or c) discovery of new evidence sufficient to reverse or modify order.

6. Judicial Review (§227.52 et seq., Wis. Stats.)

Must be petitioned for within 30 days following receipt of hearing examiner's decision.

D. Right to Attorneys Fees (§§227.485 and 814.245 Wis. Stats.)

1. Introduction

In 1985, Wisconsin adopted what is commonly referred to as the Wisconsin Equal Access to Justice Act (WEAJA). Similar to the Federal Equal Access to Justice Act, the WEAJA was designed to help offset costs of hiring an attorney for persons who are adversely affected by administrative agency actions that are without substantial justification. The WEAJA provides for

payment of attorney's fees at the administrative hearing level as well as in actions for judicial review of administrative agency decisions.

2. Parties

Attorney's fees are potentially available to individuals, small businesses and small non-profit corporations. (§ 227.485(2), §814.245(2) Wis. Stats.)

3. When attorney's fees will be paid (§§227.485(3), 814.245(3) Wis. Stats.).

Attorney's fees and costs shall be awarded whenever an individual, small business or small non-profit corporation is the prevailing party unless the hearing examiner or judge finds that the losing state agency was:

a. substantially justified in taking original action or

b. some special circumstance exists which would make an award unjust

- "substantially justified" is defined as "having a reasonable basis in law and fact." (§ 227.485(1)(e), 814.245(1)(e) Wis. Stats.). The Wisconsin Court of Appeals has interpreted this as an "arguable merit" standard. According to the court "...a position with arguable merit is one which lends itself to legitimate legal debate and difference of opinion as viewed from the standpoint of reasonable advocacy." Behnke v. DHSS 146 Wis. 2d 178, 183-184 (Ct. App. 1988).
- In a case currently pending before the Court of Appeals, DHSS takes the position that "special circumstances" exist when the unjustified administrative action is based on a county worker's action that has not been specifically directed by the state DHSS. Look for the decision in Palfrey v. DHSS Court of Appeals case #90-1825. The decision has the potential to eviscerate the laudable intent of the WEAJA.

4. Procedure for requesting attorney's fees - Administrative Hearing

a. Within 30 days after receiving a decision on the merits of the case, the attorney must make a motion to the agency requesting payment. The motion, or a supporting memorandum of law, should state the basis for the request. Affidavits relating to reasonableness of the fee requested and

client eligibility under §227.485(7) Wis. Stats. should be submitted at this time.

b. State agency has 15 days to respond to motion. Generally, county agency makes response on behalf of state.

c. Hearing examiner issues a new hearing decision dealing only with the merits of the attorney's fee request.

5. Procedure for requesting fees - petition for review in circuit court.

a. How the attorney's fee issue will be raised in a petition for review depends on which hearing decision is being reviewed.

b. If the decision being reviewed is a decision denying attorney's fees after your client has prevailed on the merits, all matters relating to the attorney's fee issue should be raised in the petition for review itself.

c. If the petition for review involves the initial agency action itself, you must first establish that your client is the prevailing party. In these cases, it is more appropriate to raise the issue of attorney's fees in a post-judgment motion to the court once the court has determined you are the prevailing party. You should be sure to request fees for your work at the administrative hearing level as well as your circuit court work.

Note: If the only relief you obtain as the result of your petition for review on the merits is a remand to the state agency for a new hearing, you are not considered to be a prevailing party. Kitsemble v. DHSS, 143 Wis. 2d 863 (Ct. App. 1988). However, if you prevail on the merits at the remanded hearing and the hearing examiner or judge then finds the agency acted without substantial justification, you should request costs and fees for all previous levels of advocacy. Generally, a return trip to the court is required. The court retains jurisdiction until your client has become the prevailing party. Sheeley v. DHSS, 150 Wis. 2d 320, 329-333 (1989). The request for fees in that case must be made within 30 days after you receive a favorable decision from the agency.

APPENDIX A

EXAMPLES OF MA DETERMINATIONS: INCOME, RESOURCES, 503 CASE

EXAMPLES OF MA APPLICATION

I. Income Eligibility

Example A:

Husband in MA nursing home. Wife at home and not SSI eligible

Income

H $620/month $1,700/month institution expense

W $300/month

Husband applies for MA in Wisconsin on first day of institutionalization.

Income

H $620/month

W $300/month

Deductions

$40	PNA to husband
$1,362	community spouse minimum allowance of $1,662 - $300 of her own income
$1,402	total possible deductions

Wife receives $580/month from H's income for total of $880 ($580 from him and her $300)

Even though wife could receive up to $1,362 per month, only $580 is available to her. State does not supplement her monthly income to raise it to $1,662.

H keeps $40 PNA and pays $0 to nursing home. MA pays entire bill.

Example B:

H in MA nursing home. W at home and not SSI eligible

Income

H $2,200/month

$2,100/month institution expenses

W $300/month

Husband applies for MA; has no medical expenses or insurance costs

H's monthly need = $2,140 (cost of institution + PNA of $40)

H is ineligible for MA because his gross income ($2,200) exceeds his monthly need ($2,140). W would not benefit from income diversion provisions of spousal impoverishment because they are only available to a person whose spouse is MA eligible.

Example C:

Assume same facts as in Example C except H has other medical expenses of $200 per month.

H's monthly need = $2,340 (cost of institution + PNA + other medical expenses)

H is eligible for MA because his monthly need ($2,340) exceeds his gross monthly income ($2,200). Once he is eligible for MA, he may make deductions from his income before he must contribute to the cost of his institutionalization.

Income

H $2,200

W $300

Deductions from his income

$40	PNA
$1,362	community spouse minimum allowance of $1,662 - $300 of her income
$200	unmet medical expenses
$1,602	total deductions

W receives $1,362/month from his income for total of $1,662 ($1,362 from his and her $300)

H keeps $240; $40 PNA and $200 to pay for his unmet medical expenses. Remaining income of $598 paid to nursing home. MA pays balance of nursing home bill.

II. RESOURCE ELIGIBILITY

Facts: H in nursing home, spouse lives in family home.

Assets of Couple

Home	$ 60,000	
Auto	$ 10,000	
Joint Bank Account	$ 20,000	
Mutual Fund	$ 75,000	(wife's name solely)
Certificate of Deposit	$5,000	(husband's name solely)
Life Insurance Policy	$1,500	(on husband's life)
Irrevocable Burial Trust	$1,500	(husband's name)
Joint Burial Plot	$1,000	
Total Assets	$174,000	

Countable Assets attributable to H		Countable Assets attributable to W	
Joint Bank Account	$20,000	Mutual Fund	$75,000
Cert. of Deposit -	$ 5,000		
Total -	$25,000		

Exempt Assets
Home
Auto
Life Insurance Policy
Irrevocable Burial Trust
Joint Burial Plot

Example A:

If H Entered Nursing Home On or After 9/30/89 and applies for MA during 1990 (community spouse keeps first $62,580 of couples' assets)

Countable Assets

Mutual Fund	$75,000
Joint Bank Account	$20,000
Certificate of Deposit	$5,000
Total Assets	$100,000

Exempt Assets
Home
Auto
Life Insurance Policy
Irrevocable Burial Trust
Joint Burial Plot

W share	$62,580
H share	$37,420

Wife would be permitted to retain $62,580 of this couples' resources. H will have to spend $35,420 ($37,420 - $2,000 excludable liquid resources) before he is eligible to receive MA.

Example B:

If H Entered Nursing Home After 9/30/89 but does not apply for MA until 1991 (community spouse keeps $66,480)

Countable Assets	
Mutual Fund	$75,000
Joint Bank Account	$20,000
Certificate of Deposit	$ 5,000
Total Assets	$100,000
Exempt Assets	
Home	
Auto	
Life Insurance Policy	
Irrevocable Burial Trust	
Joint Burial Plot	
W share	$66,480
H share	$33,520

H will have to expend $31,520 ($33,520 - $2,000 excludable resources) before eligible for MA. Nowhere does the law suggest that his resources must be spent down on his institutional care. However, current law sets the limit on resources an individual may have in order to qualify for MA. He must convert assets and spend the money to get below the resource limit. He may wish to spend it on making improvements to the couples' home or on his wife's monthly living expenses. The only limitation on the disposition of his resource share is that he cannot make a prohibited divestment.

Before spending H's resource share, however, advocates should remember that it is possible to increase wife's share of resources above the amount dictated by the normal formula. If wife's share of assets is insufficient to generate enough income to raise her monthly income to $1,662, she may request a fair hearing and ask that her share of the assets be increased to a level that will insure her a monthly income of $1,662 in 1991.

Also note that transferring the countable resources to the community spouse will not affect the ultimate apportionment since the new law does not look at "name on the title;" at the time of institutionalization, the assets are looked at together and a spousal share of one-half is computed.

Example C:

If Husband's institutionalization began prior to 9/30/89 (Title based asset determination controls eligibility)

Countable Assets Attributable to H		Countable Assets Attributable to W	
Jt. Bank Acct.	$20,000	Mutual Fund	$75,000
Cert. of Dep.	$ 5,000		
Total	$25,000		

Exempt Assets

Home

Auto

Life Insurance Policy

Irrevocable Burial Trust

Joint Burial Plot

Husband is not eligible - he must spend $23,000 on institutional care before he is eligible.

Wife may withdraw the $20,000 from the joint bank account and receive the entire amount. Husband would then have to spend only $3,000 on institutional care before becoming eligible.

NOTE: Wife's withdrawal of funds from joint account must be at own instigation with no suggestion or involvement from Husband.

SECTION 503 CASE

(Pickle Amendment)

Section 503 eligibility example: Mrs. Jones received both Social Security and SSI checks in 1976-78. However, the SSI was terminated in March 1978 because she started receiving a private pension that, combined with her Social Security benefits, raised her income to an amount above the 1978 SSI income limits. There have been gradual increases in her income since 1978. She now receives Social Security benefits of $450 per month and her private pension is $130 per month, for a combined total income of $580 monthly.

In 1990, the income limit for SSI (taking into account a $20 general income disregard) is $488.72 for an individual. Thus, Mrs. Jones is nearly $100 over the SSI income limit which Wisconsin has adopted as the Medicaid limit for persons who are aged, blind or disabled.

You screen Mrs. Jones for Pickle eligiblity. After determining that the last month in which she received both Social Security and SSI was March 1978, you find out from the Social Security Administration that the cost of living reduction factor is 1.863. You apply that reduction factor to Mrs. Jones' current Social Security benefit of $450 as follows:

$450 divided by 1.863 = $241 ("Pickled" Social Security income, rounded downward)

$241 countable Social Secuirty income
+ $100 private pension
$341 total countable "Pickle" income

Since $341 is less than the current SSI income limit of $509.72, Mrs. Jones is eligible under the Pickle Amendment to receive a regular monthly Medicaid card, even though she is ineligible for SSI.

APPENDIX B

Questions and Answers on spousal protection and transfer of assets provisions in Medicare Catastrophic Coverage

1. Q: What rules apply to attribution of a couple's income between them (deeming), when one spouse applies for MA?

   A: Since §49.455(3)(b), Wis. Stats., attribution provisions only apply to post-eligibility situations, old law would govern eligibility of a non-institutionalized person applying for MA. However, if the person is institutionalized on or after September 30, 1989, has a non-institutionalized spouse and is expected to be institutionalized for at least 30 consecutive days, then the institutionalized spouse will be attributed only his or her income and no income of the community spouse shall be deemed available to the institutionalized spouse 49.455(3)(a), Wis. Stats. This is a slight change in the law which formerly provided that an institutionalized spouse had to be institutionalized for one month before income of the community spouse is no longer deemed available to the spouse in the institution.

2. Q: How will the new income and resource provisions relating to an institutionalized spouse in §49.455, Wis. Stats., affect persons institutionalized prior to 9/30/89?

   A: The resource provisions of §49.455, Wis. Stats. only apply to individuals who began a continuous period of institutionalization on or after 9/30/89. The income provisions and the expanded fair hearing rights, however, apply to individuals already institutionalized and those who became institutionalized on or after 9/30/89.

3. Q: Can you transfer a resource for less than fair market value after application without facing divestment penalties?

   A: According to §49.45(17), Wis. Stats. the divestment rules and attendant penalties apply if a prohibited divestment is made 30 months prior to or anytime after application for Medical Assistance. Originally, the Federal provision upon which this section is based did not apply penalties to divestments made after application. However, that provision was amended so as to apply the penalties to post-application divestments (42 USC §1396p(c)(1)).

4. Q: Can an otherwise-eligible non-institutionalized person in Wisconsin safely divest a homestead in a way that does not fit the four exceptions and apply for Medical Assistance?

   A: Not necessarily safely, although it can be done. Medical Assistance in the form of card services is assured for such a person only if s/he does not suffer illness (e.g., a stroke) requiring institutionalization during

the look-back period after the date of divesting. Should the person be institutionalized within that period, the divestment prohibitions would attach, even if the person had already applied for and received Medical Assistance card services.

5. Q: What does "institutionalized individual" mean within the Catastrophic Care Act?

   A: Federal law describes the institutionalized person as "...any individual who is an inpatient in a medical institution or nursing facility." (42 USC §1396p(c)(3)). Wisconsin's MA handbook imposes the additional requirement that the inpatient stay be expected to last at least 30 days (MA Handbook, Appendix 37f).

6. Q: Can a person divest a homestead to a spouse who can then divest the homestead to children?

   A: Yes. The new spousal transfer prohibitions do not apply to homestead property. However, if the property becomes non-homestead property the transfer becomes a divestment. At the very least such a transfer could jeopardize the community spouse's eligibility for MA should he or she need to apply for it.

7. Q: Can a person who has excess assets buy a car and divest it to someone and still be eligible?

   A: Yes, because a vehicle is an exempt asset.

8. Q: If a non-institutionalized person divests $60,000 in Certificates of Deposit prior to August 9, 1989, all of which were non-exempt monies, makes application and is denied on the basis of divestment, how will the length of his/her ineligibility be computed?

   A: The DHSS regulations require that, for a person not in an ICF, SNF or inpatient psychiatric facility, the computation necessary to expend the full value (e.g., $60,000) of the divested resource is made by adding the person's medical care expenses plus the "appropriate Medically Needy income limit for ...[SSI]" (HSS §103.063(2)(c)2, Wis. Admin. Code). Therefore, taking into account the Medically Needy income limit of $509.72 per month ($6116.64 per year), unless the person incurs very high medical bills, the ineligibility for a $60,000 divestment could last almost ten years. Remember, however, if the transfer occurred on or after August 9, 1989, there is no divestment penalty so long as the person remains outside a nursing home.

9. Q: Can a person divest $2,000 (1989 and thereafter) in Wisconsin without penalty?

A: Yes, because that $2,000 is an exempt asset. Technically an individual may divest up to $2,042 per month. Such a divestment incurs less than a 1-month ineligibility period so it does not count.

10. Q: How can elderly persons who previously promised to give property to family members in return for receiving care from those members make these transfers without fear of divestment penalties?

A: This is a frequent problem for families who have, in fact, given older persons care on the basis of undocumented, non-formalized agreements. Since the statutes create a presumption that divested property was given in order to achieve MA eligibility, it must be proven that another purpose motivated the gift, i.e., the older person's paying back for care received. An oral promise between the parties is almost certainly unacceptable as sufficient evidence to rebut the presumption. The best safeguard would be a written contract between the parties, executed and witnessed at the time the agreement for care was made. But remember, the new exception to a homestead divestment -- where given to a child who lived in parents' home and provided care to the individual which enabled him or her to avoid institutionalization.

11. Q: In the situation of a joint account, what is the consequence if the non-MA joint account owner withdraws some or all of the funds in the joint account? Will that be considered divestment?

A: No, that is not divestment. Either of the joint account owners may withdraw any amount from the joint account without this withdrawal being considered divestment -- exceptions: the non-MA joint owner, in making the withdrawal, was acting on behalf of the MA joint owner, the MA person initiated the transfer to someone, or where collusion between joint owners can be shown. It should be noted that it is generally accepted that the account must have been in existence for at least 30 months. The act of changing an account's title within the 30-month look-back period will probably be considered a divestment.

§ 1396p. Liens, adjustments and recoveries, and transfers of assets

[See main volume for text of (a) and (b)]

(c) Taking into account certain transfers of assets

(1) In order to meet the requirements of this subsection (for purposes of section 1396a(a)(51)(B)) of this title, the State plan must provide for a period of ineligibility for nursing facility services and for a level of care in a medical institution equivalent to that of nursing facility services and for services under section 1396n(c) of this title in the case of an institutionalized individual (as defined in paragraph (3)) who, or whose spouse at any time during or after the 30-month period immediately before the date the individual becomes an institutionalized individual (if the individual is entitled to medical assistance under the State plan on such date) or, if the individual is not so entitled, the date the individual applies for such assistance while an institutionalized individual disposed of resources for less than fair market value. The period of ineligibility shall begin with the month in which such resources were transferred and the number of months in such period shall be equal to the lesser of—

(A) 30 months, or

(B)(i) the total uncompensated value of the resources so transferred, divided by (ii) the average cost, to a private patient at the time of the application, of nursing facility services in the State or, at State option, in the community in which the individual is institutionalized.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

(A) the resources transferred were a home and title to the home was transferred to—

(i) the spouse of such individual;

(ii) a child of such individual who (I) is under age 21, or (II) (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1396*o* of this title;

(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

(B) the resources were transferred (i) to or from (or to another for the sole benefit of) the individual's spouse, or (ii) to the individual's child described in subparagraph (A)(ii)(II);

(C) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that (i) the individual intended to dispose of the resources either at fair market value, or for other valuable consideration, or (ii) the resources were transferred exclusively for a purpose other than to qualify for medical assistance; or

(D) the State determines that denial of eligibility would work an undue hardship.

(3) In this subsection, the term "institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1396a(a)(10)(A)(ii)(VI) of this title.

(4) A State (including a State which has elected treatment under section 1396a(f) of this title) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection.

(5) In this subsection, the term "resources" has the meaning given such term in section 1382b of this title, without regard to the exclusion described in subsection (a)(1) thereof.

(As amended July 1, 1988, Pub.L. 100–360, Title III, § 303(b), 102 Stat. 760; Oct. 13, 1988, Pub.L. 100–485, Title VI, § 608(d)(16)(B), 102 Stat. 2417; Dec. 19, 1989, Pub.L. 101–239, Title VI, § 6411, (c)(1), 103 Stat. 2271.)

§ 1396r–5. Treatment of income and resources for certain institutionalized spouses

(a) Special treatment for institutionalized spouses

(1) Supersedes other provisions

In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (h)(1) of this section), the provisions of this section supersede any other provision of this subchapter (including sections 1396a(a)(17) and 1396a(f) of this title which is inconsistent with them.

(2) No comparable treatment required

Any different treatment provided under this section for institutionalized spouses shall not, by reason of paragraph (10) or (17) of section 1396a(a) of this title, require such treatment for other individuals.

(3) Does not affect certain determinations

Except as this section specifically provides, this section does not apply to—

(A) the determination of what constitutes income or resources, or

(B) the methodology and standards for determining and evaluating income and resources.

(4) Application in certain states and territories

(A) Application in states operating under demonstration projects

In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1315 of this title, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this subchapter.

(B) No application in commonwealths and territories

This section shall only apply to a State that is one of the 50 States or the District of Columbia.

(b) Rules for treatment of income

(1) Separate treatment of income

During any month in which an institutionalized spouse is in the institution, except as provided in paragraph (2), no income of the community spouse shall be deemed available to the institutionalized spouse.

(2) Attribution of income

In determining the income of an institutionalized spouse or community spouse, after the institutionalized spouse has been determined or redetermined to be eligible for medical assistance, except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

(A) Non-trust property

Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides—

(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

(iii) if payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

(B) Trust property

In the case of a trust—

(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this title (including sections 1396a(a)(17) and 1396a(k) of this title), and

(ii) income shall be considered available to each spouse as provided in the trust, or, in the absence of a specific provision in the trust—

(I) if payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(II) if payment of income is made to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

(III) if payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

(C) Property with no instrument

In the case of income not from a trust in which there is no instrument establishing ownership, subject to subparagraph (D), one-half of the income shall be considered to be available to the institutionalized spouse and one-half to the community spouse.

(D) Rebutting ownership

The rules of subparagraphs (A) and (C) are superseded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under such subparagraphs.

(c) Rules for treatment of resources

(1) Computation of spousal share at time of institutionalization

(A) Total joint resources

There shall be computed (as of the beginning of a continuous period of institutionalization of the institutionalized spouse)—

(i) the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest, and

(ii) a spousal share which is equal to ½ of such total value.

(B) Assessment

At the request of an institutionalized spouse or community spouse, at the beginning of a continuous period of institutionalization of the institutionalized spouse and upon the receipt of relevant documentation of resources, the State shall promptly assess and document the total value described in subparagraph (A)(i) and shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment for use under this section. If the request is not part of an application for medical assistance under this subchapter, the State may, at its option as a condition of providing the assessment, require payment of a fee not exceeding the reasonable expenses of providing and documenting the assessment. At the time of providing the copy of the assessment, the State shall include a notice indicating that the spouse will have a right to a fair hearing under subsection (e)(2) of this section.

(2) Attribution of resources at time of initial eligibility determination

In determining the resources of an institutionalized spouse at the time of application for benefits under this subchapter, regardless of any State laws relating to community property or the division of marital property—

(A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and

(B) resources shall be considered to be available to an institutionalized spouse, but only to the extent that the amount of such resources exceeds the amount computed under subsection (f)(2)(A) of this section (as of the time of application for benefits).

(3) Assignment of support rights

The institutionalized spouse shall not be ineligible by reason of resources determined under paragraph (2) to be available for the cost of care where—

(A) the institutionalized spouse has assigned to the State any rights to support from the community spouse;

(B) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the State has the right to bring a support proceeding against a community spouse without such assignment; or

(C) the State determines that denial of eligibility would work an undue hardship.

(4) Separate treatment of resources after eligibility for benefits established

During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for benefits under this subchapter, no resources of the community spouse shall be deemed available to the institutionalized spouse.

(5) Resources defined

In this section, the term "resources" does not include—

(A) resources excluded under subsection (a) or (d) of section 1382b of this title, and

(B) resources that would be excluded under section 1382b(a)(2)(A) of this title but for the limitation on total value described in such section.

(d) Protecting income for community spouse

(1) Allowances to be offset from income of institutionalized spouse

After an institutionalized spouse is determined or redetermined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

(A) A personal needs allowance (described in section 1396a(q)(1) of this title), in an amount not less than the amount specified in section 1396a(q)(2) of this title.

(B) A community spouse monthly income allowance (as defined in paragraph (2)), but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

(C) A family allowance, for each family member, equal to at least ⅓ of the amount by which the amount described in paragraph (3)(A)(i) exceeds the amount of the monthly income of that family member.

(D) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse (as provided under section 1396a(r) of this title).

In subparagraph (C), the term "family member" only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

(2) Community spouse monthly income allowance defined

In this section (except as provided in paragraph (5)), the "community spouse monthly income allowance" for a community spouse is an amount by which—

(A) except as provided in subsection (e) of this section, the minimum monthly maintenance needs allowance (established under and in accordance with paragraph (3)) for the spouse, exceeds

(B) the amount of monthly income otherwise available to the community spouse (determined without regard to such an allowance).

(3) Establishment of minimum monthly maintenance needs allowance

(A) In general

Each State shall establish a minimum monthly maintenance needs allowance for each community spouse which, subject to subparagraph (C), is equal to or exceeds—

(i) the applicable percent (described in subparagraph (B)) of 1/12 of the income official poverty line (defined by the Office of Management and Budget and revised annually in accordance with sections 9847 and 9902(2) of this title) for a family unit of 2 members; plus

(ii) an excess shelter allowance (as defined in paragraph (4)).

A revision of the official poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

(B) Applicable percent

For purposes of subparagraph (A)(i), the "applicable percent" described in this paragraph, effective as of—

(i) September 30, 1989, is 122 percent,

(ii) July 1, 1991, is 133 percent, and

(iii) July 1, 1992, is 150 percent.

(C) Cap on minimum monthly maintenance needs allowance

The minimum monthly maintenance needs allowance established under subparagraph (A) may not exceed $1,500 (subject to adjustment under subsections (e) and (g) of this section).

(4) Excess shelter allowance defined

In paragraph (3)(A)(ii), the term "excess shelter allowance" means, for a community spouse, the amount by which the sum of—

(A) the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a condominium or cooperative, required maintenance charge, for the community spouse's principal residence, and

(B) the standard utility allowance (used by the State under section 2014(e) of Title 7) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (3)(A)(i), except that, in the case of a condominium or cooperative, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (B) shall be reduced to the extent the maintenance charge includes utility expenses.

(5) Court ordered support

If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

(e) Notice and fair hearing

(1) Notice

Upon—

(A) a determination of eligibility for medical assistance of an institutionalized spouse, or

(B) a request by either the institutionalized spouse, or the community spouse, or a representative acting on behalf of either spouse,

each State shall notify both spouses (in the case described in subparagraph (A)) or the spouse making the request (in the case described in subparagraph (B)) of the amount of the community spouse monthly income allowance (described in subsection (d)(1)(B) of this section), of the amount of any family allowances (described in subsection (d)(1)(C) of this section), of the method for computing the amount of the community spouse resources allowance permitted under subsection (f) of this section, and of the spouse's right to a fair hearing under this subsection respecting ownership or availability of income or resources, and the determination of the community spouse monthly income or resource allowance.

(2) Fair hearing

(A) In general

If either the institutionalized spouse or the community spouse is dissatisfied with a determination of—

(i) the community spouse monthly income allowance;

(ii) the amount of monthly income otherwise available to the community spouse (as applied under subsection (d)(2)(B) of this section);

(iii) the computation of the spousal share of resources under subsection (c)(1) of this section;

(iv) the attribution of resources under subsection (c)(2) of this section; or

(v) the determination of the community spouse resource allowance (as defined in subsection (f)(2) of this section);

such spouse is entitled to a fair hearing described in section 1396a(a)(3) of this title with respect to such determination if an application for benefits under this subchapter has been made on behalf of the institutionalized spouse. Any such hearing respecting the determination of the community spouse resource allowance shall be held within 30 days of the date of the request for the hearing.

(B) Revision of minimum monthly maintenance needs allowance

If either such spouse establishes that the community spouse needs income, above the level otherwise provided by the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance in subsection (d)(2)(A) of this section, an amount adequate to provide such additional income as is necessary.

(C) Revision of community spouse resource allowance

If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2) of this section, an amount adequate to provide such a minimum monthly maintenance needs allowance.

(f) Permitting transfer of resources to community spouse

(1) In general

An institutionalized spouse may, without regard to section 1396p of this title, transfer an amount equal to the community spouse resource allowance (as defined in paragraph (2)), but only to the extent the resources of the institutionalized spouse are transferred to (or for the sole benefit of) the community spouse. The transfer under the preceding sentence shall be made as soon as practicable after the date of the initial determination of eligibility, taking into account such time as may be necessary to obtain a court order under paragraph (3).

(2) Community spouse resource allowance defined

In paragraph (1), the "community spouse resource allowance" for a community spouse is an amount (if any) by which—

(A) the greatest of—

(i) $12,000 (subject to adjustment under subsection (g) of this section), or, if greater (but not to exceed the amount specified in clause (ii)(II)) an amount specified under the State plan,

(ii) the lesser of (I) the spousal share computed under subsection (c)(1) of this section, or (II) $60,000 (subject to adjustment under subsection (g) of this section),

(iii) the amount established under subsection (e)(2) of this section; or

(iv) the amount transferred under a court order under paragraph (3);

exceeds

(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance).

(3) Transfers under court orders

If a court has entered an order against an institutionalized spouse for the support of the community spouse, section 1396p of this title shall not apply to amounts of resources transferred pursuant to such order for the support of the spouse or a family member (as defined in subsection (d)(1) of this section).

(g) Indexing dollar amounts

For services furnished during a calendar year after 1989, the dollar amounts specified in subsections (d)(3)(C), (f)(2)(A)(i), and (f)(2)(A)(ii)(II) of this section shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1988 and the September before the calendar year involved.

(h) Definitions

In this section:

(1) The term "institutionalized spouse" means an individual who—

(A) is in a medical institution or nursing facility or who (at the option of the State) is described in section 1396a(a)(10)(A)(ii)(VI) of this title, and

(B) is married to a spouse who is not in a medical institution or nursing facility;

but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.

(2) The term "community spouse" means the spouse of an institutionalized spouse.

(Aug. 14, 1935, c. 531, Title XIX, § 1924, as added July 1, 1988, Pub.L. 100–360, Title III, § 303(a)(1)(B), 102 Stat. 754, and amended Oct. 13, 1988, Pub.L. 100–485, Title VI, § 608(d)(16)(A), 102 Stat. 2417; Dec. 19, 1989, Pub.L. 101–239, Title Vi, § 6411(e)(3), 103 Stat. 2271.)

(b) CLARIFICATION OF TRANSFER OF RESOURCES TO COMMUNITY SPOUSE.—Section 1924(f)(1) (42 U.S.C. 1396r-5(f)(1)) is amended by striking "section 1917" and inserting "section 1917(c)(1)".

(c) CLARIFICATION OF PERIOD OF CONTINUOUS ELIGIBILITY.—Section 1924(c)(1) (42 U.S.C. 1396r-1(c)(1)) is amended by striking "the beginning of a continuous period of institutionalization of the institutionalized spouse" each place it appears and inserting "the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989) of the institutionalized spouse".

(d) EFFECTIVE DATE.—The amendments made this section shall take effect as if included in the enactment of section 303 of the Medicare Catastrophic Coverage Act of 1988.

SEC. 4714. PROVISIONS RELATING TO SPOUSAL IMPOVERISHMENT.

(a) CLARIFICATION OF NON-APPLICATION OF STATE COMMUNITY PROPERTY LAWS.—Section 1924(b)(2) (42 U.S.C. 1396r-1(b)(2)) as amended by subsection (a), is further amended by striking ", after the institutionalized spouse has been determined or redetermined to be eligible for medical assistance" and inserting "for purposes of the post-eligibility income determination described in subsection (d)".

(17) DIVESTMENT. (a) In this subsection:

1. "Institutionalized individual" has the meaning given in 42 USC 1396p (c) (3).

2. "Resources" has the meaning given in 42 USC 1396p (c) (5).

(b) Except as provided in par. (d), all of the following are ineligible under medical assistance for nursing facility services, for a level of care in a medical institution equivalent to that of a nursing facility and for services under a waiver under 42 USC 1396n for the period beginning with the month in which the resources were transferred:

1. An institutionalized individual who is a recipient of medical assistance on the date that he or she is institutionalized if, during the 30 months immediately before the date that the individual becomes an institutionalized individual or at any time thereafter, the institutionalized individual or his or her spouse, as defined in s. 49.47 (2) (c), disposes of resources for less than fair market value.

2. An institutionalized individual if, during the 30 months immediately before the date that he or she applies for medical assistance or at any time thereafter, the institutionalized individual or his or her spouse, as defined in s. 49.47 (2) (c), disposes of resources for less than fair market value.

(c) The number of months in the period of ineligibility under par. (b) equals the lesser of the following:

1. Thirty months.

2. The number of months equal to the total uncompensated value of the transferred resources divided by the average monthly cost to a private patient of nursing facility services in this state at the time of application.

(d) Paragraphs (b) and (c) do not apply to transfers of resources exempt under 42 USC 1396p (c) (2) or if the department determines that application of pars. (b) and (c) would work an undue hardship. The department shall promulgate rules concerning the transfer of resources exempt under 42 USC 1396p (c) (2).

(17) DIVESTMENT. (a) In this subsection, "resource" does not include any resource excluded when determining eligibility for supplemental security income under 42 USC 1382b (a). For the purposes of this subsection the value of any resource is its fair market value at the time it was disposed of, minus the amount of compensation received for the resource.

(b) In determining the resources of each applicant for medical assistance or in redetermining a recipient's eligibility for medical assistance, the department shall include any resource the applicant or recipient has disposed of for less than its fair market value, if the disposal occurred within 24 months preceding the determination. The department shall presume that the disposal occurred for the purpose of establishing eligibility for medical assistance, unless the person provides convincing evidence to the contrary.

(c) 1. If the uncompensated value of resources disposed of by an applicant or recipient exceeds $12,000, the department shall find that person ineligible for medical assistance. If the department holds the person ineligible for medical assistance for a period exceeding 24 months, the period of ineligibility shall be reasonably related to the uncompensated value of the resources.

2. If the uncompensated value of resources disposed of by an applicant or recipient is less than or equal to $12,000, the department may find that person ineligible for medical assistance until the uncompensated value of these resources is expended for the person's maintenance needs. In this subdivision, "maintenance needs" include needs for medical care.

(d) Any person described in section 1917 (c) (2) (B) of the federal social security act, as created by P.L. 97-248, section 132, who disposes of a home for less than its fair market value is ineligible for medical assistance to the extent authorized by that section.

(e) This subsection is subject to the limitations specified in section 1917 (c) of the federal social security act, as created by P.L. 97-248, section 132. This subsection does not apply to the disposal of any resource before July 2, 1983.

49.455 Protection of income and resources of couple for maintenance of community spouse. (1) DEFINITIONS. In this section:

(a) "Community spouse" means an individual who is married to an institutionalized spouse.

(b) "Consumer price index" means the consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor.

(c) "Family member" means a minor or dependent child, dependent parent or dependent sibling of an institutionalized or community spouse who resides with the community spouse.

(d) "Institutionalized spouse" means either an individual who is in a medical institution or nursing facility and is married to an individual who is not in a medical institution or nursing facility or an individual who receives services under a waiver under 42 USC 1396n (c) or (d) and is married to an individual who is not in a medical institution or nursing facility and does not receive services under a waiver under 42 USC 1396n (c) or (d).

(e) "Resources" does not include items excluded under 42 USC 1382b (a) or (d) or items that would be excluded under 42 USC 1382b (a) (2) (A) but for the limitation on total value established under that provision.

(2) APPLICABILITY. The department shall use the provisions of this section in determining the eligibility for medical assistance under s. 49.46 or 49.47 and the required contribution toward care of an institutionalized spouse.

(3) ATTRIBUTION OF INCOME. (a) Except as provided in par. (b), no income of a spouse is considered to be available to the other spouse during any month in which that other spouse is an institutionalized spouse.

(b) Notwithstanding ch. 766, after an institutionalized spouse is determined to be eligible for medical assistance the following criteria apply in determining the income of an institutionalized spouse or a community spouse:

1. Except as determined under subd. 2 or 3, unless the instrument providing the income specifically provides otherwise:

a. Income paid solely in the name of one spouse is considered to be available only to that spouse.

b. Income paid in the names of both spouses is considered to be available one-half to each spouse.

c. Income paid in the name of either or both spouses and to one or more other persons is considered to be available to each spouse in proportion to the spouse's interest or, if payment is made to both spouses and each spouse's individual interest is not specified, one-half of the joint interest is considered to be available to each spouse.

2. Except as provided in subd. 3, if there is no trust or other instrument establishing ownership, income received by a couple is considered to be available one-half to each spouse.

3. Subdivisions 1 and 2 do not apply to income other than income from a trust if the institutionalized spouse establishes, by a preponderance of the evidence, that the ownership interests in the income are other than as provided in subds. 1 and 2.

(4) PROTECTING INCOME FOR COMMUNITY SPOUSE. (a) After an institutionalized spouse is determined to be eligible for medical assistance, in determining the amount of that institutionalized spouse's income that must be applied monthly to payment for the costs of care in the institution, the department shall deduct the following amounts in the following order from the institutionalized spouse's income:

1. The personal needs allowance under s. 49.45 (7) (a).

2. The community spouse monthly income allowance calculated under par. (b) or the amount of income of the institutionalized spouse that is actually made available to, or for the benefit of, the community spouse, whichever is less.

3. A family allowance for each family member equal to one-third of the amount by which the family member's monthly income is exceeded by the following:

a. Beginning on September 30, 1989, and ending on June 30, 1991, 122% of one-twelfth of the poverty line.

b. Beginning on July 1, 1991, and ending on June 30, 1992, 133% of one-twelfth of the poverty line.

c. Beginning on July 1, 1992, 150% of one-twelfth of the poverty line.

4. The amount incurred as expenses for medical or remedial care for the institutionalized spouse.

(b) The community spouse monthly income allowance equals the greater of the following:

1. The minimum monthly maintenance needs allowance determined under par. (c) or the amount determined at a fair hearing under sub. (8) (c), if such an amount has been determined, minus the amount of monthly income otherwise available to the community spouse.

2. The amount of monthly support which a court orders the institutionalized spouse to pay for the support of the community spouse.

(c) The minimum monthly maintenance needs allowance is $1,500 in 1989. For a calendar year after 1989, the minimum monthly maintenance needs allowance is $1,500 increased by the same percentage as the percentage increase in the consumer price index between September 1988 and September of the year before the calendar year involved.

(5) RULES FOR TREATMENT OF RESOURCES. (a) 1. The department shall determine the total value of the ownership interest of the institutionalized spouse plus the ownership interest of the community spouse in resources as of the beginning of a continuous period of institutionalization. The spousal share of resources equals one-half of that total value.

2. At the beginning of a continuous period of institutionalization, upon the request of an institutionalized spouse or a community spouse and the receipt of necessary documentation, the department shall assess and document the total value of resources under subd. 1 and shall provide a copy of the assessment and documentation to each spouse and retain a copy for departmental use. If the request is not part of an application for medical assistance, the department may charge a fee not exceeding the reasonable expenses of providing and documenting the assessment. When the department

provides a copy of an assessment, it shall provide notice of the right to a fair hearing under sub. (8).

(b) Notwithstanding ch. 766, in determining the resources of an institutionalized spouse at the time of application for medical assistance, the amount of resources considered to be available to the institutionalized spouse equals the value of all of the resources held by either or both spouses minus the greatest of the amounts determined under sub. (6) (b) 1 to 4.

(c) The amount of resources determined under par. (b) to be available for the cost of care does not cause an institutionalized spouse to be ineligible for medical assistance, if any of the following applies:

1. The institutionalized spouse has assigned to the state any rights to support from the community spouse.

2. The institutionalized spouse lacks the ability to execute an assignment under subd. 1 due to a physical or mental impairment but the state has the right to bring a support proceeding against the community spouse without an assignment.

3. The department determines that denial of eligibility would work an undue hardship.

(d) During a continuous period of institutionalization, after an institutionalized spouse is determined to be eligible for medical assistance, no resources of the community spouse are considered to be available to the institutionalized spouse.

(6) PERMITTING TRANSFER OF RESOURCES TO COMMUNITY SPOUSE. (a) Notwithstanding s. 49.45 (17), an institutionalized spouse may transfer an amount of resources equal to the community spouse resource allowance determined under par. (b) to, or for the sole benefit of, the community spouse. The institutionalized spouse shall make the transfer as soon as practicable after the initial determination of eligibility for medical assistance, taking into account the amount of time that is necessary to obtain a court order under par. (c).

(b) The community spouse resource allowance equals the amount by which the amount of resources otherwise available to the community spouse is exceeded by the greatest of the following:

1. In 1989, $60,000; in a calendar year after 1989, $60,000 increased by the same percentage as the percentage increase in the consumer price index between September 1988 and September of the year before the calendar year involved.

3. The amount established in a fair hearing under sub. (8) (d).

4. The amount transferred under a court order under par. (c).

(c) If a court has entered a support order against a community spouse, s. 49.45 (17) does not apply to resources transferred under the order for the support of the community spouse or a family member.

(7) NOTICE. The department shall notify both spouses upon a determination of medical assistance eligibility of an institutionalized spouse, or shall notify the spouse making the request upon a request by either an institutionalized spouse or a community spouse, of all of the following:

(a) The amount of the community spouse monthly income allowance calculated under sub. (4) (b).

(b) The amount of any family allowances under sub. (4) (a) 3.

(c) The method for computing the amount of the community spouse resource allowance under sub. (6) (b).

(d) The spouse's right to a fair hearing under sub. (8) concerning ownership or availability of income or resources and the determination of the community spouse monthly income or resource allowance.

(8) FAIR HEARING. (a) An institutionalized spouse or a community spouse is entitled to a departmental fair hearing concerning any of the following:

1. The determination of the community spouse monthly income allowance under sub. (4) (b).

2. The determination of the amount of monthly income otherwise available to the community spouse used in the calculation under sub. (4) (b).

3. The computation of the spousal share of resources under sub. (5) (a) 1.

4. The attribution of resources under sub. (5) (b).

5. The determination of the community spouse resource allowance under sub. (6) (b).

(b) If the institutionalized spouse has made an application for medical assistance, and a fair hearing is requested under par. (a) concerning the determination of community spouse resource allowance, the department shall hold the hearing within 30 days after the request.

(c) If either spouse establishes at a fair hearing that, due to exceptional circumstances resulting in financial duress, the community spouse needs income above the level provided by the minimum monthly maintenance needs allowance determined under sub. (4) (c), the department shall determine an amount adequate to provide for the community spouse's needs and use that amount in place of the minimum monthly maintenance needs allowance in determining the community spouse monthly income allowance under sub. (4) (b).

(d) If either spouse establishes at a fair hearing that the community spouse resource allowance determined under sub. (6) (b) without a fair hearing does not generate enough income to raise the community spouse's income to the minimum monthly maintenance needs allowance under sub. (4) (c), the department shall establish an amount to be used under sub. (6) (b) 3 that results in a community spouse resource allowance that generates enough income to raise the community spouse's income to the minimum monthly maintenance needs allowance under sub. (4) (c).

History: 1989 a. 31, 81.

227.485 Costs to certain prevailing parties. (1) The legislature intends that hearing examiners and courts in this state, when interpreting this section, be guided by federal case law, as of November 20, 1985, interpreting substantially similar provisions under the federal equal access to justice act, 5 USC 504.

(2) In this section:

(a) "Hearing examiner" means the agency or hearing examiner conducting the hearing.

(b) "Nonprofit corporation" has the meaning designated in s. 181.02 (8).

(c) "Small business" means a business entity, including its affiliates, which is independently owned and operated, and which employs fewer than 25 full-time employes or which has gross annual sales of less than $2,500,000.

(d) "Small nonprofit corporation" means a nonprofit corporation which employs fewer than 25 full-time employes.

(e) "State agency" does not include the public intervenor or citizens utility board.

(f) "Substantially justified" means having a reasonable basis in law and fact.

(3) In any contested case in which an individual, a small nonprofit corporation or a small business is the prevailing party and submits a motion for costs under this section, the hearing examiner shall award the prevailing party the costs incurred in connection with the contested case, unless the hearing examiner finds that the state agency which is the losing party was substantially justified in taking its position or that special circumstances exist that would make the award unjust.

(4) In determining the prevailing party in cases in which more than one issue is contested, the examiner shall take into account the relative importance of each issue. The examiner shall provide for partial awards of costs under this section based on determinations made under this subsection.

(5) If the hearing examiner awards costs under sub. (3), he or she shall determine the costs under this subsection, except as modified under sub. (4). The decision on the merits of the case shall be placed in a proposed decision and submitted under ss. 227.47 and 227.48. The prevailing party shall submit, within 30 days after service of the proposed decision, to the hearing examiner and to the state agency which is the losing party an itemized application for fees and other expenses, including an itemized statement from any attorney or expert witness representing or appearing on behalf of the party stating the actual time expended and the rate at which fees and other expenses were computed. The state agency which is the losing party has 15 working days from the date of receipt of the application to respond in writing to the hearing examiner. The hearing examiner shall determine the amount of costs using the criteria specified in s. 814.245 (5) and include an order for payment of costs in the final decision.

(6) A final decision under sub. (5) is subject to judicial review under s. 227.52. If the individual, small nonprofit corporation or small business is the prevailing party in the proceeding for judicial review, the court shall make the findings applicable under s. 814.245 and, if appropriate, award costs related to that proceeding under s. 814.245, regardless of who petitions for judicial review. In addition, the court on review may modify the order for payment of costs in the final decision under sub. (5).

(7) An individual is not eligible to recover costs under this section if the person's properly reported federal adjusted gross income was $150,000 or more in each of the 3 calendar years or corresponding fiscal years immediately prior to the commencement of the case. This subsection applies whether the person files the tax return individually or in combination with a spouse.

(8) If a state agency is ordered to pay costs under this section, the costs shall be paid from the applicable appropriation under s. 20.865 (1) (a), (g) or (q).

(9) Each state agency that is ordered to pay costs under this section or that recovers costs under sub. (10) shall submit a report annually, as soon as is practicable after June 30, to the chief clerk of each house of the legislature, for distribution to the appropriate standing committees under s. 13.172 (3), the number, nature and amounts of the claims paid, the claims involved in the contested case in which the costs were incurred, the costs recovered under sub. (10) and any other relevant information to aid the legislature in evaluating the effect of this section.

(10) If the examiner finds that the motion under sub. (3) is frivolous, the examiner may award the state agency all reasonable costs in responding to the motion. In order to find a motion to be frivolous, the examiner must find one or more of the following:

(a) The motion was submitted in bad faith, solely for purposes of harassing or maliciously injuring the state agency.

(b) The party or the party's attorney knew, or should have known, that the motion was without any reasonable basis in law or equity and could not be supported by a good faith argument for an extension, modification or reversal of existing law.

History: 1985 a. 52; Stats. 1985 s. 227.115; 1985 a. 182 ss. 33s, 57; 1985 a. 332 s. 253; Stats. 1985 s. 227.485; 1987 a. 186.

Fact that government loses case does not justify automatic imposition of fees and costs; award depends upon whether government's position has arguable merit. Behnke v. DHSS, 146 W (2d) 178, 430 NW (2d) 600 (Ct. App. 1988).

814.245 Actions by state agencies. (1) The legislature intends that courts in this state, when interpreting this section, be guided by federal case law, as of November 20, 1985, interpreting substantially similar provisions under the federal equal access to justice act, 5 USC 504.

(2) In this section:

(a) "Nonprofit corporation" has the meaning designated in s. 181.02 (8).

(b) "Small business" means a business entity, including its affiliates, which is independently owned and operated, and which employs fewer than 25 full-time employes or which has gross annual sales of less than $2,500,000.

(c) "Small nonprofit corporation" means a nonprofit corporation which employs fewer than 25 full-time employes.

(d) "State agency" does not include the public intervenor or citizens utility board.

(e) "Substantially justified" means having a reasonable basis in law and fact.

(3) If an individual, a small nonprofit corporation or a small business is the prevailing party in any action by a state agency or in any proceeding for judicial review under s. 227.485 (6) and submits a motion for costs under this section, the court shall award costs to the prevailing party, unless the court finds that the state agency was substantially justified in taking its position or that special circumstances exist that would make the award unjust.

(4) In determining the prevailing party in actions in which more than one issue is contested, the court shall take into account the relative importance of each issue. The court shall provide for partial awards of costs under this section based on determinations made under this subsection.

(5) If the court awards costs under sub. (3), the costs shall include all of the following which are applicable:

(a) The reasonable expenses of expert witnesses, the reasonable cost of any study, analysis, engineering report, test or project which is found by the court to be necessary for the preparation of the case and reasonable attorney or agent fees. The amount of fees awarded under this section shall be based upon prevailing market rates for the kind and quality of the services furnished, except that:

1. No expert witness may be compensated at a rate in excess of the highest rate of compensation for expert witnesses paid by the agency which is the losing party.

2. Attorney or agent fees may not be awarded in excess of $75 per hour unless the court determines that an increase in the cost of living or a special factor, such as the limited availability of qualified attorneys or agents, justifies a higher fee.

(b) Any other allowable cost specified under s. 814.04 (2).

(6) A party seeking an award under this section shall, within 30 days after final judgment in the action, submit to the clerk under s. 814.10 (1) an itemized application for fees and other expenses, including an itemized statement from any attorney or expert witness representing or appearing on behalf of the party stating the actual time expended and the rate at which fees and other expenses were computed. Section 814.10 applies for the procedure for taxation of costs, except that the clerk shall allow the state agency 15 working days to respond under s. 814.10 (3).

(7) The court acting under s. 814.10 (4) may reduce the amount awarded under this section or deny an award if it finds that the prevailing party engaged in conduct which unduly and unreasonably delayed the action.

(8) An individual is not eligible to recover costs under this section if the person's properly reported federal adjusted gross income was $150,000 or more in each of the 3 calendar years or corresponding fiscal years immediately prior to the commencement of the action. This subsection applies whether the person files the tax return individually or in combination with a spouse.

(9) If a state agency is ordered to pay costs under this section, the costs shall be paid from the applicable appropriation under s. 20.865 (1) (a), (g) or (q).

(10) Each state agency that is ordered to pay costs under this section or that recovers costs under sub. (11) shall report annually, as soon as is practicable after June 30, to the presiding officer of each house of the legislature the number, nature and amounts awarded, the claims involved in the action in which the costs were incurred, the costs recovered under sub. (11) and any other relevant information to aid the legislature in evaluating the effect of this section.

(11) If the court finds that the motion under sub. (3) is frivolous, the examiner may award the state agency all reasonable costs in responding to the motion. In order to find a motion to be frivolous, the court must find one or more of the following:

(a) The motion was submitted in bad faith, solely for purposes of harassing or maliciously injuring the state agency.

(b) The party or the party's attorney knew, or should have known, that the motion was without any reasonable basis in law or equity and could not be supported by a good faith argument for an extension, modification or reversal of existing law.

History: 1985 a. 52; 1985 a. 182 s. 57; 1985 a. 332 s. 253.

Petitioner must receive at least some of requested relief in order to "prevail" under (3). Kitsemble v. DHSS, 143 W (2d) 863, 422 NW (2d) 896 (Ct. App. 1988).

30-day period in (6) commences at time matter is disposed of in favor of party following remand to administrative agency. Sheely v. DHSS, 150 W (2d) 320, 442 NW (2d) 1 (1989).

HSS 103.06 Assets. (1) SPECIAL SITUATIONS OF INSTITUTIONALIZED PERSONS. (a) In determining the eligibility of an institutionalized person, only the assets actually available to that person shall be considered.

(b) The homestead property of an institutionalized person is not counted as an asset if:

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1. The institutionalized person's home is currently occupied by the institutionalized person's spouse, child who is under age 18, or child who is 18 years or older and who is developmentally disabled;

2. The institutionalized person intends to return to the home and the anticipated absence from the home, as verified by a physician, is less than 12 months; or

3. The anticipated absence of the institutionalized person from the home is for more than 12 months but there is a realistic expectation, as verified by a physician, that the person will return to the home. That expectation shall include a determination of the availability of home health care services which would enable the recipient to live at home.

(c) If none of the conditions under par. (b) is met, the property is no longer the principal residence and becomes non-homestead property.

(d) When income that has been protected for institutionalized recipients accumulates to the point that the asset limit is exceeded, MA eligibility shall terminate. Eligibility may not be reinstated until the assets are below the limit at which time a new application shall be required.

(e) To maintain continuous MA eligibility the recipient may apply assets as a refund of MA benefits to the department. In no instance may refunds exceed benefits received.

(2) MOTOR VEHICLES. (a) In this section:

1. "Motor vehicle" means a passenger car or other motor vehicle used to provide transportation of persons or goods and which is owned by a person in the MA or fiscal test group.

2. "Equity value" means the fair market value minus any encumbrances which are legal debts.

3. "Fair market value" means the wholesale value shown in a standard guide on motor vehicle values or the value as estimated by a reliable expert.

(b) For persons whose eligibility is being determined according to AFDC categorically needy financial standards, the following conditions shall apply:

1. If one vehicle is owned, up to $1,500 of equity value is exempt; and

2. If more than one vehicle is owned, up to $1,500 of equity value of the vehicle with the greatest equity value is exempt. The equity value of the vehicle with the greatest equity value in excess of $1,500 and the equity value of any other vehicle is counted as an asset.

(bm) For persons whose eligibility is being determined according to AFDC medically needy financial standards, the following conditions shall apply:

1. If one vehicle is owned, it is exempt from consideration as an asset regardless of value;

2. If more than one vehicle is owned, a second vehicle is exempt from consideration as an asset-if the agency determines that it is necessary for the purpose of employment or to obtain medical care; and

3. The equity value of any nonexempt vehicle owned by the applicant is counted as an asset.

(c) For persons whose eligibility is being determined according to SSI categorically needy or medically needy financial standards, the following conditions shall apply:

1. If one vehicle is owned it is exempt if it meets one of the following conditions:

a. It is necessary for employment;

b. It is necessary for medical treatment of a specific or regular medical problem;

c. It is modified for operation by or transportation of a handicapped person; or

d. It is necessary because of climate, terrain, distance or similar factors to provide transportation to perform essential daily activities.

2. If no automobile is exempt under subd. 1, one automobile is not counted as an asset to the extent that its current fair market value does not exceed $4,500. Fair market value in excess of $4,500 counts toward the asset limit.

3. If more than one vehicle is owned, the equity value of the nonexempt vehicle is counted as an asset.

(3) JOINT ACCOUNTS AND JOINTLY HELD PROPERTY. (a) *Joint accounts.* A joint account shall be deemed available to each person whose name is on the account or listed as an owner. The value of a joint savings or checking account shall be determined as follows in determining eligibility for MA:

1. For persons who receive MA who are not age 65 or over, or not blind or disabled, the division of a joint account shall be determined according to applicable federal law; and

2. For persons who receive MA who are age 65 or over or who are blind or disabled, joint accounts shall be divided as follows:

a. If both owners of the joint account receive MA, equal shares of the joint account shall be included for the purpose of determining MA eligibility; and

b. If only one owner of the joint account receives MA, the full amount of the joint account shall be included for the purpose of determining MA eligibility.

(b) *Jointly held property.* If the applicant or recipient is a joint owner of property with a person who refuses to sell the property and who is not a legally responsible relative of the applicant or recipient, the property shall not be considered available to the applicant or recipient and may not be counted as an asset. If the property is available to the applicant or recipient, it shall be divided equally between the joint owners.

(4) HOMESTEAD PROPERTY. (a) A home owned and lived in by an applicant or recipient is an exempt asset.

(b) Net proceeds from the sale of homestead property shall be treated as assets except when the proceeds are placed in escrow in contemplation of purchase of another home. Proceeds in escrow are exempt assets for a maximum of one year.

(5) NON-HOMESTEAD REAL PROPERTY. (a) If the equity value of the non-homestead property together with all other assets does not exceed the asset limit, the person may retain the property and be eligible for MA.

(b) If the value of non-homestead property together with the value of the other assets exceeds the asset limit, the non-homestead property need not be counted as an asset if it produces a reasonable amount of income. In this paragraph, "reasonable amount of income" means a fair return considering the value and marketability of the property.

(c) If the total value of non-homestead property and non-exempt assets exceeds the asset limit, the person who owns the non-homestead property shall list the property for sale with a licensed realtor at a price which the realtor certifies as appropriate. If the property is listed for sale, it may not be counted as an asset. When the property is sold, the net proceeds shall be counted as an asset.

(6) LIFE ESTATE. The applicant or recipient may hold a life estate without affecting eligibility for MA. If the property or the life estate is sold, any proceeds received by the applicant or recipient shall be considered assets. In this subsection, "life estate" means a claim or interest a person has in a homestead or other property, the duration of the interest being limited to the life of the party holding it with that party being entitled to the use of the property including the income from the property in his or her lifetime.

(7) TRUSTS. (a) Trust funds shall be considered available assets, except that:

1. Trust funds payable to a beneficiary only upon order of a court shall not be considered available assets if the trustee or other person interested in the trust first applied to the court for an order allowing use of part or all of the trust fund to meet the needs of the beneficiary and the court denied such application;

2. Trust funds held in a trust which meets the requirements of s. 701.06, Stats., shall not be considered available assets unless the settlor is legally obligated to support the beneficiary;

3. For SSI-related MA applicants and recipients, the pertinent SSI standards on the treatment of trusts as resources shall apply; and

4. For AFDC-related applicants and recipients, the pertinent AFDC standards on the treatment of trusts as resources shall apply.

(8) PERSONAL PROPERTY. Household and personal effects of reasonable value, considering the number of members in the fiscal test group, shall be exempt.

(9) LOANS. Money received on loan shall be exempt unless it is available for current living expenses, in which case the money shall be treated as an asset even if a repayment schedule exists.

(10) LIFE INSURANCE POLICIES. The cash value of a life insurance policy shall be considered an asset, except that for SSI-related persons it is an asset only when the total face value of all policies owned by the person exceeds $1,500. In this subsection, "cash value" means the net amount of cash for which the policy could be surrendered after deducting any loans or liens against it, and "face value" means the dollar amount of the policy which is payable on death.

(11) LUMP SUM PAYMENTS. All lump sum payments, unless specifically exempted by federal statute or regulation, shall be treated as assets instead of income. In this subsection, "lump sum payment" means a nonrecurring payment such as retroactive social security benefits, income tax refunds, and retroactive unemployment benefits.

(12) WORK-RELATED ITEMS. Work-related items essential to the employment or self-employment of a household member, except motor vehicles, are exempt from being counted as assets. For business or farm operations, internal revenue service (IRS) returns shall be used to determine whether or not the operation is profitable or moving toward becoming profitable. If the operation is not profitable or becoming profitable, all assets related to the operation shall be counted in the determination of eligibility.

(13) SPECIAL EXEMPT ASSETS FOR BLIND OR DISABLED PERSONS. The following assets shall be exempted in determining the eligibility of blind or disabled persons:

(a) Assets essential to the continuing operation of the person's trade or business;

(b) Income-producing property; and

(c) Funds conserved for a departmentally approved plan for self-support of a blind or disabled person. The conserved funds shall be segregated from other funds. Interest earned on conserved funds is exempt so long as the conserved funds do not exceed the provision of the approved plan.

(14) LAND CONTRACTS. (a) The applicant or recipient shall obtain a written estimate of the fair market value of a land contract from a source active in the market for land contracts in Wisconsin.

(b) If the applicant's or recipient's vendor interest in a land contract exceeds the medically needy asset limit under s. 49.47 (4) (b), Stats., the applicant or recipient shall offer the land contract for sale. The applicant's or recipient's vendor interest in a land contract shall be counted as an available asset unless he or she provides written documentation from a source active in the market for land contracts in Wisconsin proving that his or her interest in the land contract cannot be sold.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; am. (1) (d), r. and recr. (1) (e), Register, January, 1987, No. 373, eff. 2-1-87; am. (6), cr. (14), Register, July, 1989, No. 403, eff. 8-1-89; am. (2) (b), cr. (2) (bm), r. and recr. (2) (c), Register, December, 1990, No. 420, eff. 1-1-91.

HSS 103.063 Divestment prior to August 9, 1989. (1) APPLICABILITY. This section applies to all applicants for MA and recipients of MA who disposed of a resource at less than fair market value prior to August 9, 1989 and to all inter-spousal transfers occurring before October 1, 1989. Section HSS 103.065 applies to all institutionalized applicants and recip-

ients who divest on or after August 9, 1989, except for inter-spousal transfers occurring before October 1, 1989.

(1m) PURPOSE. This section implements s. 49.45 (17), 1987-88 Stats., which makes an applicant for or recipient of MA ineligible when the applicant or recipient disposed of a resource at less than fair market value within 2 years before or at any time after his or her most recent application for MA or any review of eligibility for MA. Section 49.45 (17) (d), 1987-88 Stats., is specifically concerned with an applicant for or recipient of MA who resides as an inpatient in a skilled nursing facility (SNF), intermediate care facility (ICF) or inpatient psychiatric facility and who disposed of homestead property at any time during or after the 2 year period prior to the date of the most recent application or any review of eligibility.

(2) DIVESTMENT OF NON-HOMESTEAD PROPERTY. (a) *Amount of divestment.* For any person who disposed of a resource, except a homestead or other exempt resource, at less than fair market value within 2 years before or at any time after his or her most recent application for MA, or any review of eligibility, the agency shall determine the amount of the divestment in the following manner:

1. If the compensation received is less than net market value, the difference between the compensation received and the net market value is the divested amount and shall be considered an asset.

2. If the divested amount plus other nonexempt assets are equal to or less than the appropriate assets limit, the divestment shall not be considered a bar to eligibility.

3. If the divested amount plus the other nonexempt assets are greater than the appropriate assets limit, the excess over this limit shall be the amount of divestment to be expended for maintenance needs and medical care.

(b) *Divestment as a barrier to eligibility.* 1. Divestment by any person within 2 years before or at any time after his or her most recent application for MA or any review of eligibility shall, unless shown to the contrary, be presumed to have been made in contemplation of receiving MA. Divestment bars eligibility for MA except as provided in subds. 2 and 3 and par. (c).

2. To rebut the presumption that divestment was made in contemplation of seeking aid, the applicant shall furnish convincing evidence to establish that the transaction was exclusively for some other purpose. For example, the applicant may rebut the presumption that the divestment was done in contemplation of receiving aid by showing by convincing evidence that at the time of divesting the applicant had provided for future maintenance needs and medical care.

3. Divestment shall only be considered a barrier to eligibility when the net market value of all the resources disposed of exceeds the medically needy asset levels in s. 49.47 (4) (b) 3, Stats.

4. Division of resources as part of a divorce or separation action, the loss of a resource due to foreclosure or the repossession of a resource due to failure to meet payments is not divestment.

(c) *Removing divestment as a barrier to eligibility.* 1. Divestment is no longer a barrier to MA eligibility for persons who are determined to have divested non-homestead property:

a. If the divested amount is $12,000 or less, when the sum of the divestment has been expended for maintenance needs and medical care of the applicant or recipient or when 2 years have elapsed since the date of divestment, whichever occurs first; or,

b. If the divested amount exceeds $12,000, when the entire sum of the divestment has been expended for maintenance needs and medical care of the applicant or recipient.

2. The amount expended for maintenance needs and medical care of the applicant or recipient shall be calculated monthly, as follows:

a. For a non-institutionalized person, the expended amount is the medical care expenses for the person plus the appropriate medically needy income limit for either AFDC or SSI, depending upon which program the person would be eligible for under MA, were it not for the divestment; and

b. For a person institutionalized in a SNF, ICF or inpatient psychiatric facility, the expended amount is the total cost of the institutional care.

(3) DIVESTMENT OF HOMESTEAD PROPERTY. (a) *Applicability.* Divestment by any person of his or her homestead property is a barrier to eligi-

bility only if he or she is a resident of an SNF, ICF or inpatient psychiatric facility.

(b) *Amount of divestment.* A person who is a resident of an SNF, ICF or inpatient psychiatric facility who disposed of his or her homestead for less than fair market value on or after July 2, 1983, but within 2 years before or at any time after his or her most recent application for MA or any review of his or her eligibility for MA, shall have the amount of divestment determined in the same manner as in sub. (2) (a).

(c) *Divestment as a barrier to eligibility.* 1. Divestment of a homestead by any person residing as an inpatient in an SNF, ICF or inpatient psychiatric facility within 2 years prior to the date of his or her most recent application for MA or any review of his or her eligibility for MA, shall, unless shown to the contrary, be presumed to have been made in contemplation of receiving MA. Divestment bars eligibility for MA except as provided in subds. 2 and 3 and par. (d).

2. To rebut the presumption that divestment was made in contemplation of receiving aid, the applicant shall furnish convincing evidence to establish that the transaction was exclusively for some other purpose. For example, the applicant may rebut the presumption that the divestment was done in contemplation of receiving aid by showing by convincing evidence that, at the time of divesting, the applicant had provided for his or her future maintenance needs and medical care.

3. Divestment shall only be considered a barrier to eligibility when the net market value of all the resources disposed of exceeds the medically needy asset levels in s. 49.47 (4) (b)3, Stats.

4. Divestment does not occur in cases of division of resources as part of a divorce or separation action, the loss of a resource due to foreclosure or the repossession of a resource due to failure to meet payments.

(d) *Removing divestment as a barrier to eligibility.* 1. Divestment of a homestead is no longer a barrier to eligibility for institutionalized persons:

a. If the amount of divestment to be expended for maintenance needs and medical care is less than the average MA expenditures for 24 months of care in an SNF, when the entire amount of the divestment is expended for this care, or 2 years has elapsed since the date of the divestment, whichever occurs first; or

b. If the amount of divestment to be expended for maintenance needs and medical care is greater than the average MA expenditure for 24 months of care in an SNF, when the entire amount of the divestment has been expended.

2. Expended amounts shall be determined, as long as the person is institutionalized, by using the average monthly MA expenditure, statewide, for care provided in an SNF.

3. An individual who is an inpatient in a SNF, ICF or inpatient psychiatric facility who has been determined to have divested a homestead, may be found eligible if:

a. It is shown to the satisfaction of the department that the individual can reasonably be expected to be discharged from the medical institution and return to that homestead;

b. The title to the homestead was transferred to the individual's spouse or child who is under age 21 or is blind or totally and permanently disabled according to a determination made by the department's bureau of social security disability insurance;

c. It is shown to the satisfaction of the department that the individual intended to dispose of the homestead either at fair market value or for other valuable consideration; or

d. It is determined by the department that the denial of eligibility would work undue hardship on the individual.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; renum. from HSS 103.02 and am., cr. (1), Register, April, 1990, No. 412, eff. 5-1-90.

HSS 103.065 Divestment on or after August 9, 1989. (1) APPLICABILITY. This section applies to all institutionalized applicants for and recipients of MA who dispose of resources at less than fair market value on or after August 9, 1989, except for inter-spousal transfers occurring before October 1, 1989. Section HSS 103.063 applies to all applicants and recipients who divested before August 9, 1989 and to inter-spousal transfers occurring before October 1, 1989.

(2) PURPOSE. This section implements s. 49.45 (17), Stats., which provides for a period of restricted MA coverage when an individual who is institutionalized or becomes institutionalized disposes of a resource at less than fair market value.

(3) DEFINITIONS. In this section:

(a) "Community spouse" means a person who is married to an institutionalized individual but is not himself or herself an institutionalized individual.

(b) "Institutionalized individual" means an applicant or recipient who is an inpatient in an SNF or ICF, an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in an SNF or ICF, or receiving home and community-based care MA services under ss. 49.46 and 49.47, Stats.

(c) "Medical assistance" or "MA" means payment for services provided to a resident of an SNF or ICF under s. HSS 107.09 (2) and (4) (a), payment to a medical institution as defined under 42 CFR 435.1009 for care based on a level of care provided in an SNF or ICF, or payment for services provided under a home and community-based care waiver program authorized under 42 USC 1396n (c).

(d) "Medical assistance card services" means the services covered under ch. HSS 107, except for services reimbursed as institutional care, as defined by s. HSS 107.09 (2) and (4) (a), services received in an SNF or ICF or a medical institution and services reimbursed under a home and community-based care waiver program authorized under 42 USC 1396n (c).

(e) "Resource" has the meaning given in 42 USC 1382b, except that the home, as defined in s. HSS 101.03 (75), is a nonexempt resource.

(4) DIVESTMENT. (a) *Divestment resulting in ineligibility.* An institutionalized individual or someone acting on behalf of that individual who disposes of a resource at less than fair market value within 30 months

immediately before or at any time after the individual becomes institutionalized if the individual is receiving MA on the date he or she becomes institutionalized or, if the individual is not a recipient on that date, within 30 months immediately before or at any time after the date the individual applies for MA while institutionalized, shall be determined to have divested. A divestment results in ineligibility for MA unless made to an exempt party under par. (b) or (c) or when one of the circumstances in par. (d) exist. In this paragraph, "receiving" means entitled to receive as well as actually receiving, in the same way that "recipient" as defined in s. HSS 101.03 (150) means a person who is entitled to receive benefits under MA as defined under s. HSS 101.03 (95).

(b) *Permitted divestment to an exempt party — homestead property.* Transfer of homestead property at less than fair market value is not divestment resulting in ineligibility under this section if the individual transferred title to the homestead property to:

1. The spouse of the institutionalized individual on or after October 1, 1989;

2. A child of the institutionalized individual who is under age 21 or who meets the SSI definition of total and permanent disability or blindness under 42 USC 1382c;

3. A sibling of the institutionalized individual who has an equity interest in the homestead and who was residing in the institutionalized individual's home for at least one year immediately before the date the individual became an institutionalized individual. In this subdivision, "equity interest" means ownership interest in a homestead by one or more persons who pay or have paid all or a portion of mortgage or land contract payments, expenses for upkeep and repair or payment of real estate taxes. The institutionalized individual shall provide documentation to verify the sibling's equity interest in the homestead; or

4. The child, other than a child described in subd. 2, of the institutionalized individual who was residing in the institutionalized individual's home for a period of at least 2 years immediately before the date the individual became an institutionalized individual and who provided care to the institutionalized individual which permitted him or her to reside at home rather than in an SNF, ICF or medical institution which receives payment based on a level of care provided in an SNF or ICF. The institutionalized individual shall provide a notarized statement to the agency from his or her physician or another person or persons who have personal knowledge of the living circumstances of the institutionalized individual stating that the individual was able to remain in his or her home because of the care provided by the child. A notarized statement only from the child does not satisfy the requirements of this subdivision.

(c) *Permitted divestment to an exempt party — non-homestead property.* Transfer of a non-homestead resource at less than fair market value is not divestment resulting in ineligibility under this section if the individual transferred the resource to one of the following individuals:

1. Beginning October 1, 1989, to the community spouse or to another individual for the sole benefit of the community spouse after the individual became an institutionalized individual;

2. To a minor or adult child of the institutionalized individual who meets the SSI definition of total and permanent disability or blindness under 42 USC 1382c; or

3. Beginning October 1, 1989, to the individual's spouse or to another person for the sole benefit of the individual's spouse before the individual became an institutionalized individual. Such a transfer is not considered divestment resulting in ineligibility for as long as the individual's spouse does not transfer the resource to another person other than his or her spouse at less than fair market value. The individual's spouse shall report any transfer of the resource to the agency within 10 days after the transfer is made as required under s. 49.12 (9), Stats. Failure of the institutionalized individual's spouse to report the transfer may be fraud under s. 49.49 (1) (a) 3, Stats.

(d) *Circumstances under which divestment is not a barrier to eligibility.* An institutionalized individual who has been determined to have made a prohibited divestment under this section shall be found ineligible for MA as defined under s. HSS 101.03 (95) unless:

1. The transfer of property occurred as the result of a division of resources as part of a divorce or separation action, the loss of a resource due to foreclosure or the repossession of a resource due to failure to meet payments; or

2. It is shown to the satisfaction of the department that one of the following occurred:

a. The individual intended to dispose of the resource either at fair market value or for other valuable consideration;

b. The resource was transferred exclusively for some purpose other than to become eligible for MA;

c. The ownership of the divested property was returned to the individual who originally disposed of it; or

d. The denial or termination of eligibility would work an undue hardship. In this subparagraph, "undue hardship" means that a serious impairment to the institutionalized individual's immediate health status exists.

(5) DETERMINING THE PERIOD OF INELIGIBILITY. An institutionalized individual who has made a prohibited divestment under this section as determined by the agency without a condition under sub. (4) (d) existing shall be ineligible for MA as defined in this section for, beginning with the month of divestment, the lesser of:

(a) Thirty months; or

(b) The number of months obtained by dividing the total uncompensated value of the transferred resources by the statewide average monthly cost to a private pay patient in an SNF at the time of application. In this paragraph, "total uncompensated value of the transferred resource" means the difference between the compensation received for the resource and the fair market value of the resource less any outstanding loans, mortgages or other encumbrances on the resource.

(6) AGENCY RESPONSIBILITIES. (a) The agency shall determine if an applicant or recipient who is ineligible for MA under this section is eligi-

ble for MA card services. The applicant or recipient's income eligibility shall be determined using the standards under s. HSS 103.04 (4).

(b) The agency shall monitor retention of assets by the non-institutionalized spouse under sub. (4) (c) 3 at each application or review of eligibility for the institutionalized spouse.

History: Cr. Register, March, 1990, No. 412, eff. 5-1-90.

State of Wisconsin \ DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF COMMUNITY SERVICES
1 WEST WILSON STREET
P.O. BOX 7851
MADISON, WISCONSIN 53707

April 19, 1985

Ms. Betsy Abramson
Attorney and Director
Access for Senior Citizens Project
Center for Public Representation
520 University Avenue
Madison WI 53703

Re: MEDICAL ASSISTANCE (MA) JOINTLY HELD ACCOUNTS

Dear Ms. Abramson:

This is in response to your March 22, 1985 correspondence concerning the Department's policy relative to MA Joint Accounts. As you know, your letter to Kathryn Morrison was also referred to me for response.

The current joint account policy became effective August 1, 1984. The change from the previous policy was required by Federal law 42 U.S.C. 1396(a)(10)(C). Because SSI eligibility results in automatic eligibility for Medical Assistance in Wisconsin, we are obligated to use the Social Security Administration's asset policies. Thus, when an SSI related MA applicant or recipient shares a joint account with another person, the SSA/SSI related policies must be utilized. The Medical Assistance Handbook incorporates those policies in Appendix 23.

The principle of the SSA policy of joint accounts is that a co-owner of a joint account with unrestricted access to the account has 100% of the account available to him/her. Thus, 100% of the account is deemed to the applicant/recipient when the co-owner is someone other than another SSI applicant/recipient. For the same reason, 100% of the account is legally available to the non-SSI related applicant/recipient, and he/she cannot be restricted from withdrawal or use of the account. The SSA/SSI policy concerning "Transfer of Resources" (i.e., divestment) does not apply to "a withdrawal of funds by another person from a bank account jointly held with the eligible individual nor do they apply to transfers made by an ineligible spouse or parent unless the spouse or parent was acting on behalf of the eligible individual..." as a legal representative.

The policy, therefore, allows the non-applicant/recipient to withdraw from the joint account without a consideration of divestment, if the withdrawal was not on behalf of the SSI related individual. If, however, the applicant/recipient initiates the transfer of all or a part of the joint account to someone, divestment is to be considered.

In regard to your question about proceeds from the sale of jointly held real property, if the money is placed in a "joint account," the policy as described above, and in the MA Handbook, apply.

Your suggestion that the Department change the policy to "deem only an equal share of the account to each spouse," which was the previous policy, is prohibited by the change in the Federal law which caused the revision of State policy.

The Department has been in contact with SSA to determine if the transfer of funds by the co-owners of joint accounts can be controlled, or prohibited. There appears to be no means, within the federal policies, to limit the access of the non-SSI applicant/recipient at the present time. We must, therefore, follow the policies established by SSA to remain compatible with the SSI program.

It should be noted, however, that if the non-applicant/recipient has a large amount of assets, legal action may be taken to determine if some of these assets must be made available to the applicant/recipient. If the spouse refuses to contribute to the support of the applicant/recipient, the county agency may pursue support under WI Statute 52.01.

If you have further questions concerning this issue, feel free to contact me.

Sincerely,

Gerald A. Berge

Gerald A. Berge
Administrator
Division of Community Services

cc Kathryn Morrison, DOH

January 14, 1986

Ms. Judith S. Stec
Associate Regional Administrator
Division of Program Operations
Health Care Financing Administration
Region V, 175 West Jackson Boulevard
Chicago IL 60604

Dear Ms. Stec:

Wisconsin's new marital property law became effective January 1, 1986. The new law provides that both spouses have an equal ownership interest in income and property acquired during marriage, except property acquired by gift or inheritance. The general provisions of the Wisconsin marital property law are based on the Uniform Marital Property Act.

It is our understanding that California and Washington have similar marital property laws, that these states submitted MA State Plan amendments in order to conform Medical Assistance eligibility determinations to their state laws, and that these plan amendments were not approved. We are seeking an answer as to what HCFA's position is in regard to state laws governing marital property when they conflict with the federal MA regulations.

We look forward to your early reply.

Sincerely,

John F. Erickson

John F. Erickson, Director
Bureau of Economic Assistance

bcc Mary Ann Cook
John F. Erickson
Dianne Reynolds
Greg Smith
Richard Tillema

By Dianne Reynolds (BEA 6-0988)ba jfe stec

Mr. John Erickson, Director
Bureau of Economic Assistance
Wisconsin Department of Health
and Social Services
1 West Wilson Street
P.O. Box 7851
Madison, Wisconsin 53707

Dear Mr. Erickson:

This is in reply to your inquiry to the Regional Administrator, Region V, concerning the use of State community property rules in determining Medicaid eligibility.

Your understanding that HCFA disapproved California and Washington State plan amendment provisions which proposed the use of State community property rules in determining Medicaid eligibility of aged, blind, and disabled individuals is correct. Additionally, the Washington proposal has undergone reconsideration proceedings as specified in 45 CFR part 213 and the Administrator's final decision affirmed the initial disapproval action. These amendments specifically proposed the use of community property rules in determining income eligibility under Medicaid.

The position on use of State community property rules stems from sections 1902(a)(10)(A), 1902(a)(10)(C)(i)(III), and 1902(a)(17) of the Social Security Act. With regard to the mandatory categorically needy, section 1902(a)(10)(A)(i)(II) requires that medical assistance be available to individuals "being paid" a Supplemental Security Income (SSI) benefit. Obviously, SSI uses the rules of its own program in determining eligibility for SSI benefits. Most of the optional categorically needy groups found in section 1902(a)(10)(A)(ii) are individuals "who meet (or would meet) the income and resource requirements" of the SSI program or are related to eligibility for State supplementary payments, which are also tied to SSI rules. With respect to the aged, blind, and disabled medically needy, section 1902(a)(10)(C)(i)(III) requires the use of the same methodology as is used in the SSI program. Even before the statute explicitly contained these references, the use of the SSI methodology was validated by the United States Supreme Court in Herweg v. Ray, 455. U.S. 265 (1982). SSI regulations at 20 CFR part 416 specify the methods which States must apply in determining what is income and how it affects eligibility.

SSI by statute is a Federal program with uniform eligibility rules and requirements. The SSI regulations (see 20 CFR part 416 subpart K) apply nationwide rules to determine what income will be considered as the individual's and what income will

be considered as the spouse's. The SSI rules do not provide for any special treatment of income in those States which have in effect community property laws. Medicaid follows SSI rules as required by law. (See sections 1902(a)(10)(A)(ii) and 1902(a)(17)(B) and regulations at 42 CFR 435.721 and section 1902(a)(10)(C)(i)(III).)

The HCFA position with regard to application of State community property rules or application of any other rules which may deviate from the SSI methods, (except in those States which elect the option under 1902(f) and thereby are authorized to use certain rules which are more restrictive than SSI's) is that such rules, to the extent they deviate from the SSI methods, violate title XIX provisions which require that the SSI methods be applied in determining Medicaid eligibility.

Sincerely yours,

for Robert A. Streimer
Acting Director
Bureau of Eligibility, Reimbursement
and Coverage

State of Wisconsin \ DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF COMMUNITY SERVICES

1 WEST WILSON STREET
P.O. BOX 7851
MADISON, WISCONSIN 53707
608-266-2701

August 24, 1988

Mr. Mark Tyczkowski
Legal Intern
Center for Public Representation
520 University Avenue
MADISON WI 53703

Dear Mr. Tyczkowski:

Your letter of July 19 to Christine Nye has been forwarded to this Bureau for response. You inquired about the effect of the provisions of the Omnibus Budget Reconciliation Act (P.L. 100-203) and the Medicare Catastrophic Coverage Act (P.L. 100-360) on the amount of the personal needs allowance which is deducted from the institutionalized medical assistance (MA) recipient's income.

Section 9119 of P.L. 100-203 amends section 1611(e)(1)(B) of the Social Security Act to provide for a personal needs allowance of $30.00 for a Supplemental Security Income (SSI) recipient who enters a nursing home and whose sole source of income is SSI. This means that when a SSI recipient enters a nursing home and receives categorically needy MA benefits, his or her SSI payment is reduced only to $30, not $25 as it was prior to the passage of P.L. 100-203.

Section 411(n)(3) of the Medicare Catastrophic Coverage Act (P.L. 100-360) amends section 1902 of the Social Security Act to include a minimum personal needs allowance of $30 for medically needy institutionalized recipients. However, in Wisconsin, medically needy institutionalized recipients are entitled to retain $40 of unearned income as a personal needs allowance under s.49.45(7), Stats. This amount is not related or connected to the reduced benefit level for an SSI recipient who enters a nursing home. Since Wisconsin's personal needs allowance exceeds the minimum amount of $30, there is no obligation under P.L. 100-203 or P.L. 100-360 for Wisconsin to increase the medically needy personal needs allowance.

The pass-through provision contained in s.9119 of P.L. 100-203 does not apply to the personal needs allowance under s.49.45(7), Stats. The pass-through provision prevents states from decreasing their state supplements when the federal SSI benefits increase; it does not require states to increase their state supplements in such a situation.

Mr. Mark Tyczkowski
August 24, 1988
Page 2

Please contact me if you have further questions regarding this matter.

Sincerely,

Silvia R. Jackson

Silvia R. Jackson
Director
Bureau of Economic Assistance

cc Christine Nye, BHCF

ELDERLY

Spousal Transfers in Medical Assistance: Did Congress Close a Loophole or Open a Cesspool?

In December of last year the Congress closed what it perceived as a loophole in its recently "recrafted" Medical Assistance anti-divestment law. The Medicare Catastrophic Coverage Act of 1988 changed the federal divestment law to permit spouses to freely transfer assets between each other once one spouse entered a nursing home. The assumption behind permitting such interspousal transfers was that all the couples property, regardless of title, would be considered when the asset "snapshot" was taken at the beginning of one spouse's nursing home stay.

What the Congress failed to consider was the possibility that the spouse outside the nursing home — now the sole title holder of all the couple's property — would transfer all or large parts of the couple's property to third parties. While such transfers could jeopardize the community spouse's future eligibility for Medical Assistance benefits, it would have no effect on the MA eligibility of the spouse already in a nursing home.

Once informed of this "loophole" in the law, Congress acted with uncharacteristic speed but characteristic ineptness to close it. As part of the gigantic annual spending bill (OBRA '89), phrases were inserted and deleted in the federal divestment law which were designed to prohibit all spousal transfers. Unfortunately, the changes appear to directly conflict with each other.

The law now states that any transfer for less than fair market value by a nursing home resident or his or her spouse will be considered a divestment. Later, however, in a section devoted to exceptions to divestment, the statute states that any transfer "to or from" a nursing home resident spouse is an allowable transfer. Clearly, Congress meant to exempt transfers "between" spouses. Unfortunately, the enacted language does not say that.

"As part of the gigantic annual spending bill (OBRA '89), phrases were inserted and deleted in the federal divestment law which were designed to prohibit all spousal transfers. Unfortunately, the changes appear to directly conflict with each other."

Defining transfers from community spouses as non-divestments merely restates the old loophole. Indeed, it may expand it. Previously, such a transfer would have been considered a divestment if the transferring spouse ever required nursing home care. Now an argument can be made that, such a transfer is not a divestment under any circumstances because it was specifically sanctioned when it was made.

It is not at all clear what practical effect this congressional gaff will have in Wisconsin. Effective July 1, 1990, Wisconsin's divestment law was amended to reflect the federal changes. Wisconsin law also explicitly exempts from divestment penalties the transfers sanctioned by the federal law. Thus the federal gaff has been encased in Wisconsin law. Despite the plain language of the statute, the federal Health Care Financing Administration has instructed states to interpret the statute as permitting transfers between spouses only.

The amendments to the Medical Assistance divestment law demonstrate the difficulty inherent in trying to prevent wealthy people from impoverishing themselves in order to avoid escalating nursing home costs. Even if this loophole is properly closed, other legal methods of circumventing divestment penalties remain available to those who can afford legal and financial advice. The fact that so many elderly people are obsessed about the specter of financial ruin resulting from nursing home care manifests the acute need to fashion an affordable long-term care plan in this country.

By Attorney Mitch Hagopian, Elderly Program

From Vol. 16, No. 1, *The Public Eye*, (September, 1990)

PROPOSED ORDER OF THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES AMENDING AND CREATING RULES

To amend HSS 103.065(1), (2), (4)(a) and (c), (5)(intro.) and (6)(b) and to create HSS 103.065(4)(cm), relating to divestment for the purpose of becoming eligible for Medical Assistance.

Analysis Prepared by the Department of Health and Social Services

To be eligible for Medical Assistance (MA) an applicant or recipient may not have more resources than are permitted under s.49.46(1)(e) or 49.47(4)(b), Stats. In practice an applicant or recipient often attempts to meet asset eligibility limits by selling or giving away resources for less than fair market value. This is called divestment. There are restrictions on divestment.

This order implements the amendments made to s.49.45(17)(b)1 and 2, Stats., by 1989 Wisconsin Act 336, by modifying the current rules on divestment that went into effect on May 1, 1990, to include within the meaning of divestment the transfer of a resource by a spouse without the spouse receiving fair market value for it in addition to a transfer made by the MA applicant or recipient. Transfer by a spouse may occur either before or after the individual becomes an institutionalized individual and requests that MA pay for the costs of the nursing home services or services under a home and community based care waiver program such as the Community Integration Program, otherwise known as CIP II. These provisions affecting transfers by spouses apply to transfers of resources for less than fair market value that occur on or after July 1, 1990. Transfers that occur prior to July 1, 1990, will be considered under the statute and rule provisions that were in effect when the transfer occurred.

The changes in s.49.45(17)(b)1 and 2, Stats., made by 1989 Wisconsin Act 336 and the proposed rule changes will bring Wisconsin policy on disposal of resources at less than fair market value in order to qualify for Medical Assistance into conformity with s.1917(c) of the Social Security Act as amended by s.6411(e) of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239). Section 1917(c) as amended by P.L. 101-239 provides that an institutionalized individual may be ineligible for a period of time for payment by the MA program for institutional care if he or she or his or her spouse disposes of resources for less than fair market value.

The Department's authority to amend and create these rules is found in s.49.45(10), Stats., and s.49.45(17)(d), Stats., as repealed and recreated by 1989 Wisconsin Act 31. The rules interpret s.49.45(17)(b)1 and 2, Stats., as affected by 1989 Wisconsin Acts 31 and 336.

SECTION 1. HSS 103.065(1), (2) and (4)(a) and (c)(intro.) are amended to read:

HSS 103.065(1) APPLICABILITY. This section applies to all institutionalized applicants for and recipients of MA who dispose of resources at less than fair market value on or after August 9, 1989, except for inter-spousal transfers occurring before October 1, 1989, and to all institutionalized applicants for and recipients of MA whose spouse disposes of resources at less than fair market value on or after July 1, 1990. Section HSS 103.063 applies to all applicants and recipients who divested before August 9, 1989, and to inter-spousal transfers occurring before October 1, 1989.

(2) PURPOSE. This section implements s.49.45(17), Stats., which provides for a period of restricted MA coverage when an individual who is institutionalized or becomes institutionalized, or the individual's spouse disposes of a resource at less than fair market value.

(4) DIVESTMENT. (a) Divestment resulting in ineligibility. An institutionalized individual or someone acting on behalf on that individual who disposes of a resource at less than fair market value within 30 months immediately before or at any time after the individual becomes institutionalized if the individual is receiving MA on the date he or she becomes institutionalized or, if the individual is not a recipient on that date, within 30 months immediately before or at any time after the date the individual applies for MA while institutionalized, shall be determined to have divested. A divestment results in ineligibility for MA for the institutionalized individual unless made to an exempt party under par. (b) or (c) or when one of the circumstances in par. (d) exist. An institutionalized individual may also be determined ineligible for MA if his or her spouse disposes of a resource at less than fair market value on or after July 1, 1990. In this paragraph, "receiving" means entitled to

receive as well as actually receiving, in the same way that "recipient" as defined in s. HSS 101.03(150) means a person who is entitled to receive benefits under MA as defined under s. HSS 101.03(95).

Note: The department advises that when the transfer for less than fair market value has been made by the spouse of the institutionalized applicant or recipient, the determination of whether or not the transfer will be treated as a divestment will be made pursuant to both the divestment provisions under s.49.45(17), Stats., and the spousal impoverishment provisions under s.49.455(5)(d), Stats.

(c)(intro.) Permitted divestment on or after August 9, 1989, but before July 1, 1990, to an exempt party -- non-homestead property. For transfers that occurred on or after August 9, 1989, but before July 1, 1990, ~~Transfer~~ transfer of a non-homestead resource at less than fair market value is not divestment resulting in ineligibility under this section if the individual transferred the resource to one of the following individuals:

SECTION 2. HSS 103.065(4)(cm) is created to read:

HSS 103.065(4)(cm) Permitted divestment on or after July 1, 1990, to an exempt party -- non-homestead property. Transfer of a non-homestead resource at less than fair market value on or after July 1, 1990, is not divestment resulting in ineligibility under this section to the extent that the resource was transferred:

1. To or from the individual's spouse or to another individual for the sole benefit of the spouse; or

2. To a minor or adult child of the institutionalized individual who meets the SSI definition of total and permanent disability or blindness under 42 USC 1382c.

SECTION 3. HSS 103.065(5)(intro.) and (6)(b) are amended to read:

HSS 103.065(5) DETERMINING THE PERIOD OF INELIGIBILITY. An institutionalized individual who has made a prohibited divestment under this section or whose spouse has made a prohibited divestment on or after July 1, 1990, under this section, as determined by the agency, without a condition under sub. (4)(d) existing shall be ineligible for MA as defined in this section for, beginning with the month of divestment, the lesser of:

(6)(b) The agency shall monitor retention of assets by the non-institutionalized spouse for those transfers that occur on or after August 9, 1989, but before July 1, 1990, under sub. (4)(c)3 at each application or review of eligibility for the institutionalized spouse.

The rules contained in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register as provided in s.227.22(2), Stats.

Wisconsin Department of Health
and Social Services

Dated:

By: _____
Patricia A. Goodrich
Secretary

SEAL:

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Division of Economic Support
DES-513 (Rev.10/89)

STATE OF WISCONSIN

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Estate Liability

The Department of Health and Social Services proposes to establish an estate liability program to offset the cost of Medical Assistance (MA) services furnished to MA recipients age 65 and older and MA recipients who are or have been in a nursing home, regardless of age. The Department will file claims against the estate of the recipient or the estate of the recipient's spouse to recover up to the amount the Medical Assistance Program paid to health care providers for services provided to the recipient. The estate liability program will be modeled after a program administered by the State of Oregon which was also the focus of a 1989 study by the General Accounting Office (GAO). The GAO study concluded that estate liability programs provide an acceptable mechanism for the elderly to share in the costs of nursing home care. According to the study, 21 states currently administer estate liability programs. The Department estimates collections from the estate liability program will total $13,330,000 ($5,253,200 GPR) over the two years of the 1991-93 biennium. Once fully operational, the Department estimates collections will total $13.1 million annually.

14.1.0 **Introduction**

A person who disposes of a nonexempt asset for less than its fair market value and for the purpose of qualifying for MA may be found ineligible. If found ineligible, s/he cannot become eligible again until s/he has satisfied certain conditions imposed by federal and state law.

14.2.0 **Definitions**

14.2.1 Community Spouse

A community spouse is a person who is legally married to an institutionalized person and is not residing in an institution or participating in a community waivers program (If the community spouse is in an institution or in community waivers, but won't be there for more than 30 consecutive days, consider him-her as living in the community).

14.2.2 Divestment

Divestment is the disposal of any nonexempt asset for a value received which is less than the fair market value. Disposal is the act of changing legal title or other right of ownership to another person or other persons.

For purposes of determining MA eligibility, the only divestments that matter are those which occur within 24 or 30 months before and any time after the date of application or the date an MA recipient enters an institution. The specific time period is either 24 or 30 months. Ignore any divestment that occurred outside this period.

Example: In 1985 Lucy gave half her lottery winnings to a TV evangelist. In 1990, ill and penniless, she applies for MA. Ignore the 1985 divestment.

The date of application is the date the CAF is signed by the applicant or his-her representative (IM Manual-I-A-28.1.0). If s/he does not sign the CAF, the application has not been completed and no divestment penalty can be imposed.

Example: Sandy wants to get rid of his assets so that he can be eligible for MA and go into the nursing home. He gives away his house, his boat, an Arabian horse, and the VCR. The next day he applies for MA. He acknowleges to his Economic Support Specialist that he gave away a lot of stuff. A friend informs him that he could be ineligible for a long time if he continues with the application. So he withdraws his application

14.2.2 Divestment (cont.)

without having signed it. He cannot be penalized for this divestment at this time.

In general, disposing of an exempt asset is not divestment. However, if a non-institutionalized person divests a homestead, even though it was exempt at the time of the transfer, the divestment may become a bar to eligibility at the time the person is institutionalized.

Converting an asset from one form to another is not divestment.

14.2.3 Divested Amount

The divested amount equals the property's net market value (14.2.7) minus the value received (14.2.10) for the property.

To find the divested amount, first find the property's net market value. Secondly, subtract the value received for the property from the property's net market value. The result is the divested amount.

14.2.4 Fair Market Value

Fair market value is an estimate of the prevailing price an asset would have had if it had been sold on the open market at the time it was actually disposed of.

14.2.5 Institutionalized Person

An institutionalized person is an MA applicant or recipient who is:

1. A resident of an SNF or ICF, or
2. A resident of a medical institution and for whom payment is made based upon a level of care provided in an SNF or ICF, or
3. A community waivers participant (Appendix 25.1.0).

14.2.6 Multiple Divestments

Multiple divestments are 2 or more separate divestments which a person has made in different months within a 30 month period.

All divestments that occur within a 1 month period are added together and considered as 1 divestment.

14.2.6 Multiple Divestments (cont.)

When there are multiple divestments, don't combine the periods of ineligibility; allow them to run concurrently.

EXAMPLE: A person divests $20,000 in September. $20,000 divided by $2,043 is 9.7 months. Rounded down, the number of months of ineligibility is 9. The person could be eligible again on June 1 of the following year.

In November, s/he divests $1,900. $1,900 divided by $2,043 is .9 months. Rounded down, the number of months of ineligibility is 0.

In December, s/he divests another $20,000. This is another 9 months of ineligibility. But don't add it to the 6 months of ineligibility still left to run on the September divestment. Both periods run concurrently. Ineligibility for the September divestment will end May 31; ineligibility for the December divestment will end August 31. So, if s/he makes no other divestments before September 1 of the next year, s/he could be eligible again on September 1.

14.2.7 Net Market Value

Net market value is the fair market value at the time of the transfer minus any outstanding loans, mortgages, or other encumbrances on the property.

14.2.8 Nonexempt Assets

Nonexempt assets are any goods or property which must be counted against the asset limit in the MA asset test. Disposal of nonexempt assets, whether available (11.1.0) or not available, may be divestment.

Nonexempt assets are those real and nonreal properties counted in the MA AFDC-related and SSI-related resource test sections in this handbook. Assets that aren't counted in the resource test sections of this handbook are called exempt assets.

14.2.9 Undue Hardship

Undue hardship is a serious impairment to the institutionalized person's immediate health status.

14.2.10 Value Received

Value received is the amount of money or value of any property or services received in return for the applicant/ recipient's property. The value received may be in any of the following forms:

1. Cash.

2. Other assets such as accounts receivable and promissory notes (both of which must be valid and collectible to be of value), stocks, bonds, and both land contracts and life estates which are evaluated over an extended time period.

3. Discharge of a debt.

14.2.10 Value Received (cont.)

4. Prepayment of a bona fide and irrevocable contract such as a mortgage, shelter lease, loan, or prepayment of taxes.

5. Services which shall be assigned a valuation equal to the cost of purchase on the open market. Assume that services and accommodations provided to each other by family members or other relatives were free of charge, unless there exists a written contract (made prior to the date of transfer) for payment.

14.3.0 **Instructions**

The divestment policy is complicated by the fact that it is applied differently depending upon the date the divestment occurred. To find which is the correct policy to apply to the case for which you are determining eligibility, begin with the date of the divestment:

1. **Before August 9, 1989**, apply the policies found in 14.4.0. These policies apply to all MA applicants/recipients.

2. **On or after August 9, 1989, through June 30, 1990**, apply the policies found in 14.5.0. These policies apply only to institutionalized MA applicants/recipients.

   If an institutionalized person transfers non-homestead property at less than fair market value to his-her spouse anytime from August 9, 1989, through September 30, 1989, apply the policies found in 14.4.0.

14.3.0 **Instructions** (cont.)

3. **On or after July 1, 1990**, apply the policies found in 14.6.0. These policies apply to institutionalized MA applicants/recipients and their community spouses (14.2.1).

14.4.0 **Divestments Occurring Before August 9, 1989**

The following divestment policies apply only to divestments made before August 9, 1989. (Disregard any divestments made on or after July 12, 1988, through September 22, 1988.)

14.4.1 General Policy: Non-institutionalized Persons

Homestead:

Divestment of homestead property is not a barrier to eligibility.

Non-Homestead:

Non-institutionalized applicants or recipients who divest non-homestead property within 2 years before or at any time after their most recent application for MA or any review of eligibility for MA are presumed to have divested for the purpose of receiving MA.

14.4.2 General Policy: Institutionalized Persons

Homestead:

A person who is a resident of an SNF, ICF or inpatient psychiatric facility who disposed of his-her homestead for less than fair market value on or after July 2, 1983, but within 2 years before or at any time after his-her most recent MA application or eligibility review is presumed to have divested in order to be eligible for MA.

Divestment of homestead property by an institutionalized person is not a bar to eligibility if:

1. The person who divested can reasonably be expected to be discharged and to return to that homestead; or

2. The title to the homestead was transferred to the person's spouse or child. The child must be either under age 21 or be blind or totally and permanently disabled as determined by the Disability Determination Bureau (DDB). Divestment does not occur, if the spouse or child to whom the homestead was transferred gives away, sells for less than market value, or bequeaths the homestead to somebody else.

14.4.2 General Policy: Institutionalized Persons (cont.)

3. The person can show that s/he intended to dispose of the homestead either at a fair market value or for other valuable considerations; or

4. The agency determines that denial of eligibility would work undue hardship on the person.

14.4.2 General Policy: Institutionalized Persons (cont.)

Non-Homestead:

Institutionalized applicants or recipients who divest non-homestead property within 2 years before or at any time after their most recent application for MA or any review of eligibility for MA are presumed to have divested for the purpose of receiving MA.

14.4.3 Exceptions to General Policy

Disregard the divestment in the following circumstances:

1. The total net market value of all the divested assets is equal to or less than the fiscal group's medically needy asset limit.

2. The person who divested furnished convincing evidence to show that the divestment wasn't made with the intent of receiving MA. For example, s/he may show that at the time of divesting s/he had already provided for future maintenance needs and medical care.

3. The ownership of the property is returned to the person in the fiscal group who originally disposed of it.

4. Division of property as part of a divorce or separation action, and loss of property due to foreclosure or repossession of property due to failure to meet payments aren't divestment.

5. The person intended to dispose of the asset either at fair market value or other valuable consideration.

   Example: Gary had a lucky 3-cent postage stamp that he carried in his wallet. A friend admired it, so Gary sold it to him for $0.03, unaware that it was worth more. The friend sold it to a stamp dealer for $7300. When Gary applies for MA, this divestment will be disregarded.

14.4.4 Amount to Be Satisfied

When a person has divested, and none of the exceptions listed above apply, it is necessary to find out how much the person will have to spend on his-her maintenance needs and medical care in order to remove the divestment. This is called the amount to be satisfied.

To find the amount to be satisfied, add the divested amount (14.2.3) to the person's other nonexempt assets. If the sum of these 2 amounts is greater than the fiscal group's medically needy asset limit, the amount over the limit is the amount to be satisfied and has to be removed before the person can become eligible.

14.4.5 Removal of Divestment: Non-institutionalized Persons

Homestead divestment: Disregard.

Non-homestead divestment of $12,000 or less: If the divested amount of non-homestead property is $12,000 or less, the person can satisfy it in 1 of the following ways:

1. When 2 years have elapsed since the date of divestment, the divestment is satisfied.

2. When the person spends the amount to be satisfied (14.4.4) on his-her maintenance needs and medical costs that occur after the date of divestment.

   To calculate how much the person has spent toward satisfying the divestment:

   a. Each month add the medically needy income limit for his-her group size to the amount the person has paid that month for medical care.

   b. When the monthly totals of all months taken together equal the amount to be satisfied (14.4.4) the person can become eligible for MA if s/he passes all other MA eligibility tests.

14.4.5 Removal of Divestment: Non-institutionalized Persons (cont.)

Example: Mary Anne has an amount of $2700 to satisfy. The medically needy income limit for her group size is $689.33. Her month 1 medical expenses are $540. $689.33 + $540 = $1229.33. In month 2 her medical expenses are $711. $689.33 + $711 = $1400.33. She has now satisfied $2629.66 of the amount to be satisfied. When, in month 3, her expenses reach $2700 she may be determined eligible.

Non-homestead Divestment of more than $12,000 : If the divested amount of non-homestead property is $12,000 or more, the person can satisfy it in only 1 way. She must spend the amount to be satisfied (14.4.4) on his-her maintenance needs and medical costs that occur after the date of divestment. The 2-year time period does not apply as it did in divestments of $12,000 or less.

To calculate how much the person has spent toward satisfying the divestment, use the same method of calculation as for non-homestead divestments of $12,000 or less (14.4.5, #2 a & b).

14.4.6 Removal of Divestment: Institutionalized Persons

Homestead divestment of less than $49,032:

If the divested amount of homestead property is less than $49,032, the person can satisfy it in 1 of the following ways:

1. When 2 years have elapsed since the date of divestment, the divestment is satisfied.

   Example: Dianne has a home that has a net market value of $27,000. She gives it away to a friend on May 1, 1990. She waits for 2 years. On May 2, 1992, she enters a nursing home and applies for MA. The $27,000 homestead divestment has been satisfied because it was prior to 2 years to the date of the application.

2. When the average monthly cost of care ($2043) X the number of months the person is institutionalized (after the date of the divestment) = amount to be satisfied (14.4.4) the divestment is satisfied.

14.4.6 Removal of Divestment: Institutionalized Persons (cont.)

Example: Manny divests a home that has a net market value of $43,000. He has other assets of $3500. The amount to be satisfied is $44,500 ($43,000 plus $3500 minus his asset limit of $2000). Shortly thereafter (before 2 years have elapsed) he takes up permanent residence in a nursing home and applies for MA. He must spend $44,500 on his institutional care before he can be eligible for MA. Calculate his expenditure at the rate of $2,043 a month. $44,500 divided by $2,043 is 21.78 months. After 21.78 months have elapsed, Manny can be eligible for MA.

Homestead divestment of $49,032 or more:

If the divested amount of homestead property is $49,032 or more, the person can satisfy it only in the following way:

When the average monthly cost of care ($2043) X the number of months the person is institutionalized (after the date of the divestment) = amount to be satisfied (14.4.4) the divestment is satisfied. The 2-year time period does not apply as it did in homestead divestment of less than $49,032.

Example: Patricia owns a home that has net market value of $73,000. She donates it to her nephew. Shortly thereafter (before 2 years have elapsed) she takes up permanent residence in a nursing home and applies for MA. The amount to be satisfied is $73,000 minus $2000 (medically needy asset limit) = $71,000. Patricia may be determined eligible in 34.75 months. Note that Patricia cannot satisfy her divestment at a rate greater than $2043 a month, even if her actual monthly rate at her nursing home is greater than $2043.

Non-homestead divestment of any amount:

Using the actual care rate (not $2043) keep a running total of how much the institutionalized person has paid for his-her institutional care. When the total equals the amount to be satisfied (14.4.4), the person can become eligible for MA if s/he passes all other MA eligibility tests.

14.4.6 Removal of Divestment: Institutionalized Persons (cont.)

Example: Jim has a sailboat with a net market value of $4200. He gives the boat away to a friend. He has divested $4200. Two months later he enters a nursing home. Since he has no other assets, his amount to be satisfied is $2200 ($4200 minus the medically needy asset limit of $2000). His 1st month in the nursing home costs him $1200. Now his amount to be satisfied is $1000 ($2200 minus $1200). His 2nd month in the nursing home costs him $1300. He has now spent $2500 on his institutional care. This is more than the amount to be satisfied, so he may now be eligible for MA.

14.5.0 **Divestments Occurring On or After August 9, 1989, through June 30, 1990**

The following divestment policies apply only to institutionalized persons.

Note: If an institutionalized person divests non-homestead property to his-her spouse anytime from August 9, 1989, through September 30, 1989, apply the policies found in 14.4.0.

14.5.1 General Policy

Institutionalized persons may be determined ineligible for a period of time for MA payment of nursing home/ community waiver services if:

1. They are MA applicants and have divested during the 30 months immediately before or any time after the date of application.

2. They are MA recipients on the date they are institutionalized and they divested during the 30 months immediately before or any time after the date they became institutionalized.

Institutionalized person means an MA applicant/recipient who is:

1. A resident of an SNF or ICF, or

2. A resident of a medical institution and for whom payment is made based upon a level of care provided in an SNF or ICF, or

3. A community waivers participant (Appendix 25.1.0).

14.5.2 Exceptions to General Policy

Disregard the divestment in the following circumstances:

1. The person who divested furnished convincing evidence to show that the divestment wasn't made with the intent of receiving MA. For example, s/he may show that at the time of divesting s/he had already provided for future maintenance needs and medical care.

2. The ownership of the property is returned to the person in the fiscal group who originally disposed of it.

3. Division of property as part of a divorce or separation action, and loss of property due to foreclosure or repossession of property due to failure to meet payments aren't divestment.

4. The person intended to dispose of the asset either at fair market value or other valuable consideration.

   Example: Gary had a lucky 3-cent postage stamp that he carried in his wallet. A friend admired it, so Gary sold it to him for $0.03, unaware that it was worth more. The friend sold it to a stamp dealer for $7300. When Gary applies for MA, this divestment will be disregarded.

5. The institutionalized person divests homestead property to his-her:

   a. Spouse.

   b. Child who meets at least 1 of the following conditions:

      1) under 21 years of age
      2) blind
      3) permanently & totally disabled

   c. Sibling who 1) was residing in the institutionalized person's home for at least 1 year immediately before the date the person became institutionalized and 2) has a verified equity interest in the home.

14.5.2 Exceptions to General Policy (cont.)

Equity interest means:

After 5/1/90, an ownership interest in a homestead by one or more persons who pay or have paid all or a portion of mortgage or land contract payments, expenses for upkeep and repair or payment of real estate taxes.

Before 5/1/90, an ownership interest in a homestead by one or more persons who pay or have paid all or a portion of mortgage or land contract payments for the homestead.

Ask to see a copy of the deed or the land contract or some other document that will verify the sibling's equity interest in the homestead.

Verify that the sibling was residing in the institutionalized person's home for at least 1 year immediately before the person became institutionalized. Don't require a specific type of verification. Some suggested sources are:

Written statement from a nonrelative
Social services records
Tax records
Utility bills with the address and the sibling's name on them
Dated check stubs with the address and the sibling's name printed on them

d. Child (other than the child described in item b above) who was residing in the person's home for at least 2 years immediately before the person became institutionalized and who provided care to him-her which permitted him-her to reside at home rather than in the institution.

Some suggested sources to verify the child's residence are:

Written statement from a nonrelative
Social services records
Tax records
Utility bills with the address and the child's name on them
Dated check stubs with the address and the child's name printed on them

14.5.2 Exceptions to General Policy (cont.)

Get a notarized statement that says the person was able to remain in his-her home because of the care provided by the child.

The statement must be from his-her physician or from someone else who has personal knowledge of his-her living circumstances. A notarized statement from the child doesn't satisfy these requirements.

6. The institutionalized person divests <u>non-homestead</u> property to:

   a. A child of any age of either spouse who is either blind or permanently and totally disabled or both.

   b. A spouse (if the divestment occurred prior to the institutionalized person entering the institution).

      If, <u>before entering the institution</u>, an institutionalized person has divested <u>non-home property</u> to his-her spouse or to another person for the sole benefit of the spouse, the spouse who receives the property is not allowed to divest it to anyone else except a child of any age of either spouse who is either blind or permanently and totally disabled or both.

      To ensure that the spouse who received the property understands that a divestment of this asset to someone other than a minor or adult blind or disabled son or daughter may impact on the eligibility of the institutionalized spouse, do the following:

      1) Notify the spouse that a divestment may affect the institutionalized spouse's MA eligibility.

      2) If s/he fails to report a divestment, refer him-her for fraud.

      3) If s/he divested, determine if the institutionalized spouse is ineligible for MA payment of nursing home or community waiver services because of the divestment.

14.5.2 Exceptions to General Policy (cont.)

4) At each eligibility review, determine if the spouse has retained the property. If s/he does not respond within 10 days to your question whether s/he still has the property, presume s/he divested it.

Make the institutionalized spouse ineligible for the reason that the community spouse is failing to cooperate.

The person to whom the property was transferred can be referred for fraud.

14.5.3 Divestment Consequences

If none of the above exceptions apply, the institutionalized person must be determined ineligible for MA payment of nursing home/community waiver services for a period of time. S/he may, however, still be eligible for MA card services. Apply the policies in 14.7.0 & 14.8.0.

14.6.0 **Divestments Occurring On or After July 1, 1990**

The following divestment policies apply only to institutionalized persons and their community spouses.

14.6.1 General Policy

Institutionalized persons may be determined ineligible for a period of time for MA payment of nursing home or community waiver services if:

1. They are MA applicants and they or their community spouse have divested during the 30 months immediately before or any time after the date of application.

2. They are MA recipients on the date they are institutionalized and they or their community spouse have divested during the 30 months immediately before or any time after the date they became institutionalized.

   A community spouse is a person who is legally married to an institutionalized person and is not residing in an institution or participating in a community waivers program.

14.6.2 Exceptions to General Policy

Disregard the divestment in the following circumstances:

1. The person who divested furnished convincing evidence to show that the divestment wasn't made with the intent of receiving MA. For example, s/he may show that at the time of divesting s/he had already provided for future maintenance needs and medical care.

2. The ownership of the property is returned to the person in the fiscal group who originally disposed of it.

3. Division of property as part of a divorce or separation action, and loss of property due to foreclosure or repossession of property due to failure to meet payments aren't divestment.

4. The person intended to dispose of the asset either at fair market value or other valuable consideration.

   Example: Gary had a lucky 3-cent postage stamp that he carried in his wallet. A friend admired it, so Gary sold it to him for $0.03, unaware that it was worth more. The friend sold it to a stamp dealer for $7300. When Gary applies for MA, this divestment will be disregarded.

5. The institutionalized person <u>or his-her community spouse</u> transfers <u>non-homestead</u> property to:

   a. Spouse.

   b. A child of any age of either spouse who is either blind or permanently and totally disabled or both.

   After the institutionalized person has become eligible, s/he does not lose eligibility if the community spouse divests any assets that belong to the community spouse, including the spousal share (23.3.1).

   But the institutionalized person may lose eligibility if the community spouse divests an asset that s/he received from the institutionalized person that was not part of the spousal share.

14.6.2 Exceptions to General Policy (cont.)

Example: Ralph is an institutionalized MA recipient. He recently inherited $25,000, and immediately transferred it to Edith, his community spouse. Edith would like to donate it to charity. But she keeps it because it is not part of the spousal share. She knows that if she transfers it to anyone besides their blind son, Abraham, Ralph's eligibility for institutional services would be affected.

14.6.3 Divestment Consequences

If none of the above exceptions apply, the institutionalized person must be determined ineligible for MA payment of nursing home/community waiver services for a period of time. S/he may, however, still be eligible for MA card services. Apply the policies in 14.7.0 & 14.8.0.

14.7.0 **Penalty Period**

When institutionalized persons are ineligible due to divestment, they are ineligible for MA payment of nursing home/community waiver services for a period of time.

The penalty period begins with the month of divestment and extends for the number of months equal to the lesser of:

1. 30 months, or

2. The number of months that result from dividing the divested amount (14.2.3) by the statewide average monthly cost to an SNF private pay patient ($2,043). Round all fractions downward. For example, 8.6 = 8 months, .7 = 0 months.

Example: Jeff transfers $65,376 in cash, stocks, and CDs to The Green Tree Brethren, Inc. $65,376 divided by $2043 is 32. Jeff will be ineligible for 30 months for MA payment of nursing home/community waiver services.

Example: Claire divests $9600. $9600 divided by $2043 is 4.69 months. She will be ineligible for 4 months for MA payment of institutional services.

14.8.0 **MA Card Services**

A person who, because of divestment, isn't eligible for services reimbursed within the daily institutional care rate, may still be eligible for MA card services.

14.8.0 **MA Card Services** (cont.)

MA card services are all the MA covered services except SNF/ICF payments and ancillary services (Wis. Ad. Code 107.09(2) and (4)(a). These excepted services consist of the routine, day-to-day health care services that are provided to MA recipients by a nursing home and that are reimbursed within the daily care rate.

14.8.1 Nursing Home Residents

After you have found that a person will receive limited MA coverage because of a divestment, do the following:

1. Process the case manually.

2. Send a notice to the Bureau of Quality Compliance (BQC) giving the person's name, date of birth, sex, SSN, and the name of the nursing home where s/he resides. Inform BQC that the person's MA eligibility is being reduced due to divestment. Address the notice to:

   Bureau of Quality Compliance
   Division of Health
   Department of Health & Social Services
   1 West Wilson Street
   P.O. Box 309
   Madison, WI 53701-0309

3. Test the person's eligibility for MA card services by applying the financial tests in the Institutions Unit of this handbook.

4. If the person is found eligible, certify him-her using 1 of the following medical status codes:

   04 - aged, categorically needy
   05 - aged, medically needy

   14 - blind, categorically needy
   15 - blind, medically needy

   22 - disabled, categorically needy
   23 - disabled, medically needy

   Send a Medical Assistance Certification Form (DCS-3070) to EDS. Write "divestment" in the area of the 3070 entitled Remarks.

   EDS will issue an MA card that the person can use for the allowed MA services.

23.1.0 Defined

This is a general overview of the spousal impoverishment provisions that are in the Medicare Catastrophic Coverage Act of 1988 (MCCA). After this general overview you will find a set of specific instructions for implementing the policy.

23.1.1 Spousal Impoverishment

Spousal impoverishment is the policy that directs how to determine MA eligibility for an individual who is institutionalized or who participates in a community waivers program and whose spouse continues to live in the community.

23.1.2 Institutionalized Person

These new procedures apply to any institutionalized person who:

1. Is married and

2. Has a spouse living in the community. (If the community spouse is in an institution or in community waivers, but won't be there for more than 30 consecutive days, consider him-her as living in the community.

An institutionalized person is any person who:

1. Has been participating in a community waivers program:

   a. For 30 days or more, or

   b. For less than 30 days but is expected to be a participant for at least 30 days.

2. Has been residing in an SNF, ICF, or medical institution:

   a. For 30 days or more, or

   b. For less than 30 days but is expected to be a resident for at least 30 days.

If a person hasn't been in an institution or waivers program for 30 consecutive days or more, she must obtain verification from a physician, medical institution or waivers staff, or caseworker, that s/he is likely to remain for 30 consecutive days or more.

EXAMPLE: Mrs. S is admitted to an SNF for recovery

23.1.2 Institutionalized Person (cont.)

from surgery. She has been a resident for only 1 week before she applies for MA. Her physician indicates she must be a resident for no less than 6 weeks. Because you have documentation that she will be there for at least 30 days, consider her an institutionalized person.

When a person residing in a medical institution or taking part in a community waivers program has a community spouse and applies for MA, both spouses must tell you how many assets and how much income they have, as well as the income of any other dependent family members who live with the community spouse.

23.2.0 Procedure

Apply the spousal impoverishment policy in the following sequence:

1. Assess the assets (23.3.0)

2. Determine financial eligibility (23.4.0)

3. Allocate the income (23.5.0)

23.3.0 Assessment of Assets

The assessment of assets is the procedure for finding the total amount of assets owned and available to the couple on the date one of them entered an institution for an extended period. An extended period means that the person has resided or is expected to reside in the institution for at least 30 consecutive days.

An institutionalized spouse and his-her community spouse can request an assessment of assets at any time, provided the period of institutionalization began on or after September 30, 1989, or a request was made for a community waiver eligibility determination on or after September 30, 1989.

To determine the availability of an asset, use the same guidelines you would use in a case that is not subject to spousal impoverishment policy. See 11.0.0.

The list of noncountable (exempt) assets (23.7.3) differs somewhat from that which is used for determining total assets of a person who isn't subject to the spousal impoverishment policy.

The total amount of assets the couple owned on the date the period of institutionalization began is the amount used to calculate the Community Spouse Asset Share.

23.3.1 Community Spouse Asset Share

The amount that the community spouse is allowed to keep is called the Community Spouse Asset Share. This amount is calculated as of the date the person becomes institutionalized or requests a community waiver eligibility determination; it does not change during the period of continuous institutionalization.

If the assets available to the community spouse are less than the Community Spouse Asset Share, the institutionalized spouse is allowed to transfer assets to the community spouse in an amount that brings the community spouse's total assets up to the amount of the Community Spouse Asset Share.

23.3.2 Protected Spousal Amount

The amount of assets that the institutionalized spouse is allowed to transfer to the community spouse is called the Protected Spousal Amount. The Protected Spousal Amount is determined at the time the institutionalized spouse applies for MA.

Notice that the Protected Spousal Amount is calculated at the time he/she applies for MA. Whereas the Community Spouse Asset Share is calculated as of the date the person enters the institution or requests a community waiver.

At the time of application the institutionalized spouse cannot transfer an amount higher than the Protected Spousal Amount unless the amount is increased by a fair hearing or a court order.

The institutionalized person isn't allowed to transfer assets for less than fair market value to anyone other than the community spouse. See 14.0.0.

23.3.3 Effective Date

The spousal impoverishment asset policy applies only to those persons who begin continuous periods of institutionalization on or after September 30, 1989, or who have requested eligibility determination for a community waiver on or after September 30, 1989.

23.4.0 Financial Tests

The financial eligibility of the institutionalized spouse is tested as follows:

1. The asset limit is: Community Spouse Asset Share + $2000.

23.4.0 Financial Tests (cont.)

2. The income limit is the same as for institutionalized persons who don't have a community spouse. Follow the procedures that are in the Institutions Unit.

When you're counting the income of the institutionalized spouse, use the following guidelines:

23.4.1 Non-Trust Income

Count non-trust income as belonging to the person who receives the payment.

If the payment is received in both spouses' names, count half for each.

If the payment doesn't specify the payee, count half for each spouse.

If the payment is shared with others, count amounts equal to each spouse's proportionate share.

Count as income to the institutionalized spouse any income that the community spouse actually makes available to him-her, whether voluntarily or under a court order.

23.4.2 Trust Income

Follow the specific terms of the trust as to which spouse is the payee and what percentage of the income belongs to him-her. If the percentage is unspecified, consider half the payment to belong to each spouse. If any trust income goes to dependent family members, attribute it to whom it is assigned; if it isn't assigned to a specific family member, divide it equally among those who receive it.

23.5.0 Allocation of Income

After the institutionalized spouse has been determined eligible for MA, s/he may allocate some of his-her income to the community spouse. The maximum allocation allowed is $1565, unless a fair hearing or a court order increases the amount.

If the community spouse's income is below $1565, the institutionalized spouse may allocate some of his-her income to bring the community spouse's income up to $1565 a month (or a larger amount if ordered by a fair hearing or court). The insti-

23.5.0 Allocation of Income (cont.)

tionalized spouse can also allocate additional amounts of his-her income to certain dependent family members living with the community spouse to bring each dependent family member's income up to $285.34 a month.

The institutionalized spouse is responsible for deciding how much of his-her income (up to the maximum allowed) to allocate to the community spouse. The amount s/he chooses may be less (but can't be more) than the allocation formula allows.

The institutionalized spouse should keep in mind that s/he may have some medical costs that aren't covered by MA and, because of these, s/he may wish to keep some of his-her income and not allocate it all to the community spouse. Another consideration is that the community spouse's financial eligibility for other programs may be affected by the income that is allocated to him-her.

23.5.1 Effective Date

The effective date of the **income allocation** policy is:

1. For persons residing in an institution or eligible for community waivers on or after September 30, 1989: October 1, 1989.

2. For persons entering a skilled nursing facility (SNF), intermediate care facility (ICF), or medical institution on or after September 30, 1989: The date they are determined eligible on or after entering the institution.

In some cases when you are backdating the income allocation policy to October 1, 1989, a refund to the applicant will be called for. See the following specific instructions for how to deal with a case that's entitled to a refund.

22.6.0 Signing the CAF

After you've obtained all the nonfinancial and financial information needed to file the MA application, ask both spouses (or their authorized representatives) to sign the combined application form (CAF). If the community spouse refuses to sign the CAF, determine eligibility for the institutionalized spouse as though s/he were unmarried.

22.6.0 Signing the CAF (cont.)

An administrative rule is being promulgated which will require as a condition of eligibility that both the community spouse and the institutionalized spouse sign the CAF. You will be advised when that rule is effective. Effective with the date of that rule, if the community spouse refuses to sign the CAF, the institutionalized spouse will not be eligible for MA.

If the community spouse is unable to get to the IM agency to sign the CAF, s/he can have his-her signature witnessed by a notary public.

If you cannot locate the community spouse, determine eligibility for the institutionalized spouse as if s/he were unmarried. Don't refer the community spouse to the district attorney for nonsupport.

23.7.0 Instructions

The pages that follow are specific instructions on how to 1) assess the assets, 2) determine financial eligibility, and 3) allocate the income.

An individual who is institutionalized, or his or her spouse, or a representative acting on behalf of either spouse may apply for MA for the institutionalized spouse. Both the institutionalized spouse and the community spouse must appear on the CAF (lines 1 and 2, respectively). Close the community spouse for AFDC, MA and Food Stamps with the reason 'REM'.

23.8.0 Assess the Assets

If an assessment was done previously, you can use the previous information and can request further documentation if necessary. Before using this previous information, find out if it was based upon assets owned at the beginning of the most recent continuous period of institutionalization.

23.8.1 Effective Date

Apply the asset policy only to those individuals who:

1. Begin a continuous period of institutionalization on or after September 30, 1989, or

2. Have requested a community waivers eligibility determination on September 30, 1989 or later.

23.8.1 Effective Date (cont.)

Don't apply this policy if an individual is in a continuous period of institutionalization or community waivers eligibility which began before September 30, 1989.

A continuous period of institutionalization means:

1. A stay which has already lasted 30 or more consecutive days, or

2. Evidence from the person's physician, medical institution/nursing facility or case worker that the person is likely to remain in the institution for 30 or more consecutive days.

If a person leaves the nursing home, or loses eligibility for a community waivers program, for at least 30 days, and later begins a continuous period of institutionalization on or after September 30, 1989, do an asset assessment.

23.8.2 Procedure

A couple doesn't have to file an MA application in order to get an assessment of countable assets. They may ask the IM agency to assess their countable assets at the time one of them has begun a continuous period of institutionalization or any time after.

The 30 day 'promptness' rule applies to asset assessments as well as applications (Income Maintenance Manual, Chapter I, Part A).

Using the Asset Assessment Worksheet, determine the value of the couple's total countable assets on the date that the institutionalized person began his-her most recent period of continuous institutionalization or the date community waivers eligibility determination was requested.

Tell the person for whom you're making the assessment what documentation is required. S/he must document his-her and the community spouse's ownership interest in and the value of any available assets they had at the beginning of the most recent period of continuous institutionalization. Use the same documentation and verification procedures as are used when an application is filed (Income Maintenance Manual, Chapter I, Part C).

23.8.2 Procedure (cont.)

Sometimes the beginning of the most recent period of institutionalization may have begun in the past, and the applicant may no longer have the necessary documentation. In this situation, ask for a notarized list of what undocumented assets were owned and what their values were at the beginning of the most recent period of continuous institutionalization.

23.8.3 Noncountable Assets

Don't count the following assets:

1. Homestead Property;
2. One Automobile (regardless of value or purpose);
3. Burial assets and funds set aside for burial. This includes all burial trusts, burial funds, burial plots, burial insurance, etc. Notice that this policy differs from SSI-related burial policies that apply to non-institutionalized persons and to institutionalized persons without a community spouse.
4. Household goods and personal items, regardless of their value.
5. Any other asset that is noncountable in determining SSI-related MA eligibility.

23.8.4 Community Spouse Asset Share

Use the following table to figure out the Community Spouse Asset Share:

COUNTABLE ASSETS	COMMUNITY SPOUSE ASSET SHARE
$ 0 - $62,580	Couple's total countable assets
Greater than $62,580	$62,580

The asset assessment is a 'snapshot' of the couple's assets at the beginning of the most recent period of institutionalization. Ownership and value of the couple's assets at the time of application do not affect the Community Spouse Asset Share.

23.8.4 Community Spouse Asset Share (cont.)

Send each member of the couple a copy of the Community Spouse Asset Share Notice (35.23.7.4). Attach a copy of the Asset Assessment Worksheet they completed. File a copy of each in the case record. When you do an assessment, you must create a case file even if no application for MA results immediately. But don't enter the case into CRN until there is an application.

23.8.5 Asset Test

Do the asset test as follows:

1. Compare the couple's combined available assets with:

   Community Spouse Asset Share + $2000

2. If the couple's combined available assets are equal to or less than this total, the institutionalized person is eligible for MA.

23.8.6 Undue Hardship

When ineligibility due to excess assets results, the institutionalized person will not be denied MA if the IM agency determines that the denial creates undue hardship for the institutionalized person.

Undue hardship means that an immediate life-threatening circumstance exists for the institutionalized person. This is a situation in which, because of denial or termination of MA eligibility and subsequent lack of access to needed medical care, a person is in an immediate life-threatening circumstance. This definition doesn't apply to a situation in which a person is asked to leave a nursing home because of inability to pay but no immediate life-threatening circumstance exists.

23.8.7 Transfer of Assets

If the institutionalized person passes the asset test, s/he must transfer to his-her community spouse all assets that exceed $2000. S/he must do this by the time of his-her next regularly scheduled review.

If s/he doesn't transfer the assets by the next regularly scheduled review, they will be counted in determining his-her continued MA eligibility at the time of review.

23.8.7 Transfer of Assets (cont.)

At the time of the next regularly scheduled review, if the institutionalized spouse is found ineligible because s/he didn't transfer the assets to his-her community spouse, there is no recovery of payment by MA for the MA services already provided to the institutionalized spouse.

23.8.8 Asset Examples

EXAMPLE:

Frank and Bertha have combined countable assets of $7000 at the beginning of Frank's most recent period of continuous institutionalization. All are in Frank's name. Since this is less than $62,580, the Community Spouse Asset Share is all the assets ($7,000).

A month after entering the nursing home, Frank applies for MA. By this time, his assets have dropped to $6,000. Frank passes the asset test because the couple's combined assets are less than $9000 [the Community Spouse Asset Share ($7,000) + $2,000].

To remain eligible for MA, Frank must transfer at least enough assets to get him down to $2000. So he must transfer at least $4,000 to Bertha.

EXAMPLE:

Bert and Eunice had combined total assets of $120,000 at the beginning of Bert's most recent period of continuous institutionalization. Since their total assets are greater than $62,580, the Community Spouse Asset Share is $62,580. If Bert eventually applies for MA, his asset test limit will be $62,580 + $2000.

By the time Bert gets around to applying for MA, the couple's combined asset total is $70,000. Since Bert's asset test limit is $64,580, he isn't eligible. He and Eunice must reduce their assets by another $5420 in order for Bert to become eligible. They should reapply at that time.

When he becomes eligible, Bert must transfer sufficient assets to Eunice so that he doesn't have more than $2,000 left in his name. At the time of transfer, Eunice can have no more than $62,580 worth of assets, including those that Bert transfers to her.

23.8.8 Asset Examples (cont.)

EXAMPLE:

Bud and Louise have come in for an assessment. Bud entered the nursing home this morning and Louise wants to know how many assets they can keep and still have Bud be eligible for MA. They own their home, which is worth $76,000. They also have two cars. One is worth $17,000 and the other is worth $5,500. They have CD's and bonds worth $75,000. Louise also has a savings account with $30,000 in it. Bud has an IRA account with $25,000 in it. Louise also has a diamond pendant worth $2,500.

The home ($76,000), one car ($17,000) and the diamond pendant ($2,500) aren't countable. Bud and Louise's total countable assets are:

$ 5,500 (second automobile)
+ $ 75,000 (CDs and bonds)
+ $ 30,000 (Louise's savings account)
+ $ 25,000 (Bud's IRA)
$135,500 (total countable assets)

Since their total countable assets are greater than $62,580, Louise's Community Spouse Asset Share is $62,580. The asset test limit is $64,580 ($62,580 + $2000).

If Bud chooses to apply for MA during this stay in the nursing home, he won't be eligible unless his and Louise's total assets are $64,580 or less.

23.9.0 Allocate the Income
23.9.1 Effective Date

This income allocation policy is effective:

1. October 1, 1989 for persons who are residing in an institution or are eligible for community waivers on or after September 30, 1989.

   Since it is necessary to know the income of the spouse and other family members before determining the spousal and family member income allocation amount, do a redetermination for all MA eligible institutionalized persons who have a community spouse.

   Until the redetermination is completed, apply the income and asset policies you would apply if this were not a spousal impoverishment case.

23.9.1 Effective Date (cont.)

When the redetermination is done, the nursing home liability/cost sharing amount may decrease retroactively to October 1, 1989.

2. On the date of admission for persons who enter a SNF, ICF, or medical institution:

   a. On or after September 30, 1989, and

   b. Are determined to have been MA eligible as of the date of admission.

   Backdating: When requested by the applicant, test for MA eligibility in the three months prior to the application month. Apply the MA policies in effect during the backdate period. Thus, for months prior to October, 1989, don't apply these spousal impoverishment policies.

   For backdate months including October, 1989, and following, don't deduct the spousal income allocation amount from the institutionalized person's income unless it was actually transferred to the community spouse in the backdate period.

   Calculate the income amount and the dependent family member income allocation in the same way as for current months.

3. On the date of being determined MA eligible for persons who:

   a. Are participating in community waivers, and

   b. Are determined MA eligible on or after September 30, 1989.

23.9.2 Procedure

After the institutionalized spouse is determined MA eligible, s/he must decide how much income to allocate to the community spouse and to other dependent family members who live with the community spouse. The institutionalized spouse may transfer an amount not to exceed the maximum allocation determined by the following procedures for determining income allocation.

23.9.2 Procedure (cont.)

"Other dependent family members" includes:

1. Any dependent minor children (natural, adopted, step), of either the institutionalized spouse or the community spouse, who are residing with the community spouse.

2. Any children (natural, adopted, step), 18 years of age or older, of either parent, who are claimed as dependents by either parent for tax purposes under the Internal Revenue Service Code (IRSC) and who reside with the community spouse.

3. Siblings of either member of the couple who are claimed as dependents by either member of the couple for tax purposes under IRSC and who reside with the community spouse.

4. Parents of either member of the couple who are claimed as dependents by either member of the couple for tax purposes under IRSC and who reside with the community spouse.

Use the Income Allocation Worksheet to determine how much of the institutionalized spouse's income:

1. May be allocated to his-her spouse (Section A).

2. Will be deducted, regardless of whether or not s/he actually allocated it to other dependent family members (Section B).

3. Will be paid toward his-her cost of care. (Section C).

On the Income Allocation Worksheet, do the following:

Section A -- Community Spouse Allocation

1. Enter on line 1 the Community Spouse Income Allocation ($1565; unless a larger amount is ordered by a fair hearing or court).

2. Enter on line 2 the community spouse's monthly gross income. Use the SSI-related income rules; but don't give earned income, unearned income, and work related deductions.

23.9.2 Procedure (cont.)

3. Do the math from line 1 through line 3. The result on line 3 is the maximum amount of income the institutionalized spouse may allocate to his-her community spouse.

   If the institutionalized spouse doesn't allocate the maximum amount, the amount s/he retains counts as income in determining the amount contributed to the cost of care.

   A hearing officer or a court can increase the community spouse income allocation if s/he determines that the spouse isn't able to provide for his-her necessary and basic maintenance needs with the amount allocated.

Section B -- Family Member Allocation

1. Enter $285.34 on line 1 under the name of each dependent family member who lives with the community spouse.

2. Enter the gross monthly income of each dependent family member under his-her name. Use the SSI-related income rules; but don't give earned income, unearned income, and work related deductions.

3. Do the math from line 1 through line 3.

4. Add the line 3 amounts together and enter the total on line 4. Deduct the amount on line 4 from the institutionalized spouse's income.

Section C -- Cost of Care

1. Enter the institutionalized person's gross monthly income on line 1. Use the SSI-related income rules; but don't give earned income, unearned income, and work related deductions.

2. Enter his-her personal allowance on line 2:

   $40 (for a person in an SNF, ICF, or medical institution), or

   $590 to $850 (for a person in community waivers).

23.9.2 Procedure (cont.)

3. Enter on line 4 the community spouse income allocation amount (Section A, line 3) actually allocated to the community spouse.

4. Enter on line 6 the dependent family member allocation from Section B, line 4.

5. (community waivers only) Enter on line 8 the institutionalized spouse's medical/remedial expenses.

   (nursing home cases: See Income Maintenance Manual, Chapter V, Part B, NONCOVERED SERVICES)

6. Do the math from line 1 through line 9. The result on line 9 is the amount the institutionalized spouse must pay toward cost of care.

EXAMPLE:

Harry resides in a nursing home. He has $2000 in unearned income per month. He is medically needy for MA. His wife, Edith, gets $200 per month from Social Security. Her sisters, Mabel and Maxine, who she claims as dependents on her IRS tax forms, live with Edith. Mabel has no income, but Maxine gets $20 a month from her son.

Community Spouse Income Allocation (Section A)

$1565 (maximum community spouse income allocation)
\- 200 (Edith's monthly income)
$1365 (spousal income allocation)

Family Member Income Allocation (Section B)

$285.34 (maximum family member income allocation)
\- 0.00 (Mabel's income)
$285.34 (Mabel's income allocation)

$285.34 (maximum family member income allocation)
\- 20.00 (Maxine's income)
$265.34 (Maxine's income allocation)

$285.34 (Mabel's income allocation)
\+ 265.34 (Maxine's income allocation)
$550.68 (total family member allocation)

23.9.2 Procedure (cont.)

Payment Toward Cost of Care (Section C)

$2000.00 (Harry's income)
- 40.00 (personal allowance)
- 1365.00 (spousal income allocation)
- 550.68 (family member income allocation)
$ 44.32 (nursing home liability amount)

23.9.3 Other Medical Expenses

In deciding how much income to allocate to his-her spouse, the institutionalized spouse should consider whether s/he has medical expenses that aren't covered by MA.

EXAMPLE:

S/he may have income of $400 a month. S/he is allowed to keep $40 a month as a personal allowance. If s/he decides to transfer $360 to the community spouse, s/he won't have any money other than the $40 personal allowance to pay for medical services not covered by MA. If s/he has $80 a month in medical expenses that aren't covered by MA, those expenses will first be charged to any amount of money that is assigned to the cost of care. If there isn't money available or if that amount is reduced to zero, then s/he will have to pay it out of his-her $40 personal allowance. If the expense is more than $40, the provider of service would try to obtain the balance of the payment from the community spouse.

23.10.0 CRN/IMP

When the Income Allocation Worksheet is completed and you've determined the total amount of income the institutionalized spouse is going to allocate, enter the total amount in the Actual Support field (Screen 14R, Item 10). For community waiver cases, don't enter an amount in 14R,10. Community waiver eligibility is manually determined.

23.11.0 Signing the CAF

Ask the institutionalized spouse and the community spouse (or someone acting on the behalf of either spouse) to sign the CAF. If the community spouse is unable to get to the IM agency, s/he can have his-her signature witnessed by a notary public.

The community spouse is obliged to report changes in his-her income and changes in family members incomes. The community spouse does this because the income is used in determining the Community Spouse Income Allocation and the Family Member Income Allocation.

23.12.0 Notice from IM Agency

After the institutionalized person has been determined MA eligible, send both spouses a Notice of Recipient Income and Asset Allocation (35.23.11.0). The notice will contain:

1. The amount of the Community Spouse Income Allocation and how it was calculated, and

2. The amount of the Dependent Family Member Income Allocation and how it was calculated, and

3. The amount of the Community Spouse Asset Share and how it was calculated, and

4. A statement that either spouse or both spouses are entitled to a fair hearing concerning:

   a. Ownership and availability of income or assets,

   b. The determination of the community spouse monthly income allocation and community spouse asset share.

5. A statement notifying both spouses that they may file for a fair hearing to raise the income of the community spouse up to $1565, or to raise the income standard ($1565) because of exceptional circumstances.

23.13.0 Community Spouse's MA Application

Community spouses who apply for MA must apply on a separate CAF from that of the institutionalized person. Count assets & income allocated and transferred to them by the institutionalized person when you are determining the community spouse's MA eligibility. Beyond these, count only the assets & income belonging to the community spouse.

14.8.2 Community Waivers

After you have found that a person will receive limited MA coverage because of a divestment, do the following:

1. Process the case manually.

2 Send a notice to the Bureau of Long Term Support (BLTS) giving the person's name, date of birth, sex, SSN, and waiver program. Inform BLTS that the person is ineligible for MA coverage of community waiver services due to divestment. Address the notice to:

   Bureau of Long Term Support
   Division of Community Services
   Department of Health & Social Services
   1 W. Wilson Street
   PO Box 7851
   Madison, WI 53707-7851

3. Test the person's eligibility for MA card services by applying the financial tests in Appendix 25.0.0 of this Handbook.

4. If the person is found eligible, certify him-her using 1 of the following medical status codes:

   04 - aged, categorically needy
   05 - aged, medically needy

   14 - blind, categorically needy
   15 - blind, medically needy

   22 - disabled, categorically needy
   23 - disabled, medically needy

   Send a Medical Assistance Certification Form (DCS-3070) to EDS. Write "divestment" in the area of the 3070 entitled Remarks.

   EDS will issue an MA card that the person can use for the allowed MA services.

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