August 2, 2012 Summary of Changes

Chapter	Passage	Summary
1640	**1640.0594** **1640.0609.03**	Updated passages to indicate the Agency for Health Care Administration's Third Party Liability vendor with reference to Form CF-ES 2356 (vendor's name and address).
1840	**1840.0110**	Updated passages to indicate the Agency for Health Care Administration's Third Party Liability vendor with reference to Form CF-ES 2356 (vendor's name and address).

1640.0594 Long-Term Care Insurance Partnership Payments (MSSI)

This policy applies to the Medicaid Institutional Care Program (ICP), Home and Community Based Services, Hospice, and Program for All-inclusive Care for the Elderly.

An individual who is a beneficiary of a qualified state Long-Term Care (LTC) Insurance Partnership Policy will have a portion of their total countable resources disregarded when evaluating their Medicaid eligibility for the programs listed above. The disregarded portion is equal to the actual amount of LTC insurance partnership benefits paid out to or on behalf of the individual by the company. The resource disregard will continue to apply for the duration of the individual's Medicaid coverage.

For example, an individual has countable resources of $61,000 and reports that his LTC Insurance Partnership Policy paid out $60,000 toward his nursing home bill. The individual's countable resources are reduced by $60,000 and the remaining $1,000 is considered countable in the eligibility determination.

The resource disregard is protected from estate recovery. Complete and send a Third Party Recovery Transmittal (CF-ES 2356) to notify the Agency for Health Care Administration's Third Party Liability vendor ~~ACS Recovery Services~~ of the amount to be disregarded for estate recovery purposes.

If the individual will continue to receive the LTC insurance benefits, determine if the payments will be considered income to the individual or a third party source. If the recipient directly receives the insurance payments, follow instructions in manual passage 1840.1007 to determine if the payments are considered income to the individual. If the insurance benefits are paid to the nursing home, exclude the payments under 1840.0118 as a third party source that the provider must bill prior to billing Medicaid.

Verification Requirements:

Not all long-term care insurance policies are a qualified LTC Insurance Partnership Policy. Eligibility staff must request documentation at the time of application to verify the:

1. policy is a qualified LTC Insurance Partnership Policy, and
2. total amount of long term care benefits paid out to or for the applicant.

The insurance company may use the approved Office of Insurance Regulation Form (OIR-B2-1781) or a similar form developed by the insurance company.

1640.0609.03 Transfers to Annuities on or After 11/1/07 (MSSI)

This policy applies to ICP, institutionalized MEDS-AD, institutionalized Hospice, HCBS Programs and PACE.

Applicant's or Recipient's Annuity

The purchase of an annuity on or after 11/01/2007, and within the look-back period, by an individual (or his representative) will be considered a transfer of assets for less than fair compensation unless the annuity meets all of the following requirements:

1. Names the state of Florida, Agency for Health Care Administration (AHCA), as the primary beneficiary, for the total amount of medical assistance paid on behalf of the individual, except for when the individual has a spouse or minor or disabled adult child.

In this case, the state shall be named as secondary beneficiary after the spouse and/or the minor or disabled child.

Note: If the spouse or minor/disabled child disposes of their primary remainder beneficiary interest for less than fair market value (for example, transferred their interest to someone who does not meet the criteria), AHCA must be named primary beneficiary or the individual will be subject to a transfer of asset penalty.

2. Is irrevocable and nonassignable.

3. Makes payments (that include both principal and interest) to the individual in equal amounts during the term of the annuity, with no balloon or deferred payments.

4. Is actuarially sound based on the actuarial tables used by the Social Security Administration, (refer to Appendix A-14).

If the annuity meets all of the above criteria, funds in the annuity are excluded as a resource and the periodic payments are counted as income in the eligibility determination and patient responsibility.

If all of the requirements above are not met, the total amount of funds transferred into the annuity is considered a transfer without fair compensation, except when the annuity is revocable or assignable. When the annuity is revocable, count as an asset the amount the purchaser would receive from the annuity issuer if the annuity is cancelled. When the annuity is assignable, count as an asset the amount the annuity can be sold for on the secondary market.

Certain transactions that occur on or after 11/01/2007 make an annuity (including an annuity purchased before 11/01/2007) subject to the transfer of assets provisions. The transactions include such actions as additions of principal to an existing annuity or electing to annuitize an existing annuity.

Exception: Certain Individual Retirement Accounts (IRAs) or annuities that were established by an employee or their employer are not considered under the transfer of assets provisions and do not have to meet the above criteria. These include such financial vehicles as an individual retirement annuity, a simplified employee pension or a Roth IRA.

Community Spouse's Annuity

The purchase of an annuity on or after 11/01/2007 (and within the look-back period) by the community spouse of an applicant of ICP, institutionalized MEDS-AD, institutionalized Hospice, HCBS Programs and PACE will be considered a transfer of assets for less than fair compensation unless the annuity meets the criteria below:

1. Names AHCA as the primary beneficiary for the total amount of medical assistance paid on behalf of the applicant/recipient spouse, except for when the spouse has a minor or disabled child. In this case, AHCA shall be name as secondary after the minor or disabled child.

2. Is actuarially sound based on the spouse's age on the actuarial table used by the Social Security Administration (Refer to Appendix A-14).

Community spouse annuities that are revocable or assignable shall count as an asset, in the same manner as an applicant's/recipient's annuity counts, as indicated above.

Annuities purchased by the community spouse after approval of long-term care Medicaid for the applicant spouse are not evaluated for transfer of assets provisions.

Evaluating Annuities

At application, when an individual indicates ownership interest in an annuity, request a copy of the annuity contract and evaluate the annuity using the Evaluating Annuities job aid (Appendix A-34) to determine if the annuity will be subject to transfer of asset provisions. For annuities that name AHCA as beneficiary, send a copy of CF-ES 2355, Letter to Annuity Issuers (along with a copy of the contract) to the annuity company. At each annual review, send form CF-ES 2355 to the annuity issuer to solicit information about any changes that might have occurred during the year. Any time an issuer reports a change to the individual's (or spouse's) annuity, evaluate the change to determine if it subjects the annuity to transfer of asset provisions.

AHCA Notification

The Agency for Health Care Administration must be notified of annuities that name the state as beneficiary. Using Form CF-ES 2356, eligibility staff must forward to the AHCA Third Party Liability (TPL) vendor a copy of each annuity that names the state as beneficiary. ~~to the following address:~~

~~ACS Recovery Services~~
~~Post Office Box 12188~~
~~Tallahassee, FL 32317-2188~~

When eligibility staff becomes aware of the death of an individual whose annuity was forwarded to the AHCA TPL vendor ~~ACS Recovery Services~~, eligibility staff must notify the TPL vendor ~~ACS the~~ of the individual's death to assist them in collecting beneficiary proceeds from the annuity.

1840.0110 Income Trusts (MSSI)

The following policy applies only to the Institutionalized Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice, Home and Community Based Services (HCBS) and PACE. It does not apply to Community Hospice.

To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate (refer to Appendix A-9 for the current income standard). If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they set up and fund a qualified income trust. A trust is considered a qualified income trust if:

1. it is established on or after 10/01/93 for the benefit of the individual;
2. it is irrevocable;
3. it is composed only of the individual's income (Social Security, pensions, or other income sources); and
4. the trust stipulates the state will receive the balance in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on their behalf.

The eligibility specialist must forward all income trusts to their Region or Circuit Program Office for review and submission to the Circuit Legal Counsel for a decision on whether the trust meets the criteria to be a qualified income trust. Refer to Appendix A-22.1, Guidance for Reviewing Income Trusts, for instructions on processing income trust cases.

The individual (or their legally authorized representative) must deposit sufficient income into the income trust account in the month in which the income is received to reduce their countable income (the income outside the trust) to within the program income standard. The individual must

make the deposit each month that eligibility is requested. This may require the individual to begin funding an executed income trust account prior to its official approval by the Circuit Legal Counsel.

Once the Circuit Legal Counsel returns the income trust transmittal through the Region or Circuit Program Office, the eligibility specialist must promptly process the Medicaid application, making sure proper notification of eligibility and patient responsibility is given.

If the Region or Circuit Program Office and the Circuit Legal Counsel determine the trust is a qualified income trust:

1. do not consider the corpus of the trust an asset to the individual for any month the qualified income trust exists and eligibility is requested;
2. do not apply penalties for transfers of income placed in a qualified income trust account provided the individual receives fair compensation;
3. do not count income deposited into the trust account as income when determining if the individual's income is less than the program income standard;
4. do not consider disbursements from the trust account to third parties as income to the individual;
5. do not count income generated by the trust account which remains in the trust as income to the individual;
6. count any payments made directly to the individual as their income; and
7. count all income going into the trust (plus any not going into the trust) in determining patient responsibility, unless protection of income for the month of admission or discharge policies apply (refer to Chapter 2600).

Note: The amount computed for patient responsibility exceeds the provider's Medicaid rate. The trustee of the qualified income trust must provide quarterly statements identifying the deposits made to the trust for each month.

Funds deposited into a qualified income trust are not subject to transfer penalties provided they are paid out of the trust for medical care for the individual. When such payments are made, the individual is considered to have received fair compensation for income placed in the trust account up to the amount paid for the medical care and to the extent medical care costs are at fair market value. If the individual's patient responsibility exceeds the Medicaid cost of care, the eligibility specialist must determine if fair compensation is received for income transferred into the income trust. If necessary, the eligibility specialist must refer the case to the Region or Circuit Program Office for review and clearance.

If the individual's patient responsibility is less than the Medicaid rate, the eligibility specialist does not need to look at the disbursements (unless funds are paid to the individual, in which case the funds must be counted as their income). All income must be verified at the source, including income placed into the trust.

Using Form CF-ES 2356, Third Party Recovery Transmittal, ~~F~~fax or send a copy of the approved qualified income trust to the AHCA Third Party Liability vendor.~~:~~

~~ACS Recovery Services~~
~~Post Office Box 12188~~
~~Tallahassee, Florida 32317-2188~~
~~Fax: (866) 443-5559~~

When inquiries are received regarding the settlement of remaining funds in the trust after the individual's death, staff can advise callers to make checks payable to Florida Medicaid and send

to the AHCA Third Party Liability vendor (refer to Form CF-ES 2536 for the mailing address) ~~above address~~. The correspondence must clearly identify the individual by including a note with the individual's full name and Social Security number or Medicaid number.

An individual may choose to revoke an income trust at the time of their discharge from a Medicaid facility if the trust document allows them to do so. If revoked, Florida Medicaid must receive reimbursement (following above instructions) prior to any other beneficiary.