3210 CITIZENSHIP AND ALIENAGE

3210.1 General Requirements.--The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) significantly changed Medicaid eligibility for individuals who are not citizens of the United States. Medicaid must be provided to eligible citizens or nationals of the United States. Individuals who meet the eligibility requirements of Medicaid but are not citizens or nationals of the United States are Medicaid eligible only as provided in §§3211.1 - 3211.10. Those noncitizens described in §§3211.6 - 3211.10 may be eligible to receive treatment for an emergency medical condition as defined in §3211.11 as permitted by the particular section. The documentation and verification requirements in §§3212ff. must also be met.

Submit an amendment to your approved State plan if you make any change in the eligibility of aliens whose coverage is optional, as described in §§3211.5 - 3211.7.

3210.2 United States Citizenship.--For purposes of qualifying as a United States citizen, the United States as defined in the Immigration and Nationality Act includes the 50 States, the District of Columbia, Puerto Rico, Guam, Virgin Islands, and the Northern Mariana Islands. Nationals from American Samoa or Swain's Island are also regarded as United States citizens for purposes of Medicaid.

3211. ALIENS

Medicaid eligibility for aliens is based on whether the alien is a qualified or non-qualified alien, regardless of whether the alien entered the United States before or on or after August 22, 1996 (the date of enactment of P.L. 104-193). The previous categories of lawful permanent residents and aliens permanently residing in the United States under color of law (PRUCOL) no longer apply.

For policies on eligibility for the optional program of presumptive eligibility for pregnant women, see §3570.

3211.1 Qualified Aliens.--A qualified alien is an alien who is:

- o A lawful permanent resident,
- o A refugee (§207 of INA),
- o An asylee (§208 of INA),
- o An alien who has had deportation withheld under §243(h) of the Immigration and Nationality Act (INA),
- o An alien granted parole for at least 1 year by the INS (§21(d)(5) of INA),
- o An alien granted conditional entry under §203(a)(7) of immigration law in effect before April 1, 1980, or
- o A battered immigrant, who meets certain requirements.

This definition eliminates most of the PRUCOL categories as well as PRUCOL as an eligibility classification.

3211.2 Mandatory Eligibility of Certain Qualified Aliens Living in the United States Before August 22, 1996.--Qualified aliens who were in the United States prior to August 22, 1996, who are members of the groups described below, and who otherwise meet Medicaid eligibility criteria, are eligible for Medicaid. The alien need not be receiving Medicaid on that date. These qualified alien groups are:

o Lawful permanent residents to whom 40 qualifying quarters of Social Security coverage can be credited (see §3212.7 for 40 quarters definition);

o Refugees until 5 years after the date of the alien's entry into the United States;

o Asylees until 5 years after the grant of asylum;

o Aliens who have had deportation withheld under §243(h) of the INA until 5 years after the grant of withholding; and

o Honorably discharged veterans and aliens on active duty in the United States armed forces and the spouse or unmarried dependent child(ren) of such individuals.

3211.3 Mandatory Coverage of Qualified Aliens Entering the United States On or After August 22, 1996.--Qualified aliens entering the United States on or after August 22, 1996 who are members of the groups described below and who otherwise meet Medicaid eligibility criteria are eligible for Medicaid:

o Refugees for 5 years from date of entry;

o Asylees for 5 years from date of entry;

o Aliens whose deportation has been withheld under §243(h) of the INA for 5 years from grant of withholding;

o Honorably discharged veterans and aliens on active duty in the United States' armed forces and the spouse or unmarried dependent child(ren) of such individuals; and

o After the 5 year ban (see §3211.6), aliens who are lawful permanent residents who can be credited with 40 qualifying quarters of Social Security coverage.

3211.4 American Indian Born in Canada.--An American Indian born in Canada may freely enter and reside in the United States and is considered to be lawfully admitted for permanent residence if he/she is of at least one-half American Indian blood. As such, he/she is a qualified alien. This does not include a spouse or child of such an Indian nor a noncitizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least 50 percent or more Indian blood. Such aliens are to be considered qualified aliens because they are considered lawful permanent residents.

3211.5 Transition for Aliens Receiving Medicaid Benefits On August 22, 1996 or Receiving SSI.--In general, two broad groups of aliens are affected by transition provisions in welfare reform (aliens receiving SSI on the date of enactment (August 22, 1996) and aliens receiving Medicaid on August 22, 1996 but not receiving SSI).

A. Aliens Receiving Medicaid on August 22, 1996.--Continue to provide Medicaid to any alien who was lawfully residing in a State, who continues to meet the State's Medicaid eligibility criteria, and who was receiving Medicaid on August 22, 1996 but is not receiving SSI, until January 1, 1997. An individual is considered to be receiving Medicaid" on August 22, 1996 if the individual had a valid Medicaid card or your records show Medicaid eligibility on that date. Aliens eligible on August 22, 1996 because of PRUCOL status will not continue to be eligible after January 1, 1997 unless the individual is a qualified alien as described in §3211.1.

o After January 1, 1997, continue to provide Medicaid to qualified aliens described in §3211.7 unless you elect otherwise.

o If you continue to cover qualified aliens who have not been receiving SSI, redetermine the Medicaid eligibility of such qualified aliens no later than the next regularly scheduled redetermination.

o If you do not elect to cover qualified aliens who have not been receiving SSI, redetermine the Medicaid eligibility of such qualified aliens as soon as possible after January 1, 1997.

- Qualified aliens who are included under §3211.2 are mandatorily eligible for Medicaid.

B. Aliens Receiving SSI.--States must continue to provide Medicaid to aliens receiving SSI (unless the State has elected the §209(b) option). In January and February 1997, informational notices will be sent to those SSI recipients who have questionable or unknown citizenship status. The notices have been tailored to the individual's situation, informing them of what they need to do to retain their SSI eligibility. If they can provide the necessary proofs, or if SSA can obtain the proof for them, their SSI payments will continue to be made. For those existing recipients who cannot establish eligibility under the new law, a suspension notice (a notice of planned action) will be released in the summer of 1997, informing them that their SSI payments will stop effective the month after the notice is received. The notice of planned action will generate an SDX record. Upon receipt of the SDX from SSA indicating that a Medicaid eligible SSI alien recipient's SSI benefits have stopped, redetermine the alien's Medicaid eligibility. FFP will be available in such cases within the context of 42 CFR 435.1003 for the period of time HCFA specifies. Complete the redetermination within this time period.

3211.6 5 Year Bar Qualified Aliens.--Qualified aliens entering the United States on or after August 22, 1996 who are not described in §3211.3 are not eligible for Medicaid for 5 years after entry into the United States. However, such qualified aliens who otherwise meet the Medicaid eligibility criteria will be eligible to receive emergency services. Once the 5-year period has expired, the aliens described in this section will be eligible for Medicaid in the same manner as qualified aliens are covered under your State plan who are not subject to the 5-year bar.

3211.7 Optional Eligibility of Qualified Aliens.--

A. Qualified aliens, described in 3211.1, living in the United States prior to August 22, 1996 who are not described in §3211.3 may be provided Medicaid at the option of the State if they otherwise meet Medicaid eligibility criteria. (See §3211.6 for special transition rules for aliens receiving Medicaid on August 22, 1996.) The following requirements and limitations apply to optional eligibility under this section:

o You may not choose to make eligible only those qualified aliens receiving benefits on August 22, 1996.

B. Qualified aliens arriving in the United States on or after August 22, 1996, who have lived in the United States for 5 years may be provided Medicaid at the option of the State to otherwise eligible individuals.

3211.8 Eligibility of Aliens Who Are QMBs.--The eligibility of a noncitizen who has Medicare coverage and meets the criteria to be a QMB is determined by whether the individual is a qualified alien in one of the groups covered by §§3211.2 - 3211.7.

3211.9 Eligibility of Non-Qualified Aliens.--These aliens do not meet the requirements of §3211.1. If otherwise Medicaid eligible, a non-qualified alien is eligible for Medicaid only for treatment of emergency medical conditions. Non-qualified aliens in this section do not include legal non-immigrants described in §3211.10. Treatment of an emergency medical condition is defined and explained in §3211.11. These aliens do not have to make a declaration of immigration status. Nor do you have to verify the immigration status of non-qualified aliens. However, such aliens do have to provide their SSN(s) if one is available, or apply for an SSN if the applicant does not have one, as provided in §1137(a) of the Act and 42 CFR 435.910.

The term "non-qualified alien" also includes illegal aliens. These aliens either were never legally admitted to the United States for any period of time or were admitted for a limited period of time and did not leave the United States when the period of time expired. These individuals, if they are otherwise eligible for Medicaid as provided by §1903(v) of the Act, may be eligible for Medicaid for treatment of an emergency medical condition. However, unlike other non-qualified aliens, they are not issued SSNs. Therefore, such aliens do not have to provide an SSN as permitted by §1137(f) of the Act.

3211.10 Ineligible Aliens.--Some aliens may be lawfully admitted to the United States but only for a temporary or specified period of time as legal non-immigrants. These aliens are never qualified aliens. However, in some cases an alien in a currently valid non-immigrant classification may meet the State residence rules. When this is the case, such an alien is eligible for Medicaid for the treatment of emergency medical conditions as defined in §3211.11 if the individual also meets the other eligibility criteria of the State's Medicaid plan. Such individuals may possess valid employment authorization documents (Form I-688B or Form I-766).

Among otherwise ineligible aliens are visitors, tourists, some workers, and diplomats who are currently lawfully admitted as legal non-immigrants. These aliens would have the following types of INS documentation: Form I-94, Arrival-Departure Record; Form I-185, Canadian Border Crossing Card; Form I-186, Mexican Border Crossing Card; Form SW-434, Mexican Border Visitor's Permit; or Form I-95A, Crewman's Landing Permit. These aliens are not eligible for Medicaid because of the temporary nature of their admission status. The following categories of individuals are ineligible aliens:

- o Foreign government representatives on official business and their families and servants,
- o Visitors for business or pleasure, including exchange visitors,
- o Aliens in travel status while traveling directly through the U.S.,
- o Crewmen on shore leave,
- o Treaty traders and investors and their families,
- o Foreign students,
- o International organization representation and personnel and their families and servants,
- o Temporary workers including agricultural contract workers, and
- o Members of foreign press, radio, film, or other information media and their families.

3211.11 Definition of Treatment of Emergency Medical Condition.--Aliens meeting the requirements of §3211.9, qualified aliens described in §3211.5 or §3211.6 whom the State has not elected to cover, and ineligible aliens described in §3211.10 who meet the residence and other Medicaid eligibility criteria will be eligible for Medicaid only for treatment of medical conditions meeting the following definition:

A. To be eligible for emergency services, an alien must meet all eligibility requirements for Medicaid as set forth in your approved State plan except the requirements in §1137(d) of the Act concerning the declaration of satisfactory immigration status and verification of that status;

B. Such care and services are necessary for the treatment of an emergency medical condition of the alien, as defined in subsection C, provided such care and services are not related to either an organ transplant procedure or routine prenatal or post-partum care; and

C. The alien has, after sudden onset, a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- o Placing the patient's health in serious jeopardy,
- o Serious impairment to bodily functions, or
- o Serious dysfunction of any bodily organ or part.

D. For purposes of this section, all labor and delivery is considered emergency labor and delivery.

3212 DOCUMENTATION AND VERIFICATION OF STATUS AS CITIZEN OR ALIEN

3212.1 Declaration of Satisfactory Immigration Status.--The State must require, as a condition of eligibility for Medicaid, a signed declaration under penalty of perjury that the individual is a citizen or national of the United States as defined in §3210.2, or a qualified alien as defined in §3211.1. In the case of a child or incompetent applicant, another individual on the applicant's behalf must complete the same written declaration under the same terms and penalties as previously mentioned. If the applicant is not a citizen or national of the United States, nor a qualified alien, the declaration of satisfactory immigration status and verification of such status is not required as provided by §1137(f) of the Act.

3212.2 Documentation and Verification of an Applicant's Citizenship or Alien Status.--Citizens, nationals, and qualified alien applicants for Medicaid must:

A. Provide the State with documentation of citizenship or alien status, and

B. Sign a declaration under penalty of perjury that the applicant is a citizen or national of the United States or an alien in a satisfactory immigration status (henceforth qualified alien) as provided in §3212.1.

All non-citizen applicants for Medicaid who declare they are qualified aliens, must provide Immigration and Naturalization Service (INS) documents to establish immigration status as described in §3212.4. Examples of acceptable documentation for U.S. citizens are given in §3212.3. You must give the alien a reasonable opportunity to provide the required documentation. If the alien does not provide the requested documentation within the State's reasonable opportunity time frame, you may deny eligibility. If the alien does provide the requested documentation within your reasonable opportunity time frame, verify the documentation with the INS using SAVE or your alternative approved system of verification as provided in §3212.9.

States are required to provide Medicaid eligibility pending verification of immigration status to an individual who meets all other non-immigration Medicaid eligibility requirements, as provided in §1137(d)(4) of the Social Security Act, and who has provided INS documents showing satisfactory immigration status or who has been given a reasonable opportunity to provide such documents to the State.

3212.3 Methods of Documenting United States Citizenship.--The following are examples of acceptable documentation of U.S. citizenship for all Medicaid applicants.

- o Birth certificate,
- Religious record of birth recorded in the United States or its territories within 3 months of birth, which indicates a U.S. place of birth. The document must show either the date of birth or individual's age at the time the record was made,
- o United States passport (not limited passports, which are issued for periods of less than 5 years),
- o Report of Birth Abroad of a Citizen of the U.S. (Form FS-240),
- o Certification of Birth (INS Form FS-545),
- o U.S. Citizen I.D. Card (INS Form I-197),
- o Naturalization Certificate (INS Forms N-550 or N-570),

o Certificate of Citizenship (INS Forms N-560 or N-561),

o Northern Mariana Identification Card (issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 3, 1986),

o American Indian Card with a classification code "KIC" and a statement on the back (issued by the INS to identify U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border), or

o Contemporaneous hospital record of birth in one of the 50 States, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam (on or after April 10, 1899), the U.S. Virgin Islands (on or after January 17, 1917), American Somoa, Swain's Island, or the Northern Mariana Islands (unless the person was born to foreign diplomats residing in such a jurisdiction).

3212.4 Documentation That Applicant Is a Qualified Alien.--The following instructions set forth the documents you may accept to determine qualified alien status, including whether the alien meets the 5 year limitations.

A. Acceptable documentation of qualified alien status consists of the following:

o Lawful Permanent Resident--INS Form I-551, or for recent arrivals, a temporary I-551 stamp in a foreign passport or on Form I-94.

NOTE: Expired or Absent Documentation: If an applicant presents an expired INS document or is unable to present any document demonstrating his or her immigration status, refer the person to the local INS district office to obtain evidence of status unless he or she can provide you with an alien registration number. If the applicant provides an alien registration number, file INS Form G-845 along with the alien registration number with the local INS district office to verify status.

o Refugees--INS Form I-94 annotated with stamp showing entry as refugee under §207 of the INA and date of entry to the United States; INS Forms I-688B annotated "274a.12(a)(3)," I-766 annotated "A3", or I-571. Refugees usually adjust to Lawful Permanent Resident status after 12 months in the U.S. But for purposes of establishing eligibility are still considered refugees. Therefore, check the coding on Form I-551 for codes RE-6, RE-7, RE-8, or RE-9.

o Asylees--INS Form I-94 annotated with stamp showing grant of asylum under §208 of the INA; a grant letter from the Asylum Office of the INS; Forms I-688B annotated "274a.12(a)(5)" or I-766 annotated "A5".

o An alien who has had deportation withheld under §243(h) of the INA--Order of an Immigration Judge showing deportation withheld under §243(h) of the INA and date of the grant; or INS Forms I-688B annotated "274a.12(a)(10)" or I-766 annotated "A10".

o An alien granted parole for at least 1 year by the INS--INS Form I-94 annotated with stamp showing grant of parole under §212(d)(5) of the INA and a date showing granting of parole for at least 1 year.

o An alien granted conditional entry under the immigration law in effect before April 1, 1980--INS Form I-94 with stamp showing admission under §203(a)(7) of the INA, refugee-conditional entry; or INS Forms I-688B annotated "274a.12(a)(3)" or I-766 annotated "A3".

B. Determine 5-year limitation as follows:

o Form I-94, the date of admission should be found on the refugee stamp. If missing, contact INS to verify the date of admission by filing Form G-845, attaching a copy of the document.

o If an alien presents INS Forms I-688B (Employment Authorization Document), I-766, or I-571 (refugee travel document), ask the alien to present Form I-94. If not available, contact INS by submitting Form G-845, attaching a copy of the document presented.

o If an alien presents a grant letter or court order, derive date status granted from the date of the letter or court order. If missing, contact INS to verify date of grant by filing a Form G-845, attaching a copy of the document.

C. In general, if an applicant/beneficiary presents a receipt indicating that he or she has applied to INS for a replacement document for one of the documents identified above, contact the INS to verify status by filing a Form G-845 with the local INS district office, attaching a copy of the receipt. Contact the INS at any time if there is any reason to question the authenticity of a document presented or the information on the document is insufficient to determine whether the alien status requirements are met.

3212.5 Evidence of Honorable Discharge or Active Duty Status.--Acceptable documentation (as determined by DOD and VA) of honorable discharge or active duty status include the following documents:

o For discharge status, an original, or notarized copy, of the veteran's discharge papers issued by the branch of service in which the applicant was a member;

o For active duty military status, an original, or notarized copy, of the applicant's current orders showing the individual is on full-time duty in the U.S. Army, Navy, Air Force, Marine Corps, or Coast Guard (full-time Natonal Guard duty is excluded), or a military identification card (DD Form 2 (active));

o Other documentation acceptable under DOD/VA guidelines; or

o A self declaration under penalty of perjury may be accepted pending receipt of acceptable documentation.

3212.6 American Indian Born in Canada - Types of Documentation.--Examples of acceptable types of documentation are:

o Birth or baptismal certificate issued on a reservation,

o Tribal records,

o Letter from the Canadian Department of Indian Affairs, or

o School records.

3212.7 Definition of 40 Qualifying Quarters.--A qualifying quarter means a quarter of coverage as defined under title II of the Social Security Act, which is worked by the alien, and/or

o All the qualifying quarters worked by the spouse of such alien during their marriage and the alien remains married to such spouse or such spouse is deceased, and

o All of the qualifying quarters worked by a parent of such alien while the alien was under age 18.

Any quarter of coverage, beginning after December 31, 1996, in which the alien or spouse or parent of the alien applicant received any Federal means tested public benefit cannot be credited to the alien for purposes of meeting the 40-quarter requirement for eligibility for Medicaid.

3212.8 Verification of Quarters of Coverage.--States will be able to verify most qualified aliens allegations of quarters of employment through the Social Security Administration's electronic query system known as the State Verification and Exchange System (SVES). This data may be available in the future on an overnight batch basis. To get that information, the State need only sign an addendum to its existing SDX/BENDEX agreement with SSA. Use the record layouts already provided to you by SSA. However, not all employment that would count toward a quarter of coverage will be verifyable through SVES.

Therefore, you should accept the alien's attestation in the limited situations (which must be later verified) in which the qualified alien appears, either alone or in combination with his/her parents and/or spouse, to have lived in the United States long enough to have acquired 40 quarters of coverage.

3212.9 Verification of Immigration Alien Status.--States must verify the immigration status of all alien applicants for Medicaid benefits, who have signed the declaration under §3212.1 and presented documentation of satisfactory immigration status. When verifying immigration status, use either:

o The Systematic Alien Verification for Entitlements (SAVE) Program administered by the Immigration and Naturalization Service (INS), or

o Your approved alternative system under a waiver granted by the Secretary of Health and Human Services.

If you use SAVE, this verification should be accomplished via the appropriate SAVE access methods specified in the individual Memorandum of Agreement (MOA) between the State and the INS. Care should also be exercised to assure that the data restrictions and safeguards and the applicant's rights as outlined in the MOA are strictly adhered to.

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3213 REDETERMINATIONS AND FFP AVAILABILITY

3213.1 Effect on Medicaid Eligibility When Alien Loses SSI Because of Alien Status.--A Medicaid-eligible alien who was receiving SSI on August 22, 1996 who loses SSI eligibility because of the provisions of welfare reform may still be eligible for Medicaid, for example, under an SSI related group covered by the State plan. The State must redetermine the individual's Medicaid eligibility when it receives information from SSA, the eligible individual, or someone acting responsibly on the eligible individual's behalf that the individual's SSI eligibility has been terminated. Follow the procedures in §§3211.5, 3211.6, or 3211.9 when an SSI alien recipient loses SSI eligibility to determine whether the alien is eligible for Medicaid

3213.2 FFP for Services Provided to Non-Citizens.--FFP is available for services provided to Medicaid eligible non citizens in the following situations.

A. Qualified Aliens Meeting the Criteria in §§3211.1 - 3211.8.--FFP is available for all Medicaid covered services provided to eligible individuals meeting the criteria. This includes emergency services (which are a subset of regular Medicaid covered services).

B. Eligible Non Qualified Aliens.--FFP is available for services needed to treat an emergency medical condition. Emergency medical condition is defined in §3211.11.

C. Redeterminations.--FFP is available for both administrative and service costs during the period of time specified by HCFA pursuant to 42 CFR 435.1003(c) to complete a redetermination and during any administrative appeal requested by the applicant/beneficiary.

3215. TREATMENT OF POTENTIAL PAYMENTS FROM MEDICAID QUALIFYING TRUST

As a condition of eligibility, count as available resources to the applicant or recipient the maximum amount of permissible payments from a Medicaid qualifying trust, as defined in §3215.3, established by the applicant or recipient or his or her spouse except as specified at §3215.5. Deem to be available to the applicant or recipient the maximum amount of payments for applicable budget periods that the trustee could disburse if he exercised his full discretion under the terms of the trust. The law provides that this amount will be counted as available resources for purposes of §1902(a)(17) of the Act.

Distributions are considered available to the individual establishing the trust whether or not the distributions are actually made or the trustee(s) exercise their authority under the trust. The amount deemed available to the beneficiary is the maximum undistributed amount of payments that may be permitted under the terms of the trust for the applicable budget period assuming the full exercise of discretion by the trustee or trustees. Amounts actually distributed under the terms of the trust are considered under the other applicable provisions of the most closely-related cash assistance program.

This provision on grantor trusts affects the medically needy, optional categorically needy groups and mandatory categorically needy groups.

3215.1 Definition of Medicaid Qualifying Trusts.--For purposes of §3215 a "Medicaid qualifying trust" is a trust or similar legal device established by an individual (or his or her spouse) under which (a) the individual is the beneficiary of all or part of the payments from the trust, and (b) the amount of such distribution is determined by one or more trustees who are permitted to exercise any discretion with respect to the amount to be distributed to the individual. The distributable amount from a Medicaid qualifying trust has no use limitation, and Medicaid qualifying trusts include trusts that are irrevocable or revocable or which are for purposes other than to enable the individuals to qualify for Medicaid. Because there are no "use" limits on the trust funds in a Medicaid qualifying trust, trusts such as irrevocable burial trusts, educational trusts, and medical trusts could be Medicaid qualifying trusts, provided they meet the criteria as specified in this instruction. For example, the terms of the trust may be written so that the trustee may make payments directly to the health care provider for medical services. Thus, although payments from the trust are not directly paid to the beneficiary, he is in fact receiving benefits from the payments.

An "individual" is the person who both establishes the trust (or whose spouse establishes the trust) and is beneficiary of the trust. A trust that is established by an individual's guardian or legal representative, acting on the individual's behalf, falls under the definition of a Medicaid qualifying trust. If an individual is not legally competent, for example, a trust established by his legal guardian (including a parent) using the individual's assets can be treated as having been established by the individual, since the individual could not establish the trust for himself.

In cases where the beneficiary of a trust is a mentally retarded individual, §9435(c) of OBRA of 1986 provides that if a beneficiary of a trust is a mentally retarded individual who resides in an intermediate care facility for the mentally retarded, that individual's trust is not considered a Medicaid qualifying trust provided the trust or initial trust decree was established prior to April 7, 1986 and is solely for the benefit of that mentally retarded individual.

When the use of an attorney is solicited to establish a trust, the beneficiary of that trust is not exempt from requirements of the Medicaid qualifying trust provision. Legal instruments such as trusts are almost always drafted by an attorney. It is the grantor (beneficiary) himself who actually establishes or creates the trust when he signs or executes it.

3215.2 Similar Legal Devices.--The term "similar legal devices" refers to any arrangements, instruments or devices which are established by applicants or recipients (or by their spouses), which are not called trusts or which do not qualify as trusts under State law, but which have all of the other characteristics described in the definition of a Medicaid qualifying trust at §3215.1.

When the language of the trust or "similar legal device" is unclear or nonspecific, confer with your legal counsel to get an interpretation of the trust agreement under applicable State law to determine whether the document is a Medicaid qualifying trust.

3215.3 Determination and Counting of Maximum Amount Deemed Available.--The amount from the trust that is deemed to be available to the beneficiary is the maximum amount that could have been distributed to the beneficiary under the terms of the trust in an applicable budget period, provided the trustee exercised his full discretion under the terms of the trust to distribute the maximum amount to the beneficiary.

The maximum distributable amount deemed available includes only amounts which can be but are not distributed from either the income (interest) or principal of the trust. Amounts which are actually distributed to the beneficiary for any purpose, including amounts to pay for the beneficiary's health, personal and other maintenance needs, are treated as income and/or resources under other applicable financial rules of the most closely-related cash assistance program.

The maximum distributable amount counts as resources. (Trust income, if it is not disbursed, will carry forward and be counted as resource under the applicable financial rules of the most closely-related cash assistance program.)

Since the terms of the trust dictate the amount that is deemed to be available, a copy of the trust document must be made available to the State along with information detailing any investments and distributions that have been made by the trustee.

If the trust is revoked, or if the full amount of the principal of the trust is actually distributed to the applicant or recipient, the requirements of this provision do not apply.

3215.4 Waiver.--Application of this provision may be waived in cases where undue hardship would occur. An example of undue hardship would be if an individual who may be forced to go without life-sustaining services because the trust funds could not be made available to pay for the services. It is left to the States' discretion as to how they define what constitutes undue hardship. The definition must be set forth in the State plan preprint and approved by HCFA.

3215.5 Relationship to Transfer of Assets.--Medicaid qualifying trusts may fall under transfer of assets rules. Under the transfer of assets rules an institutionalized individual who disposes of resources for less than fair market value may be denied nursing facility or similar services under Medicaid by reason of the disposal for less than fair market value, except in any instance where the State determines the denial of Medicaid would work an undue hardship. In determining what constitutes a transfer of resources, the States must adopt the policy set forth in §1917(c) of the Social Security Act (as amended by the Medicare Catastrophic Coverage Act of 1988.)

3230. STATE RESIDENCE

Provide Medicaid to eligible residents of the State, including residents who are absent from the State. The conditions under which payment for services is provided to out-of-State residents are set forth in 42 CFR 431.52, 435.403(a), and 436.403(a)).

A. Definitions. --For purposes of the rules governing the State residency requirements "institution" has the same meaning as institution and medical institution as defined in 42 CFR 435.1009. For purposes of State placement the term "institution" also includes "foster care homes" licensed as set forth in 45 CFR 1355.20 providing food, shelter and supportive services to one or more persons unrelated to the proprietor.

B. Criteria for Determining Incapability of Expressing Intent for State Residence. -For purposes of the rules governing the State residency requirements, an individual is incapable of expressing intent when the following situations exist:

- The individual has an I.Q. of 49 or less or has a mental age of 7 or less, based on tests acceptable to the mental retardation agency in the State;
- The individual is judged legally incompetent by a court of law; or
- Medical documentation obtained only from a physician, psychologist or other person licensed by the State in the field of mental retardation indicates that the individual is incapable of indicating intent.

C. Who is a State Resident.--A resident of a State is any individual who meets the conditions in subsection D, through §3230.2 and who meets the criteria as specified in an interstate agreement under §3230.4. If an exception exists as specified in §3230.3, then the exception supercedes the general residency rules as set forth in §§3230.1 through 3230.2.

D. Placement by States in an Out-of-State Institution. --When any agency of State A, including an entity recognized under State law as being under contract with State A, arranges for an individual to be placed in an institution located in State B, the agency is recognized as acting on behalf of State A in making a placement. The State or the agency making the placement on behalf of State A will retain responsibility for that individual for purposes of establishing residence under Medicaid, irrespective of the individual's intent or ability to indicate intent. State A also retains responsibility for an individual when placement is initiated by it because the State lacks a sufficient number of appropriate facilities to provide services to its residents. This placement supercedes the general residency rules. (See 3230.3B)

E. Actions Which Do Not Constitute State Placement. --The following actions do not constitute State placement :

1. Basic Information Provided by State.--Basic information is provided to individuals about another State's Medicaid program, and the availability of health care (services and facilities in another State.)

2. Assistance in Locating an Institution.--An individual is assisted in locating an institution in another State, provided the individual is capable of indicating intent and independently decides to move.

3. Departure From Facility By Competent Individual.--A competent individual leaves the facility in which he/she is placed by a State, the individual's State of residence for Medicaid purposes is the State where the individual is physically located.

F. Individuals Receiving a State Supplementary Payment (SSP).--An individual who is receiving an SSP (optional or mandatory) is considered a resident of the State making the payment.

G. Individuals Receiving Title IV-E Payments.--For individuals of any age who are receiving Federal payments for foster care under title IV-E of the Social Security Act, (the Act) and individuals with respect to whom there is an adoption assistance agreement in effect under title IV-E, the State of residence is the State where the individual is living.

3230.1 State Of Residence Criteria Specific To Individuals Under Age 21.--

A. Social Security Income (SSI) Related Individuals.--For an individual not residing in an institution, whose Medicaid eligibility is SSI related, and is based on blindness or disability, the State of residence is the State where the individual is living.

B. Aid to Families With Dependent Children (AFDC) Related Individuals.-- For individuals not residing in an institution who belong to an AFDC cash assistance group or an AFDC related Medicaid only assistance group, the title IV-A regulation at 45 CFR 233.40(a) is used for determining residence.

Residence is assigned in one of two ways:

- Where the individual is living other than on a temporary basis, or
- Where the caretaker is a resident.

C. Individuals Emancipated/Married.--For any individual who is emancipated from his/her parents or who is married and capable of indicating intent, the State of residence is where the individual is living with the intention to remain there permanently or for an indefinite period.

D. Determining State of Residence for an Institutionalized Individual.--To determine the State of residence for any institutionalized individual who is neither married nor emancipated, use one of the following. (If a legal guardian is appointed, and parental rights are terminated, the State of residence of the guardian is used instead of the parent(s').

1. The Parent(s) Or Legal Guardian's State of Residence At The Time of Placement.--In determining the parent(s') or guardian's State of residence, apply the same rules for determining residence for an applicant or recipient over 21 and noninstitutionalized (as specified in §3230.2A).

2. Current State of Residence of Parents' or Legal Guardian.--The parent(s) or legal guardian's current State of residence is used if the individual is institutionalized in that State.

3. Application Filed by a Parent.--When the parents State of residence is used and the parents live in different States, the State of residence of the parent filing the application for assistance is the individual's State of residence.

4. Application Filed by a Legal Guardian.--If a legal guardian is appointed, and parental rights have been terminated the State of residence of the guardian is used instead of the parent(s').

5. Financial Guardian and a Legal Guardian.--There may be instances when an individual has both a financial guardian and a legal guardian. The legal guardian is used in establishing residence. States may have laws delegating guardianship to a State official or agency for individuals who are admitted to State institutions. If this guardianship conveys to the State official or agency the responsibility for making decisions about the care and supervision of individuals, the State where the facility is located is the individual's State of residence, except where another State makes the placement. (See 3230, D concerning placement by States).

6. Application Filed by Someone Other Than Parent/Guardian When Individual Has Been Abandoned.--If the individual has been abandoned by his/her parents and he/she does not have a legal guardian, use the State of residence of the individual or party who files the application if the individual is institutionalized in that State.

NOTE: Abandonment also includes deceased parents, as well as those parents who desert their children.

3230.2 Residence Criteria Specific To Individuals Age 21 and Over.--

A. Determining State Residence for an Individual Not Residing in an Institution.--The State of residence is the State where the individual is living with the intention to remain there permanently or for an indefinite period, or where the individual is living and which he/she entered with a job committment, or seeking employment whether or not currently employed.

B. Institutionalized Individuals Who Became Incapable of Indicating Intent Before Age 21.--For an individual who became incapable of indicating intent before age 21, use one of the following to determine the State of residence except when a State places the individual in an institution. (See §§3230.C and 3230.3B.)

o If a legal guardian is appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent(s).

o The parents' or legal guardian's current State of residence at the time of placement. In determining the parent(s') or guardian's State of residence, apply the same rules for determining residence for an applicant or recipient over 21 and noninstitutionalized (See §3230(D)(1).

C. Determining State of Residence for an Institutionalized Individual Who Became Incapable of Indicating Intent at or after Age 21. --The State of residence is the State where the individual is physically present, except where another State makes a placement. (See §§3230.D and 3230.3B.)

D. Determining State of Residence for an Institutionalized Individual Capable of Indicating Intent.--The State of residence is the State where the individual is living with the intention to remain there permanently or for an indefinite period.

3230.3 Specific Prohibitions and Exceptions.--Factors which must be taken into account when determining State of residence are variables such as age, institutional status and ability to express intent. These factors were included in the State residence regulations to avoid problems such as State durational residence requirements by a State in the absence of a compelling governmental interest. (Shapiro v. Thompson, 394 U.S. 618 (1969)) When determining State of residence, the following prohibitions and exceptions must always be considered by the State in conjunction with the conditions in §3230, D through §3230.2 or who meets the criteria as specified in an interstate agreement under §3230.4.

A. Prohibitions.--You may not:

o Deny Medicaid eligibility to an otherwise qualified resident of the State because the individual's residence is not maintained permanently or at a fixed address;

o Deny Medicaid eligibility because of a durational residence requirement;

o Deny Medicaid to an institutionalized individual because the individual did not establish residence in the community prior to admission to an institution; or

o Deny or terminate a resident's Medicaid eligibility due to temporary absence from the State.

B. Exceptions.--When one of the following exists, it supercedes the general residency rules set forth in §§3230.1 - 3230.2. When more than one exception exists, you may decide which exception takes priority.

o An individual is receiving an SSP, the State of residence is the State paying the SSP;

o An individual of any age is receiving adoption assistance or foster care payments, the State of residence is where they reside even if it is not the State making the title IV-E payment or the State where the adoption assistance agreement was entered;

o An Interstate Agreement waives specific eligibility criteria; or

o A State or agency of the State, including an entity recognized under State law as being under contract with the State, arranges for an individual to be placed in an institution in another State, the State arranging that placement is the individual's State of residence.

An institutionalized individual, who is capable of expressing his/her intent may wish to change their residence and request assistance from the current State of residence to carry out this plan. This request may include locating an institutional placement in the new State of residence. The regulation at 42 CFR 435.403(e) or 436.403(e) is not intented to discourage or preclude a State or local agency from providing this type of assistance.

o An individual involved in work of a transient nature or who goes to another State seeking employment has two choices--the individual can establish residence in the State in which he/she is employed or seeking employment, or the individual may wish to claim one particular State as his/her domicile or State of residence, provided he/she satisfies the rules set forth in this section.

Example 1: A migrant worker who resides in State A enters the migrant stream in State A and returns to State A every year. He may choose to retain State A as his residence or may change his State of residence as he goes from State to State.

Example 2: An individual has a spouse in the service. They are residing in State B because of the spouse's work assignment. The couple maintains State A as the residence for payroll and tax purposes.

The individual may choose State B as his/her State of residence due to the spouse's job commitment or the individual may choose State A as the State of residence because he/she considers it their permanent residence.

3230.4 Interstate Agreements.--States and Territories are permitted to enter into a written agreement with another State to resolve cases of disputed residence. You may establish criteria other than the criteria set forth defining " who is a State resident" at 42 CFR 435.403(d), and 436.403(d). Do not include criteria that are prohibited, as specified in §3230.3, or that result in loss of residency in both States. The agreement must also contain a procedure for providing Medicaid to individuals pending resolution of the case.

The regulations established the provision for interstate agreements to deal with cases of disputed residence, and allows you to expand the use of such agreements for reasons other than cases specifically related to disputed residence.

You may use interstate agreements to facilitate the placement and adoption of title IV-E individuals when the child and his/her adoptive parent(s) move into another State. However, you may not use interstate agreements to override the provisions added to §1902(a) of the Act by §9529 of COBRA.

If you enter into interstate compacts as provided for under P.L. 96-272, you may establish reciprocal agreements for providing medical assistance for individuals receiving adoption assistance payments.

An agreement may be very limited or very broad at your option, e.g., an agreement can pertain to one individual, all institutionalized individuals, or all individuals.

3230.5 Open Agreement.--You may allow all individuals or certain individuals who are physically present in the State to be residents of the State although they may not meet the definition of being a resident of that State under 42 CFR 435.403 or 436.403. The individual resident State may not be interested in an "interstate agreement". At your option, you may have an "open agreement."

An "open agreement" does not have the same effect as an "interstate agreement" since it only waives residency criteria in one State. Therefore, an individual who is physically residing in a State with an "open agreement," but is a resident of another State in accordance with 42 CFR 435.403 may choose one of the two States as his/her State of residence for Medicaid purposes.

If you exercise your option for an "open agreement" you cannot deny Medicaid to an otherwise eligible resident of the State under 42 CFR 435.403 who is physically residing in another State.

3230.6 Cases of Disputed Residency.--When two or more States cannot resolve which State is the State of residence, the State where the individual is physically located is the State of residence for Medicaid purposes.

3230.7 Homeless Eligibility --Method for Issuance of Medicaid Eligibility Cards To Homeless Individuals.--A State plan must provide a method of making Medicaid eligibility cards available to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address.

In the interest of affording you flexibility in the administration of the Medicaid programs, we are not imposing a specific method or methods to be used for this purpose. We require that the method you decide on be reflected in the State plan. Any reasonable method you employ which achieves the objective of making eligibility cards available to these individuals will be approved, eg., you may issue Medicaid cards to eligible homeless individuals through specific shelters or similar facilities; you may designate specific District offices and indicate specific times when homeless individuals or their designees may pick-up-cards.

3240. MORE LIBERAL INCOME AND RESOURCE METHODS

Subject to Federal Financial Participation (FFP) limits described in this section, you may use income and resource eligibility methods which are more liberal, but no more restrictive, than those used under the most closely related cash assistance program (Aid to Families with Dependent Children (AFDC) or Supplementary Security Income (SSI)). Or, in the case of States electing to use, for the aged, blind or disabled, more restrictive eligibility requirements than those used under SSI, more liberal income and resource methods than permitted under §1902(f) may be used.

Guam, Puerto Rico and the Virgin Islands may use more liberal methods than those of their plan programs under titles I, X, XIV, and XVI, and (old) XVI of the Act.

3240.1 Groups for Which More Liberal Methods May be Applied.--You may use more liberal methods for all Medicaid only eligibility groups except for recipients of AFDC and SSI (in SSI States) and groups deemed to be, for purposes of the Medicaid program, recipients of AFDC or SSI.

If you have elected the more restrictive option under §1902(f), you may use more liberal methods for persons you are required to cover, at a minimum, under that election (i.e., recipients of SSI benefits and persons who, for purposes of the Medicaid program, are deemed to be SSI recipients). You may also use more liberal methods for optional §1902(f) groups included under your plan.

3240.2 Comparability Requirements.--More liberal methods elected under this option must be comparable for all persons within each category of assistance (aged, or blind or disabled or AFDC-related) within an eligibility group (e.g., the medically needy). Therefore, if you elect more liberal AFDC methods for one or more eligibility groups, use the same more liberal methods for all AFDC-related persons within the eligibility groups selected; and if you elect more liberal methods for one or more groups of aged, blind and disabled use the same more liberal methods for all aged, or all blind or all disabled within the selected groups.

Do not limit more liberal methods based on living arrangements (e.g., a more liberal method applied only to institutionalized persons). However, this occurs legitimately when a more liberal method is applied to an eligibility group which only includes institutionalized persons (e.g., institutionalized persons under a special income level).

Application of comparability rules under this section of law does not, however, prohibit you from exercising additional options to use more liberal methods for specific optional eligibility groups where the option specifically authorizes use of a different method. Such

options are offered under separate statutory authority. For example, there is separate authority to use more liberal income disregards than those of the SSI program for optional State supplement recipients, and separate authority to use more liberal methods for certain poverty level eligibility groups.

3240.3 Description of More Liberal Methods.--More liberal methods are limited to income and resource methods. They do not extend to standards. Continue to use, for categorically needy groups, the appropriate income or resource standards specified in the description of the group under §1902(a)(10), unless such standards violate FFP limits. For example, qualified children are described as children who meet the income and resource requirements of States' AFDC plans. Therefore, your AFDC standards are used to determine eligibility. In the case of medically needy, use your single medically needy income and resource standards. You could, however, use income and/or resource disregards that are more liberal than those used under your AFDC plan or under SSI.

Following are examples of policies for which you may choose more liberal methods, provided application of such policies does not result in individuals' or families' income exceeding appropriate FFP limits:

- o $6,000/6 percent rule for exempting income producing property (SSI);
- o limits on household goods and personal effects;
- o limits on burial funds (SSI);
- o limits on numbers and values of automobiles;
- o rules for valuing in-kind support and maintenance;
- o first day of the month resource rule;
- o income producing property exclusions;
- o equity in non-home property; and
- o income disregards (including types of disregards: e.g., projected medical expenses).

3240.4 More Restrictive Methods Prohibited Under This Option--Unless it is specifically authorized under the Medicaid statute (e.g., you have elected the option under §1902(f) of the Act to use more restrictive eligibility requirements), you may not use income or resource methods that are more restrictive than those used under the most closely related cash assistance program. A method is more restrictive if any individual who is otherwise eligible under the rules of the most closely related cash assistance program is ineligible under your alternative method. Therefore, do not employ a policy which, although it may result in a more liberal application of policy in some instances, results in denying Medicaid to persons who are eligible if the equivalent cash assistance rule is used to determine eligibility.

EXAMPLE: A policy defines a couple, for purposes of determining eligibility in SSI States, as persons who are legally married. This is a more limited definition than that used under the SSI program, which also includes, under the definition of couples, persons who are not legally married but hold themselves out to the community to be husband and wife.

Under the proposed alternative policy, couples who are not legally married, but hold themselves out to the community to be husband and wife, are considered as individuals for purposes of determining their Medicaid eligibility. Therefore, separate income and resource standards are used to determine eligibility rather than the standards for couples, which are lower than two times the individual standards.

Use of the higher separate standards is advantageous to some couples,e.g., in cases where one member of a couple has a higher income and the combined income of the couple exceeds the couple standard. Under the alternative policy, one member of the couple is eligible. However, in other cases, the couple may be ineligible when the alternative policy is applied, but eligible if the SSI policy were applied, e.g., in cases where the combined income and resources are below the couple standard.

3240.5 Federal Financial Participation Levels.--In order to receive FFP for services provided to recipients under your plan, place limits on the income of those individuals and families. There are two separate limits which apply to the eligibility groups for whom you may employ more liberal income methods. (There are no FFP limits on resources held by recipients.)

Adhere to the following descriptions of the maximum income limits in developing your eligibility plan policies.

A. The 133 and 1/3 Percent Limit.--This income limit applies to the medically needy and to most other Medicaid only eligibility groups (including AFDC-related categorically needy groups) except those subject to the 300 percent limit described below, and the groups described in §3240.6. The AFDC program has a separate income threshold test that is equal to 185% of the AFDC need standard. You are not required to use the 185% income test for AFDC-related categorically needy eligibility groups, but may apply it provided Medicaid FFP limits are not exceeded.

The 133 and 1/3% FFP limit with respect to any family is an amount (minus appropriate cash assistance deductions and incurred medical and remedial care expenses) which does not exceed a standard that is equal to 133 1/3 percent of the highest amount that ordinarily is paid to an AFDC family of the same size that has no countable income. Income deductions for purposes of defining countable income are limited to those of the cash assistance programs. More liberal deductions authorized under §1902(r)(2) of the Act are not deducted for this purpose.

Families for this purpose include all persons living in the home who are applying for Medicaid and who would be in the same family unit for purposes of determining AFDC eligibility whether or not the family is AFDC-related. Families always include financially responsible relatives living in the home, unless such relatives are receiving SSI benefits. This same family configuration applies to families including aged, blind and disabled, as well as AFDC-related families.

If your AFDC plan specifies a maximum family size beyond which there is no increase in benefits, determine income standards for families exceeding that maximum by adding an amount for each individual family member beyond the maximum. The amounts added must be reasonably related to amounts by which your AFDC plan increases benefits per additional family member up to the maximum size.

B. The 300 Percent Limit.--This income limit applies to persons receiving optional State supplements, those who are eligible for State supplements, those who would be eligible for State supplements if they were not in medical institutions, and institutionalized individuals who are eligible under State established special income levels. These groups are described in §§1902(a)(10)(A)(ii)(IV),(V) and (XI) of the Act. Although not specifically identified in the statute, the income limit also applies to groups in §§1902(a)(10)(A)(ii)(VI) and (VII). This is because members of these groups derive their eligibility by virtue of the eligibility rules of groups which are subject to the 300% limit. This includes individuals who are receiving home and community-based services under a waiver or hospice care who would be eligible if they were in a medical institution.

Under this provision, FFP is not available for services rendered to individuals whose income (without regard to the exclusions of income described in §1612(b) of the Act) exceeds 300% of the Federal Benefit Rate (FBR) for an individual under §1611(b)(1) of the Act.

3240.6 Exemptions from FFP Limits.--There are no limits on qualified pregnant women, qualified children, or the poverty level groups because they are not subject to the FFP limits of §1903(f) of the Act.

3240.7 Applying More Liberal Income Disregards Within FFP Limits.--For groups subject to §1903(f), more liberal income disregards cannot exceed the difference between your current eligibility income standards and the maximum standards used in establishing the FFP limit. If your income eligibility standard is at the maximum FFP standard, do not apply more liberal disregards for those eligibility groups subject to the FFP limit.

For example, if your medically needy income level (MNIL) is at the 133 1/3% maximum limit, you cannot use more liberal income disregards for the medically needy. If your MNIL is not at the maximum level, you may use disregards in the amount of the difference between your MNIL and the FFP limit. Even though you may not be able to use more liberal disregards for the medically needy, you can use more liberal disregards for AFDC-related categorically needy eligibility groups whose income eligibility payment standards are always below the FFP limit.

The maximum amount of the disregard for any family in all such categorically needy cases is the difference between the payment standard and 133 1/3% of that standard. For example, if the difference in your AFDC payment standard for an AFDC family of two is $98, you may allow up to $98 in additional disregards for families of two. For optional State supplement recipients and individuals under a special income level no additional disregards can be used if you are at the 300% FFP limit. If not, you may apply disregards in an amount not to exceed your lower income standard and the 300% maximum FFP limit.

If you implement more liberal disregards by type or source of income, establish a total maximum amount on such disregards to assure that they do not result in FFP limits being exceeded. Given the maximum dollar limits which must be imposed on income disregards, there will be instances when the total maximum limit will be exceeded when all availble disregards are applied. When this occurs, you may prioritize the order of the disregards, allow applicants and recipients to choose the disregards to be used in their eligibility determinations, or just impose the total maximum limit.

3250. TRANSFER OF RESOURCES

Under the transfer of resources provisions in §1917(c) of the Social Security Act (the Act), you must restrict Medicaid coverage to an otherwise eligible institutionalized individual if he/she or his/her spouse transfers resources for less than fair market value:

- if the transfer occurred during the prohibited period, and
- if the uncompensated value of the transferred resources exceeds the average monthly cost of nursing facility services in the State or community in which the individual is institutionalized.

The following definitions apply:

- Resources--For purposes of this section, resources mean cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his/her support and maintenance. Also, in this section, the term "resources", for purposes of exclusions from resources, has the meaning given such term in §1613 of the Act, except the home and the land that appertains thereto are not to be considered as exclusions from resources.

Under the SSI rules in §1613(a)(1), a home is excluded from the definition of "resources" for purposes of SSI and Medicaid eligibility. However, under the new §1917(c)(5), "resources" is defined as having the same meaning as in §1613 with one exception that a home and the land that appertains thereto is not excluded from resources. That is, there is no such concept of an "excluded homestead" under the new Medicaid transfer of resources provisions. However, the homestead would not count as a resource if the individual retained it, rather than transferred it.

- Fair market value--An estimate of the prevailing price of a resource if sold at the time it was actually transferred, based on criteria used in appraising the value of other resources for the purpose of determining Medicaid eligibility.
- Uncompensated value--The difference between the fair market value at the time of transfer (less any outstanding loans, mortgages or other encumbrances on the resource), and the amount received for the resources.
- Institutionalized Individual--An individual who is an inpatient in a nursing facility, or who is an inpatient in a medical institution and with respect to whom payment is made based upon a level of care provided in a nursing facility, or who is a home and community-based services recipient described in §1902(a)(10)(A)(ii)(VI).

o Prohibited Period--Anytime 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 that date) or, if the individual is not entitled on the date of institutionalization, the date the individual applies for assistance while an institutionalized individual.

o Nursing facility services - Skilled nursing facility (SNF) services as described in 42 CFR §440.40, and intermediate care facility (ICF) services as described in 42 CFR §440.150.

3250.1 Provisions Applicable to Transfer of Resources.--You must provide for a period of restricted coverage in the case of an institutionalized individual or his/her spouse who disposed of resources for less than fair market value, at anytime 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 that date) or, if the individual is not entitled on the date of institutionalization, the date the individual applies for assistance while an institutionalized individual.

The period of restricted coverage must begin with the month in which the resources were transferred. The number of months in the restricted coverage period is equal to 30 months or less if a lesser period of restricted coverage results when the total uncompensated value of the transferred resource is divided by the average cost, to a private patient at the time of application, of nursing facility services in the State or, at your option, in the community in which the individual is institutionalized. In figuring periods of ineligibility, count full months only, regardless of the date in a month a transfer actually occurs. A full month is counted at the beginning of a period of restricted coverage. That is, a period of restricted coverage begins with the first day of the month in which a transfer has occurred. (For example, if an individual has made a transfer on September 28, the period of restricted coverage begins on September 1.) If a calculation of the penalty period results in a partial month, round the days down to the end of the preceding month (for example, from a September 28 transfer, round down to make August the last month in the period). However, do not round a month up to the end of the month in which the transfer occurred (for example, to round September 28 up to include the whole month of September). During the period of restricted coverage, the individual is not eligible for nursing facility services, equivalent services in a medical institution, and home and community-based services, provided under the authority of §1915(c) of the Act.

EXAMPLE 1: Mr. Smith transferred his home for less than fair market value on July 15, 1988. He was institutionalized on November 1, 1988 and was not entitled to Medicaid at that time. On December 7, 1988, while institutionalized, he applied for Medicaid. No exceptions apply under which the State is required not to apply the transfer of resources

penalty. Since Mr. Smith is institutionalized and transferred resources for less than fair market value during the 30-month period prior to December 7, 1988, and no exceptions apply, he is subject to a period of restricted coverage. The uncompensated value of the home is $90,000 and the average monthly cost to a private patient at the time of application for nursing facility services (SNF and ICF) in the State is $1,500. The $90,000 uncompensated value divided by the average monthly nursing facility rate ($90,000/$1,500) equals 60, the number of months that the coverage restriction applies. However, §1917 of the Act limits this period of restricted coverage to not more than 30 months.

Mr. Smith remains ineligible for nursing facility services, equivalent services in a medical institution, and home and community-based services from July 1988 through December 1990 (30 months from the month of the transfer and 25 months from the month of application).

EXAMPLE 2: Mr. Smith transferred his home for less than fair market value on July 1, 1988. He was institutionalized on August 1, 1989 and was not entitled to Medicaid. While institutionalized, he applied for Medicaid on September 1, 1989, 14 months after the home was transferred. No exceptions apply under which the State is required to not apply the transfer of resources penalty. Since Mr. Smith is institutionalized and transferred resources for less than fair market value during the 30-month period prior to his application for Medicaid and no exceptions apply, he is subject to a period of restricted coverage. The uncompensated value of the home is $36,000 and the average monthly cost to a private patient at the time of application for nursing facility services (SNF and ICF) in the city is $1,800. The $36,000 uncompensated value divided by the average monthly nursing facility rate ($36,000/$1,800) equals 20, the number of months that the coverage restriction applies.

Mr. Smith remains ineligible for specified services from July 1988 through February 1990 (20 months from the date of transfer and 6 months from the month of his application).

EXAMPLE 3: Mr. Smith was institutionalized on August 15, 1989 and he is entitled to Medicaid. He transferred his home on October 25, 1989. No exceptions apply under which the State is required not to apply the transfer of resources penalty. Since Mr. Smith is institutionalized and transferred resources for less than fair market value after the 30-month period which occurred immediately before the date he became institutionalized, and no exceptions apply, he is subject to a period of restricted coverage. The uncompensated value of the home is $48,000 and the average monthly cost to a private patient at the time of application for nursing facility services (SNF and ICF) in the State is $2,572. The $48,000 uncompensated value divided by the average monthly nursing facility rate ($48,000/$2,572) results in 18 months and a partial month penalty period. Therefore, round the days down to the end of the preceding month (in this case, make March the last month in the period).

Mr. Smith remains ineligible for nursing facility services, equivalent services in a medical institution, and home and community-based services through March 1991 (18 months from the date of transfer).

NOTE: With respect to resources transferred for less than fair market value on or after July 1, 1988, the rules set forth in this section regarding computation of the period of ineligibility and exceptions to the transfer prohibition in §3250.2 apply in all States, including the "209(b)" States which have elected the option to use more restrictive eligibility standards with respect to their aged, blind, and disabled beneficiaries than those applied under SSI.

3250.2 Exceptions to Application of Transfer of Resources Provisions.--Do not restrict Medicaid coverage to institutionalized individuals under the provisions in §3208.1 if:

o The title to the home was transferred to the individual's spouse or child who is under age 21, or who is blind or permanently and totally disabled;

o The title to the home was transferred to the individual's sibling who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the date of the individual's admission to nursing facility, a medical institution where payment is made for the individual based upon a level of care provided in a nursing facility, or to a program of home and community-based services described in §1902(a)(10)(A)(ii)(VI).

o The title to the home was transferred to the individual's son or daughter (other than a child who is under age 21, or who is blind or permanently and totally disabled) who: (1) was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to a nursing facility, a medical institution where payment is made for the individual based upon a level of care provided in a nursing facility, or to a program of home and community-based services described in §1902(a)(10)(A)(ii)(VI); and (2) who, you have determined, provided care to the individual which permitted the individual to reside at home rather than in a medical institution or nursing facility.

o The resources were transferred to or from, i.e., between the spouses, (or to another for the sole benefit of) the individual's spouse or to the individual's child who is blind or permanently and totally disabled.

o The individual makes a satisfactory showing to you that he or she intended to dispose of the resources either at fair market value or for other valuable consideration; or the resources were transferred exclusively for a purpose other than to qualify for medical assistance; or

o You determine that, based on criteria specified in your approved State plan, denial of eligibility would result in undue hardship.

3250.3 Opportunity to Rebut State on Presumptive Transfer Finding.--You may presume when an institutionalized individual or his or her spouse has transferred resources for less than fair market value during the prohibited period that the penalties in §1917(c) apply to the institutionalized individual. However, the institutionalized individual must be given an opportunity to rebut that presumption by making a satisfactory showing that he or she:

- o intended to dispose of the resources at either fair market value or for other valuable consideration or;
- o transferred the resources exclusively for a purpose other than to qualify for Medicaid.

You may provide the opportunity for rebuttal as part of the application process, redetermination process or the State's fair hearing procedure. However, in any case in which an individual receives restricted coverage due to a transfer of resources, the individual must be provided with an opportunity for a fair hearing as specified in 42 CFR Part 431, Subpart E.

3250.4 Implementation of Provisions of § 303(b) of Medicare Catastrophic Coverage Act (MCCA) of 1988.--The transfer of resource provisions in §303(b) of the MCCA totally revised §1917(c) of the Social Security Act. Apply the new requirements in §1917(c) to all transfers of resources which take place on or after July 1, 1988 (excluding transfers between spouses, which are discussed below). The new rules do not apply to any transfers which occurred before July 1, 1988. As for these pre-July 1, 1988 transfers, you may continue to apply to them any transfer policies contained in your State plan as of June 30, 1988, or you can apply no transfer rules at all. If you had no transfer policy in your plan on June 30, 1988, then there are no transfer rules for you to apply to the pre-July 1 transfers.

Continue to apply the laws and policies you have established as of June 30, 1988, or that you have provided for before July 1, 1988, with respect to inter-spousal transfers which occur through September 30, 1989. Even after September 30, 1989, you may continue to apply your June 30, 1988 rules governing inter-spousal transfers which occurred prior to October 1, 1989.

Where the Secretary determines that State legislation is required (other than legislation to appropriate funds) for the State plan to be amended to include the requirements of the new §1917(c), then a State may delay the effective dates. The effective dates can be delayed until after the close of the first regular session of the State legislature beginning after July 1, 1988. The dates can be delayed up until the first day of the first calendar quarter that begins after the close of this session.

If you require legislation in order to amend your State plan request a delayed effective date through the regional office. Provide sufficient documentation, including an Attorney General's opinion, to demonstrate that State legislation is required.

If you have requested and received a delayed effective date for the new transfer of resources law, continue to apply any existing transfer rules in your State plan. Apply the existing rules to transfers which occur after July 1, 1988, up until the delayed effective date, even if the existing rules conflict with the new rules.

After the delayed effective date has passed, do no apply the new rules retroactively to the original effective date of the rules. However, beginning on the delayed effective date, apply the new rules to all transfers which occur on or after July 1, 1988.

3250.5 State Plan Requirements.--The State plan must specify the following:

o The procedure used to implement a denial due to transfer of resources. That procedure must provide an individual with an opportunity to present convincing evidence that the resource was transferred exclusively for some reason other than establishing eligibility for Medicaid or that the individual intended to dispose of the resources either at fair market value, or for other valuable consideration.

o The criteria you use for determining that an individual has made a satisfactory showing that he or she intended to dispose of the resources either at fair market value or for other valuable consideration; or that the resources were transferred exclusively for a purpose other than to qualify for medical assistance, and

o The definition of the following term:

- Undue hardship, resulting from a denial of eligibility.

3255 ELIMINATION OF SSI PROVISION ON RESOURCES TRANSFERRED FOR LESS THAN FAIR MARKET VALUE AND NOTIFICATION BY SSA

Effective for transfers of resources for less than fair market value occurring on or after July 1, 1988, the statutory requirement for the Supplemental Security Income (SSI) program to count any uncompensated value (UV) of a transferred resource has been eliminated. Therefore, under no circumstances is UV to be charged for transfers made on or after July 1, 1988. However, tranfers occurring before July 1, 1988 will be developed and UV charged under prior SSI policy, even if discovered after July 1, 1988.

In place of the SSI provision which was eliminated is a requirement for the Social Security Administration (SSA) to obtain transfer information for use in your Medicaid eligibility determinations. SSA will make this transfer information available to you upon request. In addition, SSA is required to inform an individual at the time the individual (and spouse, if any) applies for SSI or for a redetermination of SSI eligibility, that resources transferred for less than fair market value may have an effect on Medicaid eligibility when the individual (or spouse, if any) enters a nursing facility, medical institution, or home and community-based services program.

Inform SSA when the individual is no longer an institutionalized individual as defined in §3250 so that SSA can remove the $30 cap and pay him/her an amount based upon the Federal benefit rate.

3256. TRANSFER OF RESOURCES PROCEDURES

Section 303(c) of the Medicare Catastrophic Coverage Act (MCCA) of 1988 (P.L. 100-360) revises §1613(c) of the Act. This section provides that, when an individual applies for SSI benefits under title XVI of the Act or has eligibility for SSI redetermined, SSA informs the individual of the Medicaid policy regarding transfer of resources and asks the individual whether he or she has transferred any resources on or after July 1, 1988 and/or within the past 30 months.

SSA obtains allegations of the following information about transfers when an SSI applicant or recipient informs them that he or she has transferred resources:

- A description of the resource transferred (e.g., real estate, automobiles, stocks, cash);
- The name of the party to whom the resource was transferred;
- The amount of compensation received or expected;
- The approximate value of the transferred resource;
- The date the resource was transferred;
- Whether the applicant was the sole owner of the resource and, if not, the names of any co-owners; and
- The relationship to the individual to whom the resource was transferred.

SSA sends this information to you in hard copy on a flow basis. "Hard copy" includes photocopies of resource transfer questions from SSI applications. SSA has been collecting this information since August 1988 and will forward all accumulated information with the first transmittal. Backlogged listings of alleged transfers will contain some, but not all, of this information. Information gathered on an ongoing basis will contain all of the information listed above. In a 1634 State SSA will send the transfer of

resource information to the same address that SSA sends third party liability information. (SSA regional issuances list these addresses.) In a non-1634 State, SSA will send the information to the addresses provided by the Health Care Financing Administration. The RO can provide these addresses upon request.

SSA will provide all States with monthly listings of individuals who allege to have transferred resources. Once the transfer of resources information is on the State Data Exchange (SDX), the provisions for independent verification in the Computer Matching Act will be triggered. SSA will inform you when they include a transfer of resources indicator on the SDX.

Transfer of resources information is based on the client's declaration unless there is evidence to the contrary (i.e., conflicting client statement or conflicting information in SSA's file). When the file contains conflicting information SSA will ask the client for enough information to establish that an alleged transfer has occurred. You are accountable for errors made as a result of incorrect information provided by SSA concerning transfer of resources.

SSA notifies each SSI applicant and each recipient at the time of redetermination, that he or she may not be eligible for institutional services under Medicaid as a result of Medicaid's transfer of resources policy. (See Exhibit 1.)

Report Medicaid denials based on transfers and the Medicaid ineligibility expiration date to SSA. When an institutionalized individual ceases to be eligible for institutional services under Medicaid due to the transfer of resources provision, SSA is required to consider such an individual a Medicaid recipient for purposes of determining the amount of his or her SSI payment. Notify SSA whenever an institutionalized individual ceases to be eligible for institutional services solely because of a transfer. SSA uses this information to decide whether to apply the SSI payment limit ($30 per month) and avoid overpayment of SSI and federally administered State supplementary benefits.

Provide SSA with:

- o A name and social security number of the individual;
- o A statement or other indication by the Medicaid agency that the individual is ineligible for institutional services under Medicaid because of a transfer; and
- o The month and year the individual could again be eligible for institutional services, all other facts unchanged.

Report this information to SSA through local established procedures for reporting discrepancies between State data and SDX information to SSA.

Exhibit 1

THIS SPACE IS RESERVED FOR

SSA Transfer of Resource Notice