
SMD# 18-004

**RE: Penalty period start date for
certain HCBS waiver participants**

April 17, 2018

Dear State Medicaid Director:

The purpose of this letter is to provide guidance on the proper start date of an asset transfer penalty period under section 1917(c) of the Social Security Act (the Act) for certain Medicaid applicants who are seeking eligibility for Home and Community-Based Services (HCBS) delivered through waivers approved under section 1915(c) of the Act.

Background. Section 1917(c)(1)(A) of the Act requires that states apply a coverage penalty against certain individuals when such individuals have transferred assets for less than fair market value on or after the “look back date,” which is the date that precedes by 60 months the point at which an individual has both applied for Medicaid and is an “institutionalized individual.” The coverage penalty applies to nursing facility services, a level of care in an institution equivalent to that of nursing facility services, and HCBS provided under a section 1915(c) waiver (“waiver services”). The length of the penalty period is calculated by dividing the total amount transferred for less than fair market value by the average monthly cost of nursing facility services in the state (or locality in which the individual is located). The quotient is the number of months the individual will be denied institutional or waiver services.

For purposes of penalties, an “institutionalized individual” is defined in section 1917(h)(3) of the Act as an inpatient of a nursing facility or similar medical institution or individuals who are eligible for Medicaid under section 1902(a)(10)(A)(ii)(VI) of the Act, implemented at 42 CFR §435.217 (referred to as the “217” group). The 217 group provides Medicaid coverage to individuals who need HCBS to avert institutional placement, who would be eligible for Medicaid under another eligibility group if they were in an institution, and who receive waiver services.

The Deficit Reduction Act of 2005 (Pub. L. No. 109-171, “DRA”) amended section 1917(c)(1)(D) of the Act to make the asset transfer penalty start date (for post-DRA transfers) the later of (1) the month during or after which a transfer is made or (2) “the date on which the individual is eligible for medical assistance under the State plan and *would otherwise* be receiving institutional level [of] care services” but for the penalty. (Emphasis added.)

Prior Guidance. In an enclosure to the State Medicaid Director Letter (SMDL) published on July 27, 2006 (SMDL #06-018), we explained that the penalty start date for post-DRA transfers is the later of the month during or after which a transfer is made or “the date on which the

individual is eligible for Medicaid and *is receiving* institutional level of care services” but for the penalty.¹ (Emphasis added.)

The substitution of “is receiving institutional level care services” for “would otherwise be receiving institutional level [of] care services” has had unintended consequences for 217 group applicants. This is because, in contrast to nursing facility services and other institutional services, HCBS received by an individual only become “waiver services” once the individual is enrolled in the state’s 1915(c) waiver program and Medicaid is providing coverage.

For example, the personal care services an individual is receiving under the Medicaid state plan prior to placement in a 1915(c) waiver, and which become part of the individual’s service plan under the relevant 1915(c) waiver after placement in the waiver, only become *waiver* services after the individual’s waiver enrollment. Thus, for 217 group applicants who are subject to an asset transfer penalty period, the penalty period does not begin to run until the individual begins *receiving* HCBS waiver services, but the individual cannot begin to receive waiver services until the penalty period has run.

The result under the prior guidance is an infinite penalty period. Under the interpretation of the DRA’s changes expressed in our July 27, 2006, guidance, an individual would have to enter an institution to begin the penalty period. We do not believe that this result is supported by the language or intent of the DRA.

Revised Guidance. We are revising our earlier guidance to be consistent with the statute. Under the revised interpretation, the penalty period start date for a 217 applicant is no later than the point at which a 217 applicant *would otherwise* be receiving HCBS waiver coverage based on an approved application for such care but for a penalty. For a 217 group applicant, this would be at the point at which a state has: determined that the applicant meets the financial and nonfinancial requirements for Medicaid eligibility and the level-of-care criteria for the 1915(c) waiver; developed for the individual a person-centered service plan; and identified an available waiver slot for the individual’s placement. The penalty period for a 217 group applicant begins no later than the date on which a state has confirmed that all of these requirements are met. Transfers that would be subject to a penalty would be those that were made on or after the 60 months preceding this same date.²

¹ See State Medicaid Director Letter, #06-018 (July 27, 2006), Enclosure, “Sections 6011 and 6016 – New Medicaid Transfer of Asset Rules Under the Deficit Reduction Act of 2005.”

² Under section 1917(c)(1)(B) of the Act, the look-back period is “the first date as of which the individual is both an institutionalized individual and has applied for medical assistance. . . .” As indicated above, an “institutionalized individual” is one who is actually in an institution or who “is described in section 1902(a)(10)(A)(ii)(VI).” An individual is not described in section 1902(a)(10)(A)(ii)(VI) of the Act unless and until he or she is eligible to actually receive services under the 217 group. This means that, for individuals seeking coverage under the 217 group, the look-back period dates back from the point at which the state has confirmed all of the requirements for coverage under that group are met.

If you have any questions about this guidance, please contact Gene Coffey at 410-786-2234, or gene.coffey@cms.hhs.gov, or contact your SOTA team lead.

Sincerely,

/s/

Timothy B. Hill
Acting Director, CMCS