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Medicaid Financial Eligibility for Long-Term Services and Supports

Updated March 7, 2017

Congressional Research Service
https://crsreports.congress.gov
R43506

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

Medicaid is a means-tested entitlement program that finances the delivery of health care and long-term services and supports (LTSS) to certain eligible low-income individuals. Established under Title XIX of the Social Security Act (SSA), the Medicaid program is state-operated within broad federal guidelines, and is jointly funded by the federal government and states. To qualify for Medicaid, individuals must meet certain *categorical* and *financial* requirements. To qualify for Medicaid LTSS, individuals must also meet state-based functional eligibility criteria that determine need for long-term care. The rules for determining financial eligibility for persons who need LTSS under the Medicaid program are complex. Generally, individuals must have assets that are equal to or below established thresholds to be considered eligible for Medicaid. While these financial eligibility rules also vary by state, states must set these limits in accordance with certain federal requirements.

Under federal Medicaid law, states are required to provide coverage to aged, blind, and disabled (ABD) persons receiving cash-assistance through the Supplemental Security Income (SSI) program, also referred to as mandatory eligibility groups. However, federal law gives states the option to use eligibility criteria that are more restrictive than SSI. States that use this alternative to SSI program rules are typically referred to as "209(b) states." Thus, in general the Medicaid program uses SSI program rules as the basis for determining financial eligibility. States may also extend Medicaid coverage to other population groups, referred to as optional eligibility groups. For elderly and disabled individuals potentially eligible for Medicaid LTSS coverage through these optional eligibility groups, states may use more liberal standards for determining financial eligibility than those specified under SSI program rules. Section 1902(r)(2) of the SSA gives states flexibility to modify SSI program rules with respect to counting assets (both income and resources) for the purposes of determining Medicaid eligibility. Most states use these Medicaid statutory provisions to ignore or disregard certain types of income and/or resources, thereby extending Medicaid coverage to ABD individuals with higher asset levels.

In addition, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) included the ACA Medicaid expansion, which allows states to expand Medicaid eligibility beyond the historical categorical eligibility groups to individuals under age 65 with income up to 133% of the federal poverty level (FPL) (effectively 138% FPL). In general, states are not required to offer LTSS under the ACA Medicaid expansion. However, the ACA Medicaid expansion affords states options to include LTSS or otherwise make available state plan Medicaid-covered LTSS to certain beneficiaries. As of January 1, 2014, most of Medicaid's non-elderly populations (i.e., parents, children, pregnant women) now use modified adjusted gross income (MAGI) financial eligibility rules to determine financial eligibility for Medicaid, including those individuals eligible under the ACA Medicaid expansion.

Congress has enacted several laws over the years aimed at limiting the ability of individuals to divest financial resources in order to become eligible for Medicaid LTSS. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA, P.L. 97-248) was the first such legislation enacted to limit the actions of individuals who divest resources for this purpose. The Omnibus Budget and Reconciliation Act of 1993 (OBRA 93, P.L. 103-66) included several provisions to restrict access to Medicaid LTSS to only those individuals who were low-income or to those who applied their assets toward the cost of their care. The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) was the most recent action taken by Congress to amend the SSA by further limiting the ability of individuals to divest their assets for the purpose of qualifying for Medicaid LTSS.

This report provides an overview of the financial requirements used for determining eligibility for Medicaid LTSS. It first provides background information on the Medicaid program, including

general eligibility requirements. Then it describes federal statute as well as selected regulations and guidance regarding these financial eligibility requirements, including rules related to spousal impoverishment, asset transfers, treatment of certain assets, post-eligibility treatment of income, and estate recovery.

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Introduction

Long-term services and supports (LTSS) refer to a broad range of health and health-related services and supports needed by individuals who lack the capacity for self-care due to a physical, cognitive, or mental disability or condition. Often the individual's disability or condition results in the need for hands-on assistance or supervision over an extended period of time. LTSS includes services provided in institutional settings such as nursing homes as well as services provided in home and community-based residential settings such as private homes and assisted living facilities.

The cost of obtaining paid LTSS may far exceed many individuals' financial resources. In 2016, the median annual cost of nursing home care was just over $82,000 for a semi-private room and more than $92,000 for a private room.[1] For those receiving paid LTSS at home, the cost for these services can vary depending on the amount and duration of care provided. Assuming full-time care in the home, the median annual cost of home health aide services would have been about $46,000 in 2016.[2] Large personal financial liabilities associated with paying for LTSS may leave some individuals and their families at financial risk. As a result, some individuals may turn to public programs for assistance with the high costs of needed LTSS.

Medicaid is a means-tested entitlement program that finances the delivery of health care and LTSS to certain eligible low-income individuals. Established under Title XIX of the Social Security Act (SSA), the Medicaid program is state-operated within broad federal guidelines, and is jointly funded by the federal government and states. Medicaid is the largest payer of LTSS in the United States. In 2015, Medicaid paid 42.5% of *total LTSS expenditures* at $149.4 billion, out of $351.8 billion in 2015.[3] Medicaid LTSS expenditures also represent a significant portion of federal and state Medicaid spending. In 2015, Medicaid LTSS comprised 30.7% of *total Medicaid expenditures* in 2015. However, Medicaid LTSS users represent a small share of all Medicaid enrollees. It is estimated that 4.1 million Medicaid enrollees (or 5.9%) of the 68.5 million *total enrolled Medicaid population* received LTSS in FY2013 (the most recent data available).[4] Some states are reexamining their Medicaid programs in an effort to control state LTSS spending.

Historically, Medicaid has covered LTSS for individuals who are unable to afford the cost of their care. Moreover, federal and state governments have a financial interest in ensuring that only eligible individuals receive Medicaid coverage for LTSS. In response, Congress has enacted several laws aimed at limiting the ability of individuals to divest financial resources in an effort to protect them (e.g., preserve them for a family member), thereby meeting financial requirements for Medicaid and any applicable LTSS. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA, P.L. 97-248) was the first such legislation enacted to limit the actions of individuals who divest resources for this purpose. The Omnibus Budget and Reconciliation Act of 1993 (OBRA 93, P.L. 103-66) included several provisions to restrict access to Medicaid LTSS to only those individuals who were low-income or to those who applied their financial resources toward the cost of their care. The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) was the most

[1] Genworth Financial, *Genworth 2016 Cost of Care Survey*, 2016, https://www.genworth.com/about-us/industry-expertise/cost-of-care.html.

[2] Ibid.; based on 44 hours of care per week multiplied by 52 weeks.

[3] CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December, 2016; see CRS In Focus IF10343, *Who Pays for Long-Term Services and Supports?*

[4] Medicaid and CHIP Payment and Access Commission (MACPAC), *MACStats: Medicaid and CHIP Data Book*, December, 2016, p. 53.

recent action taken by Congress to amend the SSA by further limiting the ability of individuals to divest their resources for the purpose of qualifying for Medicaid LTSS.

This report provides an overview of the financial requirements used for determining eligibility for Medicaid LTSS. It first provides background information on the Medicaid program, including general eligibility requirements. Next, it describes federal statute as well as selected regulations and guidance regarding these financial eligibility requirements, including rules related to spousal impoverishment, asset transfers, treatment of certain assets, post-eligibility treatment of income, and estate recovery.

Medicaid Financial Eligibility for Long-Term Services and Supports

Eligibility for Medicaid is determined by both federal and state law, whereby states set individual eligibility criteria within federal minimum standards. Individuals must meet *categorical* (e.g., individuals aged 65 and over, individuals with disabilities, children, pregnant women, parents, certain nonelderly childless adults) and *financial* (i.e., income and sometimes resource standards) criteria. The categorical groups most often associated with the need for Medicaid-covered LTSS are the aged and disabled. Individuals must also meet other non-financial eligibility criteria, including federal and state residency requirements, immigration status, and documentation of U.S. citizenship. In addition to categorical and financial eligibility criteria, individuals in need of Medicaid-covered LTSS must also meet state-based functional eligibility criteria.[5]

The rules for determining financial eligibility for individuals who need Medicaid-covered LTSS are complex. Federal Medicaid law requires states to cover certain population groups (mandatory eligibility groups) and gives states the flexibility to cover other population groups (optional eligibility groups).[6] Eligibility for the program's benefits has traditionally been linked to eligibility for cash assistance programs. For example, under federal Medicaid law, states are required to provide coverage to aged and disabled individuals receiving cash-assistance through the Supplemental Security Income (SSI) program. In doing so, Medicaid eligibility for aged and disabled individuals uses SSI program rules as the basis for determining financial eligibility. However, federal law also gives states the option to use financial eligibility criteria that are more restrictive than SSI (i.e., 209(b) states).[7] For 2017, the SSI rules specify that recipients must have monthly countable income at or below $735 for an individual (or $1,103 for a couple), about 74%

[5] To define level-of-care criteria, states may use "functional" criteria such as an individual's ability to perform certain Activities of Daily Living (ADLs, e.g., eating, bathing, dressing, and walking) or to perform certain Instrumental Activities of Daily Living (IADLs, e.g., shopping, housework, and meal preparation) that allow an individual to live independently in the community. Other states may use "clinical" level-of-care criteria that include diagnosis of an illness, injury, disability or other medical condition, treatment and medications, and cognitive status, among other information. Most states use a combination of functional and clinical criteria in defining the need for LTSS. For further information on state specific level-of-care criteria, see L. Hendrickson and G. Kyzr-Sheeley, "Determining Medicaid Nursing Home Eligibility: A Survey of State Level of Care Assessment," Rutgers Center for State Health Policy, March 2008.

[6] For more information, see CRS Report R43357, *Medicaid: An Overview*.

[7] States that use this alternative to SSI program rules are typically referred to as "209(b) states," which refers to the statutory authority in the Social Security Amendments of 1972 (SSA 72, P.L. 92-603) that allows states to use more restrictive eligibility criteria than the SSI program, but no more restrictive than those criteria in effect on January 1, 1972. In these states, SSI receipt does not guarantee Medicaid eligibility. There are nine 209(b) states: Connecticut, Hawaii, Illinois, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, and Virginia.

of the federal poverty level (FPL).[8] SSI rules also limit the countable resources individuals may have to $2,000 for an individual (or $3,000 for a couple).[9]

States may also extend Medicaid coverage to other aged and disabled individuals, referred to as optional eligibility groups. For aged and disabled individuals eligible for Medicaid through optional eligibility groups, states may use SSI program rules or they may use more liberal standards for determining financial eligibility than those specified under SSI.[10] Most states use these Medicaid statutory provisions to ignore or disregard certain types of income and/or resources, thereby extending Medicaid eligibility to aged and disabled individuals with higher asset levels. For example, states may extend Medicaid coverage to individuals who have income up to three times the basic SSI payment level (referred to as the 300% rule) and reside in a nursing facility or other institution. Medicaid also provides states the option of covering elderly and disabled persons who are not poor by SSI standards but who need assistance with medical expenses. Under the medically needy pathway, individuals can qualify for Medicaid if they have income and resources that exceed the standards established by the states for the medically needy programs, but only if they incur medical expenses that "spend-down" or deplete their income and resources to specified levels.

In contrast, the rules for determining financial eligibility for most of Medicaid's non-elderly populations (i.e., parents, children, pregnant women) use modified adjusted gross income (MAGI). These MAGI rules also apply to those individuals eligible under the ACA Medicaid expansion.[11] In this report, individuals who are determined eligible for Medicaid using MAGI rules are collectively referred to as "MAGI individuals." There are *no additional resource requirements* used to determine Medicaid financial eligibility for MAGI individuals (i.e., no resource standard). According to CMS, in ACA Medicaid expansion states individuals under age 65 with disabilities who have LTSS needs are likely to continue to qualify for Medicaid under optional eligibility groups related to disability.[12,13] These "non-MAGI individuals" are still subject to the financial eligibility rules associated with those eligibility groups (i.e., both income and resource standards). Nevertheless, some adults with disabilities who need LTSS may still qualify and receive Medicaid-covered LTSS under the ACA Medicaid expansion. These individuals would be subject to MAGI financial eligibility rules (i.e., income limit, but no resource limit). For example, individuals who meet the categorical requirements for disabled and have income under

[8] CMS, *2017 SSI and Spousal Impoverishment Standards*, https://www.medicaid.gov/medicaid/eligibility/downloads/spousal-impoverishment/2017-ssi-and-spousal-impoverishment-standards.pdf.

[9] The SSI resource limit is not subject to annual increases and has not changed since 1989.

[10] Section 1902(r)(2) of the SSA gives states flexibility to modify SSI program rules with respect to counting assets for the purposes of determining Medicaid eligibility.

[11] The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) included the ACA Medicaid expansion, which, at state option, extends Medicaid eligibility beyond the historical categorical eligibility groups to individuals under age 65 with income up to 133% of the federal poverty level (FPL), effectively 138% FPL (after adjusting for a 5% income disregard for individuals at the highest income limits for coverage). MAGI is defined as the Internal Revenue Code's adjusted gross income (AGI, which reflects a number of deductions, including trade and business deductions, losses from sale of property, and alimony payments) increased (if applicable) by tax-exempt interest and income earned by U.S. citizens or residents living abroad. For more information, CRS Report R43861, *The Use of Modified Adjusted Gross Income (MAGI) in Federal Health Programs*.

[12] State Medicaid Directors Letter SMDL#14-001, ACA #29, Centers for Medicare & Medicaid Services, Department of Health and Human Services, February 21, 2014, http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-001.pdf.

[13] In addition, CMS regulations enable individuals with disabilities who may need LTSS and are eligible under the ACA Medicaid expansion, as well as other optional eligibility pathways, to choose to enroll under an optional eligibility pathway which better meets their needs. Centers for Medicare & Medicaid Services, "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010," *77 Federal Register* 17194 and 17208, March 23, 2012.

138% FPL but resources above the level required to otherwise qualify through other optional groups may be eligible under the Medicaid ACA expansion.

In general, states are not required to offer LTSS for individuals in the ACA Medicaid expansion group. However, the ACA Medicaid expansion affords states options to include LTSS or otherwise make available state plan Medicaid-covered LTSS to certain newly eligible enrollees. States that chose to implement the ACA Medicaid expansion are required to provide coverage through Alternative Benefit Plans (ABPs), which must include the 10 essential health benefits (EHBs). However, specific groups are exempt from mandatory enrollment in ABPs (e.g., those with special health care needs such as disabling mental disorders or serious and complex medical conditions). These individuals must be offered the option of a benefit plan that includes Medicaid state plan services. For most adult beneficiaries receiving state plan services, they may be eligible for certain mandatory LTSS (e.g., nursing facility services, home health services) and optional state plan LTSS (e.g., personal care services). In addition, some states may choose to include LTSS in their ABPs.

Prior to the ACA Medicaid expansion, eligibility pathways available to adults with disabilities in need of LTSS required both income and resource standards. Under the ACA Medicaid expansion, adults with disabilities may be able to receive LTSS without specified resource standards. For these MAGI Individuals to potentially retain financial resources that could be applied toward the cost of their care raises beneficiary equity issues within the Medicaid program. CMS guidance to states explains how the LTSS-related resource rules apply to MAGI individuals.[14] This information is included in the report, where applicable.

General Asset Rules

Assessment of an applicant's assets for the purposes of determining Medicaid eligibility can be complicated, depending on how much and what type of assets an individual possesses. Under the Medicaid program, assets fall into one of two categories: (1) income or (2) resources. In general, income includes *earned* income such as wages, self-employment earnings, and royalties, as well as *unearned* income, which includes payments from annuities, pensions, and trusts. Resources are generally defined as cash and other liquid assets or personal property that an individual (or a spouse) owns and could convert to cash.[15] States have the flexibility to determine income and resource requirements for different Medicaid eligibility groups within broad federal guidelines. For the SSI-related mandatory eligibility groups, states rely on SSI program rules for determining financial eligibility, with options to use more restrictive requirements in 209(b) states. States have further flexibility to modify SSI program rules in determining income and resource requirements for other optional eligibility groups.

Under SSI program rules, resources may be (1) counted based on their entire value, (2) excluded for their entire value, or (3) excluded for part of their value.[16] Resources that are counted for their entire value generally include liquid assets that the applicant owns and could convert to cash (e.g., money in bank accounts, stocks and bonds, mutual fund investments, and certificates of deposit). Resources excluded for their entire value include a primary residence, personal and household items (e.g., furniture, appliances, personal computers, personal jewelry, personal care items, or

[14] Ibid.

[15] 20 C.F.R. 416.1201.

[16] Section 1613 of the SSA specifies items that are excluded from resource counting rules. Federal regulation 20 C.F.R. 416.1210 further clarifies under what conditions resources may be excluded.

items of cultural or religious significance), certain property essential to income-producing activity, and the value of a burial space. Further, one automobile, regardless of value, is excluded so long as it is used for transportation of the applicant or a member of the applicant's household. Resources that are excluded for part of their value include burial funds and the "face value" of certain life insurance policies (up to $1,500).[17]

Home Equity Limits

While a primary residence, regardless of value, is not a countable resource for the purposes of Medicaid eligibility under SSI program rules, the equity value of a home may affect whether or not an individual receives Medicaid covered LTSS. For beneficiaries applying for Medicaid coverage for nursing facility services or other LTSS, federal Medicaid law restricts eligibility if the applicant's equity interest in the home exceeds a statutorily determined amount ($560,000 in 2017).[18] At state option, this limit could be higher (up to $840,000 in 2017).[19] States choosing a home equity threshold above the minimum apply the limit statewide.[20] Such limits do not apply to individuals who have a spouse, child under the age of 21, or a child with a disability of any age residing in the home. Also, states can choose not to apply this rule if it is determined that doing so would cause an undue hardship in a given case. Similarly, MAGI individuals whose home equity exceeds the state limit are not eligible for LTSS coverage.[21]

For purposes of qualifying for Medicaid LTSS, individuals who have home equity above the state-specified limit could use a reverse mortgage or home equity loan to reduce their total equity interest in the home. In order for the proceeds of a reverse mortgage or home equity loan to be excluded from countable resources for the purposes of obtaining Medicaid coverage, federal guidance specifies that the Medicaid applicant must either spend the transaction amount or repay it to the lender in the month received.[22] Any amounts not spent or repaid in the following month

[17] Life insurance is counted as a resource to the extent of its cash surrender value. If the total face value of all life insurance policies does not exceed $1,500, no part of the cash surrender value is considered. In determining the face value of life insurance, term insurance and burial insurance are not considered (20 C.F.R. 416.1230).

[18] CMS, *2017 SSI and Spousal Impoverishment Standards*, https://www.medicaid.gov/medicaid/eligibility/downloads/spousal-impoverishment/2017-ssi-and-spousal-impoverishment-standards.pdf, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2016-ssi-and-spousal-impoverishment-standards.pdf. The equity interest in a home is the fair market value of the home (i.e., what an individual could sell the home for on the open market) minus the amount of any outstanding debts, such as a mortgage or home equity loan.

[19] Section 1917(f) of the SSA. Through 2010, federal law limited eligibility for Medicaid LTSS if an applicant's equity interest in the home was greater than $500,000. At state option, this threshold could be as high as $750,000. Starting in 2011, these thresholds increase each year based on the percentage increase in the consumer price index for all urban consumers (CPI-U), rounded to the nearest $1,000. For information on state home equity limits, see Appendix Table 7 in M. O'Malley Watts et al., "Medicaid Financial Eligibility for Seniors and People with Disabilities in 2015," Kaiser Family Foundation, March 1, 2016, http://kff.org/report-section/medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-in-2015-appendix/.

[20] In addition to the District of Columbia, the following 10 states choose a home equity limit that is above the minimum amount: California, Connecticut, Hawaii, Idaho, Maine, Massachusetts, New Jersey, New Mexico, New York, Wisconsin.

[21] State Medicaid Directors Letter SMDL#14-001, ACA #29, Centers for Medicare & Medicaid Services, Department of Health and Human Services, February 21, 2014, http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-001.pdf.

[22] In determining the value of home equity, states follow SSI program rules. With respect to guidance on SSI loan policy, see SSR 92-8p: *Policy Interpretation Ruling Title XVI: SSI Loan Policy, Including its Applicability to Advances of Food and/or Shelter*, http://www.socialsecurity.gov/OP_Home/rulings/ssi/03/SSR92-08-ssi-03.html.

are counted as resources against the state's limit; therefore, the amount would have to be depleted before qualifying for Medicaid LTSS.

Spousal Impoverishment Protections

Adding to the complexity of determining financial eligibility for Medicaid LTSS is the treatment of the assets of a couple, when one spouse needs institutional care or certain home and community-based services (the qualifying spouse) and the other is able to remain in the community (the community spouse). Medicaid specifies rules for equitably allocating how much income and resources, as well as which resources, are to be credited to each spouse for the purposes of determining Medicaid LTSS eligibility. Commonly referred to as *spousal impoverishment* rules, they are intended to prevent the impoverishment of the spouse remaining in the community.[23] In general, states must establish income and resource amounts that the community spouse may retain within federal limits. These amounts are not applied toward the qualifying spouse's Medicaid eligibility determination or LTSS costs.

Regarding income, federal Medicaid law exempts all of a community spouse's income in his or her name from being considered available to the other spouse. That is, for any month the qualifying spouse is residing in an institution or receiving certain home and community-based services, income solely attributable to the community spouse is not considered available to the institutionalized spouse.[24] For community spouses with limited income, federal law allows qualifying spouses to transfer income to the community spouse up to a state-determined minimum monthly income threshold, referred to as the minimum monthly maintenance needs allowance, which is set within federal limits. In 2017, the community spouse's minimum monthly maintenance needs allowance must be at least $2,002, but no more than $3,022, as determined by the state.[25] Following a hearing requested by either the qualifying or community spouse, states may raise the minimum amount on income that a community spouse may retain in cases of severe hardship. Finally, Medicaid provides for additional income allowances for excess housing costs and when dependents live with the community spouse.[26]

In terms of resources, federal Medicaid law allows states to select the amount of resources a community spouse may be allowed to retain within federal limits. The minimum allowed by federal law is the greater of $24,180 or one-half the couple's resources, up to $120,900. A state may set a minimum as high as $120,900.[27] For purposes of determining the amount of resources the community spouse can retain, all resources of the couple are combined, counted, and split in

[23] As per, Section 1924 of the SSA.

[24] In some cases, income that is jointly held may be attributable to the institutionalized spouse. For example, if a payment of non-trust income is made in the names of both the institutional spouse and the community spouse, half of the income is attributable to each spouse. If the income is paid from a trust, the income is considered available to each spouse depending on provisions of the trust. In the case where no provision is made on how trust income is divided and payment of income from the trust is made to each spouse, half of the income is deemed available to each spouse.

[25] CMS, *2017 SSI and Spousal Impoverishment Standards*, https://www.medicaid.gov/medicaid/eligibility/downloads/spousal-impoverishment/2017-ssi-and-spousal-impoverishment-standards.pdf.

[26] The minimum income threshold is increased to include an excess shelter allowance if the community spouse's cost of rent or mortgage payment, taxes, insurance, and utilities exceeds 30% of the amount of the minimum monthly maintenance needs allowance. A community spouse may retain additional income for every dependent family member who resides with the community spouse, so long as each family member's income is less than the minimum income threshold.

[27] These amounts are adjusted annually for increases in the CPI. CMS, *2017 SSI and Spousal Impoverishment Standards*, https://www.medicaid.gov/medicaid/eligibility/downloads/spousal-impoverishment/2017-ssi-and-spousal-impoverishment-standards.pdf.

half, regardless of which of the two spouses has ownership of the individual resources. If the community spouse's resources are less than the state threshold, then the Medicaid applicant must transfer his or her share of the resources to the community spouse until the community spouse's share reaches the threshold. All other non-exempt resources tied to the applicant must be depleted before the applicant can qualify for Medicaid. Similar to the treatment of income, no resources of the community spouse are considered available to the qualifying spouse once the institutionalized spouse is determined to be eligible for Medicaid.

How Are Spousal Protection Rules Applied?

The following three examples illustrate how resources are protected for a "community spouse" under Medicaid, when the other spouse is qualifying for Medicaid institutional care or certain home and community-based services, referred to as the "qualifying spouse."

Example 1: One couple, living in a state that protects $24,180 in resources for the community spouse, has a total of $40,000 in countable resources. One-half of the total resources are attributed to each spouse ($40,000 ÷ 2 = $20,000). This amount is less than the state's minimum resource standard of $24,180 and is also less than the maximum of $120,900. The qualifying spouse may transfer to the community spouse $4,180 to bring that spouse up to the state's standard of $24,180. The qualifying spouse may retain the state's resource standard for a single individual, generally $2,000, but must spend-down the remainder of the other half of the combined resources less the transferred amount ($20,000 - $4,180 - $2,000 = $13,820) before becoming eligible for Medicaid.

Example 2: One couple, living in a state that protects $40,000 in resources for the community spouse, has a total of $40,000 in countable resources. One-half of the total resources are attributed to each spouse ($40,000 ÷ 2 = $20,000). This amount is less than the state's minimum resource standard of $40,000 and is also less than the maximum of $120,900. The qualifying spouse may transfer all of their resources to the community spouse to bring them up to the state's standard of $40,000. The qualifying spouse can become resource eligible for Medicaid coverage with the transfer.

Example 3: One couple, living in a state that protects $120,900 in resources for the community spouse, has a total of $250,000 in countable resources. One-half of the total resources are attributed to each spouse ($250,000 ÷ 2 = $125,000). This amount is over the maximum protected under Medicaid law, $120,900. The community spouse must transfer $4,100 to the qualifying spouse ($125,000 - $120,900), to be applied to the cost of the qualifying spouse's care. The qualifying spouse can retain $2,000 in resources, but must spend-down the excess resources from the qualifying spouse and the remainder of the other half of the combined resources ($125,000 + $4,100 - $2,000 = $127,100) before becoming eligible for Medicaid.

Source: Congressional Research Service.

Prior to enactment of the ACA, spousal impoverishment rules applied only in situations where the Medicaid recipient was receiving LTSS in an institutional setting, such as a nursing facility. Section 2404 of the ACA requires states to extend spousal impoverishment rules to beneficiaries receiving certain home and community-based services (HCBS).[28] Beginning in 2014, the expansion of spousal impoverishment rules apply to individuals who (1) receive HCBS through SSA waiver authorities such as Section 1115 Research and Demonstration waivers, Section 1915(c) HCBS waivers, and the Section 1915(d) HCBS waivers for the elderly; (2) receive services through the Section 1915(i) state plan amendment option to provide HCBS; (3) are determined "medically needy";[29] or (4) receive personal attendant services under the Community

[28] For the purposes of spousal impoverishment rules, Section 2404 of ACA redefines an "institutionalized individual" under Section 1924(h) of the SSA to include persons receiving home and community-based services (HCBS) for the five-year period beginning on January 1, 2014.

[29] The medically needy include individuals eligible for medical assistance under Section 1902(a)(10)(C) of the SSA. States may offer the medically needy pathway to individuals who are aged, blind, or disabled and have high medical

First Choice Option under Section 1915(k).[30] This provision remains in effect for a five-year period from January 1, 2014.

Asset Transfers

For persons seeking Medicaid LTSS eligibility, federal Medicaid law requires states to apply rules regarding the transfer of assets prior to qualifying for Medicaid.[31] These rules attempt to ensure that Medicaid applicants apply their assets toward the cost of their care and do not divest them to gain Medicaid eligibility sooner than would occur otherwise. Specifically, Medicaid may require states to delay Medicaid eligibility for applicants seeking institutional and certain home and community-based LTSS who have disposed of certain assets for less than fair market value (FMV) on or after a "look-back" period, or period of time prior to application for services. This look-back period is five years prior to application for Medicaid.[32] In other words, transfers for less than FMV may be, but are not always, prohibited during the five-year period prior to application for Medicaid. Federal Medicaid law also prohibits spouses of applicants from transferring assets for less than FMV during this same period. These asset transfer rules apply to MAGI individuals who seek coverage for Medicaid LTSS.[33]

In order to determine whether a transfer for less than FMV occurred, applicants are first asked whether they made any transfers of monetary value during the five-year "look-back" period. If at least one transfer has occurred during this period, the state must determine whether the transfer was made for FMV. If the transfer was made for less than FMV (often referred to as an improper transfer), a penalty is imposed on the applicant in the form of months of ineligibility. To calculate the penalty period, the monetary value of the transfer, or portion of the transfer, that was made for less than FMV is divided by the average monthly private pay rate for nursing facility services in the state (or at state option, the rate in the community in which the individual resides). For example, an improper transfer of $26,000 divided by an average monthly private pay rate in a nursing facility of $6,500 results in a four-month period of ineligibility for Medicaid LTSS.

The penalty period begins either on the first day of the month in which assets have been transferred for less than FMV, or the date on which the individual is eligible for Medicaid and would otherwise be receiving an institutional level of care, whichever is later. In addition, states may waive penalties for asset transfers if the applicant can demonstrate to the state that he or she either (1) intended to transfer assets for FMV; (2) transferred assets for a purpose other than to qualify for medical assistance; or (3) recovered the assets that had been previously transferred. Also, ineligibility for Medicaid coverage is limited to certain LTSS, and individuals may still be eligible for other Medicaid services.[34]

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expenses (including LTSS expenses) who deplete their income to specified levels.

[30] For a description of the various SSA waiver authorities and state plan LTSS coverage options, CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*.

[31] See Section 1917(c) of the SSA for requirements regarding the transfer of assets for less than fair market value.

[32] The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) lengthened the look-back period from three years to five years for all asset transfers that occurred on or after the date of enactment (February 8, 2006).

[33] State Medicaid Directors Letter SMDL#14-001, ACA #29, Centers for Medicare & Medicaid Services, Department of Health and Human Services, February 21, 2014, http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-001.pdf.

[34] The services for which the penalty applies in the form of ineligible months for institutionalized individuals include nursing facility services; services provided in any institution in which the level of care is equivalent to those provided by a nursing facility; and Sections 1915(c) and (d) HCBS waiver services. For non-institutionalized individuals, states

Not all asset transfers during the five-year look back period are subject to penalties.[35] For example, asset transfers for FMV, transfers to spouses of any value, and certain transfers to other individuals, such as children with disabilities, are not subject to penalties. Also, a home may be excluded from asset transfer penalties if it is transferred to certain individuals, including a spouse, a child under the age of 21, a child who is disabled, or a son or daughter who has resided in the home and has provided care that permitted the individual to delay institutionalization. These rules are intended to ensure that certain family members would not be without housing or lose their homes in order for another family member to obtain Medicaid coverage.

Treatment of Certain Types of Assets

For the purposes of Medicaid asset transfer rules, all resources (and income) of an individual or couple are evaluated to determine whether the establishment, purchase, sale, or transfer of an asset has occurred for less than FMV. Generally, states follow SSI program rules concerning the treatment of most asset types that individuals possess at the time of application to Medicaid. Although Medicaid law does not contain provisions specifying how *all* assets should be treated, it does include special rules about how states must treat *certain* types of assets, such as annuities, fees for Continuing Care Retirement Communities (CCRCs), life estates, promissory notes, loans, mortgages, and trusts. Also, the Secretary of the Department of Health and Human Services (HHS) has the authority to issue guidance to states on other categories of transactions that may be treated as transfers of assets for less than FMV. States must apply the rules relating to these transactions to MAGI individuals in the same way they are applied to non-MAGI individuals.[36]

Annuities

An annuity is a sum of money that an individual converts into a series of guaranteed future payments for a certain number of years or for the remainder of their life. For the purposes of determining Medicaid eligibility, an individual who establishes an annuity during the look-back period effectively converts a countable asset into countable income. Federal Medicaid law describes when annuities should be treated as countable resources and when they should not.[37] In general, annuities are treated as transfers for less than FMV, and thus subject to penalties, except when

- the state is named as a beneficiary of the annuity so that the state can recover payments made by Medicaid following the death of the beneficiary;
- the annuity must be actuarially sound and pay back in equal monthly payments during the term of the annuity (with no deferral and no balloon payments);

may extend asset transfer penalties to other state LTSS available under the state plan.

[35] Exceptions are made for transfers to a third-party by the applicant's spouse for the sole benefit of the spouse or transfers to a disabled or blind child for the sole benefit of the disabled or blind child. These transfers may include the establishment of a trust, such as a special needs trust or a pooled trust, for a disabled or blind child. These exceptions allow a spouse or parent of a disabled child to retain a source of financial support for another spouse or disabled child. States may waive asset transfer penalties for persons who would suffer undue hardship as a result of the penalty, according to criteria established by the HHS Secretary.

[36] State Medicaid Directors Letter SMDL#14-001, ACA #29, Centers for Medicare & Medicaid Services, Department of Health and Human Services, February 21, 2014, http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-001.pdf.

[37] DRA amended Section 1917(c)(1)(F) and (G) of the SSA to specify when the purchase of annuities should not be treated as a disposal of assets for less than FMV.

- the annuity must be irrevocable (i.e., the annuitant cannot cancel the annuity) and non-assignable and non-transferable (i.e., the annuitant cannot give the annuity to someone else); and
- the annuity must be purchased from a commercial insurance company.

Annuities that meet these conditions are sometimes referred to as "Medicaid compliant" or Medicaid qualified" annuities. Additional exceptions include annuities that fall into certain categories specified in Section 408 of the Internal Revenue Service Code of 1986 (IRC). Annuities that are defined as individual retirement accounts under federal tax code or purchased with the proceeds of certain retirement accounts and meet certain federal tax code requirements are not considered transfers for less than FMV if purchased by or on the behalf of an individual who applied for Medicaid coverage for LTSS.

Fees for Continuing Care Retirement Communities

Continuing Care Retirement Communities (CCRCs) or life care communities offer a range of housing and services, including LTSS, to older individuals as their care needs change over time. Generally, CCRCs provide housing with various levels of LTSS arrangements such as independent living, assisted living, and nursing facility care. CCRCs are paid primarily with private funds, but a number also accept Medicaid payments for certain services, such as nursing facility care. Residents of CCRCs or life care communities are required to spend their resources, declared when applying for admission, on their care before they apply for Medicaid. Federal Medicaid law requires states to consider certain entrance fees for CCRCs or life care communities as countable resources for the purposes of determining an individual's eligibility for Medicaid.[38]

Life Estates

Generally, a life estate entitles an individual to possess, use, and obtain profits from a property for as long as he or she lives, even though the actual ownership of the property has passed on to another. For example, an individual may transfer home ownership to a son or daughter, but retain the use of the home throughout their lifetime. Such a transaction would give the child a "remainder interest" in the home, while the older individuals retained a "life estate." Upon death, the title of the home automatically passes on to the son or daughter without the need for probate. With respect to Medicaid asset transfer rules, the purchase of a life estate is considered a transfer for less than FMV, and subject to an asset transfer penalty, when the value of the transferred property is greater that the value of the rights conferred by the life estate.[39] The purchase of a life estate is also considered a transfer of assets for less than FMV unless the purchaser resides in the home for at least one year after the date of purchase.[40]

Promissory Notes, Loans, and Mortgages

Funds used to purchase a promissory note, loan, or mortgage are considered a transfer of assets for less than FMV unless the repayment terms are (1) actuarially sound; (2) provide for payments to be made in equal amounts during the term of the loan (with no deferral or balloon payments);

[38] Section 1917(g) of the SSA.

[39] Section 3258.9 of the State Medicaid Manual, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html.

[40] The DRA amended Section 1917(c)(1)(J) of the SSA to specify the treatment of life estates for the purposes of Medicaid asset transfer rules.

and (3) prohibit the cancellation of the balance upon the death of the lender.[41] Should the promissory note, loan, or mortgage not satisfy the above requirements, the penalty amount is the amount of the outstanding balance due at the time the individual applies for Medicaid.

Trusts

Most trusts are considered assets available to the individual for the cost of their care, and, if transferred, could be considered assets that have been transferred for less than FMV. An individual is considered to have established a trust if the individual's assets were used to form all or part of the trust and if certain persons established the trust, including the individual, the individual's spouse, or a person with legal authority to act on behalf of the individual or spouse. Medicaid law establishes rules for the treatment of assets in two types of trusts: *revocable* and *irrevocable* and are further described.

A *revocable* trust can be altered after it is established (i.e., assets may be added or new beneficiaries may be named), whereas an *irrevocable* trust cannot be altered once it is established. In the case of a *revocable* trust, the assets used to establish the trust are deemed resources available to the individual. Payments from the trust to or for the benefit of the individual must be considered income of the individual. Any other payments from the trust are considered assets disposed of by the individual and subject to asset transfer rules. In the case of an *irrevocable* trust, if there are any circumstances under which payments can be made from the trust for the benefit of the individual, then the assets used to establish the trust and payments from the trust are considered income and resources of the individual. Any other payments from the trust are considered assets disposed of by the individual and subject to asset transfer rules. An irrevocable trust from which no portion of the trust could be considered payment to the individual shall be subject to asset transfer rules, as of the date of the trust's establishment or date on which payment occurred, whichever is later. States are required to establish procedures for waiving the application of these rules in cases of undue hardship.

Special Needs Trust Exception

There are certain exceptions to the general rule of counting trusts as an asset. Under the "special needs trust exception" Medicaid does not count certain special needs trusts and pooled trusts as assets and does not apply asset transfer rules to these trust types. In order for a trust to meet this exception, it must contain the assets of an individual under age 65 (i.e., non-elderly individual) who meets the statutory definition of disability (SSA Section 1614[a][3]).

Federal Medicaid law permits parents, grandparents, legal guardians, or a court to establish a special needs trust on behalf of a non-elderly disabled individual. Enacted under Section 5007 of Division A of P.L. 114-255 (21st Century Cures Act), federal Medicaid law also allows non-elderly individuals with disabilities to establish a special needs trust on their own behalf. Such trusts must contain assets of the disabled individual and the trust must be used to provide funding for certain expenditures that supplement Medicaid benefits, subject to certain limitations. Special needs trusts allow non-elderly individuals with disabilities to maintain their eligibility for Medicaid. When the beneficiary dies, the state receives the remaining proceeds of the trust equal to any amounts paid for medical assistance provided under the state Medicaid program.

Achieving a Better Life Experience (ABLE) Act

In 2014, the Stephen Beck Jr., Achieving a Better Life Experience (ABLE) Act of 2014 was signed into law as part of P.L. 113-295 (Division B). The ABLE Act created Section 529A of the Internal Revenue Code (IRC), which allows states to establish and maintain a new type of tax-favored savings program designed specifically for individuals

[41] Section 1917(c)(1)(I) of the SSA.

with disabilities. Once established, ABLE accounts can assist individuals and families to save for the short-term needs or long-term benefit of an individual with a disability who has a qualified impairment. ABLE account funds may be used to pay for qualified disability expenses for the account's designated beneficiary. Under Medicaid, assets in ABLE accounts would be excluded as a resource for the purposes of determining eligibility. States are in the process of implementing qualified ABLE programs. For more information see CRS In Focus IF10363, *Achieving a Better Life Experience Act (ABLE Act): Background and Implementation*.

Post-Eligibility Treatment of Income

Medicaid has another set of rules for the treatment of income after a person has become eligible for coverage and is either living in an institution, such as a nursing facility, or is receiving Section 1915(c) HCBS waiver services while living in the community. These rules are commonly referred to as the *post-eligibility treatment of income* (PETI) rules. In general, beneficiaries qualifying through certain eligibility groups are required to apply their income exceeding specified amounts toward the cost of their care. Within federal guidelines, a beneficiary may retain a certain amount of income for personal use based on the services one receives. The amounts a beneficiary may retain vary by care setting.

For beneficiaries receiving Medicaid LTSS in an institutional facility, a monthly personal needs allowance (PNA) is permitted.[42] The PNA is an amount that is considered reasonable to cover various personal care items not included in the institution's basic charge. Beneficiaries may retain a monthly PNA from their income for clothing and other personal expenses. The beneficiary then applies the remainder of his or her income toward the cost of care. When receiving nursing facility services, Medicaid statute requires states to allow individuals to retain a minimum PNA of at least $30 per month for an institutionalized individual, though the amount can be higher and varies by state.

For beneficiaries living in the community and enrolled in Section 1915(c) HCBS waivers, a monthly maintenance needs allowance (MMNA) is permitted.[43] The MMNA is an amount that is considered reasonable to cover various living expenses in the community. Beneficiaries may retain an MMNA from their income for housing, food, and other personal expenses. The beneficiary then applies the rest of his or her income toward the cost of care. Federal regulations require states to set a maximum amount for the MMNA based on a reasonable assessment of need.[44]

CMS guidance regarding the application of PETI rules to MAGI individuals states that such rules are limited to certain eligibility groups that rely on the financial methodologies from the SSI and former Aid to Families with Dependent Children (AFDC) cash assistance programs. Thus, these post-eligibility rules do not apply to Medicaid beneficiaries whose eligibility is based on MAGI methodologies. CMS states that the statute provides authority to "expand the reach" of the post-eligibility regulations to include MAGI individuals who receive LTSS coverage as there are "equity reasons to consider the application of these rules to MAGI individuals."[45] Accordingly, the agency is considering rulemaking on this issue.

[42] Section 1902(q) of the SSA.

[43] Section 1915(c) of the SSA.

[44] 42 C.F.R. 435.735.

[45] State Medicaid Directors Letter SMDL#14-001, ACA #29, Centers for Medicare & Medicaid Services, Department

Estate Recovery

Other provisions in Medicaid seek to recover Medicaid costs through estate recovery programs. Federal Medicaid law requires states to recover from beneficiary estates any amounts paid for certain LTSS and other related services upon a beneficiary's death.[46] Specifically, states are required to pursue the estates of

- individuals receiving services in a nursing facility or intermediate care facility for the developmentally disabled (ICF/DD), regardless of age upon the sale of property subject to a lien, and
- individuals aged 55 and older who received Medicaid assistance in nursing facilities, HCBS, and related hospital and prescription drug services.

States also have the option to recover funds spent on other items or services covered under the Medicaid state plan for individuals aged 55 and older.

Estate recovery is limited to the amounts paid by Medicaid for services received by an individual and is limited to only those assets owned by the beneficiary at the time of recovery. As a result, estate recovery is generally applied to a beneficiary's home, if available, and certain other assets within a beneficiary's estate. For purposes of these estate recovery requirements, Medicaid statute defines an estate as all real and personal property subject to a state's probate law. Under certain circumstances, annuities are included in this definition.[47] States may expand the definition of estate to include other real or personal property and other assets to which the Medicaid beneficiary has legal title or interest at the time of death.[48] Estate recovery may be made only after the death of the individual and his or her surviving spouse, if any, and only at a time when there is neither a surviving child under age 21 nor a child, of any age, who is blind or permanently and totally disabled.

To aid in estate recovery, states are authorized to impose liens on the property of certain beneficiaries prior to or after the beneficiary's death.[49] Liens may be imposed only when the individual resides in a nursing facility, ICF/DD, or other medical institution determined by the state; after notice of and opportunity for a hearing is given; and it is determined that the individual cannot reasonably be expected to return to the home. Liens may also be placed on property when, based on a court's judgment, Medicaid payments have been improperly paid on behalf of the individual. States are prohibited from pursuing liens under certain circumstances. For example, the state cannot place a lien on an individual's home if any of the following individuals reside in the home: a surviving spouse; a child under the age of 21 or a blind or permanently disabled child of any age; or a sibling of the individual who has equity interest in the property and has resided in the home at least one year prior to the individual entering an institution. Medicaid law also requires states to dissolve any lien placed on a home if the

of Health and Human Services, February 21, 2014, p. 6, http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-001.pdf.

[46] Section 1917(b) of the SSA describes estate recovery provisions.

[47] Annuities are exempt from the definition of estate if issued by a financial institution or other business that sells annuities as part of its regular business.

[48] A person's legal title or interest includes assets conveyed to a survivor, heir, or through the assignment of joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangements.

[49] Section 1917(a) of the SSA and Section 3810.F of the State Medicaid Manual describe circumstances in which a lien may be imposed on the property of certain beneficiaries, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html.

individual is discharged from the institution and returns home. In addition, liens can apply only to beneficiaries receiving institutional care who are also subject to the post-eligibility treatment of income (PETI) rules described in the previous section. Thus, liens cannot be applied to MAGI individuals who are not subject to PETI rules. However, as previously mentioned, CMS is considering rulemaking to expand PETI rules to include MAGI individuals who receive LTSS coverage.[50]

Furthermore, federal Medicaid law provides for exemptions from estate recovery in situations when such recovery would create undue hardship. Medicaid guidance allows for state flexibility in establishing procedures for an undue hardship waiver.[51] In addition to exemptions for undue hardship, Medicaid permits states to forgo estate recovery in cases where it would not be cost-effective.[52] Federal Medicaid law also prohibits estate recovery in cases when a lien has been placed on the home when certain individuals reside in the home. Such instances include (1) a sibling of an individual who has resided in the home at least one year prior to the individual entering an institution, and (2) an adult child who has resided in the home for at least two years prior to the parent's institutionalization, has resided there continuously since that time, and can establish to the state's satisfaction that the adult child provided care to the parent that delayed the need for nursing facility services. Special provisions apply to persons who become eligible for Medicaid under a more liberal asset standard used in certain states for those who purchase long-term care insurance.[53]

MAGI individuals who were 55 years of age or older when they received Medicaid benefits are not exempt from these estate recovery provisions; however, the above exemptions from estate recovery also apply. CMS guidance states that Medicaid estate recovery may create a potential barrier to enrollment for some newly eligible individuals in ACA Medicaid expansion states. It further articulates the agency's intention to explore options and use existing authorities to eliminate estate recovery for MAGI individuals who receive Medicaid benefits other than LTSS. CMS also notes that states have existing authority to limit the scope of estate recovery to Medicaid beneficiaries 55 and older who receive LTSS.[54]

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[50] State Medicaid Directors Letter SMDL#14-001, ACA #29, Centers for Medicare & Medicaid Services, Department of Health and Human Services, February 21, 2014, p. 6, http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-001.pdf.

[51] Section 3810.C of the State Medicaid Manual, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html.

[52] Section 3810.E of the State Medicaid Manual, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html.

[53] DRA expanded exemptions from estate recovery for those who received benefits under the Medicaid Long-Term Care Insurance Partnership Program as per Section 1917(b)(1)(C) of the SSA. As such, a private LTCI policy under the Partnership program provides a predetermined amount of assets that are disregarded, for the purposes of determining Medicaid eligibility, in the event that the lifetime benefit of the insurance plan is depleted. For example, an individual who had a dollar-for-dollar Partnership policy whose lifetime benefit is $100,000 would, upon exhausting the benefit, have $100,000 in resources exempt from Medicaid resource limits and estate recovery upon applying for Medicaid LTSS. Some Partnership policies in the original partnership states of Indiana and New York have offered policies that have total asset protection. Such policies disregard all assets of any value for the purposes of Medicaid eligibility and exempt all assets from estate recovery.

[54] State Medicaid Directors Letter SMDL#14-001, ACA #29, Centers for Medicare & Medicaid Services, Department of Health and Human Services, February 21, 2014, p. 6, http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-001.pdf.

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