QUESTIONS AND ANSWERS ON MEDICAID FOR NURSING HOME RESIDENTS AND THE CHOICE PROGRAMS

Warning: The rules governing Medicaid eligibility, especially in the area of asset transfers, are very complex and subject to change. The material is a general overview of the current rules and is not intended as a substitute for individualized legal advice. The information in this is as current as we can make it as of January 2010.

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Prepared by
Alaska Legal Services Corporation
1648 Cushman St., Suite 300
Fairbanks, Alaska 99701-6206
(907) 452-5181

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QUESTIONS AND ANSWERS ON MEDICAID FOR NURSING HOME RESIDENTS AND THE CHOICES PROGRAM

I. HOW MUCH DOES NURSING HOME CARE COST IN ALASKA?

Short answer: a lot.

The costs for nursing home care in Alaska range from $410 to $850 per day, or $12,300 to $25,500 per month, highest in the 50 states.

Most standard private health insurance policies do not cover long-term care. Separate long-term care policies may be available, through your employer, or through various associations, or indivi-dually. Some federal income tax advantages may be available to people who buy certain long-term care insurance policies, called "tax-qualified." Pay particular attention to the maximum daily benefit; many policies set this at $100 or $150, geared to "lower-48" nursing home rates, but you will need to budget to meet the gap between this amount and the cost per day for nursing home care in Alaska. Policies also vary as to premiums, rules for pre-existing conditions, and whether there is a limit on the benefit period (e.g., 3 years). You can get further background information at http://www.ltcfeds.com/start/index.html.

II. WHAT ALTERNATIVES ARE THERE TO NURSING HOME CARE?

Short answer: several.

If you need help at home and do not want to enter a nursing home, you may be able to arrange for assistance from personal care attendants or home health aides to help you stay at home. You can look in the yellow pages under "Home Health" or inquire at your local hospital about these services. Medicare or Medicaid may be available to help pay for some of these.

If your own home is too difficult, there are various "congregate housing" situations you might want to consider moving into. The Alaska Housing Finance Corporation (AHFC) assists with several apartment complexes designed specifically for the elderly or disabled. Although these housing programs do not offer direct personal services, they are generally the focus of recreational and transportation programs to make life easier for the residents. For information, you can start at http://www.ahfc.state.ak.us/rental/senior_disabled.cfm or call 1-800-478-2432; or, from Anchorage, 338-6100. The Department of Housing and Urban Development also subsidizes several apartment programs for the elderly or disabled; information at http://www.hud.gov/offices/fheo/seniors/index.cfm.

If your level-of-care needs are higher than can be met in these settings, you could look into an assisted living home. These are privately-run homes which accommodate the needs of the elderly or disabled for assistance with the activities of daily living. A license from the state is required for an assisted living home which takes in three or more residents. A list of licensed assisted living homes in Alaska is available at http://www.hss.state.ak.us/dph/CL/PDFs/ALHomes.pdf. Under some circumstances, Medicaid provides coverage towards the

cost of assisted living care, under the "Choice" Program (see below).

The Pioneer Homes are state-run assisted living facilities with three gradations of levels of care. The financial rules are discussed briefly in section XXIV below.

III. WHAT IS MEDICAID?

Short answer: program that helps pay for medical care.

Medicaid is a state and federally funded program that pays for some types of medical care, including physician and hospital care, some prescription drugs, and nursing home care, for certain categories of needy and low income people.

Many different categories of people are eligible for Medicaid, and the eligibility rules are not the same for all categories. Families with minor children may be eligible for Medicaid depending on their income. Adults who are eligible to receive federal Supplemental Security Income (SSI) and/or state Adult Public Assistance (APA) due to either age (65 or over) or disability will be eligible for Medicaid if they apply.

This pamphlet deals with the Medicaid rules for nursing home residents and the CHOICE Program. *Not everyone receiving Medicaid is eligible for these categories of coverage,* because Medicaid must first be convinced that the individual needs the level of care that a nursing home provides. If you are found not to need the level of care provided by a nursing home, Medicaid will not pay those bills. This pamphlet deals with only the financial criteria, not the medical criteria, for Medicaid nursing home coverage.

Medicaid is different from Medicare. Medicare is health insurance for elderly or disabled persons who receive Social Security payments. You apply for Medicare at the Social Security Administration office. Medicare is not limited to low-income people.

Medicaid, on the other hand, serves low-income persons, is not necessarily limited to the elderly or disabled, and is applied for through the local Department of Health and Social Services office (DHSS). Medicaid may try to reimburse itself for its expenditures by filing a claim on the estate of deceased former Medicaid recipients.

Medicare has different rules from Medicaid on nursing home coverage, discussed in sections XXV-XXVI below.

IV. WHAT ARE THE CHOICE PROGRAMS?

Short answer: a branch of Medicaid providing support for people who need medical help to avoid nursing home care.

CHOICE (Community and Home Options to Institutional Care for Everyone) offers alternatives to people who otherwise would have to be in a nursing home. Various services are paid for to enable these people (who have to meet certain criteria, see section VI) to remain in their own homes or in assisted living facilities. CHOICE is based on the philosophy that older citizens are entitled to enjoy their later years in health, honor, and dignity and that disabled citizens are entitled to live lives of maximum freedom and independence.

In this pamphlet, the CHOICE programs are referred to by the shorter abbreviation HCB Medicaid (for "Home and Community-Based" Medicaid). These programs are also often called "waiver" programs, because

HCB Medicaid requires the federal government to "waive" some of the regular Medicaid rules.

There are four HCB Medicaid programs: Older Alaskans; Adults with Physical Disabilities; People Experiencing Developmental Disabilities; and Children with Complex Medical Conditions. All these are administered by the Division of Senior and Disabilities Services within the DHSS.

While this pamphlet is directed mainly at people interested in the first two categories, most of the information contained here also applies to the other two as well.

HCB Medicaid uses higher income limits and resource limits than regular Medicaid. Additionally, HCB Medicaid pays for a broader variety of services than regular Medicaid.

V. HOW IS MEDICAID ELIGIBILITY FOR NURSING HOME CARE DETERMINED?

Short answer: it's complicated.

Before Medicaid pays for nursing home care, the Division of Health Care Services (within the Alaska Department of Health and Social Services) must approve your nursing home placement. Usually, approval is requested by the doctor, the nursing home, or the hospital.

Besides meeting that "level-of-care" requirement, you must meet the financial eligibility requirements; that is, both your *income* and *resources* must be within limits set by federal law. Income is money you receive (Social Security, VA benefits, wages, etc.). Resources are things you own (money, real estate, bank accounts, stocks, etc.). The financial eligibility requirements for both are covered below.

If you are eligible for Medicaid, DHSS will tell you how much of your monthly income to pay the nursing home, under rules laid out in sections XVII and XVIII. Medicaid will pay the rest. Medicaid can cover medical costs retroactively, for up to three months prior to the month in which you apply.

If you are not eligible, DHSS must give you a written denial notice explaining why, and you have the right to an administrative hearing (called a fair hearing) if you request it within thirty days from the date of the denial notice.

VI. HOW IS HCB MEDICAID ELIGIBILITY DETERMINED?

Short answer: even more complicated.

Like Medicaid nursing home coverage, to be eligible for HCB Medicaid services, the DHSS must find (1) that your level-of-care needs are consistent with the services traditionally offered in a nursing facility and (2) that you meet the financial eligibility requirements. But beyond that, the DHSS must also find (3) that the cost to Medicaid of paying for your HCB care will not be more expensive than paying for you to be in a nursing home.

The first and third (assessing your level-of-care needs and planning an HCB budget) are usually handled by a care coordination agency. If you want to obtain a list of care coordinators who work in your community, please contact the Division of Senior Services at 269-3666 (in Anchorage) or 1-800-478-9996, or check the website at http://www.hss.state.ak.us/dsds/docs/careCoordCCAgencies.pdf.

The financial eligibility criteria are very parallel to those for Medicaid for nursing home coverage. And like Medicaid for nursing home coverage, you may have to devote some of your income towards your expenses (see section XXI below) before Medicaid pays the rest.

Medicaid can cover medical costs retroactively, for up to three months prior to the month you apply, provided you meet the eligibility requirements in those months. (However, the unique eligibility rules of HCB Medicaid — specifically, the requirement that an individual have an assessment upon which their HCB costs can be compared to nursing home costs — may prevent people from becoming eligible until after they have applied and been assessed for the program.)

Also parallel to Medicaid for nursing homes, if you are not eligible, DHSS must give you a written denial notice and you have the opportunity to request a hearing within 30 days.

VII. WHAT IS THE INCOME LIMIT ON ELIGIBILITY FOR MEDICAID NURSING HOME COVERAGE?

Short answer: $1656/month.

To be eligible for Medicaid nursing home coverage, your gross income (that is, before deductions) must be less than or equal to $1656 per month.

Your spouse's income does not count; Medicaid bases its income eligibility determination (after thirty consecutive days of nursing home residency) on your income alone, not your spouse's income.

All an individual's income is included in making this determination, with certain narrow exceptions:

- Alaska Permanent Fund Dividends;
- Cash provided by a governmental health or social services program (for example, Veterans Administration "aid and attendance" allowances, housebound allowances, clothing allowances, and payment adjustments for unusual medical expenses; one-time refugee resettlement payments; certain payments from the Division of Vocational Rehabilitation;
- Cash provided by a nongovernmental organization (for example, American Red Cross or Salvation Army) when paid for medical or social services already received by the individual and approved by the organization, or when the payment is restricted to the future purchases of medical or social services;
- .Volunteer service payments (Americorps, Senior Corps);
- Assistance (other than wages) under the Older Americans Act;
- Federal housing assistance;
- Federal, state and local relocation assistance payments;
- Certain education assistance payments;
- The first $2000 per year in ANCSA Corporation dividends;
- World War II restitution payments;
- Agent Orange settlement payments;
- Crime victims compensation payments;
- Certain other narrower payments.

Individuals with incomes too high for the $1656 per month Medicaid limit may be able to establish a Qualifying Income Trust (often called a "Miller" trust) to qualify for Medicaid nursing home coverage; see section XIII.

VIII. WHAT IS THE INCOME LIMIT ON ELIGIBILITY FOR HCB MEDICAID?

Short answer: also $1656/month.

The eligibility limit for HCB Medicaid is the same as for nursing home Medicaid, i.e., $1656 per month. Even though you may still live at home with your spouse, HCB Medicaid bases your eligibility on your income alone and does not count your spouse's income as yours (starting in the first full month of HCB eligibility). It does not count a parent's income as belonging to a child, even a minor child. Therefore you meet the income guidelines if your own monthly income is $1656 or less, regardless of what your spouse's income is.

IX. WHAT IS THE RESOURCE LIMIT ON ELIGIBILITY FOR MEDICAID NURSING HOME COVERAGE?

Short answer: once you take out the things that don't count, $2000, or higher if you're married.

You are resource-eligible as a single person if your non-exempt resources are $2000 or less. As a married person, the resource eligibility limit is higher, and depends on whether your spouse is also on Medicaid.

If you are married, then, unlike its treatment of income, Medicaid counts the resources of both you and your spouse together. If your spouse is also on Medicaid, then each of you gets a separate $2000 ceiling on non-exempt resources. If your spouse is not on Medicaid, then a special rule to protect your spouse from impoverishment effectively sets the asset ceiling for the two of you at $111,560, as explained below in section XX.

In determining whether your resources exceed this ceiling, some resources ("exempt" or "excluded") are not counted:

1. A home owned by the nursing home resident with an equity value of less than $500,000 is excluded as a resource if the resident states an intent to return home, or if the resident has a spouse and/or dependents residing in the home. Homes with an equity value above $500,000 will make the applicant ineligible for nursing home or HCB Medicaid services, unless it is the residence of the person's spouse, child under 21, or disabled adult child. This $500,000 cap will increase for inflation starting in 2011. Only one home may be excluded.

2. Household goods and personal effects will be excluded regardless of value. Household goods are things like furniture, appliances, tools, personal computers, televisions, utensils, etc. Personal effects are things like clothing, personal jewelry, personal care items, books and musical instruments, and prosthetic devices or wheelchairs.

3. One vehicle per household is excluded if used for transportation of the eligible individual or couple or a member of the eligible individual's household. A second vehicle, however, will count as a resource unless exempt under another rule (e.g., property necessary for self-support, below).

4. A life insurance policy or policies with face values totaling $1500 or less are completely excluded. For couples, each spouse is entitled to this exclusion. If the face value is more than $1500 then the cash value is counted as a resource. Term insurance with no cash surrender value, and burial insurance, are not counted as a resource regardless of any face value (although these may reduce the amount of the burial fund exclusion, explained below).

5. A burial fund of $1500 for an individual (and an additional $1500 for a

spouse) is excluded if it is set aside in a clearly designated account to cover burial expenses. This exemption may be reduced if the individual also has certain other resources which could meet burial expenses (face value of any term life insurance; face value of burial insurance; burial contract; and face value of any life insurance excluded under the $1500 limit above). So, for example, if an individual has life insurance with a face value of $1000, then only $500 may be excluded in a designated burial fund. Once a burial fund under $1500 has been established, increases in the value of that fund (e.g., interest earned) are also excluded even if they push the fund up over $1500. Using the burial fund for another purpose, however, terminates the exclusion.

6. Burial spaces owned by you or your spouse and intended for use by you, your spouse, or any member of your immediate family are excluded, and do not reduce the $1500 burial fund exemption above.

7. Alaska Native allotments or townsite lots still held in restricted title; stock held in a regional or village corporation under the Alaska Native Claims Settlement Act (ANCSA); and land received from an ANCSA Corporation, by an Alaska Native or descendant, are excluded.

8. Property necessary for self-support, if it is in current use or has been in use and is expected to resume within 12 months. This includes: (1) regardless of value, any property used in a self-employment activity, any governmental permit (e.g., a Limited Entry Permit) used to produce income, and any personal property used by an employee for work (tools, uniforms, etc.); (2) up to $6000 in equity for non-business property used to produce goods or services for home consumption (land used for a garden, boat used for subsistence fishing, etc.) and (3) up to $6000 in equity value for nonbusiness property producing a 6% rate of return (e.g., rental home). (Although it may be unlikely that the first two categories of property are used by the nursing home resident, they are exempt if so used by the resident's community spouse.)

9. Retirement accounts: their countability depends on whether they belong to the institutionalized spouse or the community spouse.

a. Retirements accounts (like an IRA or Keogh) belonging to the institutionalized spouse are countable resources because the owner can access the principal even though a penalty may have to be paid. Other retirement accounts count as resources if the individual has the option of withdrawing a lump sum and is not yet eligible for periodic payments. If s/he is eligible for periodic payments, s/he must apply, and then the periodic payments count as income but the fund itself is not a resource.

b. Retirement accounts belonging to the community spouse: any retirement account belonging to the community spouse does not count as a resource for the institutionalized spouse, as long as the community spouse is not eligible for Adult Public Assistance. (This ineligibility could be due to the spouse being under 65 and not disabled, or could be due to financial ineligibility.)

If you are considering applying for Medicaid to pay for nursing home care, you should carefully examine your resources to determine which are exempt and which are non-exempt. Sometimes you can make decisions about your resources that will affect your eligibility for Medicaid nursing home coverage.

Example:

A single individual with income under the Medicaid limits enters a nursing home. The individual has a bank account with $31,000 and owns a home worth $90,000 with $30,000 still owing on it. This individual is not eligible for Medicaid coverage. The house is exempt because the individual intends to return to it, but the $31,000 is not exempt and is over the $2000 limit.

If this individual uses $30,000 to pay off the mortgage, then s/he is eligible for Medicaid coverage. The home is entirely exempt as long as the individual intends to return to it, and the individual has only $1000 left in the bank, below the $2000 resource limit.

X. WHAT IS THE RESOURCE LIMIT ON ELIGIBILITY FOR HCB MEDICAID?

Short answer: basically the same.

The resource eligibility limits for HCB Medicaid are the same as those given in the previous section for Medicaid for nursing homes.

For children, HCB Medicaid counts only the resources of the child, and does not count the resources of the child's parents in deciding eligibility.

XI. CAN I GET MEDICAID COVERAGE FOR SERVICES AT HOME WITHOUT BEING IN HCB MEDICAID?

Short answer: yes.

Whether or not you can participate in HCB Medicaid, regular Medicaid can help pay for medical expenses, which can include home health care and personal care attendant services to help individuals remain at home.

However, regular Medicaid sets stricter income and resource ceilings than HCB Medicaid does, and regular Medicaid will not pay for HCB services like assisted living expenses, although those HCB waiver services may be provided to regular Medicaid recipients if they meet the higher level-of-care requirement for HCB waiver services as described in section VI above.

A. Adults

The Medicaid income limits for adults outside the Project Choice program depend on your marital status and living situation. (Unlike HCB Medicaid, regular Medicaid counts the income of both spouses if they live together.) These lower ceilings are as follows:

Household members \ Living	independently or in assisted living home	in another's household
Individual	$1252	$1035
Couple, one eligible	$1504	$1187
Couple, both eligible	$1854	$1543

The resource requirements are also more stringent. For unmarried adults, the limit is the same as for HCB Medicaid: $2000 in non-exempt resources. For married adults, the limit is $3000, much lower than that allowed in HCB Medicaid.

"Regular" Medicaid does not pay for as many things as HCB Medicaid. Basically, regular Medicaid pays only for medical expenses (doctors, medicines, hospitals, etc.) HCB Medicaid, on the other hand, can pay for residential supporting living services for someone in an assisted living home, or other

services for someone living in their own home that one may not think of as strictly medical, like chore service, respite care, and environmental modifications (e.g., ramps or grab bars).

B. Children

Children can get regular non-HCB Medicaid also, but different income limits and rules apply. Most importantly, whereas HCB Medicaid children have their financial eligibility determined without taking their parents' incomes and resources into account, regular Medicaid does take into account the parents' finances when determining children's eligibility.

There is one exception, a special category of children's Medicaid (called TEFRA, or "Katie Beckett"), for disabled children, which uses the same level of care needs and same basic eligibility standards as HCB Medicaid ($1656 in income and $2000 in non-exempt resources), but even though the child lives at home, the parents' income and resources are not counted. However, although it uses the higher income limits like HCB Medicaid, it does not pay for HCB Medicaid services.

The more generally available "Denali Kid Care" makes Medicaid available to any minor children whose family income is below certain ceilings. Information on this can be found by calling the Division of Public Assistance or "Denali Kid Care" at 1-888-318-8890 (in Anchorage, 269-6529). The current income guidelines are at http://hss.state.ak.us/dhcs/DenaliKidCare/income_guide_dkc.htm.

XII. WHAT HAPPENS IF I GIVE AWAY RESOURCES IN ORDER TO BECOME ELIGIBLE FOR MEDICAID?

Short answer: there's a penalty.

Warning: the Medicaid rules on transferring property are complex, and penalties can be severe. What follows is only a summary, and you should not attempt transfers without getting legal assistance.

A. The Penalty and How It Works

If you or your spouse transferred assets (either income or resources), for less than their fair market value to become eligible for Medicaid, Medicaid imposes a "penalty period" during which you will not be eligible for either nursing home or HCB Medicaid services. The law changed as of Feb. 8, 2006, so depends in part on whether the transfer occurred before or after that date. Certain transfers will not result in this penalty, as discussed in section B.

1. The "lookback" period

From the date you are both (1) in a nursing home (or have started to receive HCB services) and (2) have applied for Medicaid, Medicaid "looks back" at any asset transfers during the previous five years (60 months).

(But, due to the change in the law, the "lookback" period doesn't extend back any earlier than Feb. 8, 2006, unless the transfer involved a trust, in which case it looks back the full five years. So, for example, as of February 2010, the "lookback" period for non-trust transfers is really only 48 months, only back as far as February 2006, rather than 60 months. As of February 2011, the "lookback" period will reach back a full 60 months, and will stay at 60 months thereafter.)

If an uncompensated transfer occurred during the "lookback" period, Medicaid will calculate a penalty period, unless the

transaction isn't subject to the penalty (part B below).

2. How long the penalty period is

If you gave away assets during that look-back period, the period that you will not be eligible for Medicaid is calculated by dividing the value of the transferred assets by the nursing home monthly cost. The result is the number of months of ineligibility.

If the transfer was made before Feb. 8, 2006, the result of the division is "rounded down" to a whole number, and that is the penalty period. If the transfer was made after Feb. 8, 2006, there is no rounding, and a partial month will be added to the penalty period.

If instead of just giving away the assets you sold assets for less than their fair market value, then it is the "uncompensated value" (difference between the fair market value and what you received) that gets divided by the monthly cost as explained above to get the number of months you will not be eligible.

3. When the penalty period starts

If the transfer was made before Feb. 8, 2006, the ineligibility period starts counting from the first of the month after the month in which the transfer occurred.

If the transfer was made after Feb. 8, 2006, the penalty period starts the first day of the month the individual is eligible for Medicaid and would be receiving institutional level of care services, except for the imposition of a transfer of asset penalty.

Either way, if you are already within an earlier penalty period, the new penalty period doesn't start until the old one ends.

Example 1:

While still healthy, you give your sister $78,000 of your $79,000 savings on July 1, 2008, placing you below the Medicaid asset ceiling. On June 10, 2009, your condition takes a turn for the worse and you are then in need of an institutional level of care and financially eligible for Medicaid. The cost of nursing home care in your community is $7500.

The July 1, 2008 transfer occurred within five years before June 10, 2009, so it's within the "lookback" period. In this case $78,000 will be divided by $7500. Since the result is 10.4, the penalty period is 10 months plus 4/10 of a month (i.e., 12 days). The ten months and twelve days starts counting June 1, 2009, and will extend through April 12, 2010.

Example 2:

You are a widower, in need of nursing home care since July 1, 2010. You own two homes. One is excluded because your adult disabled child lives there. The other home is worth $118,000. You have a bank account with $75,000 in it. To become eligible for Medicaid you sell the second home to your other (non-disabled) child, August 1, 2010, for $10,000. The cost of nursing home care in your community is $7500 per month. You pay for ten months of this care with your savings, then apply for Medicaid on June 1, 2011.

The August 1, 2010 transfer occurred within five years before June 1, 2011. In this case the "uncompensated value" of the transferred property is $108,000 ($118,000-$10,000), divided by $7500 is 14.4. You will be ineligible for Medicaid for fourteen months and twelve days. The starting date will be June 1, 2011 (you were in need of a nursing home level of care before then, but you did not become Medicaid eligible until after your bank account balance went below $2000, after you made your tenth $7500 payment in May 2011). The penalty period will run for fourteen months and twelve days after June 1, 2011, or until August 12, 2012.

B. Exceptions to the Penalty

a. You can sell any property as long as you get fair market value for it. (But the DHSS does not allow this to apply to transfers in exchange for services to be provided in the future.)

b. You can transfer any property, exempt or non-exempt, to your spouse (or to a third party for the benefit of your spouse).

c. Your spouse can transfer property to a third party for your spouse's own benefit.

d. You can transfer property to a blind or disabled child of yours, or to a third party for that child's benefit, as long as the child meets the Social Security definition of disability.

e. You can transfer property to a trust established solely for the benefit of a disabled individual under age 65, as long as the individual meets the Social Security definition of disability.

f. You can transfer your home to your spouse; to your child if the child is under 21, or disabled, or has cared for you before you entered the nursing or assisted living home, and has lived in the home for at least two years prior to the date you enter the nursing or assisted living home; or to your brother or sister if s/he has an equity interest in the home and has lived there for at least one year before you enter the nursing or assisted living home. You do not need to be living in your home at the time you transfer it.

g. Transfers that occurred before the beginning of the "look-back" period will not be penalized; thus, any transfers do not count if they occurred more than five years before the date you are in the nursing home and have applied for Medicaid (or, if the current date you are reading this is before Feb. 8, 2011, if the transfer occurred prior to Feb. 8, 2006). Note that the three years or the five years is the size of the "look-back" window, not a cap on the length of the penalty period. There is no cap on the length of the penalty period.

Example 3:

A person who made a $500,000 transfer to his church on July 1, 2009, and becomes both financially eligible for Medicaid and in need of a nursing home level of care as of June 1, 2014, will not face any penalty period if he applies for Medicaid on July 2, 2014, but if he applies on June 30, 2014, the penalty (assuming the nursing home costs $7500 per month) will be 66 months and 20 days, starting June 1, 2014 and extending to December 20, 2020.

h. If you transferred assets exclusively for some reason other than to become eligible for Medicaid you will not be penalized. DHSS will allow you to submit a statement explaining the circumstances surrounding the transfer and the reasons for the transfer. They may also ask for other documentation. They will examine your purpose for transferring the asset, the plans you had for supporting yourself after the transfer, the relationship you have with the person receiving the transfer, and your reasons for believing that you received fair market value, or your reasons for accepting less than fair market value. There are several situations in which this exception might apply. If you can show that you would have been eligible for Medicaid even if you had retained the asset, then that makes it unlikely that your motive in giving it away was to make yourself Medicaid eligible. (This would apply if you gave away an exempt asset -- except the home, which has special rules listed above -- or an asset which your spouse could have retained under the spousal impoverishment rules.) If you can show that you were over-resource for Medicaid even after giving away the asset, and some unexpected financial loss occurring after the date you gave away the asset has made you eligible, then that makes it less likely that you gave away the asset to become Medicaid eligible. If you show that your need for nursing home care was unexpected and did not arise until after you had given away the asset, then that makes it less likely that you gave it away to become Medicaid eligible.

i. If you satisfy the DHSS that you intended to sell the asset for fair market value, or for other valuable consideration, then the penalty doesn't apply. The intent of this exception, in part, is to cover situations in which you got cheated. If you conveyed away the asset in a bargain under which you were supposed to get paid but didn't, or if you got the payment but then it turns out your property was worth a lot more than what you got in exchange, you may be able to avoid the penalty if you can persuade the state that you were acting in good faith. Of course, the DHSS will examine the transaction very closely to make sure it isn't just a disguise for a gift conveyance.

j. If the DHSS determines that applying the penalty would cause an undue hardship in your case, it may grant eligibility despite the penalty. You will need to request an undue hardship determination within 30 days of getting the denial notice.

k. Also, if the transferred assets are returned to the individual, the penalty no longer applies, starting the first month after the assets are returned; but the returned assets are then included with other nonexempt assets in determining if you are Medicaid eligible.

Remember, you have a right to a fair hearing if you disagree with a decision of the DHSS and you want a chance to prove that you did not transfer assets for less than fair market value in order to become Medicaid eligible.

XIII. IS IT POSSIBLE TO MAKE MYSELF ELIGIBLE FOR MEDICAID BY PUTTING MY ASSETS INTO A TRUST?

Short answer: yes.

A "trust" is a type of property ownership arrangement under which the property's owner (called the "trustor" or "grantor" or "settler") gives legal title in the property to one person (called the "trustee") with a legal duty that the trustee use that property for the benefit of another person (called the "beneficiary"). The grantor can be the trustee as well, or be the beneficiary as well. Trusts can be made "revocable" (i.e., the trustor retains the right to "undo" the trust) or they can be "irrevocable" (i.e., they can't be "undone.")

Medicaid's rules for counting trust assets are different depending on when the trust was made, whose property went into the trust in the first place, and how the trust is written.

The laws concerning Medicaid and trusts changed August 11, 1993. This section discusses trusts created after that date. (Trusts created before that date were governed by different rules; if you were eligible under a pre-1993 trust, you will continue to be eligible.)

If the trust is set up with property that *does not belong* to the beneficiary, then the rules are as follows: the property in the trust counts as a resource to any individual who can legally have free access to the trust assets, and money paid out of the trust to that individual will not count as income, instead counting just as a change in the way the resource is held. To an individual who does not have access to the trust assets, the property in the trust does not count as an asset, and income earned by the trust does not count as the individual's income, but any money that the trustee distributes to that individual (whether from principal or income) counts as income to that individual. (However, if the trustee pays money out of the trust to a third party to pay for items other than food or shelter, that does not count as income to the individual who receives it .)

If the trust is set up with property that *does belong* to the beneficiary, then there is one general set of rules for revocable trusts, one general set of rules for irrevocable trusts, and three specific exceptions.

If you put your assets into a revocable trust (that is, one where you retain the authority to revoke the trust and take back the property), then all the resources in the trust still count as your resources. Any money paid to you from the trust counts as your income. Any money paid to anyone else from the trust counts as a transfer of assets from you.

If you put your assets into an irrevocable trust (that is, one where you don't retain the authority to revoke the trust), then any amounts which *can* be paid out of the trust to you (regardless of whether or not they are actually paid) count as your resources. Any payments actually made to you from the trust count as your income. Any payments actually made to someone else from the trust count as a transfer of assets from you. And any amounts held by the trust which can never be paid out count as a transfer of assets from you as of the date the trust is established, or (if later) the date as of which those trust assets are made unavailable to you.

For both revocable and irrevocable trusts, these rules apply not only to trusts that you yourself establish, but also to trusts established with your assets by your spouse,

your guardian, a court, or anyone acting at your direction.

The three exceptions are discussed below. For all three, the rules require that any money left in the trust at the time the beneficiary dies is to go to the State, up to the amount of Medicaid assistance the DHSS has paid for the individual.

The first exception is for trusts established for disabled people under age 65, frequently called a "special needs trust." Such trusts can contain the disabled person's own assets, as long as they are set up by a parent, grandparent, legal guardian, or a court. As noted above, to meet the exception, the trust has to provide that, upon the death of the disabled individual, the State will receive all amounts remaining in the trust up to the amount of the Medicaid assistance the State has provided for the individual. Transfers of assets into such a trust are exempt from the transfer-of-assets penalty.

The second exception is somewhat similar. It applies to trusts established and managed for disabled people by a nonprofit association which maintains separate accounts for each beneficiary (although it may "pool" the accounts for investment purposes). The accounts can be established by the parent, grandparent, or legal guardian of such individuals, or by the individuals themselves, or by the court. Again, the trust has to state that, upon the death of the disabled individual, to the extent that the trust does not retain trust assets itself, the State will receive amounts remaining in the trust up to the amount of the Medicaid assistance the State has provided for the individual. The main differences between this type of trust and the first type of trust are (1) the individual does not have to be under age 65 to become a beneficiary; (2) the individual himself or herself can establish the account and contribute money to the "pooled trust"; (3) the "pooled" trust has to be managed by a nonprofit association; (4) federal law does not make transfers of assets into these trusts automatically exempt from the transfer of assets penalties. Note that, if a person over age 65 transfers assets into a pooled trust for himself/herself, then to the extent that the transfer is "uncompensated," there might seem to be the possibility of a penalty period being imposed. However, unless the trust assets can be used for someone other than the individual beneficiary or the state, the individual is expecting to get the benefit of the trust and thus there is an argument that the transfer is not in reality "uncompensated."

The third exception is quite different from the other two: this is the Qualifying Income Trust ("Miller Trust"). These only work in certain states, of which Alaska is one. The property put into the trust must consist solely of Social Security, pension, or other income payments; and the trust must provide that upon the individual's death the State will receive all amounts remaining in the trust up to the amount of the Medicaid assistance the State has provided for the individual. This makes it possible for an individual who has income of over $1656 per month to become income-eligible for Medicaid nursing home coverage. This type of trust can be set up regardless of the individual's age, but it can only shelter income, not resources. (The funds which build up in the trust as a result of unexpended income do not disqualify the trust from this exception.) It is only useful for persons whose medical bills regularly outstrip their income.

Generally, you need the help of an attorney to set up the right kind of trust. For the exceptions, it is important that the trust documents instruct the trustee to repay the

State after the beneficiary's death for any medical assistance provided. The types of expenditures the trustee may make should be carefully limited to avoid having too much income imputed to the beneficiary. Establishing trusts is complex, and not all types of Medicaid eligibility problems can be solved by a trust. There are occasionally disagreements between federal and state agencies as to what trusts do and do not qualify, and Congress may change the laws in this area. These factors make it essential that you have the assistance of a good attorney before trying to establish a trust.

XIV. IS IT POSSIBLE TO MAKE MYSELF ELIGIBLE FOR MEDICAID BY USING MY ASSETS TO PURCHASE AN ANNUITY?

Short answer: only under pretty narrow circumstances.

An "annuity" is a contract under which you pay a flat sum in return for a stream of fixed regular payments, which can be for your lifetime or can be for a specific period of time.

Annuities present two questions: (1) is the annuity a countable asset? And (2) did the purchase of the annuity count as a transfer of assets?

Generally, once the individual is eligible to receive payment under the annuity, it doesn't count as a resource, although its payments do count as income to the person receiving them. Before the individual is eligible for the payments, then if that individual has the option of withdrawing a lump sum (cashing the annuity out), the amount the individual could get does count as a resource. If the annuity belongs to your spouse, though, it doesn't count as a resource to you.

With respect to transfers of assets, there was no transfer of assets penalty assessed on annuities purchased before Feb. 8, 2006. For annuities purchased after that date, the purchase will count as a transfer of assets resulting in a penalty period *unless* the annuity meets certain requirements. (1) The State has to be the remainder beneficiary of the annuity, unless the individual has a spouse or minor or disabled child, in which case those individuals can be the first beneficiaries with the state as the second beneficiary. (2) The annuity has to fall into one of two categories: (a) it has to be an annuity purchased with proceeds from an employee retirement account or trust, employee pension, or Roth IRA; or (b) the annuity needs to be irrevocable and non-assignable, actuarially sound, and of uniform payment stream, that is, with no deferred or balloon payments.

To assess "actuarially soundness," Medicaid multiplies the annual annuity payment amount by the number of years the individual is expected to live (tables at www.ssa.gov/OACT/STATS/table4c6.html); if that amount is greater than or equal to the price paid for the annuity, there is no transfer of assets penalty, but if that amount is less than the price paid for the annuity, the difference of the price over the expected payout amount counts as an uncompensated transfer.

XV. IS IT POSSIBLE TO MAKE MYSELF ELIGIBLE FOR MEDICAID USING A LIFE ESTATE?

Short answer: only under pretty narrow circumstances.

A "life estate" is a type of property ownership under which the deed itself gives ownership to an individual for that individual's lifetime, after which the ownership goes to someone else. This

entitles the owner of the life estate to possess, use, or profit from the property as long as he or she lives. But that person cannot sell full title to the property; the buyer could only get the use of the property for the rest of the seller's lifetime. So the life estate is not worth as much as full title.

As with annuities, life estates present two questions: (1) does it count as an asset? And (2) does conveying a life estate count as a transfer of assets?

A life estate does count as an asset (unless it is exempt as the individual's home), but figuring its value is an involved process. The value of a life estate is the amount that it would sell for. This value is usually determined by multiplying the fair market value of the property by a decimal value based on the life estate holder's life expectancy. These life expectancy tables and the applicable decimal multipliers are available at the following website: http://policy.ssa.gov/poms.nsf/lnx/0501140120. Alternatively, the individual can arrange for an individualized appraisal of the life estate's value from a real estate appraiser or financial institution.

Conveying a life estate can count as a transfer of assets, if fair market value for it is not paid. The most common transaction is one in which the owner of the property grants a life estate to himself/herself, and the remainder interest to his/her children or other heirs, usually with no money being paid. In that situation, Medicaid calculates the value of the life estate, using the decimal multipliers from the above table, and subtracts that from the full fair market value of the property. The difference is the value of the uncompensated transfer to the person or people to whom the remainder interest is being given.

XVI. IS IT POSSIBLE TO MAKE MYSELF ELIGIBLE FOR MEDICAID BY USING MY ASSETS TO LEND MONEY TO SOMEONE OR PURCHASE A PROMISSORY NOTE?

Short answer: only under pretty narrow circumstances.

Lending money, or purchasing a loan (or a promissory note or mortgage) will count as a transfer of assets unless the loan (1) is actuarially sound under criteria of the Social Security Administration; (2) does not include any balloon, deferred or other uneven payments; and (3) does not call for cancellation of the balance upon the death of the lender.

Here, "actuarially sound" means that the Medicaid applicant is expected to live long enough to receive all of the payments due under the loan, using the same tables at http://www.ssa.gov/OACT/STATS/table4c6.html.

XVII. WHAT INCOME CAN I KEEP IF I HAVE MEDICAID NURSING HOME COVERAGE?

Short answer: at least $75, maybe more.

Generally, Medicaid nursing home coverage rules require you to devote all of your income towards your nursing home costs, except for certain "allowances" mentioned below. These rules are sometimes called the "post-eligibility" rules, and the arithmetic is called the "cost of care calculation."

(Certain narrow categories of income don't count in making this cost-of-care calculation: the first $90 per month in payments from the Dept of Veterans Affairs for Unusual Medical Expenses and Aid and Attendance; money withheld from Social Security checks to repay an overpayment; SSI and APA benefits continued for up to

three months on the basis that the individual is likely to be in the nursing home only temporarily; up to two months of SSI payments maintained by the Social Security Administration under a program allowing such benefits despite the individual's "substantial gainful activity"; and income from interest-bearing accounts of up to $4 per month.)

Medicaid nursing home residents, married or unmarried, can keep $75 per month of their income as a "personal needs allowance." In a few narrow situations, this $75 can be increased. Nursing home residents who have withholdings for tax liabilities or garnishments for child support can set additional amounts aside under the personal needs allowance; this does not put more money in their pockets, but does enable them to use their income to meet those obligations. The tax allowance can cover mandatory withholding from income to cover federal, state or local taxes; or taxes not subject to mandatory withholding as long as those taxes are owed, actually paid, and not covered under one of the other allowances. The child support allowance can cover income garnished for child support, to the extent not covered under another allowance. Certain veterans can keep $90 per month of their pension in place of the $75 per month. For residents of an intermediate care facility for the mentally retarded, who have a "plan for achieving self-support," the amount of earned income needed to fulfill the plan can be added to the $75. Next, Medicaid nursing home residents are allowed to set aside sufficient income to pay for Medicare and other health insurance premiums, and to pay for medical expenses already incurred but not covered by private health insurance or public assistance.

A Medicaid nursing home resident with no spouse or dependents is entitled to keep $1,252 per month for up to six months to maintain his/her home, if the resident's physician certifies that the resident is likely to return home within six months. (Medicaid nursing home residents with spouses and/or dependents have special rules; see section XVIII).

Besides knowing about these allowances, you should be aware that certain benefit programs change your income once you are in a nursing home. With narrow exceptions, SSI/APA recipients with no other income will have their SSI/APA cash benefits cut back to $75 per month (which they can retain as their "personal needs allowance"). There are two exceptions, both temporary. First, if your physician certifies that you are likely to be in the nursing home less than three months, and you can show a need to pay the expenses of your home so that you can return to it, you can continue to receive your full SSI/APA benefits for up to three months. Second, certain blind or disabled individuals who were receiving SSI despite engaging in "substantial gainful activity" will receive their full SSI payment for two months. In all other situations, your SSI/APA will be cut back to the $75 per month you are allowed to retain as your personal needs allowance.

XVIII. WHAT INCOME CAN WE KEEP IF MY SPOUSE HAS MEDICAID NURSING HOME COVERAGE?

Short answer: significantly more than you can keep if unmarried.

There are special Medicaid rules to protect and/or increase the income of a spouse who stays at home when the other spouse enters a nursing home.

If one spouse enters a nursing home (the "institutionalized spouse"), Medicaid allows the spouse remaining at home (the

"community spouse") to keep all income that is in the name of the community spouse. Additionally, if the community spouse's own income is less than $2739 per month, the community spouse is allowed to retain as much of the institutionalized spouse's income as is necessary to bring the community spouse's income up to that $2739 per month.

Additional allowances can provide for minor and dependent children and for parents and siblings (of either the institutionalized or community spouse) if they can be claimed by either spouse as a tax dependent. The amounts depend on whether the dependent is living with the community spouse. If so, the amount is $913 per month per dependent family member, minus any income the dependent family member has. For dependent family members living away from the community spouse, the amount is $715 for the first such dependent and an additional $163 per dependent family member after that ($878 for two, $1041 for three, etc.), again minus any income that dependent family member has.

This spousal and dependent allowance amounts can be increased by a court support order, or by a hearing officer's decision that exceptional circumstances exist resulting in extreme financial duress.

Example 1:

If your monthly income is $3000 payable in your name and $1500 payable in your spouse's name when your spouse is in the nursing home, you retain your entire $3000 each month; your spouse retains the $75 personal needs allowance each month, with the remaining $1425 going toward the nursing home bill.

Example 2:

If your monthly income is $1500 payable in your name and $3000 payable in your spouse's name when your spouse is in the nursing home, your spouse can retain the $75 personal needs allowance, and you can retain your own $1500 plus $1239 of your spouse's income (enough to raise your income to $2739). The remaining $1686 of your spouse's income ($3000.00 - $75.00 - $1239) goes toward the nursing home bill. If you had dependent children at home, you could keep more of your spouse's income, depending on the number of children and their own income; this could go up to a maximum of $2425 ($2500 minus the $75 personal needs allowance).

XIX. WHAT RESOURCES CAN I KEEP IF I HAVE MEDICAID NURSING HOME COVERAGE?

Short answer: $2000, more if you're married.

For single individuals, the "post-eligibility" resource rules are the same as the "eligibility" rules. The limit on non-exempt resources is $2000. Exempt resources are listed in section IX above. The special rules for transferring assets are discussed in section XII above, and the special rules for couples in the following section (XVII).

XX. WHAT RESOURCES CAN WE KEEP IF MY SPOUSE HAS MEDICAID NURSING HOME COVERAGE?

Short answer: $111,560.

When one spouse goes into a nursing home and the other stays in the community, the non-exempt resources of both spouses are added together (with certain exceptions described below); $109,560 is then

subtracted as an allowance for the community spouse; and the remainder is compared to the $2000 limit to determine eligibility for the institutionalized spouse.

The spouses' resources are pooled together as of the date that the nursing home stay begins (that is, the values of all the resources that the couple owns are added, regardless of whether they are owned by the wife or the husband or both). Exempt resources (section IX above) do not count, whether owned by the husband, wife or both. (Note, however, that as mentioned in section IX above, the exemption for retirement accounts does depend on whose name is on the account. Retirement accounts belonging to the nursing home resident are a "resource" if the resident has the option of withdrawing a lump sum and is not yet eligible to receive periodic payments (and IRA and Keogh accounts are a "resource" even if they have started making payments). However, retirement accounts owned by a community spouse who is ineligible for SSI and/or APA are excluded from the "pooling." A community spouse is considered "eligible" for this purpose only if s/he applies for and receives APA or SSI benefits.) Then, from the pooled non-exempt resources, an amount is subtracted considered necessary for the community spouse to meet his or her needs. For 2010 this amount is $109,560. This amount is allocated to the community spouse and is not thereafter counted as part of the resources of the spouse who is going into a nursing home. The amount remaining after subtracting the $109,560 from the total non-exempt resources is the amount used to determine if the nursing home spouse is eligible. If this amount is $2000 or less, the nursing home spouse is eligible; otherwise, the spouse entering a nursing home will not be eligible for Medicaid until the resources are spent down to $2000.

This means that if a couple has more than $111,560 ($109,560 + $2,000) in countable resources, then the spouse who is going into the nursing home will not be eligible to have Medicaid pay for his or her nursing home care until those resources are spent down. Once Medicaid eligibility has been determined, the amount allocated to the community spouse should be transferred into that spouse's name, if it is not already in that spouse's name. Resources acquired by the community spouse after the nursing home spouse has been found eligible for Medicaid are considered available only to the community spouse.

Example:

A couple jointly owns a $200,000 home and a $37,000 cabin. A bank account in the wife's name has $44,000, and a bank account in the husband's name has $30,000. The wife enters a nursing home; the husband lives at home.
Here, the home is excluded because the husband lives there. The remaining resources, pooled together, total $111,000 ($37,000 + $44,000 + $30,000). Of this, $109,560 will be allocated to the husband. The remainder ($1440) is considered available to the wife. Because this is less than $2000, the wife is eligible to have Medicaid pay for her nursing home care. After Medicaid has performed its initial assessment of this couple's resources, the couple should transfer all but $1440 of these resources into the husband's name.

In certain situations the amount of resources allocated to the community spouse may be increased. In those situations the "nursing home spouse" will be eligible for Medicaid even though the couple's resources are valued at more than $111,560. The allocation to the "community spouse" may be increased in the following situations:

A. When a fair hearing decision concludes that a higher resource level is necessary to raise the community spouse's income to $2739 per month.

B. When a court support order mandates that additional amounts of the nursing home spouse's resources be transferred to the community spouse or other dependents.

C. If the DHSS determines that denying eligibility creates undue hardship.

XXI. WHAT INCOME AND RESOURCES CAN I KEEP UNDER HCB MEDICAID?

Short answer: it depends.

HCB Medicaid recipients have "allowances" that are parallel, but not exactly the same, as those outlined in the previous sections for Medicaid for nursing home residents. There are three differences.

The first has to do with the changes in a person's SSI/APA checks. As noted above, an SSI/APA recipient who moves into a nursing home has those checks reduced to $75 ($30 in SSI and $45 in APA). A recipient who moves into an assisted living home on HCB Medicaid, however, will continue to get the full SSI check, and will have the APA check reduced to $100.

The second has to do with the "six-month home maintenance" allowance; an HCB Medicaid recipient does not get the allowance that a single Medicaid nursing home resident is given to maintain his/her residence for six months.

The third, and more involved, is the "personal needs allowance." The amount of the personal needs allowance varies depending on whether the HCB Medicaid recipient is in a licensed assisted living facility or staying in his/her own home. There is not a set formula for setting the "cost of care" obligation for Medicaid HCB recipients; this gets worked out in the individualized budget that the recipient's care coordinator helps the recipient submit to Medicaid as part of the application.

For HCB Medicaid recipients *not* living in a licensed assisted living facility (including those remaining in their own homes), the personal needs allowance is the same amount as the income eligibility limit of $1656 per month. HCB Medicaid assumes that recipients remaining at home will need to use that income to pay for their non-medical needs (i.e., food, mortgage payments, and the upkeep of the home). Since this "uses up" the entire amount of the HCB Medicaid recipient's income (that is, those with over $1656 per month are not eligible for HCB Medicaid anyway), the other "allowances" for which HCB Medicaid permits a recipient to use his/her own income are less likely to be used in this category. (One situation in which they may become more important is where the recipient has an "income trust"; there, the trust takes in more than $1656, and the trust has to spend its money in accordance with the HCB Medicaid post-eligibility rules, so the other allowances do become important.)

HCB Medicaid recipients in an assisted living home are allowed to keep $1396 per month as a personal allowance to cover non-medical costs like room, board, and personal items. (Medicaid divides the cost of an assisted living facility into medical and related costs, for which HCB Medicaid can pay, and non-medical costs, which includes room, board and personal items, for which HCB Medicaid cannot pay. Although HCB Medicaid does not limit what an assisted living home can charge the resident for the non-medical portion, it recognizes $1396 as the appropriate amount of the resident's own

income that is not required to go toward his/her medical costs and is thus available for the non-medical portion. All income beyond $1396 per month is considered available to cover medical and related costs, unless covered by one of the other allowances below.)

Like the counterpart $75 "personal needs allowance" for nursing home residents, the "personal needs allowance" for HCB Medicaid recipients (whether in assisted living homes or not) can be increased to cover tax and child support obligations.

Aside from those three differences, HCB Medicaid recipients get the same list of allowances as Medicaid nursing home residents: the community spouse income allowance, the dependent family member allowance, and the uncovered medical costs allowance. (However, since the HCB Medicaid recipient's personal needs allowance is larger, the HCB Medicaid recipient may be less likely to have sufficient income to utilize for all these additional allowances.) Spouses of Medicaid HCB recipients get the same "community spouse resource allowance" as spouses of recipients of Medicaid for nursing home.

XXII. WILL THE DHSS PUT A LIEN ON MY PROPERTY IF I RECEIVE MEDICAID?

Short answer: sometimes.

The DHSS may under certain circumstances put a lien on the real property (that is, land) of a Medicaid nursing home recipient. The lien may be imposed only under certain conditions; there are exceptions under which it cannot be imposed on a person's home; and there are situations in which the lien must be canceled.

The conditions under which the lien may be imposed are: (1) the individual was an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution; (2) the DHSS required the individual to spend all but a minimal amount of the person's income for medical expenses (DHSS interprets this to mean anyone who has to follow the "posteligibility rules" discussed in section XVII and XVIII above); and (3) the DHSS, after giving the individual notice and an opportunity for a hearing, made a determination during the individual's lifetime that the individual could not reasonably be expected to return home.

Only if all three conditions are present can the lien be imposed. Thus, for example, an individual getting Medicaid benefits under a Home and Community Based Waiver to remain at home has not been institutionalized and would not be subject to the lien. And an individual who has not been given notice and an opportunity to contest the lien at a hearing could not be subject to the lien.

Even if all three conditions are present, a lien, while it may be placed on other property, cannot be placed on the person's *home* while it is occupied by the person's spouse, minor dependent or disabled child, or sibling (if the sibling has an equity interest in the home and was residing there for at least one year before the resident's admission to the nursing home).

The lien has to be discharged if the person is discharged from the institution and returns home (although a new lien can be imposed if the person later returns to the nursing home).

No recovery under the lien may be made during the lifetime of the resident's spouse. No recovery may be made while any of the resident's children are still under 21 years of age; and if an adult child is disabled, no recovery under the lien may be made during that adult child's lifetime. If the lien is on the home, then in addition to those restrictions, no recovery under the lien can be made while the home is the residence of a sibling of the resident who was residing there for at least one year prior to the resident's admission to the medical institution and has continuously resided there since then. Also, if the lien is on the home, no recovery under the lien can be made while the home is lawfully resided in by a child of the resident who was residing there for at least two years before the resident's admission to the medical institution and who provided care to the resident to enable the resident to reside at home rather than in an institution, and who has resided there continuously since the date of the resident's admission to the medical institution.

XXIII. WILL THE DHSS RECOVER MEDICAID COSTS FROM MY ESTATE?

Short answer: Only sometimes.

Federal law requires the DHSS to try to recover nursing home care costs in two types of cases, which may overlap.

First, the DHSS has to seek recovery of medical assistance consisting of nursing facility services, home and community-based services, and related hospital and prescription drug services, from the estate of an individual who received Medicaid while 55 years of age or older. (States have the option of seeking recovery for the costs of other services also; Alaska has not yet done so.)

Second, the DHSS has to seek recovery from the estates of deceased nursing home residents if they meet the three conditions for imposition of a lien on real property (see section XXII above).

Like recovery under the lien, there are limitations on recovery from the estate. No recovery from the estate may be made during the lifetime of the individual's spouse. No recovery from the estate may be made while any of the individual's children are still under 21 years of age; and if an adult child is disabled, no recovery from the estate may be made during that adult child's lifetime. Recovery from the estate may not be made as to the individual's home if the home is occupied by the individual's sibling or child meeting the conditions for precluding enforcement of the lien (see section XXII above). There are three other limitations on estate recovery. The department will not pursue a claim against an estate if the only significant asset of the estate is the recipient's primary residence with an equity value of less than $75,000. The department will pursue a claim only if the department determines that the potential recovery will exceed the administrative and legal cost of pursuing the claim. And the department will not seek recovery of Medicaid expenditures made for services that the recipient would not have been required to pay for if the recipient were not eligible for Medicaid.

Not all of an individual's property becomes part of the individual's estate upon death. Generally, property owned by the decedent and another individual with a "right of survivorship" belongs automatically to the survivor and does not become part of the decedent's estate. This would apply to joint bank accounts, vehicles with title in both names connected by "or", and land owned by a husband and wife together. There are no clear court rulings as

yet on whether property which passes by "right of survivorship" would be subject to estate recovery by the DHSS. Further, state probate law gives a decedent's family certain "allowances" set aside for family members which must be allowed prior to paying claims to creditors. Among these is an "exempt property" allowance of $10,000 which may be claimed by adult children if there is no surviving spouse, and this allowance would probably take precedence over any DHSS estate recovery claim. (If there is a surviving spouse, then DHSS cannot pursue estate recovery at all during that spouse's lifetime, as noted above.)

There are certain time restrictions for claims under the state probate law. Generally, a claim is barred if not brought within three years of the decedent's death, or within four months of publishing of notice to creditors of the decedent in probate proceedings. It is at this point not known whether, if the existence of a surviving spouse or dependent or disabled children stops the DHSS from recovering on its claims within those statutory periods, the expiration of those periods will preclude any estate recovery by the DHSS. (DHSS takes the position that it will not be precluded.)

The DHSS may *waive* estate recovery if it determines that undue hardship would be worked on the survivors. Reasons for undue hardship may include:

(1) the estate's only significant asset is an income-producing asset, and recovery would cause loss of livelihood to survivors;

(2) the estate's only significant asset is real property that is the primary residence of a survivor, and that was the primary residence of the survivor at the time of the recipient's death;

(3) without the receipt of estate proceeds a survivor would become eligible for public assistance or Medicaid;

(4) allowing a survivor to receive the estate would enable the survivor to discontinue eligibility for public assistance or Medicaid;

(5) recovery would deprive the survivor of (A) medical care, without which the survivors' health or life would be endangered; or (B) food, clothing, shelter, or other necessities of life; or

(6) the survivor made substantial personal contributions to the property or to the recipient so that the recipient could remain home.

If you set up one of the three types of trust discussed in section XIII above, then the trust has to specify that any property remaining in the trust at the time of your death has to go to the DHSS. This is separate and apart from the other estate recovery provisions discussed above. (Income trusts are not likely to accumulate much anyway, although special needs and "pooled" trusts may.)

XXIV. IS HCB MEDICAID AVAILABLE TO MEET EXPENSES IN THE PIONEER HOMES?

Short answer: yes.

The Pioneer Homes are assisted living homes, so Medicaid HCB is available. Additionally, the Pioneer Homes have their own "payment assistance program" as well. Residents have to apply for Medicaid and other available assistance programs as a requirement of applying for the Pioneer Home Payment Assistance Program (PHPAP).

To be eligible to get into the Pioneer Home, you have to be at least 65 years old, an Alaska resident for at least one year, and in need of residence at the home because of

a cognitive impairment (e.g., Alzheimer's) or other disability requiring regular assistance with activities of daily living. Residents must show that they have or will have Medicare Part A and Part B, or the equivalent in private health insurance.

The rates are set to partially compensate for the cost of services. There are three levels of service:

Level of care	Monthly charge
Level I Services	$2,350
Level II Services	$4,260
Level III Services	$6,170

Residents who cannot afford the monthly charges may receive financial assistance, under the Pioneer Home Payment Assistance Program (PHPAP) as well as HCB Medicaid.

HCB Medicaid is available for qualified residents to cover the cost of HCB Medicaid services offered through the Pioneer Homes and other non-Pioneer Home services that are covered by HCB Medicaid. Medicaid will also cover the cost of Medicare Part A and B; and, for residents who are not eligible for Medicare Part D, Medicaid will cover prescription costs including the costs of pharmaceuticals supplied by the Pioneer Home.

Many Pioneer Home residents will find it advantageous to apply for PHPAP as well as Medicaid. Each program has certain advantages. For example, if the resident's income is $0, the PHPAP will pay for the non-medical costs of room and board; whereas Medicaid does not. On the other hand, Medicaid will pay for many of the resident's medical bills, which the PHPAP might not cover. These financial assistance programs are similar in their requirements, but there are important differences in income and resource limits between the programs. Both are discussed below.

A. Medicaid

Pioneer Home residents may apply for HCB Medicaid or "regular" Medicaid.

HCB Medicaid is available to help meet the costs of the Pioneer Home, under the same rules described in this pamphlet for HCB Medicaid residents in other assisted living facilities. (Formerly, Pioneer Home residents did not receive SSI or APA, so section XVII above regarding APA and SSI in nursing homes, and section XXI above regarding SSI and APA in assisted living homes, did not apply to a Pioneer Home resident, but more recently it appears that the Social Security Administration may be willing to allow SSI to Pioneer Home residents.)

Not all Pioneer Home residents will meet the level-of-care needs sufficient to qualify for HCB services; the resident must be in need of a nursing home level of care (see section V above). Residents who require Pioneer Home Level III services are the people most likely to qualify for HCB Medicaid because that level of services is most comparable to nursing home care.

Pioneer Home residents who do not qualify for HCB Medicaid still may meet the financial requirement for "regular" Medicaid, which does not depend on level-of-care needs. It has separate eligibility requirements, reviewed in section X above; the income ceilings (listed in that section) are lower than for HCB Medicaid. "Regular" Medicaid will not pay towards the Pioneer Home expenses like HCB Medicaid would, but pays for medical expenses the PHPAP generally does not.

B. PHPAP

Generally, Pioneer Home residents receiving financial assistance through PHPAP must devote all their income and resources to those costs, with the following exceptions:

Income rules: (1) the following categories of income are exempt: Permanent Fund Dividends; ANCSA dividends (non-cash dividends in any amount; cash dividends of up to $2000); permanent fund dividends; volunteer compensation under the Retired Senior Volunteer Program (RSVP), foster grandparents, and senior companion programs; federal World War II restitution payments; state compensation to crime victims; and Agent Orange Settlement Fund payments.

(2) Residents who receive at least $100 per month in income are allowed to keep the first $100, and also pay their own income tax, medication expenses, and health insurance premiums; the remainder must be paid to the state towards the cost of care. Residents with less than $100 per month income may receive a stipend sufficient to bring their income up to $100 per month.

(3) If the resident has a spouse, that spouse can keep all of the spouse's income and, if the spouse's income is less than $2000 per month, the spouse can retain so much of the resident's income as is necessary to bring the spouse's income up to $2000 per month.

Asset rules: (1) Residents applying for a subsidy or stipend are allowed to retain any property necessitated by the resident's physical condition (e.g., prosthetic devices); a motor vehicle; any stock or land received under ANCSA; any life insurance policies with no cash surrender value; burial insurance and/or a burial account with a value up to $4500; and burial spaces for the resident, spouse, or dependents.

(2) A resident with no spouse or dependents can retain up to $10,000 in additional real or personal property.

(3) A resident with a spouse or dependent in the community can retain a home (regardless of value) if it is used as the primary residence of the spouse or dependent; and up to $98,000 in other real or personal property.

Transfer of asset rules: The application must list all income and resources (real property, other major resources, and accounts) owned currently or during the last 36 months. Resources given away or sold for less than fair market value during that 36-month period will generally be counted as still belonging to the applicant for purposes of computing eligibility for PHPAP, unless the resident can show that the transaction was for a purpose other than reducing his/her ability to pay. (Note that this 36-month lookback period is shorter than the 60-month lookback period for Medicaid.)

Estate recovery: the PHPAP has its own program for recovering the assistance paid from the estates of deceased residents.

More information on Pioneer Homes can be obtained by calling 465-4416, or writing to Division of Alaska Pioneer Homes, Box 110690, Juneau AK 99811-0690, or at http://hss.state.ak.us/dalp/. A booklet describing the Payment Assistance Program is available at: http://hss.state.ak.us/dalp/docs/payment_assistance.pdf

XXV. WHAT NURSING HOME BENEFITS ARE COVERED BY MEDICARE?

Short answer: not many.

As noted above, Medicare is the health insurance for elderly or disabled people who receive Social Security payments. It is not limited to low-income people. It does require patients to pay for part of their medical costs.

Medicare does provide some nursing home coverage, but it is limited in duration. The important points of Medicare skilled nursing facility coverage are:

(1) Only posthospital admissions are covered (and the hospital stay must have been at least three days). Ordinarily, transfer to the nursing home and provision of skilled services must begin within 30 days of leaving the hospital.

(2) The patient must need skilled nursing or rehabilitation care on a daily basis, as certified by a physician; not all patients who need "custodial care" will need "skilled nursing or rehabilitation care" which will qualify for Medicare coverage.

(3) A maximum of 100 days per spell of illness is covered. The "spell of illness" ends and a new "spell of illness" begins (with renewed hospital and skilled nursing facility coverage) only after the patient has gone 60 consecutive days without being an inpatient at a hospital or skilled nursing facility.

(4) Medicare pays the full amount of the first 20 days of skilled nursing facility care; from the 21st through the 100th day, the patient must pay a daily co-insurance amount ($137.50 per day in 2010). Medicare coverage denials can be appealed through Social Security.

This brief summary of Medicare nursing home coverage omits many details. Basically, Medicare offers valuable nursing home coverage for patients recuperating from hospital stays, but the coverage will either not apply or expire quickly in many cases where residents need long-term nursing care.

XXVI. DOES MEDICARE COVER ANY HOME HEALTH CARE BENEFITS?

Short answer: yes.

Medicare does cover some home health care: part time or intermittent nursing care provided by (or under the supervision of) a registered professional nurse; physical, occupational or speech therapy; medical social services under the direction of a physician; and in some situations, part-time or intermittent services of a home health aide.

Medicare coverage for those services is limited to individuals who are "homebound" (that is, leaving home requires a considerable or taxing effort by the individual, and any trips away from home are infrequent or of relatively short duration, or attributable to the need to seek medical treatment).

The individual must need skilled nursing care on an intermittent basis (less than seven days per week), or physical or speech therapy, or in certain circumstances occupational therapy (if the individual has been furnished home health services based on other needs which have ended, but the individual still needs occupational therapy).

The individual has to be under the care of a physician, and a plan for these services

has to be established and periodically reviewed by the physician.

Often, denials are based on the individual not being "homebound", or not requiring intermittent skilled nursing care. An individual who requires no skilled nursing care, or who requires skilled nursing care more than intermittently, will not qualify. Denials of Medicare coverage can be appealed through the Social Security office.

This brief summary of Medicare home health omits many details. If you have a question about Medicare specifically, you may want to call the Information and Referral line within the Division of Senior Services, 269-3669 in Anchorage and 800-478-6065 if you are in another part of the state.

XXVII. WHAT IS ALASKA LEGAL SERVICES CORPORATION?

Short answer: They're good people.

Alaska Legal Services Corporation is a private, non-profit corporation funded by federal, state, and local funds. The program offers civil legal assistance to Alaskans who qualify on the basis of income eligibility and case type. Office locations and contact information (phone, fax) can be found on ALSC's web site at www.alsc-law.org.

In addition to providing free legal assistance to low-income Alaskans, the program serves Alaskans age 60 or older through a grant from the Older Alaskans Commission. The seniors' Legal Services Project may be able to provide assistance or referrals in the areas of income maintenance and public assistance, health care, housing, wills, and protection of institutionalized persons. For more information, contact the Alaska Legal Services Corporation office nearest you.

XXVIII. HOW CAN I GET COPIES OF THIS BROCHURE?

Short answer: Probably the same way you got this one.

We can provide a free copy to anyone. It is also available through www.alaskalawhelp.org. Quantity orders at cost are available upon request. To obtain additional copies, contact our Fairbanks office at 907-452-5181.