

**THIS DOCUMENT CONTAINS THE RESULTS OF THE SURVEY OF STATE  
MEDICAID PROGRAMS CONDUCTED FOR THE CENTER FOR LONG-TERM CARE  
FINANCING'S NEBRASKA STUDY TITLED "CONTROLLING MEDICAID LONG-  
TERM CARE COSTS"**

**SEE BELOW FOR A LIST OF STATE CONTACTS REGARDING THIS SURVEY  
FOLLOWED BY THE FULL COMPILATION OF STATE RESPONSES TO THE  
SURVEY**

**CONTACT LIST FOR STATE MEDICAID SURVEYS**

**ALABAMA      **RECEIVED HARD COPY; ELECTRONIC COPY RECEIVED****

Elizabeth W. Conner  
Southern Regional Supervisor  
Elderly & Disabled Certification Division  
(334) 242-1732; 1-800-362-1504  
[econner@medicaid.state.al.us](mailto:econner@medicaid.state.al.us)

**ALASKA      **STILL AWAITING SURVEY****

Left several VM messages w/ Andrea, who is in charge of tracking incoming mail  
(907) 465-1164

**ARIZONA      **RECEIVED HARD COPY; RECEIVED ELECTRONIC COPY****

State Contact (name):      Dan McKeever, Supervisor, Long Term Care Policy Unit  
(Person we should contact with questions re this survey)  
Email address:              [ddmckeever@ahcccs.state.az.us](mailto:ddmckeever@ahcccs.state.az.us)  
Phone number:              602-417-4455  
Mailing address:            AHCCCS  
   P.O. Box 25520  
   Mail Drop 2600  
   Phoenix, AZ 85002-5520

**ARKANSAS      **RECEIVED HARD COPY; RECEIVED ELECTRONIC COPY****

State Contact (name):      Randy Helms  
Email address:              [Randy.Helms@medicaid.state.ar.us](mailto:Randy.Helms@medicaid.state.ar.us)  
Phone number:              501-682-1857  
Mailing address:            Arkansas Department of Human Services  
   P.O. Box 1437 Slot S416  
   Little Rock, AR 72203

**CALIFORNIA      **UNABLE TO REPLY DUE TO BUDGET ISSUES/STAFF SHORTAGES; WOULD LIKE  
COPY OF REPORT EMAILED TO BETH ([bfairbro@dhs.ca.gov](mailto:bfairbro@dhs.ca.gov))****

**COLORADO      **UNABLE TO RESPOND; WOULD LIKE COPY OF REPORT****

Vivianne M. Chaumont  
Director, Medical Assistance Office  
Department of Health Care Policy and Financing  
[vivianne.chaumont@state.co.us](mailto:vivianne.chaumont@state.co.us)

Email of 9/30: Mr. Moses: I am in receipt of your letter including the survey you are using in the project for which the Nebraska Legislature has retained you. The answers to most, if not all, of the questions you ask can be found in Colorado's statutes and regulations governing the Colorado Medicaid program. Those statutes can be accessed on the

internet at Colorado's home page. Since I have staff shortages and the information is readily accessible to your staff should they choose to do the research, Colorado will not be responding to the survey.

**CONNECTICUT            CONDUCTED PHONE INTERVIEW; ELECTRONIC COPY CREATED**

Shok, Marc C.  
[Marc.Shok@po.state.ct.us](mailto:Marc.Shok@po.state.ct.us)  
Main number: 860-424-5116  
Medical Care Administration, Dept. of Social Svcs.  
25 Sigourney St.  
Hartford, CT 06106

**DC            RECEIVED ELECTRONIC COPY OF SURVEY**

State Contact (name):        Jane Young  
(Person we should contact with questions re this survey)  
Email address:                Jane.Young@dc.gov  
Phone number:                (202) 442-9075  
Mailing address:              825 North Capitol Street, N.E.  
   Suite 5135  
   Washington, DC 20002

*or*

Milka Shephard  
Program Specialist  
Office of the Senior Deputy Director, MAA  
825 North Capitol Street, N.E. #5135  
Washington, D.C. 20002  
(202) 442-9053 (Voice)  
(202) 442-4790 (Fax)  
[Milka.Shephard@dc.gov](mailto:Milka.Shephard@dc.gov)

**DELAWARE        SURVEY RETURNED IN ELECTRONIC FORMAT; WOULD LIKE COPY OF REPORT**

Jill Williams – Social Services Administrator  
Dept. Health & Social Svcs.  
P.O. Box 906  
Lewis Bldg.  
Holloway Campus  
New Castle, DE 19720  
[jill.williams@state.de.us](mailto:jill.williams@state.de.us)  
**(main phone number: 302-577-4901)**

**FLORIDA            STILL AWAITING SURVEY**

**GEORGIA            SURVEY RETURNED IN ELECTRONIC FORMAT**

Kathanette Barnes  
Medicaid Program Consultant  
Department of Community Health  
Division of Medical Assistance  
2 Peachtree Street, NW  
Atlanta, GA 30303  
(404) 651-9985  
(404) 656-4913 (FAX)  
[kbarnes@dch.state.ga.us](mailto:kbarnes@dch.state.ga.us)

**HAWAII            STILL AWAITING SURVEY**

10/8: Emailed survey to:  
Kamaile Kinolau  
[kkinolau@medicaid.dhs.state.hi.us](mailto:kkinolau@medicaid.dhs.state.hi.us)

808-692-8056

**IDAHO            STILL AWAITING SURVEY**

Rita Hurry  
[HurryR@idhw.state.id.us](mailto:HurryR@idhw.state.id.us)

**ILLINOIS            UNABLE TO RESPOND TO SURVEY**

**INDIANA            RECEIVED HARD COPY; RECEIVED ELECTRONIC COPY**

State Contact (name): Donna Stolz Sembroski  
Email address: [dsembroski@fssa.state.in.us](mailto:dsembroski@fssa.state.in.us)  
Phone number: (317) 232-1244  
Mailing address: Indiana Family and Social Services Administration  
MS 27. Office of General Counsel  
402 W. Washington St., Rm W451  
Indianapolis, IN 46204

**Or Cheryl Sullivan, Secretary**

[Dsembroski@fssa.state.in.us](mailto:Dsembroski@fssa.state.in.us)

**(317) 232-1244**

**11/5: Email to Cheryl requesting electronic copy**

**IOWA            STILL AWAITING SURVEY**

**Left several messages w/ Eugene (Gene) Gessow, Director  
Division of Medical Svs., Dept. of Human Svs.  
Hoover State Office Bldg., 5<sup>th</sup> Floor  
Des Moines, IA 50319  
(515) 281-6249**

**KANSAS            STILL AWAITING SURVEY**

Mr. Robert (Bob) Day, Medicaid Director, Director of Medical Policy  
Dept. of Social & Rehabilitation Svs.  
915 SW Harrison, 5<sup>th</sup> FL  
Topeka, KS 66612  
(785) 296-3773/(785)296-7106

**KENTUCKY            RECEIVED HARD COPY; AWAITING ELECTRONIC COPY – DM completed from hard copy**

Jesse Williams  
[Jesse.williams@mail.state.ky.us](mailto:Jesse.williams@mail.state.ky.us)  
(502) 564-6204

**LOUISIANA            RECEIVED ELECTRONIC COPY**

State Contact: Darlene Hughes  
Email address: [dhughes@dhh.la.gov](mailto:dhughes@dhh.la.gov)  
Phone Number: 225.342.7628  
Mailing Address: Eligibility Program Operations  
P. O. Box 91288  
Baton Rouge, LA 70821-9288  
(Bureau of Health Svs. Financing, Dept. of Health & Hospitals)

**MAINE            RECEIVED ELECTRONIC COPY**

State Contact (name): Julie Tosswill  
Email address: [Julie.tosswill@maine.gov](mailto:Julie.tosswill@maine.gov)  
Phone number: 207-287-9360

Mailing address: Division of Policy & Provider Services  
Bureau of Medical Services, 11 State House Station  
442 Civic Center Dr., Augusta, ME 04333-0011

**MARYLAND STILL AWAITING SURVEY**

Stacey  
410-767-5954  
Office of Planning & Finance, Medical Care Programs  
Dept. of Health & Mental Hygiene  
201 W Preston St, 2<sup>nd</sup> FL  
Baltimore, MD 21201

**MASSACHUSETTS STILL AWAITING SURVEY**

Josaphene Bethel  
Division of Medical Assistance  
600 Washington St.  
Boston, MA 02111  
(617) 210-5314

**MICHIGAN RECEIVED HARD COPY -- DM entered text from hard copy**

**MINNESOTA RECEIVED ELECTRONIC COPY**

State Contact (name): Judy Funke  
Email address: [judy.funke@state.mn.us](mailto:judy.funke@state.mn.us)  
Phone Number: 651-296-7666  
Mailing Address: Minnesota Department of Human Services  
444 Lafayette Road  
St. Paul, MN. 55155-3848

Or

'janice.wryk@state.mn.us'  
651-297-7515

**MISSISSIPPI RECEIVED HARD COPY; AWAITING ELECTRONIC COPY -- DM entered text from hard copy**

Mississippi  
Contact: Betty Williams  
[Elbrw@medicaid.state.ms.us](mailto:Elbrw@medicaid.state.ms.us)  
601-987-3943

**MISSOURI UNABLE TO RESPOND**

This is in response to your recent survey to the Division of Medical Services regarding Controlling Medicaid Long-Term Care Costs. Due to extreme budget cuts and the resulting reduction in staffing and resources, we are unable to participate in the survey. We are referring you to the State of Missouri website located on the internet at [www.state.mo.us](http://www.state.mo.us) for information on our programs. The Division of Medical Services website may be viewed at [www.dss.state.mo.us/dms](http://www.dss.state.mo.us/dms).

Eligibility for the Medicaid program is determined by the Division of Family Services (DFS). DFS maintains offices in each Missouri county to assist individuals with eligibility questions for Medicaid and other programs. You may contact the DFS central office at 1-800-392-1261. It may also be helpful to view their website at [www.dss.state.mo.us/dfs](http://www.dss.state.mo.us/dfs).

Division of Medical Services

**MONTANA RETURNED ELECTRONIC COPY**

Kelly Williams, Administrator of Senior & LTC Division (person assigned to complete survey)  
406-444-4147  
(John Chappuis, Deputy Director)  
Dept. of Public Health & Human Svcs.  
1400 Broadway  
Helena, MT 59601

**NEBRASKA AS PER SM's DIRECTION, NO NEED TO COLLECT SURVEY**

Bob Seiffert, Administrator  
Medical Svcs. Division  
Dept. of Health & Human Svcs.  
PO Box 95026  
301 Centennial Mall S, 5<sup>th</sup> Floor  
Lincoln, NE 68509  
(402) 471-9147; 402-471-9223 (Direct to Jackie Foster, Bob's assistant)  
email: [bob.seiffert@hhss.state.ne.us](mailto:bob.seiffert@hhss.state.ne.us)

**NEVADA RETURNED HARD COPY; RETURNED ELECTRONIC COPY**

John Liveratti  
[Liveratt@dncfp.state.nv.us](mailto:Liveratt@dncfp.state.nv.us)  
(775) 684-3606  
1100 E. William St., Suite 116, Carson City, NV 89701  
11/6: Email requesting electronic copy.

**NEW HAMPSHIRE STILL AWAITING SURVEY**

Kim  
(603) 271-7857

**NEW JERSEY STILL AWAITING SURVEY**

Kathleen (Kathy) Mason  
Assistant Commissioner  
NJ Dept of Health & Senior Services  
PAAD/Senior Gold  
Phone: (609) 588-7972  
Fax: (609) 631-4667  
[kathleen.mason@doh.state.nj.us](mailto:kathleen.mason@doh.state.nj.us)

**NEW MEXICO STILL AWAITING SURVEY**

Jennifer Mondragon  
[Jennifer.mondragon@state.nm.us](mailto:Jennifer.mondragon@state.nm.us)  
(505) 827-3106

**NEW YORK STILL AWAITING SURVEY**

**NORTH CAROLINA SURVEY RETURNED IN ELECTRONIC FORMAT**

State Contact (name): Lynne Perrin  
Email address: [Lynne.Perrin@ncmail.net](mailto:Lynne.Perrin@ncmail.net)  
Phone Number: 919-857-4020  
Mailing address: Division of Medical Assistance  
2501 Mail Service Center  
Raleigh, NC 27699-2501

**NORTH DAKOTA SURVEY RETURNED IN ELECTRONIC FORMAT; WOULD LIKE COPY OF REPORT**

State Contact (name): Blaine L. Nordwall, Director

Economic Assistance Policy  
North Dakota Department of Human Services  
Email address: sonorb@state.nd.us  
Phone number: 701-328-4058  
Mailing address: State Capitol - Judicial Wing  
600 East Boulevard Avenue, Dept 325  
Bismarck, ND 58505-0250

**OHIO**                    **RECEIVED ELECTRONIC COPY**  
State Contact (name): **Kim Irwin, Chief, Facility Contracting Section**  
Email address: **irwink@odjfs.state.oh.us**  
Phone number: **(614) 466-6467**  
Mailing address: **Bureau of Long Term Care Facilities**  
**30 East Broad St., 33<sup>rd</sup> floor**  
**Columbus, OH 43215-3414**

Kim Urwin  
Ohio Child & Family Svcs.  
614-466-6467

**OKLAHOMA**    **STILL AWAITING FOR NANCY STAFFINS TO EMAIL SM HER PORTION OF THE SURVEY RESPONSES (AM gave her SM's email address on 10/20).**  
Nancy Staffins  
405-522-7107

**OREGON**            **ELECTRONIC COPY RECEIVED; WOULD LIKE COPY OF REPORT**  
Carolyn Wilson  
Executive Assistant to the Assistant Director  
DHS, Seniors and People with Disabilities  
500 Summer Street, NE - E02  
Salem, OR 97301-1073  
(503) 945-6478  
(503) 373-7823 – fax  
[carolyn.wilson@state.or.us](mailto:carolyn.wilson@state.or.us)

**PENNSYLVANIA**        **STILL AWAITING SURVEY**

**RHODE ISLAND**        **STILL AWAITING SURVEY**

**SOUTH CAROLINA**    **RETURNED HARD COPY; ELECTRONIC COPY RECEIVED**  
State Contact (name): Alicia Jacobs, Division Director  
Email address: [jacobs@dhhs.state.sc.us](mailto:jacobs@dhhs.state.sc.us)  
Phone Number: 803 898-2538  
Mailing Address: SC Department of Health and Human Services  
Post Office Box 8206  
Columbia, SC 29202-8206

**SOUTH DAKOTA**        **STILL AWAITING SURVEY**

**TENNESSEE**            **STILL AWAITING SURVEY**

**TEXAS**                **SURVEY RETURNED IN ELECTRONIC FORMAT; WOULD LIKE COPY OF REPORT**  
Randy Wyatt, Medicaid Eligibility Unit Manager  
[randy.wyatt@dhs.state.tx.us](mailto:randy.wyatt@dhs.state.tx.us)  
512/438-4807  
Texas Department of Human Services

Mail Code W-513  
P.O. Box 149030  
Austin, TX 78714-9030  
or  
Cheryl Williams-Hawkins, Administrative Assistant  
Health & Human Services Commission  
(512)424-6517  
(512)424-6585 fax

**UTAH RECEIVED HARD COPY; RECEIVED ELECTRONIC COPY**

**Richard Nelson**

[Richardnelson@utah.gov](mailto:Richardnelson@utah.gov)

(801) 538-6494

(Steve, no other contact information was provided in the electronic version; please see hard copy, if additional information is needed).

**VERMONT STILL AWAITING SURVEY**

**VIRGINIA UNABLE TO RESPOND TO SURVEY**

Bernadette T. Clark  
Freedom of Information Act Coordinator  
DMAS  
600 E. Broad St., Suite 1300  
Richmond, VA 23219  
Phone: (804) 371-6391  
Fax: (804) 371-4981  
E-mail: [bclark@dmas.state.va.us](mailto:bclark@dmas.state.va.us)  
Agency Web-site: [www.dmas.state.va.us](http://www.dmas.state.va.us)

**Email of 9/29:** I regret that we are unable to respond to your survey. The information that you desire can be found in the DSS Eligibility Manual. There is a link to this manual from the DMAS website at [www.dmas.state.va.us](http://www.dmas.state.va.us). (under the Client Services heading).

**WASHINGTON STILL AWAITING SURVEY**

**WEST VIRGINIA UNABLE TO REACH BY PHONE**

**WISCONSIN STILL AWAITING SURVEY**

**WYOMING STILL AWAITING SURVEY**

**RESPONSES TO STATE MEDICAID SURVEYS**

**1. Please answer the following questions on Medicaid eligibility policy:**

**How is income eligibility for Medicaid long-term care determined in your state? Please explain briefly.**

**Medically needy? If so, what medical and other expenses are deductible from income to determine Medical eligibility?**

**Income cap? If so, how common are "Miller Income Trusts" and what effect have they had on Medicaid eligibility since being authorized by OBRA '93?**

**What is the Community Spouse Resource Allowance (CSRA) and the Minimum Monthly Maintenance Needs Allowance (MMMNA) for your state?**

**Have these standards changed in the past three years? If so, from what to what?**

**Do you allow the "transfer of assets before income" to bring a community spouse up to the MMMNA?**

**Is the home considered exempt as long as an "intent to return" is in effect? If you impose some other requirement, please explain.**

**ALABAMA: Income limit is set at 300% of the FBR; Resource limit is \$2000.00  
Qualified Income (Miller) Trusts are allowed. At this time, there is no way to determine how many cases utilize the Miller trust provision. However, at this time, the percentage is low.**

**Alabama does not have a "Medically needy" provision.**

**Community Spouse Resource Allowance (2003)**

**Minimum \$25,000 (no change in past three years)**

**50% of total, if the spousal share is over \$25,000**

**Maximum \$90,600 (2003)**

**\$89,280 (2002)**

**\$87,000 (2001)**

**Community Spouse Allocation \$1515 (7/2003)**

**Income of institutionalized spouse is allocated to bring community spouse up to the maximum.**

**Allocation amounts change in July of each year.**

**7/2002 \$1493**

**7/2001 \$1452**

**Intent to return home is an acceptable exclusion for homestead property**

**ARIZONA: Arizona is an income-cap state with the income limit for long term care set at 300% of the FBR (currently \$1,656). Miller trusts are frequently used in establishing Medicaid long-term care eligibility. Our long-term care program is called the Arizona Long Term Care System (ALTCS).**

**Currently, 529 individuals are receiving ALTCS as a result of establishing Miller trusts. A total of 1,589 have used Miller trusts to qualify for ALTCS since 1993. Other individuals have established Miller trusts but have failed to qualify for ALTCS based on other factors.**

**Originally, Miller trusts were generally used by persons residing in nursing homes. As a result, these individuals were paying a high amount toward the cost of their care (post-eligibility treatment of income). However, an increasing number are using these trusts to qualify for HCBS services, where post-eligibility collections are not as high due to the higher personal needs allowance.**

**Our current minimum CSRA is \$18,132 and the maximum is \$90,660. The minimum CSR amount was \$17,400 in 2001 and \$17,856 in 2002. The maximum CSR was \$87,000 in 2001 and \$89,280 in 2003.**

**The MMMNA was \$2,175 in 2001, \$2,232 in 2002 and \$2,267 in 2003.**

**All of these figures were updated in January of each year as a result of federal increases in these standards.**

**Currently we use an income method, meaning that we first total the amount of the Community Spouse's income and the amount of the CSMIA. Then, resources can be set aside for the purpose of increasing the community spouse's income to make up for the deficit between the community spouse's other income, including the CSMIA, and the MMMNA. This is handled through the fair hearing process.**

**We exclude the home property as a resource when:**

- The customer or spouse resides in the home property;**

- The customer has resided in the home property, is absent due to institutionalization, but expresses the intent to return;
- The customer is absent from the home property due to institutionalization but the customer's spouse or dependent relative resides in the property as his or her principle place of residence. In this situation, the exclusion applies even when the customer does not express an intent to return or when the customer did not previously reside in the property.

If none of the conditional exclusions apply, we count the property as a resource.

**ARKANSAS:** No, regarding “Medically Needy.”

Yes, regarding “Income Cap.” Arkansas currently has 428 individuals with Miller Income Trusts on Medicaid residing in a nursing facility. This is about 2.7% of our total current nursing home Medicaid population of 15,583. The impact of Miller Trusts have been small since income levels for individuals in Arkansas tend to be low. Miller Trusts are very beneficial for individuals with income over the limit, but not enough to pay for nursing facility care.

CSRA	Minimum:	\$18,132	Maximum:	\$90,660
MMMNA		\$1515		

These are the federal standards that increase annually.

No, regarding “transfer of assets before income.”

Yes, regarding home being considered exempt as long as an "intent to return" is in effect.

**CONNECTICUT:** Medically needy? **YES**

If so, what medical and other expenses are deductible from income to determine Medicaid eligibility?  
LTC facility rate as expense

Income cap? **NO**

If so, how common are "Miller Income Trusts" and what effect have they had on Medicaid eligibility since being authorized in OBRA '93? **N/A**

What is the Community Spouse Resource Allowance (CSRA: CT refers to this as “CSPA” or Community Spouse Protected Amount; they use the federal minimum - \$18,132 and maximum – \$90,660) and the Minimum Monthly Maintenance Needs Allowance (MMMNA: Again, CT uses the federal minimum - \$15,015? And maximum - \$22,066.50?) for your state?

Have these standards changed in the past three years? **YES, the Feds increase this level each year.**  
If so, from what to what? **Not sure how to answer this.**

Do you allow the "transfer of assets before income" to bring a community spouse up to the MMMNA? **CT became an income first state this past July (2003).**

Is the home considered exempt as long as an "intent to return" is in effect? If you impose some other requirement, please explain. **YES. There is, however, a six-month limitation. In other words, if someone has a physician’s statement specifying that s/he is expected to return w/in six-months, than the home is considered exempt. If at the end of that six-month period, the person is still unable to return home, the home can remain exempt, if the physician predicts a return to home w/in the next several months. Basically, the circumstances are reviewed every 6-months.**

**DC:** Long term care (LTC) eligibility is determined by a specialized eligibility unit within the largest of the seven Income Maintenance Administration's decentralized Service Centers. A summary of the program is attached; a more detailed brochure is also attached for reference.

The District of Columbia does have a Medically Needy program, which is currently set at 50% of the federal poverty level (FPL). For customers not in LTC, their medical expenses (including insurance premiums and cost-sharing) are subtracted from their countable income; if/when the difference is below the Medically Needy threshold, we add the customer to the Spend-Down program for up to six months. For LTC customers, we simply take a customer's countable income and subtract the appropriate personal needs and other allowances; the difference is the customer's "payability" or share-of-cost.

DC has no income cap for LTC Medicaid eligibility. Given that we are a medically needy State, Miller trusts do not apply. One note: we do have a resource limit of \$2,600 for individuals, \$3,000 for couples.

**LTC Eligibility Standards: 2003\***

Maximum Monthly/Maintenance Needs Allowance: \$2,266.50

Minimum Community Spouse Resource Allowance: \$18,132.00

Maximum Community Spouse Resource Allowance: \$90,660.00

Monthly Personal Needs Allowance: \$70.00

Resource Allowance for an Individual: \$2,600.00

(for both categorically needy and medically needy eligibility groups)

Resource Allowance for a Couple: \$3,000.00 (both husband and wife in a nursing home)

\* Amounts general change on January 1st of each year.

The District of Columbia does not allow the "transfer of assets before income" for LTC customers. The home is considered exempt for six months if there is a documented "intent to return."

**DELAWARE:** Income cap state at 250% of the SSI standard. Miller trusts are very common.

CSRA: minimum = \$25,000 and maximum = \$90,660

MMMNA = \$2,267

We do income first.

The home may be considered exempt if there is an intent to return home.

**GEORGIA:** For long-term care nursing home Medicaid eligibility, Georgia uses both the Medicaid cap and Medically Needy methodologies.

Georgia uses the Maximum Monthly Income Maintenance Needs Allowance of \$2,266.50. These amounts are changed annually when the new Spousal Impoverishment amounts are published by CMS.

CSRA: \$90,660.00

MMMNA: N/A

Georgia uses the Maximum Monthly Income Maintenance Needs Allowance of \$2,266.50. These amounts are changed annually when the new Spousal Impoverishment amounts are published by CMS.

No - "transfer of Assets before Income"

Yes – Home is considered exempt.

**INDIANA:** See 405 IAC 2-3-20 and 2-3-21, attached ([http://www.in.gov/legislative/ic\\_iac/](http://www.in.gov/legislative/ic_iac/))

Indiana does not have a medically needy program, but as a 209(b) state we do allow deductions for incurred medical expenses.

Indiana does not have an income cap.

CSRA Minimum: \$18,132; Maximum: \$90,660

Yes, they are adjusted under Section 1924(g) of the Social Security Act.

Yes, regarding “transfer of assets before income”

The home is exempt as long as the applicant or recipient, or spouse, or minor or disabled child reside there. If none of those individuals reside there, and are not expected to return home to live, the property must be offered for sale or rent.

**KENTUCKY:**

1.) Income must be under the special income standard (three (3) times the SSI payment standard). If income is over the special income standard a Qualifying Income Trust (QIT) must be established (this is effective September 2003).

Effective September 1, 2003, Long Term Care Services are not covered for Medically Needy.

QITs have only been allowed since September 1, 2003 due to changes in the Kentucky Medicaid program.

CSRA: \$20,000

MMMNA: \$1,515

Prior to September 1, 2003 Kentucky allowed the maximum resource and income allowances. Effective September 1, 2003, the allowances have been changed to the above.

NO

Yes

**LOUISIANA:** Income eligibility is based on the applicant/recipient’s gross income (excluding VA Aid and Attendance). Gross income is compared to the CAP Rate - the income limit applicable to individuals in an institutionalized setting. The CAP Rate is three times the SSI Federal Benefit Rate for an individual. The couple CAP Rate is double the individual CAP Rate. As of 1/1/2003, the CAP Rate for an individual is \$1656, the couple CAP Rate is \$3312.

Yes, we are a medically needy state. If an individual is ineligible solely because his countable income is over the CAP, he may be considered under the Medically Needy Program. Under MNP, his income must be less than the Medicaid rate for the facility he is residing in, or the individual may be certified on a month by month basis if the individual’s monthly income is over the Medicaid facility rate but below the monthly MNIES (Medically Needy Income Eligibility Standard, \$100 urban, \$92 rural) after subtracting the Medicaid facility fee, any ongoing monthly medical expenses such as Medicare Part B premiums and health insurance premiums or any nonrecurring medical expenses such as prescriptions that are not paid by any medical plan. Medical expenses that the applicant is legally liable for and are recognized as medically necessary under state law are allowed as deductions provided that the service dates are not older than 3 months prior to the month of application. If the income is below the Medicaid facility fee, a vendor payment will be made and the applicant/recipient will

receive regular Medicaid benefits. If the income is above the Medicaid facility fee, no vendor payment will be made, but they will be eligible to receive regular Medicaid benefits.

Yes, we are an income cap. Miller Trusts are not allowed due to Louisiana having a Long Term Care Medically Needy program.

For individuals institutionalized 1/1/2003 or later, the spouse at home can retain resources up to \$90,660. All resources owned separately by either spouse and all resources owned jointly by the couple are considered in determining countable couple assets. Beginning 1/1/03, income of the institutionalized individual can be allocated to the spouse at home subject to the maximum of \$2,267. The institutionalized spouse can only contribute enough of his income to bring his community spouse's income up to the \$2,267 limit.

Yes, standards have changed.  
We use the maximum allowed by regulation.

<u>Year</u>	<u>Resources Allowance</u>	<u>Monthly Maintenance Needs</u>
2000	\$84,120	\$2,103
2001	\$87,000	\$2,175
2002	\$89,280	\$2,232

Louisiana is considered an income-first state.

Yes, home is considered exempt. N/A

**MAINE:** Review gross monthly, non-excluded income.

Yes, Medically Needy. Bills incurred for necessary medical services, as well as expenses to obtain the necessary services, such as transportation.

N/A regarding income cap and Miller Income Trusts.

CSRA \$90,660; MMMNA: see current national allowance

Yes, regarding "transfer of assets before income."

Yes, home is considered exempt.

**MICHIGAN:**

1.) Recipient income compared to established income limits.

Health insurance premiums, guardian/conservator fee, physician fees, Rx fees.

Income cap \$1,656 - Miller Trust not recognized in Michigan

CSRA: \$18,132  
MMMNA: 1515  
No change

YES

**MINNESOTA:**

**A: Yes, Minnesota provides coverage for medically needy. The best source of information can be found on our website at: <http://www.dhs.state.mn.us/HealthCare/ReportsManuals/ManualCounty/chapter13.htm#0913.13> or Minnesota Statute 256B.0575 at: <http://www.revisor.leg.state.mn.us/stats/256B.0575.html>**

**A: Minnesota is not an income cap state. Miller Income Trusts are not recognized in Minnesota.**

**A: Minnesota allows the CS to keep 2 of the total countable assets up to a maximum amount of \$90,660. The minimum amount of the CSRA is \$25,601. Effective January 1, 2004, these figures will increase to a minimum of \$26,109 and a maximum of \$92,760. This amount is adjusted annually to reflect the consumer price index (CPI) increase.**

**A: No, income must be transferred first. For more detail, see HCM 0909.25.05, at: <http://www.dhs.state.mn.us/HealthCare/ReportsManuals/ManualCounty/chapter09.htm#0909.25.05>**

**A: For people residing in a LTCF the homestead is excluded for the first 6 calendar months of LTCF residence, for as long as it is the residence of a qualifying relative or for as long as LTC resident intends to return home and can reasonably be expected to return home. See HCM 0909.13, at: <http://www.dhs.state.mn.us/HealthCare/ReportsManuals/ManualCounty/chapter09.htm#0909.13>**

## **MISSISSIPPI:**

**1.) Total income compared to 300% of SSI FBR**

**N/A**

**Yes, but less than 2% of nursing home eligibles are eligible via an income trust.**

**CSRA: Fed. Max**

**MMMNA; Fed. Max**

**One home is excluded regardless of intent to return.**

## **MONTANA:**

**How is income eligibility for Medicaid long-term care determined in your state? Please explain briefly. Step 1 process is test applicants income against MA cost of care; if pass then Step 2 process is post eligibility treatment of income**

**Medically needy? YES If so, what medical and other expenses are deductible from income to determine Medicaid eligibility? Medicare, other health insurance, community spouse and family income maintenance allowance, non-covered medical costs recognized by state law.**

**Income cap? NA If so, how common are "Miller Income Trusts" and what effect have they had on Medicaid eligibility since being authorized in OBRA '93?**

**What is the Community Spouse Resource Allowance (CSRA \_\_\$18,132/90,660 fed minimum) and the Minimum Monthly Maintenance Needs Allowance (MMMNA \_Fed minimum 1,493 \_\_\_\_\_) for your state? Have these standards changed in the past three years? If so, from what to what? Yes increased according to federal minimums**

**Do you allow the "transfer of assets before income" to bring a community spouse up to the MMMNA? NO**

**Is the home considered exempt as long as an "intent to return" is in effect? Yes for 6 months If you impose some other requirement, please explain. State rules define primary place of residence to be that place in which an individual resides or has resided within the past 6 months, and will return within 6 months of leaving.**

Yes, the home is considered exempt as long as an “intent to return home”<sup>?</sup> is in effect.

**N DAKOTA:** Applications are made by or on behalf of all covered Medicaid groups at local (County) offices using application forms supplied by this State. Cases are "worked" in a mainframe computer system. The application asks about all types of income. Verifications are required for all income sources. If eligibility is established, each medically needy Medicaid unit has a "recipient liability" ("RL") determined. The Medicaid unit's eligibility may be subject to a redetermination requirement that ranges from monthly to annually. In any event, the RL is a monthly amount. That is, each month a medically needy unit must incur medical expenses that exceed the RL before Medicaid will pay for any necessary care. Medically needy individuals screened as requiring nursing care services have their RL determined applying "post eligibility" treatment of income. Medically needy individuals screened as requiring nursing care services are assumed to meet their RL with the facility providing services. Other medically needy units meet their RL with medical service providers at the beginning of the month. If the medically needy unit does not meet RL (that is, does not incur medical expenses exceeding the RL in three successive months, the case is closed.

Medically needy? Yes. If so, what medical and other expenses are deductible from income to determine Medicaid eligibility? For the medically needy individuals screened as requiring nursing care services, and receiving those services in a nursing facility the following deductions apply:

1. The nursing care income level (\$50 per month)
2. Maintenance needs for a spouse (up to \$2267 per month) or family member (\$505 each per month) for spousal impoverishment prevention cases
3. Medical expenses for the cost of necessary medical care in the month incurred (with limits)
4. The cost of Medicare and (with limits) health care insurance premiums
5. The cost of long term care insurance premiums
6. Payments for services of a guardian or conservator (with limits)

Income cap? No. If so, how common are "Miller Income Trusts" and what effect have they had on Medicaid eligibility since being authorized in OBRA '93?

CSRA half of available assets with a maximum of \$90,660; MMMNA \$2267

Yes, standards have changed. The upper limits have increased with the inflator provided in federal law.

Regarding "transfer of assets before income," we try not to.

No, a home is not considered exempt as long as there is an "intent to return."

A home remains exempt as long as it is occupied by a member of the Medicaid unit. If a single individual shows, by competent medical evidence, a likelihood that he or she will be able to return to that home within six months, the home remains exempt.

**OHIO:** Ohio looks at an individual's gross income and allows appropriate disregards including medical insurance premiums, personal needs allowance, unpaid past medical expenses, a monthly income allowance and or family allowance if there is a community spouse and/or dependents. Ohio Administrative Code rule 5101:1-39-08 Medicaid: Income is attached.

Ohio is not a medically needy state.

Ohio is not an income cap state.

CSRA in Ohio is 50% of the couples' assets or \$90,660, whichever is less. MMMNA in Ohio is \$1515. In the past 3 years, these standards have changed based on the COLA increase.

Transfer of assets before income are allowed but only through requesting the state hearing process.

The home in Ohio is only considered exempt during the first six months that the individual is institutionalized. After that, unless it is otherwise exempt the home must be listed for sale. OAC rule 5101:2-39-31.3, Medicaid exemption of property no longer the principal place of residence, I attached.

**OREGON:** Only the income for the person needing care is considered, and the maximum is 300% of the SSI standard (currently \$1656).

Oregon’s Medically Needy program ended January 31, 2003.

Oregon honors Miller Income Trusts when the client’s income exceeds the \$1656 cap. In July 1991 Oregon discontinued the Medically Needy population coverage for long term care and the state adopted a cap of 300% of the SSI standard. With the passage of OBRA ’93 we developed a formatted version of a Miller trust and began covering those above 300% by having the amount above that standard deposited into the trust each month. When HCFA released Transmittal #64 the version of the trust was amended to have all the income deposited into the trust and allowing the post eligibility income deductions to be made from the corpus of the trust. Of the 20,400 recipients who receive waived home and community based services or reside in a nursing facility, 1238 have Miller trusts which is 6% of that population.

Standard	Current Value	1 Year Ago	2 Years Ago
CSRA Minimum	\$18,132	\$17,856	\$17,400
CSRA Maximum	\$90,660	\$89,280	\$87,000
MMMNA	\$1515	\$1493	\$1452

No, regarding “transfer of assets before income.” Oregon adopted the “income first rule” which requires the institutionalized spouse’s income to supplement the community spouse’s income prior to diverted more resources to the community spouse. This approach was upheld by two court actions, Thomas v. Commissioner of the Division of Medical Assistance, a Massachusetts Supreme Court case and a New Jersey case Cleary v. Waldman. Oregon did face a challenge to the income first approach, however the state was upheld at the administrative hearing level and no appeal was filed.

The home is exempt as long as the client indicates an intent to return. This is consistent with 20 CFR 416.1212 (c).

**S CAROLINA:** South Carolina determines and compares an applicant’s total gross income to an Income cap. The income cap is defined as 300% of the SSI Federal Benefit Rate for an SSI eligible individual living in a non-institutional arrangement.

South Carolina’s plan does not include the medically needy option.

Use of Miller Income Trusts are fairly common in SC. Approximately 7% of applicants applying for institutional care utilize an Income trust to qualify.

CSRA \$66,480.00

MMMNA \$2,232.00

Yes. The MMMNA changed from \$1,662.00 to \$2,232.00.

Yes, regarding “transfer of assets before income.”

Yes, the home considered exempt as long as an “intent to return” is in effect. No other restrictions are imposed.

**TEXAS:** Eligibility for Medicaid includes consideration of the countable monthly income of the applicant as reported and verified by Texas Department of Human Services Medicaid eligibility staff for applications for medical assistance only, and by the Social Security Administration for applications for Supplemental Security Income.

Texas does not have a medically needy LTC program.

Yes, regarding income cap. Highest cap is \$1656 per month for the Medical Assistance Only programs using the special income cap of 300% of the SSI Federal Benefit Rate. Approximately 1% of Medicaid clients in nursing facilities and Medicaid waiver programs have these trusts. The primary effect has been to extend

Medicaid eligibility for LTC to individuals who have incomes greater than the 300% cap but below the cost of services. The individuals who establish Qualified Income Trusts pay most of their income toward the cost of care.

CSRA "minimum resource standard" is \$18,132

MMMNA is \$2,266.50

Yes, standards have changed. Effective January 1, 2000 minimum resource standard \$16,824 MMA \$2,103; January 1, 2001 minimum resource standard \$17,400 MMA \$2,175; January 2, 2002 minimum resource standard \$17,856 MMA \$2,232

Yes, regarding transfer of "assets before income."

Yes, home is considered exempt as long as an "intent to return" is in effect.

**UTAH:** Applications are taken in Medicaid eligibility offices, nursing homes, are sent through the mail, and are sometimes taken over the telephone. We have a Medicaid eligibility worker assigned to each Medicaid nursing home in the State. The number of nursing homes a worker serves depends on the number of Medicaid recipients in the nursing homes served. Information on income, assets, transfers, trusts, etc is gathered from the applications. This information is analyzed and fed into a computer. Applicants are notified of whether they are or are not eligible. For more information on this please refer to the enclosed "May I be of service to you?" pamphlet.

Utah is a Medically Needy state. Please refer to page 7 of the above mentioned pamphlet for information on income deductions.

Utah is not an income cap state.

Please refer to page 11 of the pamphlet for an explanation of the spousal resource allowance. Refer to page 12 for monthly needs allowance. These change each year in accordance with federal guidelines.

We are an asset first state.

The home is exempt if there is intent to return. Please see page 9.

2. Has a study of Medicaid estate planning (e.g. purchase of exempt assets, transfers, annuities, trusts, "just say no," etc.) and/or liens and estate recoveries been done in your state? If yes, please send copies of reports or executive summaries and key recommendations, as appropriate.

**ALABAMA:** No

**ARIZONA:** Arizona has not conducted a formal study of Medicaid estate planning regarding purchase of exempt assets or transfers. We periodically review the numbers of trusts that we have encountered (see response to Question #1). We are aware that all of these techniques are being used to establish long term care eligibility.

In 2000, we conducted a study regarding the use of annuities in Community Spouse cases and made recommendations for changes in federal law. This was submitted to CMS and our Congressional delegation but no action was taken. **A copy of our recommendations is included as a separate attachment.**

**ARKANSAS:** No

**CONNECTICUT: YES.** In the mid 90's the Braceland Institute (Institute for Living) conducted a study; in 1997 an audit of public accounts was conducted and most recently a review of transfer activity of impending LTC applications was conducted for the calendar year 2000 by their department (waiver 1115)  
Go to: [http://www.dss.state.ct.us/pubs/TOA\\_proposal.pdf](http://www.dss.state.ct.us/pubs/TOA_proposal.pdf) to find a copy of the transfer of assets waiver 1115 proposal that the CT Dept. of Social Services submitted in Feb 2002; if you can not get to this link, go to [www.dss.state.ct.us](http://www.dss.state.ct.us). Look under publications and then news and updates.

**DC: No**

**DELAWARE: No**

**GEORGIA: No**

**INDIANA: No**

**KENTUCKY: We are not aware of any study having been done.**

**LOUISIANA: The state has not conducted any studies on Medicaid estate planning.**

**MAINE: No**

**MICHIGAN: No**

**MINNESOTA: A: No formal study has been done.**

**MISSISSIPPI: No**

**MONTANA: Yes** previous analysis has been undertaken by our TPL unit prior to instituting Lien and Estate Recovery legislation and provisions. Stephen Moses involved originally. Currently we are considering this again in the area of assets as part of an overall look at redesigning the Medicaid program in Montana.

**NEVADA: No study.** Estate Recovery is pursued.

**N CAROLINA: No report of estate planning, etc. has been done.**

**N DAKOTA: No**

**OHIO: Yes,** a study was requested by the legislature in 1998, to be released by 1999. There was a release of the report in Sept. 1999 to the Senate, House, and Governor. The report, [Medicaid Estate Planning and Estate Recovery in Ohio](#), is attached. Some but not all of the recommended changes have been implemented.

**OREGON: No**

**S CAROLINA: SC has not undertaken a study of any of the listed subjects.**

**TEXAS: No**

**UTAH: Utah has not done a formal study on estate planning.** We have concerns about annuities and have submitted a proposal to change the annuity policy to sanction transfers that allow the community spouse to have assets above the spousal assessment allowance or income above the minimum monthly maintenance needs allowance. This policy was submitted to and rejected by regional and federal CMS. We are considering resubmittal of this policy because of the Wisconsin v. Blumer Supreme Court decision that held that it is appropriate for the Secretary of DHHS to leave to the States the interpretation of a provision of the statute, when the statute does not clearly or unambiguously require a particular reading of the provision in question. In this particular matter they were referring to Section 1924 of the Social Security Act.

**3. Has your state taken action to control Medicaid estate planning, to close unintended eligibility "loopholes" or to encourage private financing alternatives for long-term care?**

**ALABAMA:** Alabama allows an addition of long-term care costs paid by a private long-term care insurance policy to be added to the resource limit for the institutionalized spouse. (Ex. Long-term care policy paid \$150,000 for the 3 years prior to Medicaid application. Resource limit for applicant would be \$152,000.)

We have a pending regulation implementing existing policy that restricts the use of lump sum annuities to shelter assets.

**ARIZONA: PROVISION OF PERSONAL CARE SERVICES BY FAMILY MEMBERS** – We encountered situations where individuals transferred funds to their children in exchange for the provision of personal care services, which included visiting the individual periodically and asking about their health. As a result, Arizona imposed tight requirements for the provision of personal care services by family members. There must be a valid contract that meets state requirements and payment can only be made for necessary services actually provided. Implementation of these requirements has virtually eliminated attempts to use these contracts as a means of making transfers to family members. (See Attachment 1 for a copy of the policy manual instructions on personal care contracts.)

**PURCHASE OF SAVINGS BONDS** – We were encountering investments of sometimes large amounts of cash in U.S. Savings Bonds just prior to application for long-term care. Savings Bonds have no value during the first 12 months. Thus they were converting a resource with value to a resource with no value. In some cases, the person just kept rolling the bond over into a new bond every six months. In other cases, the bonds were transferred to a family member prior to the end of the initial 6-month period retention period, using the argument that no transfer occurred since the bond had no current resource value.

We implemented a policy change that specifies that since a Savings Bond has no value during the mandatory retention period, the purchase of a Savings Bond represents a transfer for which no compensation is received until the end of the retention period. In effect, we are considering the purchase of a Savings Bond as an uncompensated transfer. Feedback from our local offices indicates that use of this as a spend-down device has ended. (See copy of policy manual at Attachment #2.)

**PURCHASE OF ANNUITIES** - We recommended State legislation in 1999 that imposed limitations on the purchase of irrevocable annuities to eliminate the purchase of private annuities from family members, and the purchase of balloon payment annuities in which the annuitant received a token payment during most of the annuity contract, with a balloon payment to the annuitant scheduled for a month or two prior to the end of the annuitant's expected life expectancy. Although annuities are still used to spend down resources, they now produce regular income that counts in the post eligibility treatment of income.

However, the problem of having community spouse cases with annuities worth hundreds of thousands of dollars continues because of the Federal interpretation that Section 1917(c)(2)(B) of the Social Security Act allows unlimited transfers from a married individual who requires long term care services to their spouse who is still residing in the community. The law also allows for unlimited transfers from either the institutionalized spouse, or from the spouse remaining in the community, to a third party for the benefit of the spouse in the community. (See copy of state statute at Attachment #3 and policy manual at Attachment #4. Also see the separate attachment regarding our recommendation for limiting these annuities.)

**PURCHASE OF EXPENSIVE VEHICLES CO-TITLED TO FAMILY MEMBERS** –

We were encountering situations where an applicant, or more often the applicant's relative, spent down the applicant's resources by purchasing a new (often quite expensive) vehicle which is titled to the applicant "or" the applicant's relative, but which is in the physical possession of the relative. The "or" designation still maintains the vehicle as a resource to the applicant in its entirety. It is then claimed the vehicle qualifies for conditional vehicle exclusion. Often the applicant had not driven in years and

was incapable of driving, and sometimes the applicant was living in a nursing facility and did not leave the facility.

We revised our policy to impose stricter regulations regarding the application of vehicle exclusions. The vehicle must actually be used for an exclusion purpose. If not, the vehicle counts as a resource. We were upheld on this issue in Fair Hearing when a home was sold and a vehicle was purchased in the name of a person residing in an Alzheimer's lock-down unit. (See Attachment #5 for policy manual.)

**PURCHASE OF AN INTEREST IN AN ADULT CHILD'S HOME** - We revised our policy to allow the person's interest to be excluded only when the applicant or spouse actually resides in the property in which an interest has been purchased. (See Attachment #6 for policy manual.)

**TRANSFER OF THE RIGHT TO INCOME** - We encountered attempts to irrevocably assign either individual income payments or the right to all future payments as a technique both to establish eligibility and to lower post-eligibility collections. We revised policy to specify that income is still considered to be the income of the individual when the right to all future income from that source has not been irrevocably assigned. When income has been irrevocably assigned, we consider the full value of the future income to be a transfer at time of assignment. (See Attachment #7 for policy manual.)

**ARKANSAS:** No

**CONNECTICUT:** YES, through waiver 1115. The major elements of this proposal include: 1) start commencement of penalty period when otherwise eligible 2) extend look-back period of real property from 3 to 5 years

**DC:** No

**DELAWARE:** No, but we are discussing annuities.

**GEORGIA:** No

**INDIANA:** Yes. See 405 IAC 2-3-1.1, 405 IAC 1.2, and LSA Document # 03-266, attached. Indiana also encourages the purchase and use of long term care insurance through the use of an asset disregard.

**KENTUCKY:** Effective March 2003 Kentucky has changed policy to count annuities with balloon payments as a transfer of resources for less than fair market value (previously just looked to determine if annuity was actuarially sound. Effective September 1, 2003 adding an individual's name to a deed is considered a transfer of resources for less than fair market value. Effective August 2003 all trusts and annuities must be reviewed by Central Office staff prior to approving individuals for Medicaid. Effective September 1, 2003 Kentucky's Estate Recovery Program no longer provides for an exemption for a home of modest value and has expanded the definition of what assets will be pursued under the recovery program.

Regulation sites: <http://www.lrc.state.ky.us/kar/907/001/650e.htm>  
<http://www.lrc.state.ky.us/kar/907/001/585e.htm>

**LOUISIANA:** Yes. Refer to attached copy of the approved Louisiana State Plan Amendment effective January 1, 2003 concerning treatment of annuities.

**MAINE:** Left blank.

**MICHIGAN:** No

**MINNESOTA:** A: Several steps have been taken in regards to annuities and transfers of income and assets through legislative action. This information can be found in Bulletins published by the Department of Human Services (DHS) at: <http://www.dhs.state.mn.us/FMO/LegalMgt/Bulletins/pdf/2002/02-21-08.pdf> and <http://www.dhs.state.mn.us/FMO/LegalMgt/Bulletins/pdf/2003/03-21-06.pdf>.

In addition, a transfer of assets waiver is being sought from the federal government. This can be found at: <http://www.dhs.state.mn.us/HealthCare/waivers/Asset-Transfers-Waiver-2003.pdf>

Insurance counseling, including counseling about LTC insurance and reverse mortgages, is available through DHS = Website: <http://www.dhs.state.mn.us/Agingint/Services/ship.htm> and DHS offers LTC insurance to its employees.

**MISSISSIPPI:** No

**MONTANA:** See response to number 2 above, may consider alternative as part of overall system redesign.

**NEVADA:** No

**NORTH CAROLINA:** N.C. has enacted law requiring the sanctioning of transfers of tenancy-in-common interest in real property, which is an excluded resource. Prior to this, individuals who owned real property were transferring small tenancy-in-common interests of real property (with values that would not result in a sanction period), making the remaining interest in the property non-countable. Once it became non-countable, the remaining interest was transferred and not sanctioned. A copy of the provision is attached.

Previously, all real property that produced a net annual income equal to at least 6% of its equity value was totally excluded. As an excluded asset the property could be transferred without sanction. The State has enacted a law that only excludes \$6,000 of real property that meets the 6% test. Thus transfer of the property is now a non-allowable transfer.

**NORTH DAKOTA:** The Department of Human Services has tried to close loopholes, and there have been some legislative efforts to encourage the purchase of long term care insurance, but inexplicable CMS directives and effective lobbying by the elder bar counter the results of these efforts. Please explain and provide relevant reports and memoranda; statutory, regulatory or policy language. . Examples of failed Medicaid agency initiatives:

- Bill to create a right of recovery in the transferor of assets transferred to achieve Medicaid eligibility. This bill was patterned on the Uniform Fraudulent Transfer Act, but would have placed the right of recovery in the person who transferred, rather than the Medicaid agency. The idea was to assure that an asset that was "transferred" for less than adequate consideration would continue to be "available" to a Medicaid applicant for five years after it was transferred.
- Bill to extend the right to assert claims against all assets in the estates of deceased spouses of deceased Medicaid recipients that were acquired before the death of the recipient.
- Bill to allow the Medicaid agency seek a waiver to start period of disqualification at the time the individual sought Medicaid coverage, rather than the first day of the month in which the transfer was made.

Examples of North Dakota laws that create loopholes:

- N.D.C.C. § 50-24.1-02.5, passed in 1995 and amended in 2003, was intended to encourage the purchase of long term care insurance by giving the purchaser of qualifying insurance *carte blanc* to transfer any assets or income. We have yet to see a Medicaid applicant who possesses the required insurance.  
50-24.1-02.5. Effect of purchase of insurance on disqualifying transfer.  
1. An individual who secures and maintains insurance that covers the cost of substantially all necessary medical care, including necessary care in a nursing home and necessary care for an individual who qualifies for admission to a nursing home but receives care elsewhere, for at least thirty-six months after the date an asset is disposed of, may demonstrate that the asset was disposed of exclusively for a purpose other than to qualify for medical assistance by providing proof of that insurance.  
2. If purchased after July 31, 2003, the insurance coverage under this section must include home health care coverage, assisted living coverage, basic care coverage, and skilled nursing facility coverage. The coverage required under this subsection must include a daily benefit equal to at least one and fifty-seven hundredths times the average daily cost of nursing care for the year in which the policy was issued and an aggregate benefit equal to at least one thousand ninety-five times that daily benefit.

- N.D.C.C. § 50-24.1-02.8, passed in 2003, has been interpreted by legislators involved with the process to: (1) Not be a specification of what may be treated as a disqualifying transfer, but rather to be a specification of an annuity that may not be considered in determining eligibility in a spousal impoverishment case; (2) Allow the community spouse of a nursing facility resident to purchase an annuity that qualifies under the terms of the statute in addition to the other assets the community spouse may own; and (3) Preclude the Medicaid agency from requiring an irrevocable designation of the Medicaid agency as a beneficiary upon the death of both spouses. (See subdivision e of subsection 2.) Given the rate of return currently available on single-premium annuities, this increases the effective community spouse asset allowance to perhaps \$900,000. The Medicaid agency has acquiesced, effectively derailing efforts to control proliferating sales of annuities as a means of creating eligibility. We had initially seen this as a legislator-initiated effort to constrain abusive annuities. We were wrong.

50-24.1-02.8. Transfers involving annuities.

1. For purposes of this section, "annuity" means a policy, certificate, contract, or other arrangement between two or more parties whereby one party pays money or other valuable consideration to the other party in return for the right to receive payments in the future. The term does not mean an employee benefit that qualifies for favorable tax treatment under the Internal Revenue Code or a plan described in the Internal Revenue Code as a retirement plan under which contributions must end and withdrawals begin by age seventy and one-half.

2. The purchase of an annuity, an instrument purporting to be an annuity, or any other arrangement that meets the definition of annuity in subsection 1 is considered an uncompensated assignment or transfer of assets under section 50-24.1-02, resulting in a penalty under the applicable rules established by the department of human services unless the following criteria are met:

- a. The annuity is irrevocable and cannot be assigned to another person.
- b. The annuity is purchased from an insurance company or other commercial company that sells annuities as part of the normal course of business.
- c. The annuity provides substantially equal monthly payments of principal and interest and does not have a balloon or deferred payment of principal or interest. Payments will be considered substantially equal if the total annual payment in any year varies by five percent or less from the payment in the previous year.
- d. The annuity will return the full principal and interest within the purchaser's life expectancy as determined by the department of human services.
- e. The monthly payments from the annuity, unless specifically ordered otherwise by a court of competent jurisdiction, do not exceed the maximum monthly income amount allowed for a community spouse as determined by the department pursuant to 42 U.S.C. 1396r-5.

Examples of inexplicable CMS directives:

- Transmittal 64, and the foot-dragging on any effort to update a severely flawed and limited exposition on annuities;
- CMS's practice of writing letters to members of the Elder Law bar advising of what CMS perceives as incorrect State application of Medicaid requirements; and
- Persistence in seeing the extent of self-impoverishment in terms of the incidence of cases in which States successfully assert disqualifications due to transfers for less than fair market value.

**OHIO:** Ohio has revised its rules on transfer of resources, (Ohio Administrative Code 5101:1-39-07, attached), annuities (OAC 5101:1-39-22.8, attached), property (OAC 5101: 1-39-31.1 through 31.4, attached), trusts (OAC 5101: 1-39-27.1, attached), and is working on revision of our retirement funds rule (OAC 5101: 1-39-22.7, draft version attached). Ohio Administrative Code rules are available on the ODJFS web site at <http://dynaweb.odjfs.state.oh.us:6336/dynaweb>. The rule cites are in the Medicaid Eligibility Manual Chapter 3, at <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/ohpeligibility/MEM>.

Ohio ODJFS staff do public speaking engagements encouraging people to purchase LTC insurance if they are interested in preserving their assets.

**OREGON:** No

**S CAROLINA:** We have taken steps to close loopholes, but we have not looked into or encouraged private financing alternatives for long-term care. Recently, we have tightened loopholes regarding the misuse of promissory notes and special needs trusts.

### Promissory Notes

We modified an existing proviso and issued this transmittal to our staff to explain our actions:

The purpose of this transmittal is to explain the policy changes that are being made in order to comply with the new proviso on promissory notes (Proviso 8.24). First, a promissory note will be considered negotiable and counted as a resource unless it contains language plainly stating that it is not transferable under any circumstance. Second, a promissory note will be considered a transfer of assets for less than value unless it has the following characteristics:

- It is actuarially sound according to the Life Expectancy Tables found in Chapter 12, Appendix A, of the Medicaid Policy Manual.
- It requires monthly payments that fully amortize it over the life of the loan. This means that the monthly payments are equal so that the last payment is the same amount as all the previous payments. Since the loan must be amortized, the payments will include both interest and principal. The note must use a reasonable rate of interest.
- It is free of any conditional or self-canceling clauses.

Proviso 8.24 does not apply to notes given in exchange for “excluded assets,” except for those given in exchange for the home.

### Special Needs Trusts

We modified our policies on special needs trusts by adding accountability for any loans made from the trusts. The following is a transmittal to our staff:

Special Needs Trusts were authorized by federal legislation in 1993. The purpose of this type of trust is twofold: 1) to hold assets of a disabled person under 65 years of age so that these assets will not make him or her ineligible for Medicaid and 2) to retain assets that can be used by the trustee to provide for special needs of the disabled person. These special needs can be things such as the following: special wheelchair, computer, entertainment purposes, educational purposes, special trips, modifications to the home to accommodate the disability, vehicles modified for wheelchairs, etc. The trust must provide that, when the disabled person dies, Medicaid must be paid back before other beneficiaries can receive any money.

Currently, many Special Needs Trusts we are receiving have a provision allowing the trustee to make loans from the trust. These trusts usually have only a general clause stating that reasonable attempts will be made to pay back any loans. In order to protect the assets of these trusts and to ensure that they will be used for the needs of the disabled persons, we need a policy to address the payback of these loans. Without such a policy, we feel that these loans will never be paid back and, thus, the disabled person may never have full benefit of the funds and our estate recovery will be defeated. We suggest that any loan provision should be accompanied by a requirement that the trustee furnish SCDHHS with documentation of the source of the payback funds and an amortization schedule (schedule of the monthly payments of principal and interest) that is at a reasonable rate of interest and is actuarially sound (paid back over the life expectancy of the disabled person).

It is difficult to do a financial impact statement on this type of policy change. These trusts vary widely in value, as some may be funded with tort settlements in the millions and some may be funded with a small amount of assets. Also, loan amounts will vary in size. The rationale for this policy change is based on a desire to see the trust assets used for the disabled person and to preserve remaining assets for estate recovery.

**TEXAS:** The Texas Department of Human Services established administrative rules regarding annuities at 40 TAC Section 15.442(g). Administrative rules for the Medicaid program are based on federal and state statutes and are in Chapter 15 of Title 40 of the Texas Administrative Code. They can be viewed via the internet at [http://info.sos.state.tx.us/pls/pub/readtac\\$ext.ViewTAC?tac\\_view=4&ti=40&pt=1&ch=15](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=1&ch=15) .

**UTAH:** We closed an annuity loophole where clients were attempting to take out annuities and receive small sums monthly with a large balloon payment when the annuity matured.

**4. Did your state respond to provisions in Obra '93, HIPAA '96 (throw granny in jail) and BBA '97 (throw granny's lawyer in jail) regarding Medicaid estate planning, liens and estate recoveries? If so, how? How did the repeal of the germane provision in HIPAA '96 and the non enforcement of the BBA'97 proscription on Medicaid planning affect your efforts to control the practice of Medicaid planning?**

**ALABAMA:** Alabama did not take any specific actions in regards to these issues. We had seen a reduction in Medicaid estate planning participation by attorneys before the non enforcement of the BBA '97 provisions was announced.

**ARIZONA:** Arizona took no specific action to enforce either HIPAA '96 or BBA '97. At that time, we had a number of elder law attorneys who were representing persons in the application process. The existence of those provisions by themselves were sufficient to inhibit attorneys from being very creative in the way that they were assisting individuals in “repositioning their assets” to qualify for our program. However, once HIPAA '96 was repealed and Attorney General Reno decided not to enforce BBA '97, we experienced a virtual explosion in the creative tactics being used. In response, we implemented the actions described in our response to Question #3. In addition, we also witnessed a number of individuals who were not attorneys create businesses with the sole purpose of qualifying persons for long term care, for a price. In effect, the deletion of those provisions created a whole new cottage industry.

**ARKANSAS:** Not to my knowledge.

**CONNECTICUT:** Doesn't feel any of these provisions were helpful. Their regional office had been advised of these provisions – and as a result one case was referred. However, due to the controversy surrounding these provisions, the case wasn't pursued any further. Felt the repeal was a “momentary blip.”

**DC:** No

**DELAWARE:** No

**GEORGIA:** No. N/A

**INDIANA:** Left blank.

**KENTUCKY:** We do not have information available to respond.

**LOUISIANA:** We are not aware of any cases in the state where the provisions were applied before the law was overturned. At the state eligibility program level, we were aware of the provisions and the controversy, but continued to make reference to the provisions when responding to aggressive estate planning inquiries until the law was overturned. It is our opinion and experience that when the law was overturned, it took away a significant deterrent /the chilling effect on the practice of estate planning.

**MAINE:** The Bureau of Medical Services committed staff and policy to fully implement OBRA '93. All other subsequent regulations were not developed.

**MICHIGAN:** No

**MINNESOTA:** The Department understands that the United States Department of Justice is the lead agency with enforcement responsibility over these provisions in federal law. Minnesota has not enforced these provisions at the state level.

**MISSISSIPPI:** No

**MONTANA:** Unsure.

**NEVADA:** No

**N CAROLINA:** No

**NORTH DAKOTA:** We attempted to keep a lid on with the OBRA '93 changes by imposing the limits permitted. We have resisted CMS directives intended to support asset give-aways. We have vigorously opposed and litigated trust-based efforts to shelter assets. We have vigorously examined cases for disqualifying transfers. But the North Dakota legislature has steered a course that has the effect of allowing individuals with assets vastly exceeding the spousal impoverishment limits to maintain those assets in the hands of community spouses who purchase annuities. We did not attempt to implement HIPAA '96 ("throw granny in jail") and BBA '97 ("throw granny's lawyer in jail"), seeing those provisions as silly, unworkable, or unconstitutional. If so, how? How did the repeal of the germane provision in HIPAA '96 and the nonenforcement of the BBA '97 proscription on Medicaid planning affect your efforts to control the practice of Medicaid planning? No effect.

**OHIO:** Ohio promulgated OAC rule 5101:1-39-27.1 on trusts in response to the OBRA provisions. HIPAA '96 and BBA '97 provisions regarding estate planning were not implemented in Ohio; therefore there was no measurable effect in their repeal/nonenforcement. However, it is assumed that because of the provisions some people refrained from applying for eligibility.

**OREGON:** Oregon did have a court challenge to the Kennedy-Kassebaum reform bill. The case, Peebler, et al v Reno (U.S. District Court, District of Oregon CV 97-256 April 25, 1997) in which a Medicaid recipient transferred resources and applied for Medicaid. The court accepted the Defendant's motion to dismiss the action as no period of ineligibility was assessed. There have been no subsequent actions in this area.

**S CAROLINA:** No

**TEXAS:** N/A. No documented affect.

**UTAH:** We did not respond. We have no information that measures change due to the repeal of this law.

5. Is there a strong Medicaid estate-planning bar in your state? Are seminars on how to qualify for Medicaid long term care benefits without spending down advertised? Do attorneys call Medicaid eligibility workers seeking information on exclusions and exemptions? How serious an issue do you consider Medicaid planning to be?

**ALABAMA:** Yes. Alabama has a very strong estate-planning bar, as well as several private consulting firms that specialize in this type of assistance. A program on public access television often features Elder Law firm lawyers who discuss ways to do Medicaid estate planning. This is a growing problem in this state, as we receive more and more requests for hearings from these lawyers and/or consulting firms.

**ARIZONA:** We have a strong Medicaid estate planning bar in Arizona and some of them hold seminars to create business. We do not see as many seminars advertised as we did right after the "granny or her lawyer goes to jail" provisions were removed. When that occurred, we had a large number of individuals coming into the state advertising these seminars. These individuals or companies held seminars at hotels and motels with the intent of selling elderly people revocable trusts and annuities. Then they would leave town, providing no ongoing support to the persons who had gone to them for services. Some of the annuities that they sold have actually disqualified individuals from ALTCS rather than qualifying them.

At the moment, we have a generally stable population of both elder law attorneys and what we term as "paid representatives". They contact our local offices for information and also staff in our Central Office. To my knowledge, most if not all of them subscribe to our ALTCS policy manual.

We consider Medicaid planning to be a very serious issue since it results in persons who are not actually indigent qualifying for our long-term care program. In many ways, it has become a program for the rich as well as the poor.

**ARKANSAS:** There seems to be a decline in Medicaid estate planning bar activity. At one time there were frequent "Medicaid" ads in the newspaper but they are not as frequent now. Attorneys do contact eligibility workers. Workers answer specific questions about policy but do not give advice.

**CONNECTICUT:** Yes. Sees advertisements claiming they can teach people how to prevent states and nursing homes from "gobbling up their assets." Medicaid planning is very serious. The Dept. of Social Services Waiver 1115 projects a savings of \$87 million over the next 5 years if implemented.

**DC:** Yes, there is a strong Medicaid estate planning bar in the District of Columbia. Yes, MAA is aware that attorneys in the District provide seminars on who to qualify for Medicaid long-term care benefits. Attorneys in the District of Columbia are very knowledgeable about Medicaid eligibility.

Since 12.2% of the District population is 65 years and older and over 21% of the Medicaid expenditures are in the area of long-term care, Medicaid planning is a very serious issue. In the District, nursing facility patient days are consistently increasing by 5% per year. The proposed Medicaid budget for FY'05 has requested over \$2.8 million dollars increase in funding for rising enrollment in nursing facilities.

**DELAWARE:** Yes, there are seminars and attorneys call us with questions. Becoming more serious particularly with annuities.

**GEORGIA:** Yes. And yes, attorney's call. Like in many other states, we believe that we have a very serious issue with financial advisers and attorneys holding seminars throughout the state. These two entities advertise that they can show people "how to get Medicaid to pay for their long term care services" without having to purchase long term care insurance or divesting their assets. Of course they try to get the people to purchase annuities or establish trusts with their organizations. These practices are indeed having a great negative impact on the long-term care insurance industry in our state.

**INDIANA:** Yes to all questions, we do consider Medicaid planning to be a serious problem.

**KENTUCKY:** We do not have information available to respond.

Yes

Questions such as these are requested to be submitted in writing to the Commissioner of the Department for Medicaid Services.

It appears to be very serious as attorneys and estate planners are constantly inventing new ways to hide assets or try to convert them to excluded resources.

**LOUISIANA:** Yes. Yes. Yes. Very serious. In order to contain LTC spending and avoid a budget deficit, it was necessary to clarify current policy regarding annuities, so that applicants are no longer allowed to place their significant resources in excludable annuities.

**MAINE:** Legal seminars discussing Estate Recovery activities are done regularly within the legal community with state staff being invited to panel discussions. Attorneys contact this office seeking clarification on Estate recovery policy. Staff speculates Medicaid planning does occur acknowledging annual recoveries have remained fairly consistent over the last 5 years even though population and Medicaid reimbursement has risen. Values of an estate demonstrate some social stratification of Estate Planning is employed.

**MICHIGAN:** No

Very serious to those facing LTC.

**MINNESOTA:** Yes, there is a strong Medicaid Estate Planning Bar. Annual seminars devoted to the topic are held, and presentations are made at a number of related legal education classes. To date, attorneys have been reluctant to litigate in this state, but this may be changing. It is not known how often attorneys contact counties with questions, but financial planners often contact the state.

**MISSISSIPPI:** Active, but not strong

Yes

Yes

Not serious at this time.

**MONTANA:** It is a growing area. Are seminars on how to qualify for Medicaid long-term care benefits without spending down advertised? Yes for lawyers and other professionals and private citizens. State staff has even been asked to participate. Do attorneys call Medicaid eligibility workers seeking information on exclusions and exemptions? Yes weekly to the state policy specialists and also to local offices of public assistance. How serious an issue do you consider Medicaid planning to be? Growing at an alarming rate based on eligibility staff feedback. Would be an area that would be continued to be looked at in the future. Please elaborate

**NEVADA:** Very strong. Seminars are conducted. Attorneys do contact employees. The State evaluates each court petition to oppose if necessary.

**N CAROLINA:** Relative to states like NY, CA, FL, IL, and NJ, we do not have a strong Medicaid estate-planning bar in NC, but our numbers and level of expertise are growing. We have about 360 members in the state's bar association elder law section, mainly in small firms, and they get a lot of questions from the public about how to pay for long term care without being financially devastated. NC, for example, uses the minimum/maximum rules for calculating the community spouse resource allowance, so the healthy spouse will only get about \$19,000 in countable assets if his/her spouse enters a nursing home. The personal needs allowance is only \$30/month. We have no Medicaid coverage for bed-hold days, so people stand to lose their rooms in the nursing home they are used to. Putting families and ill, elderly people in this position causes them to ask questions about why they are being left with no financial assistance, and some people ask lawyers for help.

Are seminars on how to qualify for Medicaid long-term care benefits without spending down advertised? **Yes.**

Do attorneys call Medicaid eligibility workers seeking information on exclusions and exemptions? **Some do, but now that the manual is on-line, attorneys are using that more frequently to get information.**

How serious an issue do you consider Medicaid planning to be? If "serious" refers to wealthy people using attorneys to become Medicaid eligible, I have not heard of any such situation in NC. If "serious" refers to our lack of adequate health care coverage for middle class and poor people, that is definitely a problem. Most attorneys are helping the healthy spouse preserve enough live on, and are advising clients about converting countable assets into noncountable assets (such as buying burial contracts, making home repairs, or purchasing household goods). Also, some gifting of assets may take place, and these assets generally are used to pay for things like "bed hold days" (NC Medicaid covers zero days) and to assist families who continue to help parents who are in nursing homes.

**NORTH DAKOTA:** Yes to the first 3 questions. Very serious problem. North Dakota, like many other States, faces some fiscal difficulty. As a consequence, we have had to reduce covered services, and reduce coverage for children and family groups. These cuts are deeper than would have been necessary because of Medicaid planning.

I am not too concerned about the Elder Law bar. These folks make a serious effort to follow the law, and are subject to significant ethical constraints. Many North Dakotans, being a conservative bunch, decide not to engage in Medicaid planning when presented with good advice about the various alternatives. What I worry about are the insurance sales reps. Regulation is very limited, ethics are not subject to any rigorous

enforcement by anyone, and the sales group is often trained and influenced by very bad information from companies with no real knowledge of Medicaid. (For instance, it is not unusual to find insurance company trainers who don't know that States' Medicaid programs differ as to eligibility requirements as well as covered services and offered coverages.)

**OHIO:** Ohio's Medicaid estate planning bar is not as aggressive as we have heard in some other states; however Ohio attorney Bill Browning is the new national president of the National Association of Elder Law Attorneys.

Seminars are offered and advertised heavily. Attorneys often call Medicaid eligibility policy analysts at the state level seeking information on the state's eligibility policies. The seriousness of the issue in Ohio varies depending on the stakeholders perspectives.

Medicaid policy analysts consider it a serious issue because of accompanying losses in revenue during times of severe budget constraints and program cutbacks (e.g., cap on nursing home rates, loss of coverage for some ancillary services passed in biennial budget bill).

**OREGON:** Yes, there is a strong Medicaid estate planning bar in Oregon. With the spousal impoverishment changes, the Oregon State Bar established an elder law section that deals specifically with Medicaid and estate planning. Seminars are provided for clients explaining options and attorneys do call the Department to seek information on exclusions and exemptions. Oregon has never conducted a study to determine how serious an issue Medicaid planning might be.

**S CAROLINA:** South Carolina has a very strong Medicaid estate planning bar – also known as the Elder Law Bar. The Elder Lawyers sponsor several CLEs (Continuing Legal Education) every year, and the number is increasing. Attorneys consistently call our Eligibility Division seeking information on exclusions and exemption. Medicaid planning is a very serious issue in our state.

**TEXAS:** Yes. Yes. Yes, per anecdotal reports. Medicaid estate planning complicates the eligibility determination process resulting in workload impacts on staff and the need to work closely with the Office of General Counsel on legal issues beyond the expertise of policy staff.

**UTAH:** Estate planning for Medicaid has not been a big problem in Utah in the past. I have requested staff refer phone calls from estate planners and attorneys to me. The number of calls is on the increase and I believe Medicaid estate planning is on the increase. We do have attorneys and estate planners who present seminars on planning techniques. Our greatest concern on these is that some use scare tactics that rush seniors into purchasing things such as annuities before thoroughly analyzing whether or not they will likely go into a nursing home or if there are other more viable options. Options include self-pay, care by family members, long term care insurance, etc.

6. What are the most commonly used artificial impoverishment techniques in your state? How common are these practices? Do you know, or if you had to guess, what percentage of Medicaid nursing home eligibility cases involve some form of divestiture or sheltering?

**ALABAMA:** Transfer of assets to children prior to look-back period. Transfer of assets into trusts or annuities. There is no way to determine the number of these cases, but I would guess that the percentage is @ 25%.

**ARIZONA:** In addition to the tactics described in our response to Question #3, we also are encountering the following types of impoverishment techniques that we have not been able to address.

Transfers to family members or the Community Spouse through the purchase of an irrevocable stream of income annuity. For example, a single individual will purchase an irrevocable annuity (thus spending down resources) naming a family member as beneficiary in case of death. The person has established resource eligibility and, since the annuity will not go through the probate process, avoided Estate Recovery.

For Community Spouse cases, annuities are used to transfer funds to a third party for the needs of the Community Spouse in excess of the Community Spouse Resource Allowance.

As stated in our response to Question #3, we have been unable to address purchases of an annuity for a community spouse due to the federal interpretation that 1917(c)(2)(B) of the Social Security Act allows unlimited transfers from a married individual who requires long term care services to their spouse who is still residing in the community.

See the separate issue paper regarding Arizona's recommendations on community spouse annuities.

Annuities are also being used to avoid estate recovery. For example, a recipient sells home property and uses the proceeds to purchase an annuity. The recipient names another person as beneficiary of the annuity. Had the home been retained, it would be subject to estate recovery. However, since the annuity will not go through probate, it will not be subject to estate recovery.

Life Estates with Powers - A person transfers home property to a relative, but retains a life estate interest in the property with the right to sell the property during his or her lifetime. This is known as a life estate with powers. Since the property is still owned and available to the individual, it still counts as a resource rather than as a transfer and is still subject to the home property exclusion. In effect property is transferred while still owning it. No transfer penalty is imposed and the applicant avoids estate recovery.

Transfers during a month of an amount that is a little less than the Private Pay Rate (amount charged in the community for nursing home care)- When there is no carry-over from transfers in a previous month, there is no penalty for the transfer of assets since the amount is less than the private pay rate during a calendar month. Elder law attorneys and professional representatives encourage applicants and prospective applicants to implement planned gifting, a process whereby the applicant makes monthly transfers of cash resources to one or more family members in amounts just under the private pay rate. In other instances, they encourage strategic gifting prior to the look back period.

ALTCS is a managed care program where we pay a set capitated amount each month to our Program Contractors. Although Arizona has the option to impose less than a full month penalty for the uncompensated transfer of assets, this is not administratively practical in a managed care payment system.

Home Property Placed in a Trust - Federal law and the State Medicaid Manual Section 3257.B.4 specifies that when an excluded home is placed in a trust it is no longer excluded as home property and is counted as an asset of the trust. This was intended to prevent individuals from avoiding estate recovery by placing home property in a trust. However, this provision allows community spouse applicants to inflate their assets for the Community Spouse Resource Assessment. The home is placed in the trust to increase the CSRA and then is taken out in order to regain the home property exclusion reduce countable resources. We have made CMS aware of this tactic.

Strategically Planned Transfers - Section 1917(c)(1)(D) of the Social Security Act provides that a period of ineligibility resulting from a transfer shall be applied beginning with the month the transfer occurred. When a recipient transfers home property or other assets and then waits until the period of ineligibility has expired before reporting the transfer, they can avoid any penalty.

Transfers of Excluded Resources - The State Medicaid Manual at section 3257.B.4 specifies that the transfer of any excluded resource other than an individual's home shall not be evaluated as an uncompensated transfer. Arizona is seeing situations where the applicant gifts an excluded vehicle, and then uses cash resources to purchase another excluded vehicle. This allows the person to transfer a valuable item without penalty, and then purchase another as a way of spending down resources.

Arizona has no data on the percentage of time that these tactics are used. If forced to guess, I would estimate that they occur in 5 to 10 percent of our cases.

**ARKANSAS:** Probably less than 5%.

**CONNECTICUT:** “Half a Loaf” (keep half, give the other half away). Fairly common. Guesses about one-third of all eligibility cases. Doesn’t know how many of these cases involve a penalty.

**DC:** MAA is unaware of any artificial impoverishment techniques that are being used. A conservative guess would be ten percent. Although there is no data to base the above assumption, the rising enrollment in nursing facilities probably involve some form of divestiture or sheltering of assets by elderly residents.

**DELAWARE:** Half a loaf and annuities.

**GEORGIA:** Promissory notes and trusts. Yes, somewhat common. About 10%.

**INDIANA:** Common practices are the purchase of annuities, interests in income –producing property (which is exempt in Indiana), transfers of assets.

**KENTUCKY:** Annuities and IRA’s

Very

Unknown

**LOUISIANA:** Transferring or donating assets for no compensation or very little compensation, placing assets in excludable trusts and annuities, changing a bank account owner’s name from the applicant to another person, adding a name to the account and declaring that none of the money in the account belongs to the applicant, declaring the value of a countable resource to be below the actual value, not reporting all assets owned (cash, stocks, dividends, property including estate property, bank accounts, etc.) purchasing certificates of deposits, and purchasing exorbitant pre-need funeral contracts.

We estimate about 10% of cases involve some form of divestiture, hiding, or sheltering of assets.

**MAINE:** Left blank.

**MICHIGAN:** 15% - pre-arranged funeral contracts have no cost limitations.

**MINNESOTA:** Outright gifting of real and personal property, along with planning of ineligibility periods, is used most often. Life estates are a common vehicle for transferring real property. The purchase of annuities and establishing trusts are also common. New vehicles, such as the family limited partnership and business trusts have also been seen.

Although these practices are fairly common it is not possible to estimate the percentage of nursing home cases that involve sheltering. Those who are more affluent will work with an attorney or other financial planner to shelter as many assets as possible. Those with less assets may only establish a life estate interest in real property in an attempt to transfer their real property to others.

**MONTANA:** Contracts for services to reimburse family members for activities but not collecting on contracts until MA eligibility is requested. 5 - 10% and growing.

**MISSISSIPPI:** Transferring assets and waiting out the penalty period or seeking exemptions from the transfer.

**NEVADA:** QIT’s, SNT, annuities, spousal divisions, reverse mortgages, transferring exempt resources.

**N CAROLINA:** The purchase of annuities is becoming a very popular method for divesting assets. Special needs trusts are used quite frequently, but primarily those are used in personal injury settlements. We do not know how many nursing facility cases involve divestiture of assets, and would not make a guess. Since these are the cases we get questions about, the amount of a guess would be inflated just by experience

**NORTH DAKOTA:** Gifts of assets, purchase of annuities, false statements about asset transfers. We have no data, only an abundance of stories. My guess is at least 50%. It really depends on how far back you look. Our application asks for all divestitures within five years of the application, but we have very limited means of discovering false responses. Also, individuals sometimes have a history of helping their adult children by forgiving debt, selling assets at sub-market prices, gifting major assets while retaining a life estate or some other life interest, and numerous other practices that may or may not be motivated primarily by a desire to have the taxpayers bear the cost of long term care.

**OHIO:** The most commonly used artificial impoverishment techniques in Ohio are transferring the home (while person is still alive), creating annuities, and gifting money to kids. We're seeing a decline in the use of life estates. While some techniques may not be used in the majority of cases, when they are used they involve large sums of money. For example, cash and real estate transfers seem to occur more often in the range of \$100,00 to \$250,000.

We are detecting a growth in the level of awareness and sophistication about how to shelter assets. The 1999 report includes some data and comments from county eligibility workers about the sheltering techniques that they had seen being used, and these techniques continue to be used today. Since 1999, our state administrative code on annuities has been tightened up, so use of that technique is now more difficult to arrange (No balloon payment, must be commercial annuities and no private annuities, and must be based on life expectancy.)

**OREGON:** In Oregon, it is common for a couple with excess resources to purchase an annuity with the community spouse as the annuitant. That causes the asset to be counted as the community spouse's income rather than a resource available to the client. It is also common for couples that can afford the legal fees, to get a spousal support order that increases the MMMNA so that a higher CSRA is needed to generate the income needed by the community spouse to meet living expenses. Oregon would guess that perhaps 5% of Medicaid nursing home eligibility cases involve some form of divestiture or sheltering.

**S CAROLINA:** In the past, promissory notes were employed in a high percentage of our long-term care applications. With our new policy changes, we hope this will decrease. Among the other methods we see are these:

- Transferring resources (including retirement funds) into annuities in the spouse's name and calling these the spouse's retirement funds, which would be exempt because we are not counting the spouse's retirement funds as a resource to the spouse.
- Creating family limited partnerships and saying that applicant can not sell his/her shares because there is no market

**TEXAS:** Aggressive transfers just under the monthly penalty threshold. Interspousal transfers and then the ineligible spouse transfers asset. How common are these practices? Anecdotal reports indicate these techniques are common. Do you know, or if you had to guess, what percentage of Medicaid nursing home eligibility cases involve some form of divestiture or sheltering? **No data**

**UTAH:** The most common problem is the purchase of annuities. We have not had a large number of cases but this practice is increasing. I believe any percentage is low. I have no reliable information to base a percentage of transfer on. This has not been a problem in the past but I believe it will become a problem in the future unless we are able to implement policy that controls annuities

7. Are divestiture controls (such as transfer of assets restrictions), liens and estate recoveries politically sensitive issues in your state? Are there concerns about whether vulnerable seniors will fail to seek needed care if Medicaid is more restrictive?

**ALABAMA:** Alabama has had transfer of assets penalties for several years and it has never become a politically sensitive issue. As Alabama has a low median income, concerns are meeting the needs of those who qualify. We do not expect stricter rules to keep vulnerable seniors from applying.

**ARIZONA:** So far, neither transfer of asset restrictions or estate recovery have been politically sensitive issues in Arizona. Private individuals and estate planners contact our local offices and our Central Office with questions about the program. We also receive anecdotal information from our local offices that a number of persons applying for ALTCS withdraw their applications when informed about Estate Recovery. However, we do not track the reasons for withdrawals and have no data.

As discussed in our response to the next question, Arizona is in the process of implementing TEFRA liens through the administrative rule process. It is quite possible that we will receive comments from the public and elder law attorneys and estate planners. We also anticipate that some individuals will withdraw their applications rather than face the possibility of having a lien placed on their homes. However, we have no data to estimate the number of situations where that may occur.

**ARKANSAS:** Estate recoveries are politically sensitive.

**CONNECTICUT:** Yes. One of the most common criticisms the Dept of Social Svs. hears re. their waiver 1115 is that it punishes people who have nothing. The folks who argue this don't take into consideration how many "people who have nothing" "have nothing" because they've given it away.

**DC:** No, divestiture controls are not politically sensitive in the District at this time. Yes, there are concerns about vulnerable seniors in the District failing to seek needed medical services if Medicaid is more restrictive. Overall, the District senior population is very vulnerable due to their health needs. Many seniors are suffering from high blood pressure, kidney disease, and heart disease and many other health related problems.

**DELAWARE:** Yes, these are politically sensitive issues in our small state.

**GEORGIA:** Yes. Yes. So sensitive we have not yet implemented estate recovery.

**INDIANA:** Left blank.

**KENTUCKY:** Yes  
Yes

**LOUISIANA:** Estate Recovery is a sensitive subject. Some seniors do not want to apply for Medicaid, because they do not want you to know their financial situation. After hearing about estate recovery, some no longer want to apply. Some receive inaccurate information or base their situation on someone else's experience. Other barriers include: they do not know the requirements, hear rumors about what is counted or hear that a lot of information and verifications are needed, have heard that Medicaid doesn't pay for anything, etc.

**MAINE:** The concerns that the elderly population may make health decisions in response to a stiff Estate recovery program has led this Bureau to continue the estate recovery policy little changed since inception 10/93.

**MICHIGAN:** YES. Resistance to estate recovery is strong.

**MINNESOTA:** The Department is always receptive to hearing about the concerns of vulnerable seniors and persons with disabilities. The legislature has been supportive to limiting divestitures through the request of a federal waiver on two separate occasions. Minnesota is currently waiting for a response from CMS regarding a waiver at this time.

**MONTANA:** Yes they can be but will be looked at as part of overall redesign. Are there concerns about whether vulnerable seniors will fail to seek needed care if Medicaid is more restrictive? Not to our knowledge.

**MISSISSIPPI:** Yes, it is sensitive but presented as federally mandated.

**NEVADA:** No

**N CAROLINA:** It is unclear how politically sensitive this issue is. We are routinely asked for suggestions regarding this issue. Until the past couple of years no action was taken. Budget considerations have held sway.

**NORTH DAKOTA:** What appears to be politically sensitive is any constituent concern that is addressed to a legislator. That has produced effective opposition to Medicaid agency efforts to secure legislation. We have not sought liens (under 42 U.S.C. § 1396p(a). We have vigorous and effective estate recovery efforts underway, and those have not been politically sensitive. North Dakota has a disqualifying transfer provision that predates either 42 U.S.C. § 1396p(c) or its predecessor, 42 U.S.C. § 1396a(k) (repealed), and reflects this State's 209B status. However, we were prevented by the elder law bar lobbying from extending this to assets that are not part of the probate estates of the Medicaid recipient or the recipient's spouse. Are there concerns about whether vulnerable seniors will fail to seek needed care if Medicaid is more restrictive? I haven't heard this as a concern. Please explain and provide examples

**OHIO:** Estate recoveries have been a sensitive issue, erupting occasionally as an issue in local papers. Historically, Ohio legislators have not been zealous to take a hard stance on the issue and alienate constituents.

The HCBS waiver for persons over age 60, known as PASSPORT, has been the “hottest” area: Even though Ohio law forbids putting a lien on the home of an HCBS enrollee, The Ohio Dept. of Aging, which administers PASSPORT for ODJFS, remains concerned about people declining services because of the program and keeps statistics on the number of people who decline enrollment due to concerns about estate recovery. Ohio’s estate recovery definition is quite conservative.

Ohio’s “transfer on death” provision was added to state law after 1999 when its report and study was compiled. There have been significant increases in the number of “transfer on death” and “payable on death” provisions added to both real and personal property that affects the recovery of claims through estate recovery, since Ohio only recovers assets that are subject to probate.

**OREGON:** The issue of artificial impoverishment, liens and estate recovery are politically charged issues in Oregon. “Divestiture” is unknown. Regarding liens and estate recovery, historically, the Department has been reluctant to implement liens on real property because of the potential chilling effect. There have been cases where clients, informed of the estate recovery program, elect not to seek public assistance, because they want to “leave something for their children.” There are cases where the fact pattern suggests that children have persuaded/coerced their parents not to apply for Medicaid, because the children evidently felt their parents really did not need public assistance if it meant the inheritance would be diminished.

**S CAROLINA:** The Elder Bar and the Protection & Advocacy groups in our state lobby the legislature to block efforts to strengthen divestiture control measures.

**TEXAS:** Yes. Yes. Anecdotal reports speculating that individuals will not access needed services and neglect and abuse will increase.

**UTAH:** Are divestiture controls (such as transfer of assets restrictions), liens and estate recovery politically sensitive issues in your state? Transfer of Asset restrictions are not an issue. Utah does not use TEFRA liens due to the concerns from senior advocates. Estate recovery is a sensitive issue.

Are there concerns that vulnerable seniors will fail to seek needed care if Medicaid is more restrictive?

Yes, that concern has been raised in the past. It has not come up in the past several years.

Please explain and provide examples.

Over the past 20 years the issues regarding estate recovery, liens and the possible impact on seniors have been raised many times. Several committees and task forces have been convened to discuss these concerns without much outcome. Due to the concerns of senior advocates, the Utah state Medicaid agency has chosen not to implement TEFRA liens or liens of record at the time of eligibility.

However, the concerns regarding estate recovery have been countered with information about the asset divestiture and estate planning industry which actively assists middle and high income seniors and adult heirs to shelter assets at the expense of the taxpayers. That along with the drain of the Medicaid program on the

state budget seems to have minimized the political sensitivity of estate recovery. In addition, there is no empirical data which suggests that seniors are not seeking medical assistance due to the fear of not being able to leave their estate to their adult heirs. Of course in many cases adult heirs have already successfully transferred the seniors assets out of sight of the state so estate recovery becomes a non issue.

**8. Do you have a Medicaid lien program? If yes, please describe its effectiveness, i.e. cost vs. revenue generated for the past three years.**

**ALABAMA:** Yes. We have two employees in the Liens Program and one employee in Estate Recovery. The following amounts indicated are combined collections for the Liens Program and Estate Recovery:

FY 01 \$2,945,533.09 (In FY 01 there was one employee in Liens)

FY 02 \$4,418,959.43

FY 03 \$4,126,671.56

**ARIZONA:** Arizona Health Care Cost Containment System (AHCCCS), the Arizona Medicaid Program does not have a lien program at present. AHCCCS is in the process of implementing TEFRA liens. The primary reason is to increase recovery dollars.

**ARKANSAS:** Arkansas does not have a Medicaid lien program.

**CONNECTICUT:** Yes. We've had one as long as we've been allowed. Doesn't have figures regarding its effectiveness. Said it's obviously cost effective because they continue to use it.

**DC:** Yes, we do have a Medicaid lien program. The revenue generated for the last three years is as follows:

FY 2001 \$1,511,496.19

FY 2002 445,864.89

FY 2003 693,908.50

The Medicaid lien program is quite effective. The Unit has two dedicated staff persons who administer the program. The overall cost of the program is approximately \$85,000 per year.

**DELAWARE:** Delaware places liens on the real property of institutionalized long term care recipients age 55 and over. It is cost effective since the costs including filing fees and staff time are much less than the return. Liens are considered a tool in the estate recovery process and have not been tracked separately.

**GEORGIA:** No. We will implement when we implement estate recovery.

**INDIANA:** Left blank.

**KENTUCKY:** No, we have an estate recovery program, but we do not have the authority to impose actual liens within that program.

Not at this time

We are currently engaged in significant enhancements to the program to increase estate recoveries, such as eliminating any homestead deduction and removing the probate limitation. These changes are being met with opposition. It would not be practical to include liens at this time, but we may in the future.

**LOUISIANA:** Yes, we do have a Medicaid Lien Program (the unit is referred to as the Medicaid Trauma Recovery Unit). This unit has been in operation for more than 10 years. Currently, there are five Specialists responsible for all the parishes in the state of Louisiana. Each position collects more than its gross income and other benefits each year. For the past three years our collections have ranged from \$5,500,000.00 to \$6,900,000.00. We also work with a team of four staff attorneys who assist us with legal matters, when necessary.

**MAINE:** Currently, liens are not utilized in the Estate Recovery program via Probate Court. There have been discussions to implement a lien program, however discussions have not evolved into plans to develop changes in the current statute or policy.

**MICHIGAN:** No Medicaid lien program.

**MINNESOTA:** Yes. Joe Rubenstein is the contact for lien and estate recovery questions; he can be reached at (651) 297-1104. The most recent publication on the subject can be found at: <http://www.dhs.state.mn.us/FMO/LegalMgt/Bulletins/pdf/2003/03-19-01.pdf>.

**MISSISSIPPI:** No

**MONTANA:** Yes. Implemented in 1995 funds recovered have been designated for one time expenditures to improve quality of services for nursing home and HCBS waiver one time expenditures. Recently the funds have been used to fund operating costs for adult protective workers and have been used in the last legislative session to offset general fund Medicaid match in the nursing home program. Question regarding the collections and the cost for consultant for recovery of such funds can be directed to Quality Assurance Division staff at 406-444-5401.

**NEVADA:** Liens are utilized in both TPL and Medicaid Estate Recovery programs. The cost of administrating the lien program for recoveries has not been identified separately from the revenue generated by liens. Currently, Nevada has 126 filed liens representing \$7,866,571 in secured claims for possible collection.

**N CAROLINA:** N.C. does not have a lien program.

**NORTH DAKOTA:** Do you already have a Medicaid lien program? No. If yes, please describe its effectiveness, i.e. cost vs. revenue generated for the past three fiscal years. If no, do you intend to implement one? No. Why? Please see the response to the last part of question 1. North Dakota counts as an available asset virtually all of the property that would be subject to a lien under 42 U.S.C. § 1396p(a). Consequently, liens would accomplish little.

**OHIO:** Liens: the Revised Code (ORC 5111.11 and 5111.111) permits liens except for active recipients of the HCBS waivers. Because Ohio uses a more restrictive policy than most states which requires sale of the property after a six month institutional stay, the practice of putting TEFRA liens on property during a recipient's life hasn't been implemented. Additionally, Ohio's estate recovery program does not target the permanently institutionalized. Estate recovery does recover the value of any real estate that still remains under the probatable estate.

**OREGON:** Oregon does not have a program to place liens on clients' real property. There is no plan to implement one. This would require action by the Oregon Legislature. Historically, the Department has been reluctant to propose this program fearing that it would discourage eligible individuals from applying for the public assistance they need. The estate recovery program does have a chilling effect, a program to place liens on real property of public assistance recipients probably would add to the chilling effect, although how much is speculative. Regardless, the Oregon Legislature is not likely to implement such a program in the face of opposition from advocacy groups.

The Oregon Legislature recently granted the Department authority to file "Request for Notice of Sale or Encumbrance." This allows the Department to file a request for notice in the lien records of the county where a client possesses real property. This does not operate as a lien, but it does mean that title companies must inform the Department whenever the subject property is sold, transferred or encumbered. This will give the Department timely notice of these transactions so that they can be evaluated in a more timely fashion to determine how it affects a client's ongoing eligibility, or whether a client is being financially exploited.

**S CAROLINA:** No. No. There has been little interest in implementing a lien program in SC.

**TEXAS:** No. No. Requires enabling state legislation which has not been passed.

**UTAH:** We do not have a Medicaid lien program. We recover through probate. Please see the enclosed pamphlet, "Estate Recovery Information Bulletin" for information on this program.

**9. Do you have a Medicaid estate recovery program? If yes, what are your costs of recovery and total state and federal funds recovered for the past three years?**

**ALABAMA:** Yes. See #8

**ARIZONA:** Yes. Arizona has a Medicaid estate recovery program which became effective 1/1/94. AHCCCS contracts with Public Consulting Group, Inc. (PCG). PCG received a 15% contingency fee of the total dollars recovered in SFY 2001, SFY 2002, and the first nine months of SFY 2003. Beginning in April of 2003 the contingency fee was reduced to 12% due do a new contract year.

Total State and Federal funds recovered for the past three fiscal years were as follows:

SFY 2001 was \$963,286  
SFY 2002 was \$1,414,475  
SFY 2003 was \$1,602,333

Please note that the State fiscal year is July 1, through June 30. For example SFY 2001 dates would be July 1, 2000 to June 2001.

**ARKANSAS:** Arkansas does have a Medicaid estate recovery program. In FY 2000 DHS collected \$1,208,949.39 at a cost of \$3,065 in filing fees; FY 2001 \$1,247,129.59 collected at a cost of \$2,130.60; FY 2002 \$1,557,310.77 collected at a cost of \$2,805.

**CONNECTICUT:** Yes. Doesn't know. We could call Marcus Tilton at 806-424-5975 for this information.

**DC:** Yes, we do implement an estate recovery program. The recoveries for the last three years are as follows:

FY2001 \$1,589,710.93  
FY2002 974,187.95  
FY2003 1,580,412.50

There are three staff persons assigned to the estate recovery section and the total cost of recovery is approximately \$125,000 per year.

**DELAWARE:** The total estate recoveries including amounts collected on liens are:

SFY 2001 \$397,651.54  
SFY 2002 \$462,986.02  
SFY 2003 \$500,796.80

**GEORGIA:** Not at this time, but plans are underway.

**INDIANA:** Left blank.

**KENTUCKY:** Yes

We recovered \$2.5 million last year and approximately 1.5 each year the previous two years. We have no direct data on costs as the function has always been performed by state employees.

**LOUISIANA:** Yes. The recovery cost equals the annual salary of the employee handling this program, related benefits, and supplies. For the current SFY, the cost of recovery is \$59,820.00.

The Medicaid estate recoveries for the last three fiscal years are as follows:

SFY 2000-2001 = \$82,726.61 (70.48% federal match = \$58,305.71 federal, \$24,420.90 state,  
 SFY 2001-2002 = \$95,985.73 (70.36% federal match = \$67,535.56 federal, \$28,450.17 state; and  
 SFY 2002-2003 = \$85,907.89 (71.04 % federal match = \$61,028.97 federal, \$24,878.92 state.

**MAINE:** Yes. Costs 3 FTE-\$450,000/3years Recoveries state and federal-\$12.7M/3years

**MICHIGAN:** No recovery program.

**MINNESOTA:** Yes, please see response to question #8.

**MISSISSIPPI:** Cost: FY-01-\$113,000 / FY-02 \$135,000 / FY-03 \$141,000 / Amount recovered: FY-01 \$1,132,095 / FY-02 \$1,544,000 / FY-03 \$1,719,987

**MONTANA:** Yes. See 8 above

**NEVADA:** Nevada’s recovery program became operational in October of 1993. The recovery amount for the last three fiscal years from 2001 to 2003 is \$3,721,385. The cost of recovery is approximately 6% of total revenue collected.

**N CAROLINA:** Yes. We have two permanent staff and 1.5 temporaries working estate recovery.

Amounts recovered: FY ending June 2002 we collected \$3,728,708.16. FY ending June 2003 we collected \$4,974,197.18. Do not have the FY 2001 figure.

**NORTH DAKOTA:** Yes. Costs of recovery run about \$80,000 per year, primarily salary for an administrator and a part-time lawyer (me). Gross recoveries in SFY (July1 through June 30) 2000=\$1,434,014.13; 2001=\$1,619,344.16; in 2002 =\$1,743,802.47; and in 2003=\$1,774,867.32. North Dakota has cost effective practices that allow recovery in estates with a value of less than \$15,000, at a cost no greater that that of mailing a letter. Approximately 40% of the described recoveries come through this practice. North Dakota collects very little from the sale of residential property belonging to Medicaid-eligible nursing facility residents on their deaths. See the response to the last part of question 1. In most cases, the residences of these individuals are disposed of before eligibility is established, reducing the number of months of eligibility, and also reducing available assets for estate recovery.

**OHIO:** Ohio’s program has operated since 1995. Attached is a spreadsheet outlining collection activities since the history of the program, with breakouts by federal and state share and the collection agency’s (Ohio’s

**OREGON:** Oregon’s Medicaid estate recovery and costs for July 2000 through July 2003 were as follows:

*Estate Recoveries for the Medicaid Program*

<i>Agency Object</i>	<i>Agency Object Title</i>	<i>Amount Charged to Medicaid</i>
1703	<i>Estates Probate Reserve</i>	85,243.21
1749	<i>Estates Mortgage Principle Collection</i>	1,969,540.33
1755	<i>Client Account Collections</i>	20,425,108.22
	<i>Total Recoveries</i>	<u>\$22,479,891.76</u>

*Estate Expenditures Charged to the Medicaid Program (Estimate)*

*\$1,101,932.40*

**S CAROLINA:**

Yes, SC does have a Medicaid estate recovery program.

SFY 03 Recoveries	\$4,920,315	Cost	\$260,229
SFY 02 Recoveries	\$3,687,835	Cost	\$253,703
SFY 01 Recoveries	\$5,177,709	Cost	\$247,032

**TEXAS:** No. Recent legislation requires implementation of an estate recovery program which is under development.

**UTAH:** Utah does have an estate recovery program covered in Utah Code 26-19-13.5.

Total money collected for the past three fiscal years:

FY01	\$1,647,550.96
FY02	2,188,423.13
FY03	2,278,590.53

The program consists of one agent with costs of recovery around \$50,000.00 per year.

- 10. If Medicaid nursing home eligibility becomes harder to obtain and less desirable because of stricter eligibility rules and/or stronger estate recovery requirements, do citizens of your state have cost-effective alternatives, such as private-pay home and community based care, assisted living facilities, home equity conversion (e.g. reverse mortgages) for supplemental income and high quality private long-term care insurance for estate planning? Please explain.**

**ALABAMA:** The alternatives are limited and are not considered to be affordable for most of the population that Medicaid would serve. Private-pay alternatives in assisted living and community based care are available, but they are expensive.

**ARIZONA:** Yes, the state has an extensive network of assisted living facilities and in-home paraprofessional provider agencies.

**ARKANSAS:** If Medicaid eligibility became harder to obtain many Arkansans would have difficulty receiving access to needed care. Arkansas ranked first in US in 1999 in Poverty Status Above Age 65. Most individuals who access Medicaid home and community base care qualify under the “300% rule”. These individuals cannot afford to pay for home and community base care out of pocket. Assisted living is primarily a private pay industry. AR is one of nine states to participate in the Robert Wood Johnson Foundation Affordable Assisted Living project. Experience from that project demonstrates that Medicaid is key to creating affordable assisted living.

**CONNECTICUT:** Community Based Care – accepts Medicaid and private pay, so is a viable alternative for those who want to avoid nursing homes.

Assisted Living – not covered by Medicaid program.

Home Equity Conversion – they allow; don’t count proceeds.

Mentioned they are a Partnership State (protect additional assets)

The Dept of Social Services has implemented the following in order to make eligibility harder to obtain:

- 1) Transitioned from an asset first to income first state
- 2) Spelled out what “exceptional circumstances”/ “financial duress” means
- 3) Established state statute language linking annuities to trusts (transfer penalties)

**DC:** Citizens of the District of Columbia have some cost-effective alternatives to Nursing Homes. Some of these options include home and community based waiver services. Two of the principle options include the Elderly and Physical Disabilities (EPD) waiver and the Mentally Retarded and Developmentally Disabled (MRDD) waiver. The EPD waiver eligibility is based on 300% of the Supplemental Security Income (SSI). This amounts to those that have income less than \$1656/month. Assisted Living Facilities are not currently regulated in the District nor reimbursed by Medicaid in the District.

A contract Request for Inquiries (RFI) to develop Assisted Living has been proffered. Once the contract is signed and contractor is on board, key deliverables in 2004 will include development of regulatory criteria, regulations and enforcement mechanisms.

The Medical Assistance Administration has not pursued home equity conversions, such as reverse annuity mortgages to help residents supplement their income. High quality private long- term care insurance plans are offered by some insurance carriers, but are not part of Medicaid. cursory review indicates that the plans are too expensive for most District Medicaid recipients.

**DELAWARE:** We have all of these things but don't see much insurance.

**GEORGIA:** Yes Georgia citizens would have ample cost-effective alternatives for long-term care services if the state were to impose stricter eligibility rules and/or implement estate recovery. All of the items listed are available in Georgia.

**INDIANA:** Left blank.

**KENTUCKY:** Home and community based care services, assisted living facilities, continuous care retirement communities, and private long-term insurance carriers/coverage are available within the state of Kentucky.

**LOUISIANA:** Alternatives available in Louisiana to Long Term Care facility living and ways of paying for that care include the following: Independent living apartments and centers, assisted living facilities, day care centers, private home care, home and community based waiver services, Medicare Supplements, Medicare Supplement Guarantee Issue (Medigap), long term care insurance, reverse mortgages and coming in 2004, Program of All-inclusive Care for the Elderly (PACE) ..

**MAINE:** Yes. Maine tightened the medical eligibility requirements for nursing facility services in 1993. Maine Medicaid has actively developed an array of community-based services as alternatives to nursing facility care. Services include; home and community-based waiver service; In-home nursing and personal care services (targeted to meet chronic, long term care needs); consumer-directed attendant cares services; and personal care services delivered in assisted living settings.

**MICHIGAN:** Yes, all of the above apply.

**MINNESOTA:** Yes, all of these alternatives are available. In addition, it is anticipated that while many people will still be eligible for Medicaid long term care, they will use more of their own assets prior to requesting public assistance.

**MISSISSIPPI:** All such alternatives do exist and are available.

**MONTANA:** Yes. Montana has had in place an HCBS waiver for elderly and physically disabled individuals for quiet some time. We also cover some individuals under the HCBS waiver in these service settings. Most facilities will negotiate prices. And many communities now have assisted living /personal care facilities available as well as other home care alternatives for private pay and other individuals.

**NEVADA:** Yes, all are available options.

**N CAROLINA:** We do not expect significant changes in Medicaid nursing facility eligibility rules.

**NORTH DAKOTA:** All of those things are available. North Dakota has "rate equalization" for long term care facilities. That is, the State Medicaid agency sets the nursing facility rates for both public and private paying residents. Every nursing facility in the State admits Medicaid residents on the same terms as private-pay residents as there is no fiscal incentive to do otherwise.

**OHIO:** Ohio options include reverse mortgages and home equity conversion. Ohio services include private pay assisted living options, but HCBS waivers in Ohio do not cover care in assisted living facilities.

Ohio is seeing a small increase in the number of LTC insurance policies being sold. The Ohio Department of Insurance has a consumer guide on its web site about LTC insurance at <http://www.ohioinsurance.gov/consumserv/ocs/ocspub.htm> which describes the personal factors one should consider in deciding whether to purchase long-term care insurance, explains how coverage works and the variables that can be part of a long-term care insurance policy, answers common questions and gives shopping tips. It displays sample company premiums based on current age, offers complaint comparisons about companies, and contains a glossary of common definitions of long-term care words and phrases.

Family members still care for individuals at home through private pay. These are persons who do not arrive in our system so it's hard to count them.

Elder law practitioners are definitely selling their services in Ohio, and printing articles about Medicaid eligibility and estate planning in local newspapers.

**OREGON:** In Oregon, citizens have all of the options listed above. However, the clients that we see do not have income sufficient to pay privately for care or purchase long-term care insurance. In addition, most clients do not qualify for long-term care insurance because they are too disabled to be eligible when they realize that the insurance would have been a good investment.

**S CAROLINA:** Since Medicaid is by far the largest payor of long term care services in the state, much of our infrastructure has been geared toward this payment system. However, our state that has seen an influx of out-of-state retirees and a dramatic growth in the 85+ population, and the long term care continuum in South Carolina is growing to meet this demand.

There are 195 nursing facilities in the state. Of that number, approximately 150 serve Medicaid residents. Among this 150, Medicaid accounts for over 75% of the beds. It is our belief that there are an adequate number of private pay beds and facilities around the state to meet the demand.

The state has seen a rapid growth in affordable assisted living facilities. Many private pay consumers have elected this option over more costly nursing home care.

Since much of the state is rural, there are certain geographic areas where the availability of home care poses a problem. In other areas, there is a definite shortage or unlicensed assisting personnel like nursing assistants.

**TEXAS:** Private pay home care services, assisted living, home equity loans, and long term care insurance are available. Not aware of any way to address cost-effectiveness or quality.

**UTAH:** Non- Medicaid alternatives:

The Alternative to Nursing Home Program (TAP) is administered through local Area Agencies on Aging (AAAs) and provides services for adults who have health, mobility or functional limitations and who are at risk for nursing facility placement. The majority of those served are aged 60 and above. Services provided are homemaker, personal care, home health aide, nursing, respite, home delivered meals, adult day care and transportation.

Caregiver Respite Program provides intermittent and short-term services to allow caregivers a short break from the day-to-day demands of providing care to an elder person. Services include adult day care, homemaker, home health aid, short-term institutional placement, and the use of medical equipment and supplies.

**Division of Services for People with Disabilities (DSPD) Personal Assistance Support Program** - This is a State funded program for individuals not meeting the eligibility criteria of the Physical Disabilities Waiver. The program provides personal attendant services, consumer preparation, and personal emergency response systems.

11. Has Medicaid resident census (as compared to private-pay census) in your state's nursing homes increased in the past 10 years? If so, from what percentage to what percentage approximately? Is this change attributable to eligibility bracket creep and/or Medicaid estate planning? What has been done the impact on (1) the state Medicaid budget and (2) nursing home requirement levels? Please explain.

**ALABAMA:** Medicaid census over the past ten years has actually decreased from about 70.9% to about 68.8%. This is due to an increase in the number of beds available and a statewide decrease in total census. The Medicaid budget has increased because of higher rates caused by increased cost of goods and services and fewer patients to spread the cost over.

**ARIZONA:** The Medicaid NF population has remained relatively flat for the past 5 years. The limited growth is due to developing alternative residential and in-home services. The budget impact has only been related to inflation and not to a growing Medicaid NF population.

**ARKANSAS:** Arkansas has seen a dramatic decline in nursing home use in the past 10 years. Since 1998 Arkansas has experienced an approximate 12% drop in residents. The decline can be attributed to several factors, including the State's philosophy to give citizens a choice of how and where they receive long-term care. Arkansas has taken a number of steps to rebalance the long-term care system. Nursing home costs continue to rise because of rate increases and efforts to improve quality of care.

**CONNECTICUT:** It's been pretty static. There always seems to be about 21,000 Medicaid recipients at any given time.

**DC:** The Medicaid resident census (as compared to private-pay census) has increased in the past three years. There are currently twenty-one nursing facilities in the District of Columbia with 2,234 residents and 430 D.C. Medicaid out of state nursing home placements. At the time of this writing, we do not have available private pay-Medicaid comparison data for the past ten years.

There is little to no change in the number of licensed beds, but there is a small increase in the numbers of residents. The average nursing home census was 91-92 percent in 2000 and has been fairly constant at 93 percent since then. This change or increase, less than three percent, is not due to eligibility bracket creep or Medicaid Estate Planning. Less than twenty persons to date have participated in the Medicaid Estate Planning. Previously, much of this stability in the census may be due to the large numbers of relatively poor or low-income persons that are eligible for Nursing Home placement that do not have to spend down to become eligible and do not have other options. Persons are also living longer. The numbers of persons in need of SNF services has increased as has the levels of severity or acuity needs. The impact on the budget is that LTC costs are increasing. To date, Nursing Home rates have been bundled to include pharmacy. Pharmacy is growing at a rate of approximately 14 percent annually.

The District's nursing home industry has asked that MAA move to a Case Mix methodology that carves out pharmacy and bases care on prior acuity levels to compensate for the cost increases. MAA is moving to complete the transition process and looks to implement Case Mix, carving out pharmacy in mid 2004.

**DELAWARE:** Trying to get the answer to this.

**GEORGIA:** Yes the Medicaid resident census has increased. It has increased from 75% in 1996 to 85% in 2003. This has caused significant budget increases. Reimbursement rates to nursing home have increased also.

**INDIANA:** Actually, the Indiana Medicaid resident census in Nursing Facilities has decreased in the last ten years by 12.23 when compared to private pay census.

**KENTUCKY:** Nursing facility occupancy has declined during the 8-year period of 1995-2002. Medicaid patient days have either slightly decreased or remained fairly constant. In 2002, there were 5.93 million Medicaid patient days of a total 8.47 million utilized by all payor sources. Routine per diem payments have increased over the past 10 years. The current fiscal year encompassed a 2.5% increase for all nursing facilities.

**LOUISIANA:** An explanation of the comparison of NF private pay census to Medicaid NF census must be prefaced by a profile of Louisiana's unique nursing facility situation. The provision of long-term care services in Louisiana centers in nursing homes. Although other options exist, such as assisted living facilities, home and community based services (HCBS) and home health care, Louisiana still relies almost exclusively on nursing homes to provide long term care services to the elderly and disabled. In Louisiana, older and chronically disabled residents who might only need intermediate care have few options other than admission to a nursing home.

In the Medicaid program, nursing home expenditures account for nearly \$500 million yearly and until recently consumed the greatest portion of all Medicaid spending in Louisiana. Per population, Louisiana has more nursing home beds and residents and lower occupancy rates than most states in the nation, indicating excess capacity and use.

- Louisiana ranks first in the nation in the rate of nursing home residents per 1,000 population age 85 and older (550.5 residents compared to the U.S. average of 358 in 1999)
- Louisiana ranks third in the nation in the rate of nursing home beds per 1,000 population age 85 and older (477 beds compared to the U.S. average of 359 in 1999)
- Louisiana ranks 37th in the nation in nursing home occupancy rates (78.7 percent compared to the U.S. average of 82.7 percent in 2002)
- Currently, 4 in 10 New Orleans area nursing homes have occupancy rates lower than the state average, some as low as 52 percent.

Medicaid resident census numbers as compared to private-pay census have decreased over the past 10 years. Medicaid eligible nursing home residents have decreased 12.07% from 1993-2003. Private pay nursing home residents have increased by 66.6% from 1993-2003. Please note that while there has been a decrease in Medicaid NF admissions, there has been an overall 15.3% increase in LTC recipients (NF, ICF/MR and HCBS) over the last ten years. Comparably, the total LTC caseload in December, 2002 was only 585 less than it was in December, 1992; however, HCBS caseloads for December 2002 were 5,513 more than they were in December, 1992.

Some of the factors attributing to the widening of the gap between private pay NF census and Medicaid NF census are:

- The increased availability of alternative care settings and Medicaid home and community based waivers has resulted a decrease in percentage of the population that enters Medicaid NF
- Although the income CAP and the spousal impoverishment standards increase annually, the individual resource guideline has remained the same. There is a decline in the very low income population; persons are retiring with higher incomes and accumulating some resources. Some individuals have accumulated resources to enable them to pay for some period of their long term care stay. Some have purchased long term care insurance that pays for a limited time.

Desire of some individuals to avoid Medicaid estate recovery provisions.

**MAINE:** In SFY95, there were 9,945 Maine Medicaid clients in NFs (\$24,089/per capita) and total expenditures of \$239,569,164. In SFY02, there were 8,175 clients in NFs with total expenditures of \$201,554,544. This decrease is due to the tightening of medical eligibility requirements and the implementation of independent medical eligibility assessments by nurse assessors and prior authorization requirements.

**MICHIGAN:** No.

**MINNESOTA:** Yes, Medicaid resident census has increased in the past 10 years. We do not have specific statistics readily available for the prior 10 years, however it has increased several percentage point during that time period. This is attributable to both eligibility bracket creep and Medicaid estate planning.

Medicaid budget expenditures with regard to Long Term Care have been steadily rising due to a variety of factors. Increases in nursing home reimbursement levels have more correlation to the cost of living (COLA) increases for staff and increased costs of doing business than to increases in Medicaid resident census.

**MISSISSIPPI:** Increase is only due to increased beds available; otherwise, no growth (flat).

**MONTANA:** Medicaid as a percent of the total occupancy has been at the 61% range for quite some time. Private pay as a percentage of the total state wide average (SWA) occupancy has been at 31-32% for many years as well. What is significant is the total occupancy state wide in 1997 was 87% and today is at 78% on average in 2003. The budgetary impacts have been that Medicaid reimbursement has increased to nursing facilities over the last several years. The system of reimbursement was changed to a price based system utilizing Medicaid case mix adjustments beginning in FY 2002. As a result more funding was directed to the reimbursement system to close the gap or disparity from the highest to the lowest rate providers. Additionally more funding has been brought into the system of reimbursement due to increases in provider taxes on nursing homes. SWA rates increased from \$106.33 to \$116.51 from FY 2003 to FY 2004 related to increases in provider taxes. Additionally more funding has been derived from the utilization of local county funds in the form of intergovernmental fund transfers. Additional funding but not from state general fund sources.

**NEVADA:** No. Medicaid resident census has stayed relatively flat in the last 10 years despite the increase in available nursing home beds in the state. Of the approximate 5,100 beds available, roughly 54% (2,800) are being utilized by Medicaid recipients. Nevada recently converted to a case mix reimbursement system based on direct health care, capitol (fair rental value principles) and administrative costs. The Legislature passed a provider tax that became effective on 7/1/03 which created an ability to increase all nursing facility rates over \$20/day in most instances.

**N CAROLINA:** Census for nursing facilities has been flat or relative decreases for several years

**NORTH DAKOTA:** The percentage of all nursing facility beds occupied by Medicaid residents has ranged between 55% and 57% for a number of years. Is this change attributable to eligibility bracket creep and/or Medicaid estate planning? There have been many factors that affect the number of occupied beds: (1) North Dakota has been consistently had one of the nation's oldest average age for all residents; (2) North Dakota had the highest (by far) number of nursing home beds per capita for years; (3) North Dakota had in place both a freeze on the development of new beds (for six years), and a buy-back program for existing beds (for four years); (4) North Dakota has seen the development, largely unregulated, of "assisted living" feasibilities and apartment complexes for the well-heeled elderly, many of which have met the needs (and gotten the money of) individuals who would have otherwise been private pay nursing facility residents; and (5) Home and Community Based Services, supported by State funds, have proliferated until recently. What has been the impact on (1) the state Medicaid budget and (2) nursing home reimbursement levels. Please explain. The Medicaid budget has increased at rates consistent with national trends. Nursing facility rates have more than kept pace. The "rate-equalization" rate-setting mechanism accomplishes setting rates for all residents, in part, by having very generous rates for everyone to pay. Nursing facilities are well organized and effective with their

legislative agenda, which has been to effectively eliminate all controls on rates. We now allow virtually all costs, plus pay amounts that exceed costs, to all nursing facilities.

**OHIO:** We are attaching pertinent pages of the Annual Report of LTCFs based on 2001 Cost Report data, prepared in October 2002. Pages display the trend lines from 1991 through 2001 for all days, Medicaid days, Medicare days, Private Pay days, and Veteran and other days. As you can see, Medicaid days have fallen, while Medicare, VA and other days show a steady increase as a percentage of inpatient days. Declines in Ohio's nursing facility census have been attributed to the increased availability of assisted living options for private payers as well as to increased HCBS options for Medicaid-eligibles. State Medicaid budget impacts have included attempts to calculate rates on higher percentages of imputed vs. actual occupancy, and to install a per diem cap on rate growth, which for state fiscal year 2004 resulted in an overall 4% decrease in paid rates from calculated rates.

**OREGON:** Yes, the census has increased from 60% to 65%. Oregon does not believe that this small proportional change in resident census percentage was caused by eligibility bracket creep or Medicaid or estate planning. Oregon believes that this small increase is due to the increase in the number of elderly and disabled persons in the state. Oregon has not had any new nursing home beds certified since 1979. This small change in the census has not had an appreciable impact on the Medicaid budget or nursing home reimbursement levels. However, the Medicaid budget has increased and nursing home reimbursement levels have increased due to a combination of medical cost inflation and the fact that clients placed in nursing facilities are most likely in need of much higher levels of care than clients placed 10 years ago.

**S CAROLINA:** Based upon Medicaid cost reports covering the period October 1, 1992 through September 30, 1993, the occupancy statistics of the South Carolina Medicaid contracting nursing facilities were as follows:

Total Occupancy Percentage – 95.33%  
Medicaid Occupancy Percentage – 75.32%  
Medicare Occupancy Percentage – 5.56%  
All Other Payers (Which Include Private Pay) Percentage – 19.12%

Based upon Medicaid cost reports covering the period October 1, 2001 through September 30, 2002, the occupancy statistics of the South Carolina Medicaid contracting nursing facilities are as follows:

Total Occupancy Percentage – 95.10%  
Medicaid Occupancy Percentage – 75.83%  
Medicare Occupancy Percentage – 11.12%  
All Other Payers (Which Include Private Pay) Percentage – 13.05%

As you can see from the above information (on a percentage basis), the Medicaid occupancy basically remains the same but the shift appears to have occurred between Medicare and other payers (which include private pay). However, this does not rule out that eligibility bracket creep and/or Medicaid estate planning does not have an impact on our state's Medicaid expenditures – we cannot determine an impact based upon the occupancy analysis provided above.

Our Medicaid expenditures have increased from approximately \$195 million during SFY 1993 to approximately \$361 million in SFY 2002. The increase has resulted from annual rate increases and the addition of Medicaid beds which were allowed and funded by the SC General Assembly during its' work relating to the state's annual budget throughout the 10 year period. Total Medicaid days funded during SFY 1993 amounted to approximately 3.8 million as compared to approximately 4.4 million in SFY 2002.

**TEXAS:** No. The census has not increased because of preference for community-based programs.

**UTAH:** There has been no notable increase in the Medicaid census as compared to the private pay census in the past ten years.

**12. Is your state moving toward home and community-based services (HCBS) as a cost-effective substitute for nursing home placement? If so, how? How do you expect the availability of Medicaid financed HCBS to affect (a) the number of Medicaid applications, (b) the popularity of Medicaid estate planning, and (c) the demand for private long-term care insurance?**

**ALABAMA:** The Alabama Medicaid has 6 approved home and community based waivers that give targeted individuals an alternative to institutional care. We are in the process of completing an additional waiver to be submitted to CMS for approval and are discussing other potential waivers.

We are hopeful that these waivers, by providing an alternative, will reduce nursing home admissions, or at a minimum delay an admission to a nursing home.

The number of Medicaid financial applications may increase depending upon the targeted population specified in the waiver.

It is uncertain if the waivers will have a direct impact on items (b) and (c).

**ARIZONA:** Arizona has always had an HCBS program integrated into its long-term care program. The Medicaid NF dollars can follow the member to their HCBS setting. There are no limitations on the number of people that can receive HCBS. Currently AZ has 60% of its elderly and physically disabled long-term care membership residing outside of NFs.

**ARKANSAS:** For over a decade Arkansas has been moving towards a HCBS as a cost-effective substitute for nursing home care. The demand for long-term care is not set by the state or financing mechanisms. The demand is set by the number of citizens needing long term care. Although Medicaid applications may increase for HCBS, because Medicaid HCBS costs about a third of nursing home care, total cost will be lower than what they would have been if Medicaid nursing home utilization had continue on its upward path. The demand for long-term care insurance will likely have little effect on Medicaid. Most individuals who can afford private long-term care insurance will likely never qualify for Medicaid.

**CONNECTICUT:** Yes, this is a strong program. There is no cap on the number of enrollees. It seems to be the most desirable alternative to nursing home care. Doesn't know how this will affect Medicaid enrollment. Certainly estate planning will be used to access HCBS. Re. LTCi - due to loopholes, this is a hard sell. Why purchase it when they can avail themselves to estate planning mechanisms?

**DC:** The District of Columbia is moving toward home and community based services (HCBS) as a cost effective substitute for nursing home placement we have compiled the following information:

The District of Columbia Medical Assistance Administration (MAA) is moving rapidly to expand its HCBS as an option to nursing home placement. There are several benefits to this process, and some challenges. On the benefit side, it is documented that HCBS provide more consumer control and choice. We have implemented an expanded Elderly and Physical Disabilities waiver begun in 2002 with waiver services that provide reimbursement coverage for older persons over 65 years of age. In June 2003, MAA expanded the waiver to include disabled persons between the ages of 18-64.

Regarding a) the availability of Medicaid-financed HCBS affecting the number of Medicaid applications, we are seeing an incremental but steady increase in applications thus far. We believe the growth will be greater in 2004. The limited growth is in part due to a limited number of providers and many persons not knowing about the waiver services.

Regarding b) the popularity of the Medicaid Estate planning, the numbers of persons participating are very small, as stated earlier, less than twenty to date.

Regarding c) the demand for long term care insurance, to date the demand has been minimal, in part due to not many people knowing about LTC insurance or its availability in the District.

In general, the demand for HCBS is linked to individuals with stable housing. Housing stock, particularly affordable housing stock in the District is dwindling. Without more housing the ability to offer HCBS solutions will be compromised. Although not strictly a Medicaid issue, we are trying to look at realistic options for many older persons and disabled persons in need of housing options and HCBS.

**DELAWARE:** Our limited number of HCBS slots fill up almost every year.

**GEORGIA:** Georgia is budgeting more home and community based services each legislative year. Georgia has a waiting list for all home and community based services programs. We expect the lists to continue to increase. Georgia seniors are reviewing options re: estate planning to become eligible for Medicaid services. This activity is increasing. More citizens over the age of 50 are indeed buying long term care insurance but not in great numbers.

**INDIANA:** Indiana passed legislation in 2003 to increase the capacity of HCBS. Indiana currently has four Medicaid Waivers with nursing home Level-of-Care that provide a wide array of services. How do you expect the availability of Medicaid-financed HCBS to affect (a) the number of Medicaid applications: **Increased, especially if the eligibility requirements for Nursing Home versus Waiver Services is equalized.** (b) The popularity of Medicaid estate planning: **Increased, because the concept of transitioning into a HCBS is much more appealing to citizens and it is being pushed by the advocacy community.** And (c) the demand for private long-term care insurance? **Within Indiana Family Social Services Administration, there is a strategic goal to increase the number of Hoosiers with Long-term Care insurance by 15,000 in 2 years. In addition, the purchase of a State-partnership LTC policy allows the purchaser to deduct the premiums on their State income taxes as well as Federal.**

**KENTUCKY:** Kentucky Medicaid has been offering Home and Community based Waiver services for some time. Level of care requirements, which aids in establishing medical necessity, are the same for recipients requesting HCB Waiver services or for traditional nursing facility placement. Consequently, we do not believe that the total number of Medicaid applications has been impacted by the addition of HCBW. This office has not evaluated the popularity of Medicaid estate planning nor consumer demand for private long-term care insurance.

**LOUISIANA:** Yes, Louisiana is investing in home and community-based options for long-term care. Louisiana Medicaid currently provides home and community-based services under five 1915(c) waivers:

Adult Day Health Care, Personal Care Attendant, Elderly and Disabled Adult , Children’s Choice and New Opportunities (formerly referred to as MR/DD).

In 2001, Louisiana Medicaid reached an agreement that will result in persons with disabilities and persons age 65 and older having more choices about their long-term care. The settlement in Barthelemy v. Louisiana Department of Health and Hospitals draws upon the ADA and the Supreme Court decision, Olmstead v L.C. that increases state obligations to provide services in the most integrated setting. Under the original agreement and Supplemental Settlement Agreements, the minimum total number of slots for each disabled adult and elderly waiver shall be as follows:

**Elderly and Disabled Adult Waiver**

By Dec. 31, 2002:	1379 slots
By June 30, 2003:	1779 slots
By Dec. 31, 2003:	2079 slots
By June 30, 2004:	2179 slots
By Dec. 31, 2004:	2279 slots
By June 30, 2005:	2329 slots
By Dec. 31, 2005:	2379 slots

**Personal Care Attendant Waiver**

By Dec. 31, 2002:	249 slots
By June 30, 2003:	362 slots
By Dec. 31, 2003:	374 slots
By June 30, 2004:	387 slots
By Dec. 31, 2004:	399 slots
By June 30, 2005:	412 slots

By Dec. 31, 2005: 424 slots

**Adult Day Health Care Waiver**

By Dec. 31, 2002: 575 slots

By June 30, 2003: 638 slots

By Dec. 31, 2003: 650 slots

By June 30, 2004: 663 slots

By Dec. 31, 2004: 675 slots

By June 30, 2005: 688 slots

By Dec. 31, 2005: 700 slots

**How do you expect the availability of Medicaid-financed HCBS to affect (a) the number of Medicaid applications, (b) the popularity of Medicaid estate planning, and (c) the demand for private long-term care insurance?**

The number of persons on the registries (waiting lists) are disproportionately larger than the number of available slots. Under the current intake process, an application for home and community based services is not initiated until a waiver slot is offered and accepted. The number of HCBS Medicaid applications will increase in correlation to the minimum number, or a higher number of slots that are available at any given time.

Medicaid estate planning activities are on the rise in general as health care costs are sky rocketing and as marketing increases. It is anticipated that the availability of more integrated settings for long-term care will appeal to more of the masses, of which many have accumulated resources and estate planning will result. The cost of long-term care insurance is usually cost-prohibitive at the point most persons consider purchasing it.

A public service campaign supported by stakeholders and other interested parties (the state, insurance brokers, LTC industry) is needed and it particularly needs to target the younger population. The campaign should stress the advantages of buying LTC insurance while you are younger and healthier and the increased control and options available to individuals who have a private means of paying for and directing their own care.

**MAINE:** Maine Medicaid has actively developed HCBS services because consumers are requesting these alternatives and are expressing a preference for services in their home. In general, the per capita expenditures for elderly and disabled HCBS consumers is less than the annual cost for NF care. But, certain waiver populations, such as the physically disabled waiver have total expenditures that are greater than the cost of nursing facility services. Because Maine's medical eligibility for HCBS waiver services is the same as the medical eligibility for nursing facility services, when we tightened up the NF medical eligibility, reducing the number of admissions there was a similar impact upon the waiver services. The number of NF clients has been decreasing over the decade, while the numbers of HCBS clients are slightly increasing.

**MICHIGAN:** Currently have HCBS Waiver

- a) increase
- b) decrease
- c) no change

**MINNESOTA:** Minnesota has offered HCBS alternatives for the elderly in the Medicaid program since 1982. Minnesota currently has a number of MA waivers which pay for home and community-based services for persons who are elderly or have disabilities:

- § Elderly Waiver (EW)- intended for people age 65 or older who are at the nursing home level of care. Spousal Impoverishment applies to couples with a community spouse.
- § Community Alternatives for Disabled Individuals (CADI)
- § Mental Retardation/Related Conditions (MR/RC)
- § Community Alternative Care (CAC)
- § Traumatic Brain Injury (TBI)

See the following reference in the HealthCare Policy Manual for a list of references:  
<http://www.dhs.state.us/HealthCare/ReportsManuals/ManualCounty/chapter09.htm#0907.23>

The Department also appointed a Long Term Care Task Force to review these issues. See the DHS Long Term Care Task Force Final Report, dated January 2001, at:  
<http://www.dhs.state.mn.us/Agingint/lcttaskforce/report.htm#intro>

Minnesota also assists people with their home and community-based expenses through the Alternative Care Program. This program is funded with state dollars and is intended for people who are at a nursing home level of care, age 65 or older and are not eligible for MA. You may find information about this program in Minnesota Statute 256B.0913 at:  
<http://www.revisor.leg.state.mn.us/stats/256B.0913.html>.

**MISSISSIPPI:** HCBS is not viewed as a means of savings but as a means to serve the disabled in the most integrated setting possible.

**MONTANA:** We have had a Medicaid HCBS waiver since 1987. Demand for in home services is increasing which has had the most significant impact on the nursing home utilization numbers. Pressure to offer more services under the Medicaid waiver budget will be an issue in the future due to the capped nature of the waiver and the desire from consumers to age in place and remain in community settings for as long as possible. An area that will also fall under the Medicaid redesign purview.

**NEVADA:** The state currently operates four home and community based waivers for the frail elderly and for those persons with a physical disability, mentally retardation, or a related condition. These waivers have all experienced growth and have been granted expansions in the last two Legislative sessions. These waivers are an effective substitute for nursing facility placement. The “wood work effect” for each waiver is tracked monthly. The effect for two of the four waivers that are most critical to avoiding nursing facility placement illustrate an estimated 25 to 50% of the newly added recipients are also new to the Medicaid system. The effect of waivers on estate planning and use of private long-term care insurance is unknown at this time.

**N CAROLINA:** Our state is moving forward to improve the home and community based services options by improving the infrastructure and management of the programs; working on a nursing facility transitions program and better systems to target resources to meet medical needs. We cannot at this time comment on the impact on the number of Medicaid applications. Medicaid estate planning will increase as more lawyers in NC get into the business. We do expect to see an increase in purchases of LTC insurance.

**NORTH DAKOTA:** Yes. If so, how? By paying for those services, to the extent provided to Medicaid eligible individuals, with Medicaid dollars (using very generous spousal-impoverishment eligibility rules), and by assisting others with State dollars subject to very high income and asset testing. The subsidies for non-Medicaid covered services were slashed effective July 1, 2003. How do you expect the availability of Medicaid-financed HCBS to affect (a) the number of Medicaid applications, (They will increase.) (b) the popularity of Medicaid estate planning, (It will increase.) and (c) the demand for private long-term care insurance? (We don't have reliable data on the trends in long-term care insurance purchases, but it is difficult to anticipate much increase in demand as long as establishing eligibility for Medicaid remains so easy.)

**OHIO:** The Ohio Access Report includes information about community alternatives to nursing home care. It can be found at <http://www.goldenbuckeye.com/ohioaccessrpt.pdf>

An update to the report is expected to be released early in 2004.

(attached to hard copy:

**Outline for the November 13, 2003 presentation to the Ohio Medicaid Commission elder law by Donald Chapin**  
**ER Collections 1995 through 3<sup>rd</sup> qtr 2003**  
**Pg 7 of Ohio Access Report**  
**ORC 5111.11, 5111.111, 5111.112**  
**OAC 5101: 1-38-10**  
**Excerpt tables from annual Report of LTCFs from 2001 CRs, Oct. 2002**

**Draft revised rule 5101:1-39-22.7 on retirement funds**  
**OAC 5101: 1-39-35, 31.1-31.4, 27.1, -08, 22.8,-07,-31**  
**1999 Medicaid Estate Planning and Estate Recovery in Ohio)**

**OREGON:** Yes, Oregon has moved toward HCBS. Since the first HCBS waiver in 1981, Oregon has moved along a track that maximizes the placement of individuals in community (rather than nursing facility) settings. Today, over 81% of senior and physically disabled individuals receive Long-term care services under the Medicaid waiver in a community setting. Only 19% remain in the NF setting.

Oregon has seen minimal impact in the areas of actual Medicaid application rates or LTC insurance demand. There has been some increased activity in recent years in the establishment of Miller trusts. About 6% of the total nursing facility and HCBS cases have Miller trusts.

**S CAROLINA:** South Carolina, like most states, is seeking ways to expand home care options. We have received several Real Choice Medicaid Infrastructure Grants to enhance home and community based services. In particular, we are working on a statewide information and referral system to provide information about the full array of services to all consumers. We are also implementing a consumer directed care initiative. Our Elderly/Disabled waiver is among the 15 largest programs in the nation.

Since our state has a very large Medicaid population of long term care consumers, we do not believe that the expansion of home care will significantly impact the number of applications and interest in estate planning. It is difficult to assess the impact on long term care insurance.

**TEXAS:** HCBS waivers have been developed mainly as response to interest in client choice of service location, not to cost. If so, how? How do you expect the availability of Medicaid-financed HCBS to affect (a) the number of Medicaid applications, (b) the popularity of Medicaid estate planning and (c) the demand for private long-term care insurance? (a) The number of applications is not expected to change significantly based on the concept that the waiver service applicants would apply for institutional coverage if waivers did not exist. (b) No basis for speculation on this topic. (c) No basis for speculation on this topic.

**UTAH:** Utah has moved toward home and community based waiver as an alternative to nursing facility placement. We currently have 5 HCBS waivers. Please see the enclosed pamphlet 'Home and Community Based Waiver' for more information.