

Home and Community Based (HCB) Waivers and Employment

For adults, these are often referred to as "Choice" waivers.

The Medicaid manual section 5040.3, which addresses waiver eligibility, should read The Division of Seniors and Disability Services (DSDS) rather than DMHDD. This agency now has 2 sections in their manual referring to the waiver. One is for adults and the other is for children. Most waiver cases are reviewed annually (both by Division of Public Assistance and DSDS)

Medicaid manual section 5600 (section D) describes the rules for the HCB (and nursing home) cases. The opening paragraph gives a clearer picture of who should be considered for the Waivers. If a waiver recipient enters a nursing home, the waiver will end.

Income Levels

Both nursing home and waiver cases allow income up to \$1656.00 per month. This need standard was "frozen" by the legislature last year. Waivers are not considered an "entitlement" program. You could be eligible but not have one. In other words, if there are no services in your area or a wait list you may not have one. (Generally there is no wait list for any waivers except the huge MRDD waiver)

4 types of waivers:

- Children with complex medical conditions (CCMC). This waiver is only for those children under age 21. It must be ended at the 21st birthday.
- Persons with mental retardation and developmental disabilities (MRDD). This waiver can cover both children and adults. For adults to be covered, they must be able to prove that this condition existed as a child.
- Adults with physical disabilities (APD). This is for adults age 21 to age 65. (Code DA)
- Older Alaskans (OA). This waiver is for adults age 65 and older. (Code AG)

To be eligible an individual must be both medically and financially eligible for some form of Medicaid; approved for waiver services; and not under a penalty for transferring resources. (More on resource transfer on p. 2).

Waivers are reviewed both medically (by Disability Determination Services) and financially (by Adult Public Assistance) every year.

Some waiver rules

Adult Public Assistance (APA) must also consider other factors when dealing with Medicaid waivers.

The term “**community spouse**” refers to the ineligible spouse of a waiver recipient (or nursing home) who remains in the community (even if the eligible spouse lives with them!). The purpose of this provision is to allow enough money and resources to this spouse that will keep them off assistance due to the medical condition of the eligible spouse. APA can allow up to \$2319.00 in monthly income for the ineligible spouse. This amount changes yearly.

APA can also allow the community spouse to retain up to \$92,760 in countable resources. Again, this amount changes yearly. The key word is countable; the home and one car for daily needs is not part of this figure. The spouse’s retirement funds are also not considered. (This refers to the retirement account per se, not the monthly income received from it. For example, an individual may have a substantial sum of money in PERS (Public Employee’s Retirement System), and that money is not considered a resource, but the monthly income received from PERS does count as income. Medicaid does allow the waiver recipient up to the time of the first review (1 year) to transfer all resources to the community spouse that places him/her over the \$2000.00 limit.

If both spouses are on waivers, the maximum resources that can be held are \$3000.00, although each can have up to \$1656.00 in monthly income. The reason for this is that there is now no community spouse.

APA can also allow resources to be transferred to an adult disabled child or to a child who has lived with the person and provided their care for at least 2 years.

Transfer of assets. (Benefits planners should not have to worry about the transfer of assets unless their client has been on a waiver for less than a year, and in general this phenomenon is rare.)

Applicants who transfer resources to become eligible for Waivers or nursing home care subject themselves to a penalty. The penalty is ineligibility for these services for a period of months calculated by dividing the cumulative uncompensated value of all assets transferred by the average monthly cost of a private patient of institutional services (a monthly stay at Denali Center is \$12,500) in the individual’s community. The penalty is assessed starting with the month following the month the first asset was transferred. There are also rules that cover multiple transfers and how to deal with them. The lookback period for this type of transfer is 36 months from the month of application. The lookback period for assets placed into a non-Medicaid qualifying trust is 60 months. There is also an undue hardship provision for forgiving these transfers.

Cost of Care (Post-eligibility). The personal needs allowance for a waiver recipient is \$1656.00. If the income they have exceeds that amount, they must have a trust. They will also be required to pay a cost of care that reduces the cost of Medicaid. This cost of care will normally be all of the income over this level. The AKSAP has to be counted as part of this cost of care. There are also exceptions to the cost of care, such as income tax withholding, private medical insurance, past medical bills, child support, and uncovered medical expenses. All Cost of Care changes are subject to adverse action.

Sample Case: Mary (wife) is on a waiver and goes to work. Bob, (husband--also the "Community spouse" has an income of \$1611/month.

Here's how this could work. First of all, when it comes to earned income, any children don't figure in this equation, but they could be useful if the Client ever loses the waiver and needs Working Disabled Medicaid.

Total Allowable income:	\$1656
Mary's Unearned income:	<u>1125</u>
Net Earned income potential	\$ 531

Suppose Mary earns \$1200

Earned income	\$1200
Unearned income	<u>1125</u>
Total	\$2325
Allowed	<u>-1656</u>
	\$ 669 MUST go into a trust

Bob's income is	\$1611
	<u>+ 669</u>
	\$2280 He can take it out of the trust.

If Bob's income were closer to \$2319, or if Mary made enough to put him over, then he could only take enough out of the trust to bring him up to \$2319 and the rest would go to Mary's cost of care via the trust.

I hope this gives you a little more confidence with trusts. I sure learned a lot in the process of researching this information.