ALASKA LTC MEDICAID ELIGIBILITY

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Overview of Presentation

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Alaska Long Term Care Medicaid

- Long Term Care Medicaid encompasses the Alaskans Living Independently (ALI) Waiver program for care in-home and in assisted living homes and Skilled Nursing care.
- There are three eligibility criteria for Long Term Care Medicaid: one medical, two financial.
- Two State divisions are involved in LTC Medicaid eligibility determinations: DPA & SDS.
- The MED-4 Medicaid application is submitted to the Alaska Division of Public Assistance (DPA). DPA has an initial interview with the applicant within two weeks.
  - If DPA requests additional information, it can take 30 days or more before the application is reviewed again even if the information is supplied that day.
- Once DPA approves the financial portion of the application (Miller Trust funded (if needed-see 11 below) and countable assets under the resource limit (see 10 below)—any TOA is not reviewed at that time), the individual's Care Coordinator is given a "purple coupon" to prepare and submit the individual's medical application to Senior and Disability Services (SDS) for the LOC assessment.

The 3 Part LOC Determination Process

- The first and most important eligibility criterion is the Nursing Facility Level of Care (NFLOC) medical/functional need. If there is no LOC, there is no eligibility even if they would be financially eligible:
- 1. **Nursing Facility Level of Care (LOC), the "institutional level of care services".**
  - The individual must need extensive assistance with **at least three of these five Activities of Daily Living (ADLs)**: bed mobility, eating, locomotion, toileting and transfers. They may also need assistance with chores (cooking, cleaning, laundry, shopping) and medication management.
  - For individuals who are experiencing **cognitive decline** (Alzheimer's disease, Luey Body or other dementia, Traumatic Brain Injury, etc.), they must need extensive assistance with **at least 1 ADL in addition to their significant support needs** caused by their cognitive decline.

Part 1

- **ADRC—Aging and Disability Resource Centers**
- Medicaid requires that individuals who are not in a Hospital/SNF contact the ADRC at 1-855-565-2017 to schedule a "Medicaid Pre-Screen" telephone appointment. This screening can be completed by a family member or someone who knows the care needs and financial information of the individual.
- The ADRC will go through the Person-Centered Intake (PCI) form and will send a written confirmation that the person more likely than not meets the LOC criteria. If the ADRC concludes the person likely meets LOC, the individual then needs to engage a Care Coordinator.
- The ADRC maintains a list of Care Coordinators. https://health.alaska.gov/dsds/Pages/adrc/ADRCfirst.aspx

Part 2

- **Care Coordinator Support Plan.** Care Coordinators (CC) are required for the State's LOC assessment process.
- The CC obtains the individual's medical documentation including physician(s)' records of all medical visits in the last year including hospitalizations and provides the individual with a Verification of Diagnosis (VoD) form which needs to be completed by each of the individual's physicians.
- The CC uses this information to prepare an initial medical application that is submitted to the State Division of Senior and Disability Services (SDS) before LOC is determined.
- Once LOC is determined the CC prepares a Support Plan and submits it to SDS.

Part 3

- **SDS—Senior and Disability Services.** After SDS receives a complete initial medical application from a Care Coordinator:
- Intake Unit assessors (nurses or other trained professionals) schedule and conduct a functional assessment of the applicant via in person interviews or by using videoconferencing technology. This is usually scheduled about two weeks after the complete application has been received by SDS.
- "The results of each assessment are reviewed by a nurse supervisor to affirm the assessor's NFLOC determination."
- After SDS determines the individual meets LOC, the Care Coordinator has up to 60 days to work with the individual's care planning team to develop a Support Plan that outlines all services the individual will receive. That Support Plan is then submitted to SDS for approval.

What if LOC is not met?

- *If SDS finds they do not meet LOC, they cannot reapply for LTC Medicaid for one year absent a new diagnosis or decline.*
- If an applicant does not meet LOC, they will not be eligible for LTC Medicaid even if they meet the two financial eligibility prongs: resources and income.
  - They may be eligible for another type of Medicaid and General Relief (GR).

Questions about Medical Eligibility Process?

Financial Requirements for LTC Medicaid

- Once the Care Coordinator's final Support Plan is approved by SDS, the State Division of Public Assistance (DPA) is notified by SDS. At that point the individual is "eligible for Medicaid and … institutional level of care services."
- DPA then reviews the Medicaid application and supporting documentation to confirm compliance with the two financial criteria and to address any reported Transfers of Assets.
- Whether **Income** is within the program limits or a Miller Trust has been established and funded: $2,901 monthly gross income (in 2025, adjusts annually in January).
  - Only the applicant's income is considered, the income of the spouse or other household members in not counted.
- Whether **Countable Resources** are within the program limits:
  - $2,000 for a single person and for the applicant in a couple
  - $157,920 (in 2025, adjusts annually) for the community spouse in a legally married couple (all non-exempt assets are counted regardless of which spouse owns the asset; pre-nuptials are disregarded).
  - If both spouses apply for LTC Medicaid, they are considered individuals and each have a $2,000 resource exemption even if they reside in the same room/facility

Miller Trust for Income Eligibility

- If a Medicaid applicant's income exceeds the allowable amount, a Qualifying Income Trust (also called a Miller Trust) may be set up to receive and manage income in order to meet the income eligibility requirements. (See also Special Needs Trusts and Pooled Trusts below)
- A **Miller Trust is ONLY for income eligibility, not for excess resources/assets**
  - Can be used obtain or maintain income eligibility for all types of Alaska Medicaid—MAGI, APA, Working Disabled, Waivers, Nursing Home
  - Cannot be used to obtain or maintain income eligibility for SSI or APA cash
- **The Miller Trust can be established and funded any time prior to the end of the month for which income eligibility is sought.**
- The Miller Trust requires an independent trustee other than the applicant/beneficiary. The trustee will have to establish a separate bank account "John Doe Qualifying Income Trust" with the trustee as the only signer. Proof of the bank account funding must be provided to Medicaid.
- All trusts must be registered with the Superior Court for the State of Alaska and proof of registration must be provided to Medicaid along with a copy of the trust document.
- The trust is irrevocable but only month to month; it is not a permanent assignment of income. The recipient/beneficiary can stop funding the trust if they stop using Medicaid, but any funds in the trust at that point must stay in the trust.
- A Miller Trust provides that the State will receive all funds remaining in the trust at its termination, by death or court order, up to the amount of Medicaid coverage provided.

Managing Monthly Income

- The operation of a Miller Trust account (or the recipient's personal account if no Miller Trust is needed) will be reviewed annually by Medicaid. It is imperative that the trustee/recipient keep complete and accurate records with all bank statements, cancelled checks, invoices paid, receipts for purchases, etc.
- **The recipient is allowed a monthly "Personal Needs Allowance" (PNA) to pay for food, shelter, clothing, toiletries, etc. These expenses cannot be paid from the Miller Trust.**
  - Shelter expenses include: Rent or mortgage payments, Property taxes, Heating Fuel (gas, oil), Electricity, Water, Sewer, Garbage Collection Service.
- The beneficiary must have a personal bank account besides the Miller Trust account to hold and manage their PNA funds.
  - This personal account is subject to the $2,000 resource limit; the Miller Trust is not.
- The amount of the PNA is determined by where the recipient is living.
- Unless there are other allowances, all the rest of their monthly income will go to their Cost of Care Obligation.

Personal Needs Allowances

- A recipient living in a **skilled nursing facility** is allowed **$200** per month to use for their personal needs (haircuts, clothes, toiletries, cell phone, TV, internet, etc.). There is no obligation to pay room and board when in a skilled nursing facility.
- A recipient living in an **assisted living home/facility** is allowed **$1,396** per month for their PNA from which they have to pay the home/facility for room and board. Room and board rates are not set by law and the division of the personal needs allowance between room and board and other needs is not set by law. Normally the home/facility receives $1,296 and the recipient retains $100 for their other personal needs (haircuts, clothes, toiletries, cell phone, TV, internet, etc.). The home/facility may set a room and board rate higher than $1,296 which will have to be negotiated with the home/facility to provide the recipient with funds for items not covered by Medicaid or provided by the home/facility.
- A recipient who receives Medicaid covered services in **their home** is allowed **$1,656** per month to pay food, shelter, clothing and other personal expenses (haircuts, clothes, toiletries, cell phone, TV, internet, etc.).

Other Allowances from Monthly Income

- For LTC Waiver and Nursing Home Medicaid, the PNA may be increased to pay a court-appointed guardian up to $100 per month, to pay income taxes not withheld from the monthly checks, and to pay child support obligations. *ADLTC 570.E.1.*
- For LTC Waiver and Nursing Home Medicaid recipients with a Cost of Care Obligation, Medicaid Post-Eligibility rules also allow the following payments:
  - **Spousal Allowance**, if the beneficiary is married and spouse's monthly income is lower than Medicaid allowed amount, $3,948 (in 2025, adjusted annually).
  - **Dependent Family Members' Allowance** for minor and dependent children, $1,316 each in 2025, adjusted annually.
  - **Other allowable expenses** include insurance premiums, unpaid medical bills, income taxes, child support garnishments, and expenses to maintain single person's home for up to six months if person intends to return home and has doctor letter stating they are likely to return home.

Cost of Care Obligation

- **If the recipient's gross monthly income exceeds the PNA for their living situation, Medicaid will calculate a Cost of Care Obligation (COCO) for the recipient.**
  - Medicaid will send a letter showing the calculation including all income, the PNA amount and any other allowed deductions (spousal allowance, dependents allowance, income taxes, health insurance premiums, etc.).
  - Generally the Cost of Care Obligation will direct disbursement of all the funds remaining in the Miller Trust towards paying the facility or in home care provider
- If the recipient is being cared for in a nursing home or in a hospital swing bed, the COCO amount will be paid to the skilled nursing facility.
- If the recipient is residing in an assisted living home/facility, the COCO amount will be paid to the home/facility.
- If the recipient is being cared for at home, the COCO amount will be paid to one or more Waiver vendors who are providing in-home care services.

Sample Cost of Care Calculation—Married Person at Home

For example, for a married man living at home, whose spouse makes $2,925 per month, a sample of the cost of care calculation is as follows:

• CASE NAME: DOE, JOHN		CASE NUMBER: 12345 MONTH: 0304		
• CLIENT : JOHN D		CLIENT NO: 678910		
• **INCOME:**		**EXPENSES:**		
• SOC SECURITY (SS) :	2200.00	PERSONAL NEEDS :	1656.00	1656.00
• SUPL SECURITY (SI) :		INCOME TAXES :		
• ALB :		CHILD SUPPORT GARNISH :		
• VETERANS (VA) :		SPOUSAL MAINTENANCE :	1023.00	1023.00
• PENSION PERS :	2500.00	DEPENDENT MAINTENANCE :		2,679.00 available to household
• ANNUITY :		INSURANCE PREMIUM :		
•		UNCOVERED MED EXPENSE:	140.00	
• EARNED INCOME :		HOME MAINT (6 MO MAX) :		
• ADULT PUBLIC ASST :		EXPENSE ADJUSTMENT :		
• INCOME ADJUSTMENT :				
• **TOTAL INCOME :**	**4700.00**	**TOTAL EXPENSES :**	**2819.00**	
• Comments:				
• **NEW COST OF CARE LIABILITY AMOUNT:**		**1,881.00**		

Sample Cost of Care Calculation—Married Person in ALH

For example, for a married man living in assisted living, whose spouse makes $2,925 per month, a sample of the cost of care calculation is as follows:

• CASE NAME: DOE, JOHN		CASE NUMBER: 12345 MONTH: 0304		
• CLIENT : JOHN D		CLIENT NO: 678910		
• **INCOME:**		**EXPENSES:**		
• SOC SECURITY (SS) :	2200.00	PERSONAL NEEDS :	1396.00	
• SUPL SECURITY (SI) :		INCOME TAXES :		
• ALB :		CHILD SUPPORT GARNISH :		
• VETERANS (VA) :		SPOUSAL MAINTENANCE :	1023.00	Only $1,023.00 available to household
• PENSION PERS :	2500.00	DEPENDENT MAINTENANCE :		
• ANNUITY :		INSURANCE PREMIUM :		
•		UNCOVERED MED EXPENSE:	140.00	
• EARNED INCOME :		HOME MAINT (6 MO MAX) :		
• ADULT PUBLIC ASST :		EXPENSE ADJUSTMENT :		
• INCOME ADJUSTMENT :				
• **TOTAL INCOME :**	**4700.00**	**TOTAL EXPENSES :**	**2559.00**	
• Comments:				
• **NEW COST OF CARE LIABILITY AMOUNT:**		**2,141.00**		

Paying the Room and Board and COCO

- **If there is a Miller Trust,** the COCO amount will be paid directly to the provider/facility/home from the Miller Trust.
- The Room and Board amount must be paid to the provider/facility/home from the recipient's PNA that was transferred to their personal checking account because the Miller Trust cannot be used to pay Room and Board.
- **If there is not a Miller Trust and the recipient's monthly income is over the PNA**, the recipient still needs to pay the provider/facility with two separate checks/debits with different notations on the Memo line. One for their Room and Board amount and the other for their COCO as calculated by Medicaid.
- Two checks/debits are required because the provider/facility must deduct the COCO payment received from what it bills Medicaid, but the provider/facility does not deduct the Room and Board payment from the amount it bills Medicaid.

Questions about Income Eligibility and Managing Monthly Income?

Resource Eligibility

- **Resource eligibility is determined on the first moment of each month, literally at 12:01 a.m. on the 1st of the month.**
- In reviewing bank statements, Medicaid will look at the closing balance on the last day of the preceding month. The dollar amount of outstanding checks is not deducted; Medicaid looks at the actual balance in the bank at the end of the month. Monies deposited on the first day of the month do not cause loss of resource eligibility for that month.
- If the recipient is over-resource on the 1st of the month (close of business on the last day of the prior month), s/he will not be resource eligible again until the next month.
- **Resource eligibility applies each and every month the recipient is receiving Medicaid.**
  - The recipient has a duty to notify Medicaid within 10 days of receiving an asset that puts the recipient over the resource limit and that will not be spent-down prior to the end of the month of receipt.
  - If that notice is given more than 10 days prior to the end of the month, Medicaid may end the recipient's Medicaid at the end of that month.

What Assets Are Considered Resources for Medicaid Eligibility Purposes?

- Resources are cash and any other personal property, as well as any real property, that an individual (or an individual's spouse):
  - owns;
  - has the right, authority, or power to convert to cash (if not already cash); **and**
  - is not legally restricted from using for his/her support and maintenance.
- An asset that does not meet all three criteria is not a resource for Medicaid eligibility purposes.
- An asset that meets all three criteria but has no current market value is still a resource and any change in its market value will be treated as a change in resources available to the applicant.

Resources may be liquid or non-liquid

- **Liquid resources are cash and any resource which can be converted to cash within twenty working days (excluding weekends and federal holidays):**
- Cash, stocks, mutual funds, retirement accounts (of applicant)
- bonds—municipal, corporate and government bonds; savings bonds that are past the six-month mandatory retention period
- promissory note—unless there is a legal bar to its sale
- mortgage or contract for sale of real or personal property—unless there is a legal bar to its sale
- financial accounts—including joint bank accounts and certificates of deposit, **unless** the CD terms prohibit any early withdrawal
- cash surrender value of life insurance with a face amount of $1,500 or more

Valuation of Resources

- **Non-liquid resources are all resources which cannot be converted to cash within twenty working days:**
  - **personal property** such as vehicles, household goods, personal effects, machinery, livestock
  - **real property** such as land, buildings, other objects attached permanently to the land
  - **property rights** such as mineral rights, timber rights, water rights, easements, leaseholds, life estates, remainder interests
- Generally, assets are valued at their present fair market value for eligibility purposes. Any encumbrance on the asset is deducted in determining the asset's equity value for eligibility purposes.
- Real property, including its structures, are valued at the local governmental unit's tax assessed value unless a lower value is established by an appraisal. BOV used if no taxing authority.
- Personal property is generally valued at its fair market value.

Exempt Resources/Assets Not Counted

Medicaid has exemptions for various resources that are necessary for the day to day living of applicants and their spouses.

- The **home** in Alaska and all land contiguous to it; includes all outbuildings necessary for operation of the home The equity value for a single applicant is $730,000 or less (in 2025, adjusts annually)—no equity cap if the community spouse, a child under age 21 or a blind or disabled child of any age resides in the home *ADLTC 553C*
  - If the applicant's home is up for sale at the time of application or if they put it up for sale after being on Medicaid, the value of the home is immediately an available resource for Medicaid purposes. They will lose Medicaid if they have it or will be ineligible to apply until the house sells and the proceeds are spent down.
  - A reverse mortgage may be used to reduce the equity below the cap.
- If the individual has shared ownership in the home, only the fractional interest of the individual seeking long-term care or home and community-based services is considered. For example, if the home is owned by an applicant and a sibling, one-half of the home's equity value is used in calculating the equity value for the individual, unless the individual can prove that he or she does not have equal ownership in the property.
- Re-evaluation of home equity is required at each review. The appreciation of home equity could result in disqualification of institutional or waiver services if the home equity value exceeds the limit.
- The home exemption applies while the applicant is alive and intends to return home if they are no longer in the home due to their care needs. At their death, the home may be subject to Estate Recovery under ADLTC 507 unless there is a spouse, minor child or disabled child of any age living in the home.
  - There are options that may avoid estate recovery, such as transferring the home solely to the community spouse's name or recording a transfer on death deed for the home (subject to change by Medicaid revising its policies).

Exempt Resources/Assets Not Counted

- **Household goods and personal effects** are generally excluded regardless of their value, **except items that are acquired or held as investments are not excluded,** such as artwork, native crafts, etc.; unset gems; and jewelry that is not worn or that does not have family significance.
- **One motor vehicle regardless of value**, includes: "cars, trucks, motorcycles, ATVs, boats, snowmobiles, animal drawn vehicles and animals." If the applicant owns more than one vehicle, the most expensive one is excluded. A vehicle may also be excluded if it qualifies as property needed for self-support.
- **PFD**—may retain multiple years' dividends in a separate dividend account
- **Burial spaces** for the applicant and the spouse
- **Burial Funds** not to exceed $1,500 each for the applicant and spouse
- **Prepaid Burial Contract** for the applicant and spouse

Exemptions for some of the Community Spouse's Assets

- **The community spouse's retirement funds.** All of the community spouse's retirement funds are exempt assets and do not count towards the Maximum Community Spouse Resource Allowance. These include IRAs; work-related pension plans (including self-employed pension plans); Alaska's SBS; and PERS. *APA Manual § 460-4A*
- **Assets needed for the spouse's self-support.** This includes property used in a trade or business, governmental authority assets such as Limited Entry Permits, property used by an employee for work, and $6,000 of equity in nonbusiness subsistence. *APA Man. § 432-3A*
- **Community Spouse Resource Allowance Appeal.** The community spouse can appeal to request more resources if the couple has a lot of resources but little income.
- Note, spouses must be legally married under State law. *ADLTC 553 A*. Since January 1, 1964 there is no common law marriage in Alaska. *Alaska Statute 25.05.311*
  - If you can prove you had a valid common law marriage in another jurisdiction before moving to Alaska, that may be recognized.
- If a couple is not legally married, the applicant will be treated as single and none of the "spouse's" assets will be considered available to the applicant unless the title to the assets is held in joint ownership (financial account, real property, vehicle). Any transfers of the applicant's interest to the "spouse" will result in a transfer of asset penalty.

Additional Alaska Native/Native American Exempt Resources/Assets

- **Alaska Native Claims Settlement Act Stock** and land received from an ANSCA corporation by an Alaska native or descendant. *APA 432-4L*
- **ANCSA dividends** up to $2,000 per year so long as they are identifiable, preferably in a separate account
  - May accumulate as many as desire at $2,000 per year. *APA 432-4L, 432-5*
- For Waiver and Nursing Home Medicaid, **all real property in Alaska owned by an Alaska Native or Native American** regardless of status as restricted or unrestricted, no limit on number of parcels owned *ADLTC 524 L.* Can be residential, commercial or vacant land and can have more than one parcel of real property.
- For APA Medicaid, native owned land must be federally restricted land to be exempt *APA 432-1 E*.

Questions about Resource Eligibility?

Options for Applicant Over the Resource Limit

- If an applicant's countable resources exceed the applicable resource allowance, the applicant may be able to become eligible by:
  - a Medicaid spend-down
  - the conversion of nonexempt to exempt resources
  - placing excess assets in a Medicaid Qualifying Trust, if eligible to use, *ADLTC 527*
  - purchasing a Medicaid qualified annuity (converts an asset to income), *ADLTC 554K*
  - selling an asset with a Medicaid qualified promissory note, *ADLTC 554 I*
  - transferring assets with a transfer of asset penalty period of non-coverage being imposed for LTC Medicaid recipients, *ADLTC 554*

Sample spend down expenditures

- Allowable expenditures include, but are not limited to:
  - paying down debts, such as child support, credit cards, etc.
  - prepaying on or paying off a mortgage
  - repairing or upgrading the person's home (new furnace, roof, appliances, etc.)
  - purchasing medical items not covered by Medicaid or Medicare or paying for an upgrade to a better model than the one paid for by the program
  - purchasing a handicap accessible or newer or safer vehicle
  - purchasing clothing, household items, etc. for the recipient or the spouse's comfort and use
  - paying for medical care not covered by Medicare or Medicaid, such as dental work
  - prepaying for funeral and burial expenses of both spouses—irrevocable burial policy
  - paying outstanding medical bills and taxes if they will not be included in the "cost of care" calculation
- Note, if a prepayment is refundable, it is not an allowable spend down (such as prepaying rent)

Medicaid Qualifying Trusts/Vehicles

- A disabled applicant under age 65 may transfer assets (and deposit monthly income) to a First Party **Special Needs Trust** (SNT) created under 42 U.S.C. §1396p(d)(4)(A).
  - All expenditures from the trust must be made in accordance with the income and resource rules of the benefit programs for which the recipient is eligible.
  - The trust must provide that at the recipient's death, Medicaid will be paid back for services it has provided during the recipient's lifetime—including benefits received prior to the trust being created.
- A disabled applicant of any age may transfer assets (and deposit monthly income) to a **Pooled Trust** managed by a non-profit entity in accordance with 42 U.S.C. §1396p(d)(4)(c).
  - In Alaska the applicant must have a Social Security Disability determination, not just be over 65, to establish the trust. *ADLTC 527A*
  - The charity may retain funds at the applicant's death, rather than re-paying Medicaid
- **ABLE Accounts** for persons whose disability began before age 26 (age 46 starting 1-1-2026); limited amount allowed to be deposited each year--$19,000 in 2025, adjusts with Federal Gift Tax exemption

Pooled Trust Options for Alaskans

- In Alaska, a pooled trust is run by the Foundation of the ARC for persons of any age with certain disabling conditions within the ARC's charter. www.arc-anchorage.org
- For persons of any age with non-ARC disabling conditions, any nationwide non-profit that provides pooled trusts in Alaska can be used. One that operates here: Secured Futures Trust which can be contacted at http://www.securedfutures.org/
- For OPA (Office of Public Advocacy) clients, OPA maintains a pooled trust. If the client ceases to be an OPA client, the assets must be moved to another pooled trust or an irrevocable asset trust/SNT.

Questions about Spend Down and Trust Options?

Transfers of Assets within 5 years of Application

- Medicaid "looks back" five years to the day from the date of institutionalization or the date the application for LTC Medicaid is submitted, whichever is later to determine whether assets have been transferred that could have been used to pay for long term care. ADLTC 554D.
  - If an application is filed on August 28, 2025, Medicaid can only look back to August 28, 2020.
- **"For Medicaid, the presumption is that the client or spouse transferred the asset to qualify for Medicaid, continue to qualify for Medicaid, or avoid estate recovery. The client must rebut that presumption by providing convincing evidence of the specific purpose of the transfer."** ADLTC 554F.4.
- While the IRS rules allow annual gifts of up to $19,000 per person (2025 limit) without a need to file a Federal Gift Tax Return Form 709, Medicaid does not have a similar exemption for transfers made within five years of application for services.
- **"Transferring for gifts, inheritance, avoiding probate, or preservation of an estate does not rebut the presumption that the transfer was to qualify for Medicaid or to avoid estate recovery."** ADLTC 554F.4.

Transfer of Asset Penalty

- **The Transfer of Asset (TOA) Penalty Period is a TIME penalty period based on a dollar computation. It is not a dollar penalty.** Medicaid will not pay for care during the TOA penalty period even though the individual meets all three prongs of eligibility for LTC Medicaid.
- **"The penalty begins the first day of the month the individual is eligible for Medicaid and would be receiving institutional level of care services**, except for the imposition of a transfer of asset penalty." ADLTC 554.E. Medicaid will provide a specific date that the individual can reapply at the end of the penalty period, e.g. August 25, 2026.
- Not all transfers are penalized. ADLTC 554F.
- Transfers that are penalized: waiving or not pursuing: income, inheritance, Personal Injury settlements; or reducing ownership interest in an asset.
- Transfers that may be penalized: promissory notes, loans, mortgages, life estates, annuities, some irrevocable trusts.
- **There is no cap on the TOA penalty period**. If the transfer occurs within five years of applying for Medicaid, TOA the penalty period will run the full number of months computed, not just 60 months. In that case Medicaid should not applied for until more than five years after the transfer occurred.

Calculating the Penalty Period

- The period of Medicaid ineligibility is calculated by **dividing the uncompensated transfer amount** which is the difference between**:**
  - (1) the fair market value of the asset transferred less any encumbrance-the equity), and
  - (2) the amount of compensation the individual received (the numerator)
- **by the local nursing facility Medicaid daily payment rate** (the divisor). ADLTC 554.L.
- The penalty divisor is determined by the Medicaid payment rate for the Skilled Nursing Facility (SNF) located in the city or town where the individual will be receiving services or, when there is no local SNF, by a State-wide Swing Bed rate set by the DHC Services Office of Rate Review which issues new rates in January of each year. https://health.alaska.gov/Commissioner/Pages/RateReview/Rate-Setting.aspx
- If the applicant is in the divisor SNF in their town, the cost of transferring assets is generally prohibitive as the family would have to family pay 100% of the cost of care which often exceeds $1,000 a day.

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- Once the uncompensated transfer amount has been divided by the applicable divisor, the resulting whole number is the number of months of ineligibility and the remainder is the number of days of ineligibility, i.e. the penalty period.
- This means that the same dollar amount of a transfer can result in widely different penalty periods due to local differences in nursing facility costs.
- For example, for an individual who transfers $200,000 of assets (real property, cash, stocks, bonds, boats, vehicles, etc.) within five years of applying for Medicaid, the penalty period will be:
  - In Anchorage, 181 days or about 6 months based on an Anchorage penalty divisor of $1,103.55 per day, $33,658.38 per 30-day month.
  - In the Valley, 213 days or about 7 months based on a Maple Springs Wasilla penalty divisor of $939.19 per day, $28,173.60 per 30-day month.
  - In Homer, 131 days or about 4.3 months based on a South Peninsula Hospital (swing bed) penalty divisor of $1,529.15 per day, $45,874.50 per 30-day month.

Reporting Transfers of Assets

- The MED-4, Application for Adults and Children with Long Term Care Needs, asks:
  - **3.** Have you or your spouse (or their legal representative) sold, transferred, traded, given away, or put into trust any assets in the last 60 months (5 years)? __ Yes ___No. ***If yes, please complete the following information (Asset Description, Value of Asset, Date of Transfer or Trust Establishment) and provide documents about the transfer with this application.***
- Note, this reporting requirement includes arms-length sales to unrelated parties, not just intra-family transactions. Medicaid will want to know what happened to the sales proceeds.
- **Deliberately failing to report transfers of assets is Medicaid fraud.**

Why trigger a Transfer of Asset Penalty?

- When an individual meets medical/functional LOC and has too many countable resources, triggering a transfer of asset penalty period may serve them better than a systematic spend down if there is the liquidity to private pay through the penalty period.
  - "The penalty begins the first day of the month the individual is eligible for Medicaid and would be receiving institutional level of care services, except for the imposition of a transfer of asset penalty." ADLTC 554.E.
- They may benefit from triggering a TOA penalty period if:
  - They are residing at home or in an assisted living home so that the actual cost of care each month is less than the applicable penalty divisor **AND**
  - There are sufficient liquid assets to cover the actual cost of care that will be incurred during the penalty period **AND**
  - There is a reason that militates against waiting to apply until they have spent down to the resource limit, such as: they will run out of money before the application is processed by Medicaid, leaving the home with an arrearage that may not be repaid if their income does not exceed their PNA.
  - Some applicants may choose to serve a penalty period to preserve extra assets for their own use, their spouse's use or to preserve an asset with sentimental value

Example of Triggering TOA Penalty Period:

- Bob, an unmarried 70-year-old, has a cabin in Kenai with sentimental value assessed at $100,000 and $50,000 in cash. His gross income is $3,000 per month. He has a medical event which leaves him unable to live at home any longer.
- Bob lives in a community where the penalty divisor is $25,000 per month, but he resides in an assisted living home where his actual monthly cost of care is $6,000 per month.
- Bob could transfer the cabin and cash to his son and daughter and apply the next month for Medicaid, reporting the two gifts. Ideally, the adult children would create a third party SNT for Bob's benefit or otherwise safeguard the cabin and monies to ensure that the funds would be available for Bob's lifetime to supplement his care and improve his quality of life.
- Once he is determined to be fully eligible for Medicaid but for the two asset transfers, Bob would be assessed a six-month TOA penalty period ($150,000 divided by $25,000).
  - Note: During the application period if any of the transferred funds were used for his care, the Care Coordinator can provide proof to Medicaid and the penalty period may be reduced accordingly. In this example, no adjustment is made for the return of funds.
- Bob would need to continue to private pay to private pay for his care during the penalty period which would cost $36,000 ($6,000 per month times 6 months) and his income during that time would be $18,000 ($3,000 per month times 6 months), leaving a shortage of $18,000. His son and daughter would need to pay that $18,000 from the $50,000 he transferred to them.
- After the TOA penalty period is over and Medicaid begins to pay for Bob's care, his son and daughter would have the remaining approximately $32,000 in cash plus the Kenai cabin.
- Note: If the assets being transferred have a low basis or are pre-tax retirement funds that have to be cashed out, the Federal tax costs also need to be considered. Their tax preparer can run alternate versions of their returns for comparison.
- Note: For the primary residence, loss of senior property tax exemptions and owner-occupied exemptions are also costs—although some exemptions may be lost when the senior leaves the home even without transferring the home.

Care Coordinators and the TOA Penalty

- The services of a Care Coordinator are required to apply for LTC/Waiver Medicaid. It is the LOC date that corresponds with the start date of the Support Plan that marks the beginning date of the TOA penalty period.
- Normally Medicaid pays the Care Coordinator a flat fee to submit the application to the State and a separate flat fee to develop a Support Plan identifying all services needed.
- If a TOA penalty is imposed, the Care Coordinator is not paid by Medicaid and risks losing payment for all the hours they spent preparing and submitting the required application and Support Plan to SDS. They may also lose payment by Medicaid for ongoing services they have to provide between when LOC is met and the TOA penalty is imposed.
- If you are assisting a client to obtain resource eligibility by transferring assets, let them know they need to plan to pay the CC directly for their services if the CC is unable to bill Medicaid due to the length of the TOA penalty period.
- Annual applications are due to SDS 90 days before the one-year anniversary of the last LOC date. Therefore, if someone has 9-month penalty period the CC will submit two applications to SDS in one year as the individual will need a new LOC assessment to determine their LOC eligibility again before a second SP can be developed and submitted to SDS.

Questions about Transfers of Assets?

Any other Questions?

Amrit Kaur Khalsa is the owner of the Law Office of Amrit Kaur Khalsa. Since 1986, she has concentrated her practice in the areas of probate, estate planning, guardianship and elder law issues, including disability and long-term care planning, and Medicaid eligibility.

Mrs. Khalsa has spoken at seminars in Anchorage for the Alaska Bar Association, National Business Institute, Sterling Education Seminars, and around the State for care coordinators, care providers, and other professional organizations on topics relating to estate planning, probate, guardianship, elder law, and Medicaid as well as to family members at Medicaid, guardianship, and special needs trusts seminars through LINKS, the Aging and Disability Resource Centers (ADRC) and Independent Living Centers (ILC) around the state.

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MARRIED COUPLE LONG TERM CARE MEDICAID
FINANCIAL ELIGIBILITY REQUIREMENTS

***Note–all of the below financial eligibility discussion assumes the applicant will meet the Medicaid functional/level of care eligibility requirements for Long Term Care Medicaid. This determination will be made by the State Division of Senior and Disability Services after the application is submitted.**

For a pre-application determination as to whether you are applying for the correct Medicaid program, contact the Aging and Disability Resource Centers (ADRC) at 1-855-565-2017 to schedule a "Medicaid Pre-screen" telephone appointment. The Medicaid Waiver Program where services will be in the community (home or ALH) and not at long term care facility (nursing home/hospital) requires the individual to secure a Care Coordinator before or during the application process. If the applicant is in a nursing home/SNF, you do not need to call the ADRC.

A. There are two financial eligibility requirements for Long Term Care Medicaid: (1) monthly gross income and (2) total countable resources/assets.

For a Married Couple, the financial requirements are as follows:

Income Eligibility:

For Long Term Care Medicaid, only the applicant's gross monthly income is considered by Medicaid in determining income eligibility. **None of the spouse's monthly income is counted**.

The applicant's monthly *gross* income must be less than $2,901 (2025 amount, adjusted annually). If you do not have a pension pay stub, you may need to contact the income payer to obtain a pay stub or other written statement of the gross amount with an itemization of all deductions as Medicaid will need this detailed information as part of the application process. *It is not sufficient to divide their prior year's tax reported income by 12.*

In Alaska, excess monthly income is not a bar to eligibility as Medicaid qualifying income trust (known as a Miller Trust) may be set up to obtain income eligibility. Legal assistance is required as there are no forms available from State of Alaska Medicaid for these trusts. Note, if the person later goes off Medicaid the trust will no longer need to be funded; it is not a permanent assignment of income.

* Included income:

- **all** income received in the applicant's name, including private and public pensions (Civil Service, State of Alaska, unions, etc.), Social Security, Veterans' Administration (except Medal of Honor), Alaska Senior Benefits, annuity payments, survivor benefits, oil and gas royalties, trust payments, etc.

* Excluded income:

- Alaska Permanent Fund Dividend
- Alaska Native Dividends–only up to $2,000 per calendar year are excluded. Dividends received over $2,000 in a year are countable income and may require a Miller Trust to be used just for the months the excess dividends are received. Note, it is $2,000 total dividends received, not $2,000 per corporation.

Resource Eligibility:

All assets owned by either spouse separately or jointly or with another person in or out of Alaska must be disclosed to Medicaid, including interests in partnerships, corporations, LLCs, trusts. The name on an account or deed is not relevant to Medicaid (except for the spouse's retirement accounts, see below). The couple's countable resources must be within the following limits at 12:01 a.m. on the first day of the month they are seeking eligibility. If the couple is over resource at that moment in time, they will not be resource eligible for the entire month.

* For a married couple with one spouse living in the community and not on LTC Medicaid, the resource limit is **$2,000** for the applicant **plus $157,920** for the spouse for **a total of $159,920 (2025 amount, spousal amount is adjusted annually)**.

* If both spouses are on LTC Medicaid or living in an assisted living facility (even if only one spouse is receiving services) they are only each allowed $2,000.

1. **Alaska Medicaid excludes/does not count the following resources**:

    * An individual's **home**, if the spouse or a disabled or dependent relative continues to live there while the individual is institutionalized.

        * **Note, generally, the home is only exempt while both spouses are alive and at the second spouse's death Medicaid will expect the home to be sold to repay Medicaid for long term care services provided.** There are some exceptions to estate recovery for qualified survivors. There are also options a lawyer can explain**.**

    * **One automobile.** Generally the most expensive automobile is excluded; any additional automobiles, boats, motorhomes, airplanes, 4 wheelers, snow machines, trailers, etc. are counted against the resource limits.

    * **Household and personal effects.** There is no limit on equity value on household goods, personal effects; these resources are totally excluded unless they are collections.

    * **Life insurance** policies with a face value less than $1,500 for each spouse or if the combined face value exceeds $1,500 then the cash surrender value must be less than $1,500; any excess is counted against the resource limit.

    * **Prepaid irrevocable/non-refundable funeral plans** for each spouse (no limit on the amount that can be paid into the plan) **OR** a bank account for each spouse titled "'each spouse's name' burial fund account" not to exceed $1,500.

    * **Burial spaces or plots** for each spouse–no value limit on these

    * All qualified **retirement accounts of the spouse** are exempt regardless of value and are not considered in determining the $159,920 of resources.

        * But **retirement accounts owned by the applicant will have to be cashed out or annuitized** to bring the applicant's resources below $2,000. For non-Roth accounts, this will likely result in a substantial income tax bill; if there are deductible medical expenses (including

part of the cost of care) it may reduce tax impact. For large retirement accounts, the couple's tax preparer will need to advise whether cashing out over two or more years while private paying for care is more advantageous than cashing out in one year. *Also see Medicaid Qualified Annuity and legal separation below.*

* **Alaska Native Claims Settlement Act Stock**

* **All Alaska Native or Native American owned real property located in the State of Alaska** even if it is not restricted land

* **Some Trust Assets:** Assets held in a qualified Special Needs Trust or Pooled Trust are not counted. Assets held in a Trust created by someone else for the applicant are not generally counted. But, assets held in a Trust the applicant created for themself are generally counted, e.g. revocable living trust assets.

* **ABLE Account Funds:** Not counted up to $400,000 for Alaska Medicaid.

2. **Re-titling of couple's assets:**

* **All jointly owned assets allotted to the community spouse must be transferred solely to their name within one year of Medicaid approval or the assets will become countable to the Medicaid recipient.**

* Note, after the first anniversary of Medicaid's approval of the application, the couple is considered financially separated and the community spouse's assets are no longer counted. The community spouse is not limited to $157,920 of assets after that year, so long as Medicaid coverage is never allowed to lapse.

* **The community spouse must also prepare a Will to avoid the transferred assets and the assets owned by the community spouse reverting to the Medicaid recipient if the community spouse dies first.**

3. **Spend down of resources to become resource eligible.** Reducing excess countable resources to the applicable resource limit may be done by "spending down" the resources. Examples of allowable spend down items:

* purchasing exempt assets (see list above)
* modifying the home to be more accessible
* maintenance, repairs, and upgrades to home
* paying off or paying down on a mortgage or vehicle loan
* paying off credit cards and other consumer debt
* paying caregivers and medical providers, etc.
* purchase of Medicaid Qualified Annuity–converts the resource used into income stream, may require Miller Trust for increased income **Note, the community spouse may be named as the primary beneficiary but Medicaid must be named as the second beneficiary.**

4. **Transfer of resources to become resource eligible.** Applying for Medicaid within five years of giving away or transferring assets for less than fair market value will generally result in a transfer of asset penalty period being imposed during which time Alaska Medicaid will not pay for the applicant's care when the applicant's care

otherwise would have been covered. The penalty period can only be imposed after an Application and Care Coordinator Support Plan are submitted and the State Division of Senior and Disability Services (SDS) assessment has determined Level of Care eligibility exists and has approved a Support Plan. When a penalty period is imposed, Medicaid will send a letter stating the date when the applicant can reapply for Medicaid at which time the applicant will have to submit an updated Application and Support Plan, and SDS will make another determination and approval. With the assistance of legal counsel the differential between actual cost of care and the Alaska Medicaid penalty divisors may provide some planning options and opportunities. (See Overview of the Transfer of Asset Penalty handout.) **Transfers of assets to become resource eligible also may have Federal income tax or estate tax consequences and should not be done without legal advice.**

5. **Dissolution of the marriage or divorce** may be pursued if the circumstances warrant. **This process may require appointment of a guardian for an incapacitated spouse.**

Note: A **prenuptial agreement** or **legal separation** are not sufficient to have assets disregarded for long term care Medicaid eligibility. All of assets of both spouses will be considered in determining Medicaid eligibility unless there has been a decree of dissolution or divorce.

A. HOW INCOME IS TREATED ONCE MEDICAID ELIGIBILITY IS OBTAINED

1. **The recipient is allowed a monthly "Personal Needs Allowance" (PNA) to pay for food, shelter, clothing, toiletries, etc. The amount of their PNA is determined by where the recipient is living. Unless there are other allowances, all the rest of their monthly income will go to their COCO (discussed in 2 below):**

   * A recipient living in a **skilled nursing facility** is allowed **$200** per month to use for their personal needs (haircuts, clothes, toiletries, cell phone, TV, internet, etc.). There is no obligation to pay room and board when in a skilled nursing facility.

   * A recipient living in an **assisted living home/facility** is allowed **$1,396** per month for their PNA from which they have to pay the home/facility for room and board. Room and board rates are not set by law and the division of the personal needs allowance between room and board and other needs is not set by law. Normally the home/facility receives $1,296 and the recipient retains $100 for their other personal needs (haircuts, clothes, toiletries, cell phone, TV, internet, etc.). The home/facility may set a room and board rate higher than $1,296 which will have to be negotiated with the home/facility to provide the recipient with funds for items not covered by Medicaid or provided by the home/facility.

   * A recipient who receives Medicaid covered services in **their home** is allowed **$1,656** per month to pay food, shelter, clothing and other personal expenses (haircuts, clothes, toiletries, cell phone, TV, internet, etc.). Shelter expenses include: Rent or mortgage payments, Property taxes, Heating Fuel (gas, oil), Electricity, Water, Sewer, Garbage Collection Service.

2. **Medicaid increases the PNA or allows deductions for the following expenses:**

   * **Income taxes** withheld by the payer of the pension, annuity, etc.

* **Health insurance premiums–**either withheld from check or paid directly by recipient or recipient's spouse to AARP or another Medigap/Medicare Part D insurance provider. If it is a joint premium, only the portion applicable to the recipient may be deducted.

    - Note, Medicaid will start paying Medicare Part B premiums about 90 days after Medicaid coverage starts so no deduction is allowed for those premiums.

* **Community spouse allowance** (amount needed to raise spouse's monthly **gross** income to $3,928 (2025 amount); no allowance is given if the spouse's gross income exceeds that amount). This amount must be placed in the spouse's checking account that the recipient is not on; it cannot remain in the recipient's personal checking account. If there is a the Miller Trust account, the spousal allowance cannot remain in the trust account and must be disbursed to the spouse's checking account. **Adjustment:** The spousal allowance may be increased by a spousal support order or a hearing officer's decision that a greater monthly amount is needed due to exceptional circumstances resulting in extreme financial duress of the community spouse.

* **Family member allowance** of up to $1,316 per dependent depending on where dependent child/parent/sibling resides (2025 amount). This amount must be placed in the spouse's checking account, not in the recipient's checking account. If there is a Miller Trust account, the allowance cannot remain in the trust account and must be disbursed to the spouse's checking account. **Adjustment:** The allowance may be increased by court order or a hearing officer's decision affirming or establishing that a greater monthly amount is needed due to exceptional circumstances resulting in extreme financial duress of the dependent child, dependent parent or dependent sibling.

* **Unpaid medical expenses** incurred before application. Note, this can include unpaid months of Assisted Living Home care (less the monthly room and board amount) incurred before eligibility was determined. For ALH expenses, the home will have to provide a statement that 1) the invoice does not include in room and board costs and 2) the ALH is not enrolled in Medicare because cost of care in an assisted living home is not a Medicare funded service. Medicaid may also require a letter from the applicant's physician that placement in an assisted living home was medically necessary on or before the date of the first ALH cost of care invoice.

* **Child support** garnishment

* **Guardian and conservator fees** actually charged up to $100 per month

If all the recipient's income is deposited into a Miller Trust account, the PNA must be transferred each month to the recipient's personal checking account (which is usually joint with the spouse for the spouse to pay the food and shelter expenses) because the Miller Trust cannot be used to pay food and shelter expenses.

If there is not a Miller Trust, the PNA must be placed in the recipient's personal checking account (which is usually joint with the spouse for the spouse to pay the food and shelter expenses), not in the spouse's checking account (which the recipient is not on).

3. **If the recipient's gross monthly income exceeds the PNA for their living situation, Medicaid will calculate a Cost of Care Obligation (COCO) for the recipient.** Medicaid will send a letter showing the calculation including all income, the PNA amount and any other allowed deductions.

   * If the recipient is being cared for at home, the COCO amount will be paid to one or more Waiver vendors who are providing in-home care services. The provider must deduct the COCO payment received from what it bills Medicaid.

   * If the recipient is being cared for in a nursing home or in a hospital swing bed, the COCO amount will be paid to the skilled nursing facility.

   * If the recipient is residing in an assisted living home/facility, the COCO amount will be paid to the home/facility.

If there is a Miller Trust, the COCO amount will be paid directly to the provider/facility/home from the Miller Trust while the Room and Board check must be paid to the provider/facility/home from the recipient's PNA that was transferred to their personal checking account because the Miller Trust cannot be used to pay Room and Board.

If there is not a Miller Trust and the recipient's monthly income is over the PNA, the recipient still needs to pay the provider/facility with two separate checks/debits with different notations on the Memo line: one for their Room and Board amount (out of their PNA funds) and the other for their COCO as calculated by Medicaid. Two checks/debits are required because the provider/facility must deduct the COCO payment received from what it bills Medicaid, but the provider/facility does not deduct the Room and Board payment from the amount it bills Medicaid.

SINGLE PERSON LONG TERM CARE MEDICAID
FINANCIAL ELIGIBILITY REQUIREMENTS

***Note–all of the below financial eligibility discussion assumes the applicant will meet the Medicaid functional/level of care eligibility requirements for Long Term Care Medicaid. This determination will be made by the State Division of Senior and Disability Services after the application is submitted.**

For a pre-application determination as to whether you are applying for the correct Medicaid program, contact the Aging and Disability Resource Centers (ADRC) at 1-855-565-2017 to schedule a "Medicaid Pre-screen" telephone appointment. The Medicaid Waiver Program where services will be in the community (home or ALH) and not at long term care facility (nursing home/hospital) requires the individual to secure a Care Coordinator before or during the application process. If the applicant is in a nursing home/SNF, you do not need to call the ADRC.

A. There are two financial eligibility requirements for Long Term Care Medicaid: (1) monthly gross income and (2) total countable resources/assets.

For a Single Person, the financial requirements are as follows:

Income Eligibility:

The applicant's monthly *gross* income must be less than $2,901 (2025 amount, adjusted annually). If you do not have a pension pay stub, you may need to contact the income payer to obtain a pay stub or other written statement of the gross amount with an itemization of all deductions as Medicaid will need this detailed information as part of the application process. *It is **not** sufficient to divide their prior year's tax reported income by 12*.

In Alaska, excess monthly income is not a bar to eligibility as a Medicaid qualifying income trust (known as a Miller Trust) may be set up to obtain income eligibility. Legal assistance is required as there are no forms available from State of Alaska Medicaid for these trusts. Note, if the person later goes off Medicaid the trust will no longer need to be funded; it is not a permanent assignment of income.

* Included income:

- **all** income received in the applicant's name, including private and public pensions (Civil Service, State of Alaska, unions, etc.), Social Security, Veterans' Administration (except Medal of Honor), Alaska Senior Benefits, annuity payments, survivor benefits, oil and gas royalties, trust payments, etc.

* Excluded income:

- Alaska Permanent Fund Dividend
- Alaska Native Dividends–only up to $2,000 per calendar year are excluded. Dividends received over $2,000 in a year are countable income and may require a Miller Trust to be used just for the months the excess dividends are received. Note, it is $2,000 total dividends received, not $2,000 per corporation.

Resource Eligibility:

All assets owned by the applicant separately or jointly with another person in or out of Alaska must be disclosed to Medicaid, including interests in partnerships, corporations, LLCs, trusts.

1. **The applicant's countable resources must be less than $2,000 at 12:01 a.m. on the first day of the month they are seeking eligibility. If the applicant is over resource at that moment in time, they will not be resource eligible for the entire month.**

2. **Alaska Medicaid excludes/does not count the following resources**:

   * An individual's **home** if the applicant is still living in it or if the applicant is institutionalized and they state their intent to resume living in it. The home must have an equity value of less than $730,000 (2025 amount) unless a disabled or dependent relative continues to live there while the individual is institutionalized. ***Note, generally, the home is only exempt while they are alive and after death Medicaid will expect the home to be sold to repay Medicaid for long term care services provided.*** There are some exceptions to estate recovery for qualified survivors. There are also options a lawyer can explain**.**

     Note: Unless the applicant is still residing in the home, they will not be allowed to use any of their income to maintain their home for more than six months. To be granted a monthly home maintenance allowance they must have letter from physician that they are likely to return home within 6 months from when they first left the home. *See PNA section below*.

   * **One automobile.** Generally the most expensive automobile is excluded; any additional automobiles, boats, motorhomes, airplanes, 4 wheelers, snowmachines, trailers, etc. are counted against the resource limits

   * **Household and personal effects.** There is no limit on equity value on household goods, personal effects; these resources are totally excluded unless they are collections.

   * **Life insurance policies** with a face value less than $1,500 or if the combined face value exceeds $1,500 then the cash surrender value must be less than $1,500; any excess is counted against the resource limit.

   * **Prepaid irrevocable/non-refundable funeral plan** (no limit on the amount that can be paid into the plan) **OR** one bank account titled "Applicant's name burial fund account" not to exceed $1,500.

   * **Burial space or plot** –no value limit on this asset

   * **Alaska Native Claims Settlement Act Stock**

   * **All Alaska Native or Native American owned real property located in the State of Alaska** even if it is not restricted land

   * **Some Trust Assets:** Assets held in a qualified Special Needs Trust or Pooled Trust are not counted. Assets held in a Trust created by someone else for the applicant are not generally counted. But, assets held in a Trust the applicant created for themself are generally counted, e.g. revocable living trust assets.

* **ABLE Account Funds:** Not counted up to $400,000 for Alaska Medicaid.

3. **Spend down of resources to become resource eligible.** Reducing excess countable resources to the applicable resource limit may be done by "spending down" the resources. Examples of allowable spend down items:

   * purchasing exempt assets (see list above)
   * modifying the home to be more accessible
   * maintenance, repairs, and upgrades to home
   * paying off or paying down on a mortgage or vehicle loan
   * paying off credit cards and other consumer debt
   * paying caregivers and medical providers, etc.
   * purchase of Medicaid Qualified Annuity–converts the resource used into income stream, may require Miller Trust for increased income **Note, Medicaid must be named as the primary beneficiary for a single person.**

4. **Transfer of resources to become resource eligible.** Applying for Medicaid within five years of giving away or transferring assets for less than fair market value will generally result in a transfer of asset penalty period being imposed during which time Alaska Medicaid will not pay for the applicant's care when the applicant's care otherwise would have been covered. The penalty period can only be imposed after an Application and Care Coordinator Support Plan are submitted and the State Division of Senior and Disability Services (SDS) assessment has determined Level of Care eligibility exists and approved a Support Plan. When a penalty period is imposed, Medicaid will send a letter stating the date when the applicant can reapply for Medicaid at which time the application will have to submit an updated Application and Support Plan, and SDS will make another determination and approval. With the assistance of legal counsel the differential between actual cost of care and the Alaska Medicaid penalty divisors may provide some planning options and opportunities. (See Overview of the Transfer of Asset Penalty handout.) **Transfers of assets to become resource eligible also may have Federal income tax or estate tax consequences and should not be done without legal advice.**

B. HOW INCOME IS TREATED ONCE MEDICAID ELIGIBILITY IS OBTAINED

1. **The recipient is allowed a monthly "Personal Needs Allowance" (PNA) to pay for food, shelter, clothing, toiletries, etc. The amount of their PNA is determined by where the recipient is living. Unless there are other allowances, all the rest of their monthly income will go to their COCO (discussed in 2 below):**

   * A recipient living in a **skilled nursing facility** is allowed **$200** per month to use for their personal needs (haircuts, clothes, toiletries, cell phone, TV, internet, etc.). There is no obligation to pay room and board when in a skilled nursing facility.

   * A recipient living in an **assisted living home/facility** is allowed **$1,396** per month for their PNA from which they have to pay the home/facility for room and board. Room and board rates are not set by law and the division of the personal needs allowance between room and board and other needs is not set by law. Normally the home/facility receives $1,296 and the recipient retains $100 for their other personal needs (haircuts, clothes, toiletries, cell phone, TV, internet, etc.). The home/facility may set a room and board rate higher than $1,296 which will have to be negotiated with the home/facility to provide the recipient with funds for items not covered by Medicaid or provided by the home/facility.

* A recipient who receives Medicaid covered services in **their home** is allowed **$1,656** per month to pay food, shelter, clothing and other personal expenses (haircuts, clothes, toiletries, cell phone, TV, internet, etc.). Shelter expenses include: Rent or mortgage payments, Property taxes, Heating Fuel (gas, oil), Electricity, Water, Sewer, Garbage Collection Service.

2. **Medicaid increases the PNA or allows deductions for the following expenses:**

* **Income taxes** withheld by the payer of the pension, annuity, etc.

* **Health insurance premiums**–either withheld from check or paid directly by recipient to AARP or another Medigap/Medicare Part D insurance provider

- Note, Medicaid will start paying Medicare Part B premiums about 90 days after Medicaid coverage starts so no deduction is allowed for those premiums.

* **Unpaid medical expenses** incurred before application. Note, this can include unpaid months of Assisted Living Home care (less the monthly room and board amount) incurred before eligibility was determined. For ALH expenses, the home will have to provide a statement that 1) the invoice does not include in room and board costs and 2) the ALH is not enrolled in Medicare because cost of care in an assisted living home is not a Medicare funded service. Medicaid may also require a letter from the applicant's physician that placement in an assisted living home was medically necessary on or before the date of the first ALH cost of care invoice.

* For an unmarried recipient with no dependents in the home, **a six month home maintenance allowance** is given only if their physician certifies the recipient is likely to return home within six months. If the physician cannot certify the recipient is likely to return home, there will be no home maintenance allowance so other arrangements will need to be made to cover the home's expenses. This may include renting the home with the net rental income over rental expenses increasing the applicant's monthly income.

- The monthly home maintenance allowance is based on actual expenses and is up to or equal to, but cannot exceed, $1,795 (2025 amount). This home maintenance allowance can be deducted for a maximum of six months beginning with the 1st of the month after the month of admission to the medical institution or nursing facility. *If the person has been in a facility more than six months before applying for Medicaid or by the time their application is processed, no allowance will be given.*

* **Family member allowance** of up to $1,316 per dependent depending on where dependent child/parent/sibling resides (2025 amount). This amount must be placed in the dependent's guardian's checking account, not in the recipient's checking account. If there is a Miller Trust account, the allowance cannot remain in the trust account and must be disbursed to the dependent's guardian's checking account. **Adjustment:** The allowance may be increased by court order or a hearing officer's decision affirming or establishing that a greater monthly amount is needed due to exceptional circumstances resulting in extreme financial duress of the dependent child, dependent parent or dependent sibling.

* **Child support** garnishment

* **Guardian and conservator fees** actually charged up to $100 per month

If all the recipient's income is deposited into a Miller Trust account, the PNA must be transferred each month to the recipient's personal checking account (which is usually joint with the trustee) to pay food and shelter expenses because the Miller Trust cannot be used to pay food and shelter expenses.

If there is not a Miller Trust, the recipient is still limited to spending no more than the PNA amount each month for their food and shelter expenses and other personal needs.

3. **If the recipient's gross monthly income exceeds the PNA for their living situation, Medicaid will calculate a Cost of Care Obligation (COCO) for the recipient.** Medicaid will send a letter showing the calculation including all income, the PNA amount and any other allowed deductions.

    * If the recipient is being cared for at home, the COCO amount will be paid to one or more Waiver vendors who are providing in-home care services. The provider must deduct the COCO payment received from what it bills Medicaid.

    * If the recipient is being cared for in a nursing home or in a hospital swing bed, the COCO amount will be paid to the skilled nursing facility.

    * If the recipient is residing in an assisted living home/facility, the COCO amount will be paid to the home/facility.

If there is a Miller Trust, the COCO amount will be paid directly to the provider/facility/home from the Miller Trust while the Room and Board check must be paid to the provider/facility/home from the recipient's PNA that was transferred to their personal checking account because the Miller Trust cannot be used to pay Room and Board.

If there is not a Miller Trust and the recipient's monthly income is over the PNA, the recipient still needs to pay the provider/facility with two separate checks/debits with different notations on the Memo line: one for their Room and Board amount (out of their PNA funds) and the other for their COCO as calculated by Medicaid. Two checks/debits are required because the provider/facility must deduct the COCO payment received from what it bills Medicaid, but the provider/facility does not deduct the Room and Board payment from the amount it bills Medicaid.