Life Care Planning: Beyond Estate Plans and Living Wills
Bundling Legal and Non-Legal Services, Avoiding Ethical Pitfalls

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Today’s faculty features:
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patients were less likely to undergo these interventions and more likely to receive palliative care in their final days of life.” (www.medicalnewstoday.com)

Our challenge as life care planning law firms is to determine how we can best meet the needs of each client diagnosed with dementia. Throughout the course of the illness we must work diligently to protect their rights and advocate for quality care. From including them in planning for future medical care and treatment as they face the early stages of the illness to advocating for quality palliative care once they are in the most advanced stages, we must pledge to speak for those who eventually lose the ability to speak for themselves.

### Mediation - A Holistic, Client-Centered Alternative Approach to End-of-Life Treatment Disputes

By Debra K. Schuster, J.D., MHA and Kim L. Kirn, Attorney-Mediator

Among the most difficult, painful and often contentious disputes involving elderly clients and their families are those surrounding end-of-life decision-making.

With the increased awareness of the general public about Advance Directives and the “Patient Self-Determination Act”, enacted in 1991 that requires all types of in-and outpatient health care facilities, home health agencies and health maintenance organizations to provide information about the individual’s right to create Advance Directives and the entity’s policy with respect to recognizing and honoring such documents, one would hope that the opportunity to express one’s end of life treatment preferences would be taken, especially by the elderly, who are statistically more likely to confront such issues than younger individuals.

However, a study from the University of Minnesota Center for Bioethics indicates that less than 5% of individuals 65 years of age and older have created Advance Directives, an integral part of which is a Living Will or other expression of one’s end of life treatment preferences. Even when an individual has created a Living Will or has otherwise expressed in writing their end-of-life treatment wishes, whether such wishes will be honored is most often dependent upon whether the individual’s family (or appointed Attorney-in-Fact for Health Care) will respect and uphold such wishes.

When family members disagree with an individual’s stated end of life treatment preferences, discord not only within the family but with health care providers occurs. Often, when individual or multiple family members oppose honoring the principal’s end of life treatment wishes, it throws treatment of the principal into disarray, often prompting the intervention of hospital ethics committees and even litigation on the part of family and/or institutional care providers to seek court guidance.
The disputes by family members who have different end of life treatment beliefs than their relative who has stated end of life treatment wishes arise when those family members have not been informed prior to a health crisis involving the principal, when discussion about and reference to the principal’s documented wishes leads to allegations of incapacity by the principal at the time his/her Advance Directive were created, assertions of undue influence on the part of other family members that have similar perspectives on end of life treatment as those of the principal or when health care providers ask the family’s opinion on issuance of a Do Not Resuscitate Order or raise the issue of the medical futility of further curative treatment of the principal.

Attempts by institutional ethics committees to discuss enforcement of a loved one’s end of life treatment wishes and lawsuits initiated by either family seeking to prevent enforcement of the principal’s wishes or institutional health care providers seeking to enforce such wishes is costly, time consuming and most often does not satisfactorily resolve either the financial or emotional issues underlying such disputes.

Disputes such as these and those pertaining to guardian/conservator appointment, the adequacy of performance of appointees under an elder’s Durable Powers of Attorney, trust management and the like, all involve family members battling over control of the personal or financial matters of a family elder, often present in court because no other means of resolving such disputes has been recommended or is known. Mediation is precisely one such alternative. Mediation offers parties to a dispute a confidential process that keeps the lines of communication open with the goal of finding a compromise resolution.

Mediation is a voluntary discussion by the parties to a dispute, either with or without counsel, in an effort to resolve all or a part of the dispute with a trained neutral moderating the discussion. The evidentiary rules disallowing settlement discussions from being introduced in any court proceeding prevent any statements made during the mediation from use by counsel in any subsequent hearing or trial. Mediation has long been popular is some regions of the country for handling domestic relations, and popular in still more places for settling personal injury, commercial and employment litigation. Mediation can be court-ordered, but often the parties or their attorneys request mediation in situations in which they feel it would be productive, particularly in situations where relationships need to be preserved.

Although mediation can be successfully used in almost any type of dispute, it is most successful when the parties have an ongoing relationship; for example a current employee with a dispute against her employer or a boundary dispute between neighbors. Consequently, disputes over end of life decisions are an ideal circumstance for mediation. The disputing siblings or family members will still have their
familial relationship after the current dispute ends. It is possible, that the opportunity for open communication and the non-litigious environment in which mediation occurs may in fact, repair and improve strained relationships by the parties gaining an understanding of each others’ perspective. If the dispute is with the health care institution, there may be an ongoing relationship as the principal continues receiving care at the institution.

Another reason parties often choose mediation is to protect their privacy. These confidential discussions usually take place at a neutral location behind closed doors with only the actual parties and, if the parties so desire, their counsel present. Of course, the parties can agree to invite others to the mediation, but all involved must be aware how this can change the dynamics of the discussion especially if there is a strong personality on the periphery of the dispute. If an agreement is reached, the terms can be written or typed and signed by the parties at the conclusion of the mediation. This agreement can remain private but it is enforceable in court if someone reneges on his or her commitment at a later time.

Interestingly, mediation tends to be more successful with parties who have been through litigation previously and know the emotional and financial toll that must be paid while pursuing litigation. Most importantly, parties who voluntarily agree on a resolution, rather than having a court decision foisted upon them, are more likely to actually carry out the provisions of the resolution. They have an ownership interest in the resolution; they were empowered to make the decision, even if it was a compromise decision. The parties are then free to move forward in their life and with a clearly understanding of the wishes of the principal and themselves.

Mediation is not a panacea and can break down when certain personalities are involved in the process. Individuals who feel compelled to participate, have intractable positions, or difficult personalities that do not allow for consideration and compromise with others may derail an otherwise successful mediation. However, reasonable people speaking in a safe environment with accurate information about the choices before them will often engage in meaningful discussions that lead to a compromise. Clients may even surprise themselves and their attorneys with their flexibility and willingness to listen and re-consider their position on the issue at hand. Mediation can result in creative resolutions appropriate for the parties; even resolutions the court would never dare to impose.

The area of elder law and particularly Life Care Planning, due to the practice being in its infancy, are new to the concept and value of mediation in attempting to resolve the contentious disputes that often confront families and their elder loved ones going through stressful life transitions and crises. End of life disputes are among the numerous issues in which Life Care Planning attorneys and staff become intimately involved and mediation is a useful tool that can be recommended by practitioners to truly assist their clients in a meaningful way.
The Evolving Practice of Elder Law…. Life Care Planning

by Debra K. Schuster, Esq. and Wesley J. Coulson, Esq.

The population of the United States is aging. Between 1990 and 2000, there was a 12% increase in the number of individuals 65 years and older, which occurred again from 2000 to 2008. In Missouri, 13.6% of the population is 65 or older.¹

Medical technology and pharmaceuticals have enabled individuals who would have died before age 65 to live well into their 70’s, 80’s, or beyond. However, the services, benefit programs and community resources available and accessible to appropriately and adequately address the needs of these individuals are often non-centralized, inadequately funded and often-times focused on institutionalization, which is not the best and most desired option for this population.

These are the issues faced daily by adult children, aging spouses and attorneys who work with the aging population. They are the reason that the practice of elder law developed.
However, few attorneys and even fewer lay people are aware that elder law exists as a distinct practice area.

The national professional association to which most serious elder law practitioners belong is the National Academy of Elder Law Attorneys (\textsuperscript{ii} “NAELA”). Established in 1987 (at age 23, it is much younger than the clients served), NAELA defines the practice of elder law as:

“\textit{Being} defined by the client to be served. In other words, the lawyer who practices Elder Law may handle a range of issues but has a specific type of clients – seniors.

Elder Law attorneys focus on the legal needs of the elderly, and work with a variety of legal tools and techniques to meet the goals and objectives of the older client.

Under this holistic approach, the Elder Law practitioner handles general estate planning issues and counsels clients about planning for incapacity with alternative decision making documents. The attorney would also assist the client in planning for possible long-term care needs, including nursing home care. Locating the appropriate type of care, coordinating private and public resources to finance the cost of care, and working to ensure the client's right to quality care are all part of the Elder Law practice.”\textsuperscript{iii}

Many attorneys who practice elder law have a background in estate planning, tax planning or accounting. Before the manifest and devastating changes to the Medicaid laws in February, 2006\textsuperscript{iv}, a significant proportion of elder law practitioners concentrated in Medicaid planning, asset protection and estate planning, which invariably focused on the eventuality that the client – the elder individual – would end up in a nursing home and, if needed, on Medicaid\textsuperscript{v}.

The individuals that come to an elder law attorney’s office are usually in crisis – it is the rare individual who comes in a pro-active frame of mind. Most often, the client or his or her spouse, significant other, adult parent or other relative has received a life-changing diagnosis, has suffered a sudden injury (most often due to a fall), or has exhibited a significant and increasing need for help with activities of daily living or handling finances. Clients come
seeking answers to the immediate crisis they face – how to cope with a diagnosis of Alzheimer’s disease, a stroke, Multiple Sclerosis, or ALS; a parent who is leaving the stove on, doors unlocked, who wanders or gets lost in her or his neighborhood; the fear of financial exploitation as a result of a call from the bank reporting unusually large withdrawals and checks signed with suspicious handwriting; and dozens of other traumatic and fearful changes for which most families are ill-equipped and unprepared to handle. These issues often begin with legal issues, but as most elder law practitioners have seen, are fraught with a myriad of non-legal issues that must also be addressed.

Additionally, the composition of the family has changed over the past half century. In the 1950’s and 1960’s it was common for the family unit to be defined by the extended family – grandparents were integrally involved in the lives and rearing of grandchildren and in turn, elders lived with or in close proximity to their adult children who provided assistance and often care for the elder as their health declined. This is not the model of the family today. Many, if not most, families are dispersed throughout the country. It is not unusual for an elder law attorney to receive a panicked telephone call from an adult child who lives out of state, concerned about a sudden change in the health status or functionality of a parent who lives in Missouri – and for whom there is no local family support system. This is one of the rapidly growing areas of elder law – assisting and guiding long-distance “care-givers”.

Notwithstanding the multi-faceted nature of the problem at hand, the experience of elder law attorneys has been that the initial instinct of most such clients was to view the elder law attorney in a limited role, one primarily involving the drafting of documents. That need is certainly present in many instances. The elder client often does not have any estate planning documents created or the documents that exist are inappropriate for their current needs.
The attorney-client relationship would then proceed on a sporadic and reactive basis. The attorney would generally not hear from the client again for perhaps a year or more, when the next urgent situation developed. Often, the client’s condition would take a significant turn for the worse. Hospitalization, and/or a reassessment of the client’s care needs or the adequacy of the client’s housing arrangements, would often follow. In other instances, a caregiver spouse or child would die or have become gradually unable (not just physically, but mentally and emotionally) to deal with the ever-increasing burden of caring for an elder in decline. The call to the elder law attorney would often then involve a need for a further legal intervention, such as the appeal of a premature hospital discharge requiring a Medicare appeal or review of a nursing home or assisted living admission agreement. At that stage, many clients would exhibit an increasing concern for the potentially severe financial concerns raised by the prospect of paying for institutional long-term care.

Once that immediate issue (if legal in nature) was resolved, the elder or family caregiver would most often return on an increasingly frequent basis for assistance with other legal or care-related issues. At that stage, clients would develop an increasing awareness of the ability of the elder law attorney to serve in the role of family counselor and care coordinator, able to utilize professional contacts with trusted and caring social workers or other care managers to provide assistance with finding an appropriate nursing home, adult day care program, assisted living facility, home care agency or counseling for the difficult emotional transition from a known life to a “new” life.

Given the aspects of elder law practice that do not involve traditional legal activities and in fact constitute more social work or care manager functions, some elder law attorneys developed an increasing awareness of the limitations imposed by their limited role as “crisis handlers” and the tremendous potential advantages of a holistic, multi-disciplinary approach to
assisting their clients. Their body of experience in helping families successfully navigate the elder care journey and their appreciation of their ability, as attorneys, to “see the big picture” and develop plans directed toward addressing the complex and intertwined legal, financial, medical, care support, housing, practical and emotional needs of their clients, led them to develop a new approach.

This approach necessarily involved a redefinition of the role of the elder law attorney. Someone or a group of practitioners who could reduce the stress, fear, anxiety, uncertainty and complexity of the needs facing an aging or disabled loved one was acutely needed. The complexity and scope of the needs facing clients simply could not be accomplished by addressing only their legal issues. The role of the elder law attorney would need to be expanded; made more proactive and less reactive. However, that would need to be done with a keen appreciation that the role of an attorney as a client advocate can easily lead others involved in a situation, such as medical practitioners or a nursing home care team, to view the attorney’s presence as adversarial, thus tending to exacerbate rather than ameliorate the situation.

Tim Takacs, an excellent and well-respected elder law attorney in Henderson, Tennessee, was at the forefront in formulating an approach to elder law based on a practice philosophy and staff composition which found their basis in a holistic, multi-disciplinary approach to addressing all of the legal, care, economic, benefit, social and support issues modern elderly clients face. This type of practice is called “Life Care Planning”.

At its core, Life Care Planning (“LCP”) is “client-centered”. Although all attorneys believe that their practice is client-centered, in Life Care Planning, this phrase has specific meaning. The Life Care Planning attorney’s assessment, analysis and recommendations are based on the wishes, desires and goals of the elderly individual. The Life Care Plan may, and
often does, includes the more traditional components of asset preservation and government benefits planning, but that is but one of its many facets. Some clients may require more legal services; others may need more care advocacy and care management. As such, there is no place in a LCP practice for hierarchical distinctions among the staff in the office. Life Care Planning requires a team mentality to truly work, and staff members who are totally committed to that philosophy.

The Life Care Planning Law Firm Association (“LCPLFA”)vii, created in 2006 by Mr. Takacs and other elder law attorneys who believed that their traditional elder law practices were not being responsive and truly addressing the needs of their clients, requires that the attorney initially hire or contract with a social worker, nurse or geriatric care manager (a “Care manager”) on a full or part-time basis and within two years of membership have an individual in that role on a full-time basis. The Care manager functions as an essential member of the law firm.

The cornerstones of LCP are the intertwined roles of the attorney and Care manager and the process used to evaluate and determine the wishes, needs and values of the client. The LCP process views the client’s needs, values, and desires along a continuum, in each of four major areas: housing, care needs, finances/support systems and benefits. The goal is to enable the client to “age in place” – to remain wherever the client wishes to reside, while constantly assessing the client’s needs along each continuum with the ideal being to maintain as much client independence and self-sufficiency as possible.

The legal aspect of Life Care Planning consists of a comprehensive: 1) document evaluation, including preparing or revising appropriate incapacity and estate planning documents; 2) review and determination of the specific benefits for which the client is or may be or become eligible, such as Medicare, other health insurance (i.e., retiree, through spousal
employment), prescription drug coverage, long-term care insurance, long/short-term disability insurance, Veterans’ benefits, life insurance, and a pre-paid burial plan; and 3) review of financial resources, including assets, income, business ownership, real estate, and retirement and insurance benefits.

The Care manager’s role is to focus on the client’s physical, psycho-social and care needs and the realistic support systems available to the client. The Care manager meets with the client in the client’s home (wherever the client resides) to evaluate and determine: 1) the client’s current care status (by obtaining a written release to speak with the client’s physician and other care providers and treatment); 2) the goals, needs, desires and values of the client to determine where the client wants to reside now, going forward, and at the end of life; 3) the physical environment in which the client resides and if any modifications are needed; 4) whether any additional care or supportive services, supplies or equipment are needed; 5) whether and what family and community support systems exist; and 6) what immediate care or interpersonal challenges are facing the client, such as imminent eviction, children who are insisting on moving the client to an institutional setting, or so forth.

Upon completion of the attorney’s and Care manager’s evaluations, a binder containing their detailed evaluation and recommendations, a list of resources available to and appropriate for the client, and identification of the next steps in the LCP is provided to the client (and whomever the client wishes to include). Those recommendations are also discussed in a face-to-face meeting. If the client does not agree with any aspect of the LCP, it is changed to suit his or her needs and wishes.

The most significant benefit of the Life Care Planning program is that an ongoing relationship is established over a period of years –LCPs are often for term of 3 or 5 years or the even the lifetime of the client- so that at each transition, the attorney and care manager will be
available to work with the client and anticipate and respond to changes in the client’s situation by revising the LCP on a regular basis. The LCP contract is negotiated individually with each client, based on each client’s needs. A flat fee is charged for the term of the agreement. In this way, the client has an incentive to utilize the services rather than being reluctant to access services for fear of compounding charges for every call or service. Throughout the term of the agreement, legal issues pertaining to Medicare appeals, veterans’ benefits, Medicaid applications and the like may arise, all of which are handled by the attorney.

This type of long-term retention, holistic and multi-disciplinary service is the most responsive and crisis-avoidant type of practice wanted and needed by those clients who have chronic, progressively debilitating illnesses. Not every client needs nor will benefit from LCP, nor can all afford the up-front costs. However, if ongoing service is needed, the cost of the LCP is far less than the discrete, crisis-driven costs of intermittent engagement and the benefit to the client and family are incalculable.

**The Role of Veterans’ Pension Benefits in Life Care Planning**

A statistic gleaned from the most recent (2000) United States census has tremendous implications for Life Care Planning. Nearly 69% of all men in Missouri age 65 or over are veterans of the United States military. A smaller number of women are also veterans. The large percentage of male veterans means, of necessity, that a high percentage of older women are either married to or widowed from veterans.

In any instance in which a veteran or the current or widowed spouse of a veteran is “housebound” or needs “aid and attendance,” potential eligibility for veterans’ pension benefits should be explored. As noted above, a major goal of Life Care Planning is to enable the elder to “age in place” – to receive needed care in the least restrictive setting, preferably at home, where the great majority of elders would prefer to be cared for. Veterans’ pension
benefits take the form of monthly payments to the claimant, and the money can be used at his or her discretion, as long as it is needed and used toward medical or care costs. In fact, the benefits can even be used by someone who needs aid and attendance to pay for non-professional home care provided by a family member (or friend) other than a spouse. In many instances, that can make it possible for an adult child to serve as caregiver under circumstances in which that would otherwise not be a financially viable option. Use of the pension in this manner may also have positive consequences if the elder needs skilled nursing MO Health Net (Medicaid) benefits in the future.ix

The benefit amounts are not insubstantial. At publication of this article, an eligible veteran with a dependent (i.e., a married veteran) who needs aid and attendance can receive a benefit of as much as $1,949 per month, a single veteran $1,644 per month, and the widowed spouse of a veteran $1,056 per month. An eligible veteran with a dependent who is housebound can receive a benefit of as much as $1,510 per month, a single veteran $1,204 per month, and the widowed spouse of a veteran $808 per month. Technically, the “aid and attendance” and “housebound” benefits involve supplements to lower a base pension benefit potentially available to any otherwise eligible veteran who is age 65 or above or who is totally and permanently disabled. However, as will become apparent in the discussion below, only veterans with very limited income would qualify for the base pension unless they have medical or care expenses. There is one exception, and it is significant. Because the income and the medical and care expenses of both spouses are considered when a married veteran applies, an eligible veteran can receive a base pension of as much as $1,291 per month if the spouse needs care but the veteran does not.

As noted above, the implications for Life Care Planning can be profound. The availability of these benefits can make home care, or assisted living care, a viable option when
lack of affordability would otherwise rule it out. Moreover, the availability of additional income can enable the veteran or widowed spouse of a veteran to preserve assets than that can be utilized, then or later, to pay for care in the elder’s most preferred care setting. If care in a facility later becomes necessary, it can make it more likely that the elder can afford to be cared for in the facility of the elder’s choice. For example, the ability to preserve assets to pay for later care can be an absolute difference-maker in enabling an elder with limited assets to be able to choose a preferred nursing home which may have a limited number of “Medicaid beds” and a waiting list for those beds, during which time the elder would need to pay out-of-pocket for his or her care. x

The first requirement for V.A. benefit eligibility pertains to military service. The claimant, or the spouse from whom he or she is widowed, must have served at least 90 consecutive days on active military duty, at least one day of which was during a “period of war,” and must not have received a dishonorable discharge. There is no requirement that the veteran have suffered a service-connected disability, nor one that the veteran has served in combat.

To receive the enhanced benefits referred to above, the claimant must also meet the Veterans’ Administration’s definition of needing “aid and attendance” or being “housebound.” For the former, there are two “automatic qualifiers”: being a nursing home patient or being legally blind. Alternatively, a claimant can show a need for regular and ongoing assistance with certain activities of daily living or that he or she is bedridden. For the latter, the claimant must be permanently and substantially confined to his or her immediate premises due to a permanent disability, or have a 100%-disabling condition and another 60%-or-more disabling condition. A claimant may receive one benefit or the other, but not both.
There are two financial requirements for eligibility, one relating to assets and the other to income.

The VA defines its asset (“net worth”) limitation in a way that is obviously and intentionally vague: “There is no set limit on how much net worth a veteran and his dependents can have, but net worth cannot be excessive. The decision as to whether a claimant's net worth is excessive depends on the facts of each individual case.” xi Most elder law attorneys who handle veterans’ pension benefits planning seem to use “not more than $80,000 for a married claimant or $50,000 for a single claimant” (exclusive of the residence and a vehicle) as a starting point for analysis, but because of the “age analysis” in which the VA engages in considering claims, some older claimants may only be determined eligible with substantially fewer assets.

Clients with excess assets can often achieve eligibility through planning that involves the use of an irrevocable gift trust directed toward causing assets to be no longer considered as owned by the claimant, but with safeguards in place to protect the assets from financial harm that may later befall family member beneficiaries. Trust assets could be later accessed, with the help of trustworthy and cooperative fiduciaries and beneficiaries, to help cover medical, care and other expenses later incurred by the elder. Capital gains tax considerations can raise particular planning challenges in planning for a residence that may be later sold. xii Similarly, income tax considerations can pose challenges in dealing with assets, such as qualified retirement assets, savings bonds and certain annuities, which carry a built-in tax liability. xiii

Planning toward achieving eligibility for veterans’ pension benefits through asset transfers should only be responsibly undertaken by an attorney with an intimate working knowledge of VA and Medicaid eligibility laws, regulations and policies. Although the VA does not require disclosure of asset transfers completed prior to application, Medicaid does as
to all transfers made within five years prior to application, and imposes penalties that delay eligibility. Ill-conceived or poorly executed planning may accomplish the short-term good of establishing eligibility for veterans’ pension benefits to pay for less-expensive home care or assisted living care, but later cause the much greater, and potentially devastating, determination of ineligibility for Medicaid nursing home benefits. Given that the care needs of elders often increase over time, a failure to plan properly for the possibility that the elder may later need nursing home care at a cost that will exceed the elder’s income, including receipt of the VA benefit, may well expose an attorney to a professional negligence claim.

Determining eligibility for veterans’ pension benefits relative to the income limitation requires a process of mathematical calculations. First, the gross monthly income of the claimant and other members of the claimant’s household (particularly, in the case of a married veteran, his or her spouse) must be determined. From that amount, slightly less than all of the unreimbursed medical and care expenses of the claimant (and other household members, if applicable) are deducted. The difference is then compared to the maximum amount of the monthly benefit for which the claimant will apply. The claimant is eligible to the extent that the maximum benefit amount is greater.

Because of the “income vs. expense” comparison involved, any claimant whose allowable unreimbursed medical and care expenses exceed his or her income will then be eligible for the maximum potential benefit. For that reason, a claimant who may not otherwise be eligible for the maximum benefit can become eligible by increasing the amount and type (and thus the cost) of the care he or she is receiving. Such an increase in care, particularly when accomplished under the guiding hand of a care manager who can provide ongoing recommendations with regard to the manner in which the money to pay for the care can be
most wisely spent, can prove of great benefit toward accomplishing the goals of the elder’s Life Care Plan.


ii See www.NAELA.org


iv The Deficit Reduction Act of 2005, P. L. 109-171; 42 USC §1396a (as amended) SIGNIFICANTLY changed Medicaid planning both on a federal and state level.

v In Missouri “Medicaid” is the federal-state program for the Aged, Disabled and Indigent now known as “MO Health Net” citation? The program that provides skilled nursing facility coverage for the elderly is referred to as “vendor” coverage because the vendor of the services for which benefits are paid is the skilled nursing facility. Although MO Health Net provides at least two other significant programs, Medical Assistance and the Home and Community Based Waiver (“HCBW”) program that provide financial assistance to the elderly population, those programs will not be discussed in this article. Additional information about these and other programs designed to assist the elderly are, in part, found in the Department of Health and Senior Services website, www.dhss.mo.gov.

vi Not all clients are competent and therefore have Attorneys-in-Fact or Guardians/Conservators/Trustees that serve as their proxy. It is made clear to these legal representatives that the client – the elder that they serve as Agent for – is the sole focus of our services. If a conflict of interest arises between the attorney/care manager and legal representative that cannot be resolved in such a manner that benefits the client, representation is terminated and non-expended retainer is refunded.

vii See, www.lcplfa.org

viii Working definitions of those terms, and a great deal of the other information regarding veterans’ pension benefits presented later in this article, can be found on the VA’s web site (www.va.gov) at www.vba.va.gov/bln/21/pension/vetpen.htm.

ix 42 U.S.C. §1396p(c)(2)(B) – The “caregiver child exemption” allows transfer of the home of a Medicaid recipient residing in a SNF to his/her adult child who lived with the recipient for at least 2 continuous years and in doing so, delayed nursing home admission, thereby avoiding the execution of a Medicaid lien on the recipient’s home after his/her death under federal and state Estate Recovery laws.

x The term “Medicaid bed” describes one for which the nursing home has agreed to accept the Medicaid reimbursement rate, which is less than its private pay rate, in full payment. Each nursing home decides whether to have beds certified as Medicaid beds, and if so how many. It is an economic decision. An occupied private pay bed produces more revenue than an occupied Medicaid bed, but an empty bed produces no revenue.

xi www.vba.va.gov/bln/21/pension/vetpen.htm

xii The transfer of ownership of residential property to someone who will not occupy it as a residence results in loss of the $250,000 ($500,000 for most married couples) exemption from capital gains tax applicable to the sale of one’s residence under 26 U.S.C. §121.

xiii For example, cashing in an IRA worth $300,000 in order to transfer the proceeds into an irrevocable gift trust would result in the recognition of that much taxable income, likely causing much of that income to be taxed at a high marginal income tax rate.

xiv The Deficit Reduction Act of 2005, P.L. 109-171, Section 6011(a), extended the “look-back” period, the time period within which the state administrative agency that administers the Medicaid vendor (nursing home) program may retroactively consider
assets transferred for less-than-fair market value, thereby giving rise to a period of ineligibility, from three years (five years for transfers to or from a trust) to a uniform five year period.

xv There is an inherent tension in Medicaid planning and VA benefit planning with regard to the asset retention rules in each program. For VA Aid and Attendance eligibility, assets owned by an individual in excess of $50,000 or assets in excess of $80,000 for a married couple must be either transferred out of the owner’s name(s) or an Irrevocable Trust must be created which divests the individual/couple of ownership (the applicant is Grantor but not Trustee). However, under the MO Health Net rules, any transfer of assets for less than fair market value made within five years of an application for vendor benefits will render the applicant ineligible for a period of time. Very often, although the monthly pension available under the VA Aid and Attendance benefit is initially sufficient to supplement the applicant’s monthly income such that their monthly care costs are covered, if the individual requires a more intensive level of care (e.g., skilled nursing care) within five years of the transfer of assets undertaken for VA benefit eligibility) necessitating a MO Health Net application, the planning accomplished to acquire VA benefits may undermine and temporarily prevent MO Health Net eligibility, often resulting in devastating financial consequences.