

MEMORANDUM

TO: AHCA/NCAL Membership

FROM: Dianne De La Mare
VP, Regulatory Affairs

Legal Committee
Finance Committee

SUBJECT: LTC Providers Can Mitigate Potential DRA/Asset Transfer Problems

DATE: January 16, 2007

This memorandum will present a brief overview of the Medicaid asset transfer law and related eligibility provisions in the Deficit Reduction Act of 2005 (DRA). This memorandum also outlines some practical “next steps” that long term care (LTC) providers can consider implementing to mitigate the potential impact of the new rules on their individual businesses. Please note – it is critical that LTC providers consult with local counsel before making any changes to their current processes and procedures as a result of the new federal Medicaid asset transfer and eligibility rules. An attorney familiar with the relevant state law and the facility is the only individual that can determine the full impact of various changes within the facility.

Medicaid Asset Transfer Law:

Under the federal law, states must review a Medicaid applicant’s current countable assets and determine whether the individual has improperly disposed of such assets for less than fair market value. If an applicant has made improper asset transfers within the time period prescribed by the law (lookback period), the state must impose a period of ineligibility (penalty period) on the applicant. An applicant’s penalty period is calculated by dividing the value of the improperly transferred asset by the average monthly cost of institutional nursing care to a private payor in the applicant’s state. If a penalty period is imposed, applicants may file and be granted a request to ignore the penalty period (hardship waiver) under certain circumstances.

The Deficit Reduction Act of 2005 (DRA), signed into law and effective on February 8, 2006, implements significant changes to the Medicaid asset transfer rules. Most significantly, the DRA changes the:

- lookback period, from 3 years to 5 years;
- penalty period from the first day of the month during or after assets are improperly transferred to either the previously stated “old law” or the date the applicant would otherwise be eligible for Medicaid LTC benefits, whichever is later; and
- flexibility that the state’s had in implementing their own hardship waiver process to requiring specific standards that states must follow in implementing their waiver programs. The DRA also extends standing to LTC facilities to file for hardship waivers for a penalized applicant.

Some of the recent DRA changes may be helpful to LTC facilities. For example, the:

- lookback changes may increase the number of Medicaid applicants who are rendered ineligible, and may increase private pay patients;
- penalty period changes may deter individuals from inappropriately transferring assets due to the increased likelihood that they could be disqualified from the Medicaid program; and
- hardship waiver changes will allow LTC facilities to file hardship waivers for residents subject to the penalty period; and will allow states the opportunity to furnish payments of up to 30 days to hold an individual's bed at a facility while the hardship waiver is pending. This "bed-hold" provision, however, does not apply to assisted living facilities.

Some of the recent DRA changes may result in negative outcomes for LTC facilities. For example, the:

- lookback period changes could result in LTC facilities spending additional time/resources upfront during the admission process to investigate/determine the past financial dealings of potential residents;
- penalty period changes could begin when a resident has already been admitted to a LTC facility, leaving LTC facilities with the financial responsibility for caring for these residents while maneuvering through the difficult transfer and discharge regulations; and
- hardship waiver changes will not resolve the potential problems in individual state designs. It also is questionable whether states will take advantage of the opportunity to furnish payments to the LTC providers during a pending hardship waiver, as stated in the DRA.

The Congressional Budget Office (CBO) estimates that the DRA Medicaid asset transfer and related eligibility provisions will reduce federal Medicaid spending by \$21 billion over the next ten years. The government's projected savings, however, will not be realized until at least 3 years+ down the line. Only then can it be determined if the new 5-year lookback period casts a more inclusive net for identifying individuals who have made illegal transfers. The American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL) remain concerned that the projected CBO savings will likely be at the LTC provider's expense. The new Medicaid asset transfer rules make sense in theory and objective, but in the end, it may be the LTC providers who once again are financially responsible for doing what's right for the resident, with little or no help from the government or the resident's family.

To this end, AHCA/NCAL would like to offer some practical suggestions in navigating through the new asset transfer and eligibility provisions under the DRA:

I. Admission Suggestions:

- Prior to admission, carefully evaluate whether the facility can appropriately meet the resident's care requirements. State law is very important here. Some states have laws that make it difficult for facilities to manage their admissions or be selective in this way (*i.e.*, first come, first serve laws).
- Consider including into the facility application or admission process a comprehensive financial screening of potential residents. This will, to some extent, avoid finding out later that a resident has made an improper asset transfer and be penalized while in the facility. Even if an incoming resident or family

member is untruthful in completing the admission documents, that falsification in the admission agreement can help the facility in a subsequent discharge or collections actions.

- To the extent state laws allow, consider revising the facility's current admission agreement to include provisions such as:
 - Consent to access financial information;
 - Consent to apply for Medicaid and/or appeal if family members fail to do so;
 - Name the facility as the responsible payee;
 - Certification of the accuracy of the information in the admission agreement;
 - Payment guarantee from funds of the resident; and
 - Notification of assets, income or change in payor source.

Each state must review and analyze their individual and applicable state laws to determine if the aforementioned provisions can be incorporated into the facility's admission agreement. There will be variances to the law in individual states. That being said, AHCA/NCAL are very grateful to Shelly Peterson, of the AHCA affiliate North Dakota LTC Association (NDLTCA), for ND membership's willingness to share its financial screening document for screening assisted living facility and nursing facility residents. These documents were developed over the last year, and could be used as a "starting point" for other states. Further, NDLTCA has shared both the upside and downside of using this tool. The upside is that NDLTCA has persuaded, to date, 1 of the 6 major hospitals serving their providers to fill out all the financial information in the screening tools before expecting the facility to even look at a hospital discharge. The downside of using this tool, however, may be that the long admission agreement process gets even longer. Please note - The information from AHCA's ND affiliate is guidance only, and not considered to be legally binding. LTC providers must refrain from automatically incorporating these provisions into the facility's admission agreement without a thorough discussion with local counsel.

II. Training Suggestions:

Ensure that the facility staff involved in the financial screening process are trained to understand the DRA changes to the eligibility provisions so that they can accurately identify residents who have improperly transferred assets. The DRA also:

- establishes new rules for the treatment of annuities;
- establishes a cap on the amount of home equity an individual may have and still be eligible for nursing facility or other LTC benefits under Medicaid;
- establishes new rules for Continuing Care Retirement Communities (CCRCs);
- adds to the countable assets; funds used to purchase notes, loans, or mortgages;
- states that a life estate interest in another's home constitutes a countable asset unless the individual resides in the home for a period of at least one year after the date of the purchase; and
- mandates that states use the "income-first" rule in allocating an institutionalized spouse's resources.

For a model template of training materials showing disqualifying transfer of assets go to Oregon Department of Human Services at <http://www.dhs.state.or.us/spd/tools/program/osip/wg7.htm>.

III. Facility Suggestions:

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- Consider the facility's options to discharge and/or transfer penalized residents to the extent permitted by both federal and state laws. In some states, a discharge notice or pending discharge may be required for individual residents to meet the substantive standard for the state hardship waiver. Also, if a discharge is necessary and ends up occurring, it will obviously limit financial responsibility for uncompensated care.
- Seek hardship waivers on behalf of any penalized resident in the facility. This will bring some public attention to the possible impact on LTC facilities when residents are assessed a penalty period while residing in the building. It also will secure LTC facility standing should there be future litigation.
- Maintain records regarding penalized residents, particularly the type and amount of transfers that resulted in penalty periods, and the consequent financial losses incurred by the facility. Any subsequent litigation will require good fact scenarios and affidavit or other testimonial evidence to support the proposition that the LTC facilities are paying the penalty for the improper financial dealings of others.
- Enhance collections. Local counsel can help identify relevant legal theories to pursue including "fraudulent conveyance" laws and other provisions to help the facility get reimbursed. Facilities that use arbitration agreements also may want to consider including collections under arbitration, which is generally a more efficient and less costly than a judicial route.

IV. State Advocacy Suggestions:

- Work with the state Medicaid Director to develop criteria for hardship waivers. In every discussion, the state affiliate should advocate for processes/requirements that offer consumers reasonable protections that are easy to implement for both the state and LTC providers. For example, the DRA does not specifically address the length of a hardship waiver or a financial cap for a hardship waiver. These specifics must be hammered out by the state.
- Review state law with local counsel to determine if statutes incorporating similar language to the North Dakota Code referenced in the NDLTCA financial screening documents are needed. If not already implemented in state law, language that states that facilities can deny admission if they are unable to verify a viable payment source can be very helpful to facilities in mitigating non-payment situations under the DRA. *See North Dakota Code 50-24.1-22, Long Term Care Facility Information* below:

“A long-term care facility may request that an applicant for admission, a resident of the facility, or the applicant's or resident's legal representative furnish financial information regarding income and assets, including information regarding any transfers or assignments of income or assets. A long-term care facility may deny admission to an applicant for admission who is unable to verify a viable payment source.” This section became effective August 1, 2005.

- Consider whether legislation allowing a court or other state entity to “undo” disqualifying transactions or transfers of assets is feasible. Laws that allow a facility to file a court action to undue fraudulent or improper transactions to force payment also can help with DRA non-payment problems.

V. Federal Advocacy Suggestion:

- Pursue legislative options with Congress adding new language to protect nursing facilities and assisted living providers from incurring penalties based on the wrongful acts of 3rd parties. This could include permitting third party guarantees to secure payment in

the event Medicaid denies coverage. Currently, statute (SSA, Sections 1819(c)(5)(A)(ii) and 1919(c)(f)(ii)), as well as regulation (42 CFR) prohibit any 3rd party guarantee of payment to the nursing facility as a condition of admission or expedited admission, or continued stay in the facility. The legislative intent of the 3rd party guarantor prohibitions, however, was to preclude facilities from invoking the guarantee to prevent individuals from applying for Medicaid or requiring that as a condition of admission the resident agrees to be private pay for a certain period of time. AHCA/NCAL believe we may have an opportunity to ask for a “conditional” 3rd party guarantee that would only kick in, if, and only if, the resident applied for Medicaid and was denied as a result of a state's finding that an improper divestment had occurred. The guarantor would guarantee payment to the facility until the penalty expires and the resident qualifies for Medicaid.