HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1289 Medicaid Eligibility
SPONSOR(S): Health & Human Services Quality Subcommittee; Ahern and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1356

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Quality Subcommittee	8 Y, 3 N, As CS	Prater	Calamas
2) Rulemaking & Regulation Subcommittee			
3) Health Care Appropriations Subcommittee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

The bill amends s. 409.902, F.S., relating to Medicaid eligibility.

Currently, some individuals applying for long-term care Medicaid services are using various methods to shelter their assets in order to become eligible for Medicaid.

The bill requires the Department of Children and Families (DCF) to apply additional asset transfer limitations for individuals applying for Medicaid nursing facility services, institutional hospice services, and home and community-based waiver programs.

- The bill provides certain restrictions on personal services contracts, which are used to transfer assets to a family member or caregiver in return for specific services.

- The bill also provides certain conditions that must be met for a spouse that refuses make their financial resources available to the spouse receiving Medicaid long-term care services.

The bill requires the Agency for Health Care Administration (AHCA) to seek recovery of all Medicaid-covered expenses and pursue court-ordered medical support in instances of a spouse refusing to make their resources available to a spouse seeking Medicaid long-term care services.

The bill has a potential significant positive fiscal impact to the state through imposing stricter regulations on eligibility requirements for Medicaid long-term care. The bill directs AHCA to seek recovery of improper Medicaid payments which could require significant Agency resources. See Fiscal Comments.

The bill is effective upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Medicaid Overview

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by AHCA and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including DCF, the Agency for Persons with Disabilities (APD), and the Department of Elderly Affairs (DOEA).

The structure of each state's Medicaid program varies, but what states must pay for are largely determined by the federal government, as a condition of receiving federal funds. Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections.

Florida Medicaid is the second largest single program in the state behind public education, representing 28 percent of the total FY 2010-11 budget. Medicaid general revenue expenditures represent 17 percent of the total General Revenue funds appropriated in FY 2010-11. Florida's program is the 4th largest in the nation, and the 5th largest in terms of expenditures. Current estimates indicate the program will cost $20.3 billion in FY 2011-2012. By FY 2013-2014, the estimated program cost is $23.6 billion.

Medicaid Long-Term Care

Long-term care is currently provided to elderly and disabled Medicaid recipients though nursing home placement and through home and community based services. Home and community based services provide care in a community setting instead of a nursing home or other institution. Home and community based services are provided through six Medicaid waiver programs and one state plan program administered by DOEA in partnership with AHCA. These waiver programs are administered through contracts with the 11 Aging Resource Centers[1] and local service providers, and provide alternative, less restrictive long-term care options for elders who qualify for skilled nursing home care.

The Medicaid eligibility income threshold for institutional care placement, home and community based care services, and hospice services, is 300 percent of the Supplemental Security Income (SSI) federal benefit rate.[2] The current SSI federal benefit rate is $674 for an individual,[3] therefore, individuals with incomes under $2,022 per month are eligible for Medicaid long-term care services.

Medicaid Long-Term Care Planning

A 2009 study by the National Alliance for Caregiving and AARP found that about 43.5 million Americans look after someone age 50 or older, which is a 28 percent increase from 2004.[4] Some individuals, with assistance from financial planners and attorneys, have developed methods of arranging assets in such a way that they are not countable when Medicaid eligibility is determined. Elder law attorneys across the country actively advertise services to assist elderly individuals with

[1] The 2004 Legislature created the Aging Resource Center initiative to reduce fragmentation in the elder services system. To provide easier access to elder services, the Legislature directed DOEA to establish a process to help the 11 area agencies on aging transition to Aging Resource Centers.
[2] Ch. 65A-1.713, F.A.C.
[3] Social Security Administration, *see* http://www.ssa.gov/oact/cola/SSI.html (last viewed on April 2, 2011).
[4] National Alliance for Caregiving in collaboration with AARP, Caregiving in the U.S., Executive Summary, 2009. *See* http://www.caregiving.org/pubs/data.htm (last viewed on April 5, 2011).

personal service contracts and other asset protection methods. For example, the website of a South Florida law firm prominently displays the following sentences on their website:

- "Asset Protection For People With Too Much Income or Assets to Qualify for Government Programs;" and
- "For ten years we have successfully helped families preserve their assets and qualify for Florida Nursing Home Medicaid benefits and Assisted Living public benefits."[5]

Another example is from a 2006 article published by the New York State Bar Association authored by a Florida elder law attorney. The article advises New York attorneys on how to assist their "snowbird" clients. The author states: "…you should know that the spousal refusal option is working well in Florida, although change may be coming. Many Florida spouses today are able to protect themselves from impoverishment by exercising their right of spousal refusal."[6]

Transfer of Assets

According to DCF, some individuals, prior to entering a nursing facility or enrolling in a Medicaid home and community based service waiver program, transfer accumulated assets to a relative through a contract which provides that the relative will provide personal services to the individual for a specified period of time.[7] Current DCF policy does not preclude the transfer of funds to relatives when contracts are drawn up to prepay for future personal services.[8] According to DCF, many of the contracted services incorporated into the contracts are services that close relatives would normally provide without charge such as visitation, transportation, entertainment, and oversight of medical care.[9] If a transfer of assets was made in the form of a personal services contract, within a 36 month (3 year) look back period, DCF must make a determination if the contracted services were for fair market value.[10] The look back period is calculated from the date of application for Medicaid.[11] If a transfer of assets for less than fair market value is found, the state must withhold payment for nursing facility care and other long-term care services for a period of time referred to as the penalty period. The length of the penalty period is determined by dividing the value of the transferred asset by the average monthly private-pay rate for nursing facility care in the state.[12]

Spousal Impoverishment

Section 1924 of the Social Security Act provides requirements to prevent "spousal impoverishment," which can leave the spouse who is still living at home in the community with little or no income or resources.[13] When the couple applies for Medicaid, an assessment of their resources is made and a protected resource amount of $109,560[14] is set aside for the community spouse and the remainder is considered available for the individual applying for Medicaid.[15]

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[5] *See* http://www.buxtonlaw.com/flmedicaidplanning.shtml (last viewed on April 2, 2011).
[6] New York State Bar Association, Elder Law Attorney, Fall 2006, Vol. 16, No. 4. *See* www.elderlawassociates.com/.../snowbirdnews-NYSBA-fall2006.pdf (last viewed on April 4, 2011).
[7] Department of Children and Families, Staff Analysis and Economic Impact, HB 1289 (on file with the Subcommittee).
[8] *Id.*
[9] *Id.*
[10] Department of Children and Families, Policy Manual, 1640.0609.01, Identifying Potential Transfers of Assets or Income (on file with the Subcommittee).
[11] *Id.*
[12] *See* https://www.cms.gov/MedicaidEligibility/10_TransferofAssets.asp (last viewed on April 2, 2011).
[13] Department of Health and Human Services, Centers for Medicare and Medicaid Services, Spousal Impoverishment, *see* https://www.cms.gov/MedicaidEligibility/09_SpousalImpoverishment.asp (last viewed on April 4, 2011).
[14] This is an amount set by the federal government and is contained in the Social Security Act. *See* https://www.cms.gov/MedicaidEligibility/09_SpousalImpoverishment.asp (last viewed on April 3, 2011).
[15] Agency for Health Care Administration, 2011 Bill Analysis & Economic Impact Statement, HB 1289 (on file with the Subcommittee).

Additionally, section 1924 of the Social Security Act[16] provides that an individual applying for Medicaid cannot be determined ineligible for assistance based on assets of their spouse when:

- The applicant assigns his or her rights to support from the community spouse[17] to the state;
- The applicant is physically or mentally unable to assign his right by the state has the right to bring a support proceeding against the community spouse; or
- The state determines the denial of eligibility would work an undue hardship.

According to DCF, when an applicant signs a document assigning his or her rights to the state, the state has the authority to seek financial support from the community spouse for Medicaid funds spent on the spouse of the nursing facility.[18] While DCF indicates that it has authority to seek financial support from the community spouse under these circumstances, there is no mechanism to actually recover funds from the community spouse.[19]

Deficit Reduction Act

The Federal Deficit Reduction Act of 2005(DRA)[20] contained provisions aimed at discouraging the use of "Medicaid planning" techniques and to impose penalties on transactions which are intended to protect wealth while enabling access to public benefits.[21] The Congressional Budget Office (CBO) estimated that the DRA would reduce federal Medicaid spending by $11.5 billion over the first five years and $43.2 billion within ten years. The DRA made changes to:

- Medicaid transfer of asset rules;
- Medicaid annuity rules;
- spousal impoverishment rules;
- home equity rules; and
- rules pertaining to treatment of continuing care retirement community entrance fees.

Transfer of Assets

The Act extended the "look-back period" for any transfers of assets from 36 months to 60 months, on or after February 8, 2006. In addition, the Act changed the start date of the penalty period, which is the period during which and individual is ineligible for Medicaid payment for long-term care services because of a transfer of assets for less than fair market value.[22] The Act changed the start date of the penalty period from the month of the transfer of assets to the date of application for Medicaid.[23]

Spousal Impoverishment

When a couple applies for Medicaid, an assessment of their resources is made and a protected resource amount of $109,560[24] is set aside for the community spouse and the remainder is considered

[16] Social Security Act, Section 1924, Treatment of Income and Resources for Certain Institutionalized Spouses, *see* http://www.ssa.gov/OP_Home/ssact/title19/1924.htm (last viewed on April 4, 2011).
[17] A "community spouse" means the spouse that remains at home or in the community when the other spouse enters nursing facility care. *See* https://www.cms.gov/MedicaidEligibility/09_SpousalImpoverishment.asp (last viewed on April 4, 2011).
[18] Department of Children and Families, Staff Analysis and Economic Impact, HB 1289 (on file with the Subcommittee).
[19] Agency for Health Care Administration, 2011 Bill Analysis & Economic Impact Statement, HB 1289 (on file with the Subcommittee); Department of Children and Families, Staff Analysis and Economic Impact, HB 1289 (on file with the Subcommittee).
[20] P.L. 109-171 (2005).
[21] Department of Health and Human Services, Centers for Medicare and Medicaid, The Deficit Reduction Act: Important Facts for State Government Officials. *See* https://www.cms.gov/**DeficitReductionAct**/Downloads/Checklist1.pdf (last viewed on April 4, 2011).
[22] *Id.*
[23] *Id.*
[24] This is an amount set by the federal government and is contained in the Social Security Act. *See* https://www.cms.gov/MedicaidEligibility/09_SpousalImpoverishment.asp (last viewed on April 3, 2011).

available for the individual applying for Medicaid.[25] This protected amount is known as the Community Spouse Resource Allowance (CSRA). The DRA provided that an increase in the CSRA cannot be granted until the maximum available income of the institutionalized spouse is allocated to the community spouse.[26]

Medicaid Long-Term Care Costs

The average cost of long-term care varies depending on the type of care the individual receives. The statewide average annual cost of nursing home care is $76,876, while hospice care is $53,483. The average cost annual cost of the various home and community based care waivers is $13,471. As of December 2010, there were 103,405 individuals receiving Medicaid long-term care services through nursing homes, hospice, and home and community based waivers.[27]

Recovery of Medicaid-Covered Expenses

Federal regulations[28] and the Florida Third Party Liability (TPL) Act[29] allow for recovery of amounts paid for medical expenses by Medicaid for which there is another liable third party (i.e., the recipient has other insurance coverage, such as private insurance or Medicare). AHCA has a current contract with a Medicaid third party liability vendor, Affiliated Computer Services (ACS). It is the role of the ACS to identify potential third party payors and to recoup from them costs that have been paid by Medicaid.

According to DCF, New York pursues recovery of Medicaid expenses from spouses with some success in select counties. New York's public assistance programs are county-administered. The individual counties have attorneys assigned to the public welfare agency responsible for Medicaid eligibility and each county is responsible for pursuit of the spousal support and recovery of Medicaid-covered expenses.[30]

Effect of Proposed Changes

The bill requires DCF to apply additional asset transfer limitations for individuals applying for Medicaid nursing facility services, institutional hospice services, and home and community-based waiver programs. The new limitations apply to asset transfers made after July 1, 2011.

The bill applies the following new conditions to individuals who enter into personal services contracts:

- The contracted services must not duplicate services that would be available through other sources or providers, such as Medicaid, Medicare, private insurance, or another legally obligated third party;
- The contracted services must directly benefit the individual and are not services that are normally provided out of consideration for the individual;
- The cost to deliver the services must be computed in a manner that reflects the actual number of hours to be expended and the contract must clearly identify each specific service and the average number of hours required to deliver each service each month;
- The hourly rate for each contracted service must be equal to or less than the amount normally charged by a professional who traditionally provides the same or similar services;
- The cost of contracted services must be provided on a prospective basis only and does not apply to services provided before July 1, 2011; and

[25] Agency for Health Care Administration, 2011 Bill Analysis & Economic Impact Statement, HB 1289 (on file with the Subcommittee).
[26] *Id.*
[27] Email from AHCA Medicaid staff, received April 1, 2011 (on file with Subcommittee).
[28] 42 U.S.C. §1396k(a).
[29] S. 409.910, F.S.
[30] Department of Children and Families, Staff Analysis and Economic Impact, HB 1289 (on file with the Subcommittee).

- The contract must provide fair compensation to the individual during her or his lifetime as set forth in the life expectancy tables published by the Office of the Actuary of the Social Security Administration.

The bill applies the following new conditions to a community spouse who refuses to make her or his resources available to the institutional spouse:

- Requiring proof that an estrangement existed between the spouses during the months before the individual submitted an application for institutional care services. If the individuals have not lived separate and apart without cohabitation and without interruption for at least 36 months, all resources of both individuals must be considered to determine eligibility.
- Transfer of assets between spouses that are in excess of the Community Spouse Resource Allowance must be considered. If such a transfer was made within the look back period, it is considered a transfer of assets for less than fair market value and therefore subject to a penalty period.
- An undue hardship does not exist when the individual, or person acting on his or her behalf, transfers resources to the community spouse and the community spouse refuses to make her or his resources available to the institutional spouse.
- The institutional spouse must be determined ineligible for Medicaid if she or he, or the person acting on her or his behalf, refuses to provide information about the community spouse or cooperate in the pursuit of court-ordered medical support or the recovery of Medicaid expenses paid by the state on her or his behalf.

The bill requires AHCA to seek recovery of all Medicaid-covered expenses and pursue court-ordered medical support from the community spouse when she or he refuses to make her or his assets available to the institutional spouse.

The bill provides DCF sufficient rule-making authority to implement the provisions of this bill.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.902, F.S., relating to designated single state agency; payment requirements; program title; release of medical records

Section 2: Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill could result in savings to the state by applying stricter asset transfer limitations for certain individuals applying for nursing facility services under the Medicaid program.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Nursing home and Medicaid waiver providers may experience a positive fiscal impact if a greater number of individuals are required to pay for their care with private pay, rather than Medicaid.

D. FISCAL COMMENTS:

The bill directs AHCA to seek recovery from the community spouse for monies paid by Medicaid on behalf of the eligible recipient which is to be accomplished by pursuing court-ordered medical support from the community spouse. AHCA indicates this pursuit could be accomplished through its contract with a third party liability vendor by amending their current contract. AHCA further indicates that this would require significant information sharing between DCF and AHCA as well as possible investigations into financial activities to determine spousal resources. AHCA states that it is unable to determine the fiscal impact of these changes.[31]

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rule-making authority to DCF to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

AHCA indicates that it does not have the information necessary to identify individuals that are Medicaid eligible due to impoverishment and that the third party liability vendor does not currently receive information regarding assignment of spousal support. Additionally, AHCA indicates that it has little information regarding community spouses in terms of assets and finances, or their current marital status. Additionally, community spouse asset information, for those that have any substantial amounts would quite likely be concealed and would require financial investigations.[32]

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On April 6, 2011, the Health and Human Services Quality Subcommittee adopted one amendment to HB 1289.

The amendment changed the effective date from July 1, 2011 to effective upon becoming law.

The bill was reported favorable as a Committee Substitute. The analysis reflects the Committee Substitute.

[31] Agency for Health Care Administration, 2011 Bill Analysis & Economic Impact Statement, HB 1289 (on file with the Subcommittee).
[32] Agency for Health Care Administration, 2011 Bill Analysis & Economic Impact Statement, HB 1289 (on file with the Subcommittee).