The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	SB 1748
INTRODUCER:	Senator Evers
SUBJECT:	Medicaid Nursing Home Eligibility
DATE:	April 11, 2013
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Peterson	Hendon	CF	**Pre-meeting**
2.			AHS	
3.			AP	
4.				
5.				
6.				

I. Summary:

SB 1748 would limit the use of personal services contracts for individuals who are applying for Medicaid long-term care services. Some applicants shield their assets in order to qualify for Medicaid by contracting with family members to provide personal care. The bill would consider these contracts a transfer of assets without fair compensation under certain circumstances. The bill also directs the Department of Children and Families to pursue court-ordered medical support and reimbursement for services from the spouse of a Medicaid recipient when the Medicaid recipient has assigned his or her right to support to the state, as required by Medicaid eligibility rules.

This bill would have a positive fiscal impact on the state and has an effective date of July 1, 2013.

This bill substantially amends section 409.902 of the Florida Statutes.

II. Present Situation:

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid serves approximately 3.3 million people in Florida, with over half of those being children and adolescents 20 years of age or younger. Medicaid is a partnership between the federal and state governments where the federal government establishes the structure for the program and pays a share of the cost. Each state operates its own Medicaid program under a state plan that must be approved by the federal

Centers for Medicare and Medicaid Services (CMS). The plan outlines current Medicaid eligibility standards, policies, and reimbursement methodologies.

In Florida, the program is administered by the Agency for Health Care Administration (AHCA). AHCA delegates certain functions to other state agencies, including the Department of Children and Families (DCF), the Agency for Persons with Disabilities (APD), and the Department of Elder Affairs (DOEA). AHCA has overall responsibility for the program and qualifies providers, sets payment levels, and pays for services. The DCF is responsible for determining financial eligibility for Medicaid recipients. The APD operates one of the larger waiver programs under Medicaid, the Home and Community Based Waiver program serving individuals with disabilities. The DOEA assesses Medicaid recipients to determine if they require nursing home care. Specifically, an individual:

- Requires nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and requires care to be performed on a daily basis under the direct supervision of a health professional of medically complex services because of mental or physical incapacitation; or
- Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and requires care to be performed on a daily basis under the supervision of a health professional because of mental or physical incapacitation; or
- Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and requires limited care to be performed on a daily basis under the supervision of a health professional because of mild mental or physical incapacitation.

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.[1] The current SSI federal benefit rate is $710 for an individual.[2] Thus, individuals with incomes under $2,130 per month are eligible for Medicaid long-term care services.[3]

The February 25, 2013 Social Services Estimating Conference estimated that expenditures for Medicaid for FY 2012-2013 would be $20.77 billion. One of the most important and expensive components of Medicaid is long-term care. The conference estimated that $4.75 billion will be spent on long-term care under Medicaid in FY 2012-2013.

Long-Term Managed Care

In 2011, the Legislature passed and the Governor signed into law HB 7107 (Chapter 2011-134, Laws of Florida) to increase the use of managed care in Medicaid. The law requires both long-term care services and other Medicaid services to be provided through managed care plans.

[1] Rule 65A-1.713(1)(d), F.A.C.
[2] Social Security Administration, *SSI Federal Payment Amounts for 2013, available at* http://www.ssa.gov/oact/cola/SSI.html (last visited April 10, 2013).
[3] Fla. Dep't. of Children and Families, *SSI-Related Programs Fact Sheets* (April 2013), *available at* http://www.dcf.state.fl.us/programs/access/docs/ssifactsheet.pdf (last visited April 10, 2013).

Long-term Care Managed Care component of the law will be implemented first. Implementation of the program began July 1, 2012 with full implementation by October 1, 2013.

AHCA has chosen the plans that may participate in the program through a competitive bid process. AHCA chose a certain number of long-term care managed care plans for each region to ensure that enrollees in the program to ensure that recipients have a choice between plans. AHCA will now begin to notify and transition eligible Medicaid recipients into the program. It is anticipated that the Florida Long-Term Care Managed Program will be available in certain areas of the State beginning the first quarter of 2013 and will be in all areas by October 1, 2013.[4]

On February 1, 2013, the federal Centers for Medicare and Medicaid Services, approved AHCA's request for a Home and Community Based Care Services waiver for individuals 65 and older and individuals with physical disabilities ages 18 through 64 years old.

Paying for Long-Term Care

Floridians who need nursing home care, but do not qualify for Medicaid, must pay for their care privately or through insurance. According to the 2011 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs, the national average annual cost of a nursing home was $78,110 for a semi-private room in 2011. Individuals who need nursing home care may be ineligible for Medicaid because of their financial assets and/or monthly income. Many individuals paying privately for nursing home care spend their assets and then become eligible for Medicaid. Some, however, have monthly income from pensions and other sources that prevent them from becoming eligible for Medicaid.

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

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. Current DCF policy does not preclude the transfer of funds to relatives when contracts are drawn up to prepay for future personal services. If the contracts are for an amount significantly higher than the rates paid for similar services, however, the person may be attempting to shield assets in order to qualify for Medicaid. DCF indicates

[4] Agency for Health Care Administration website, *Statewide Medicaid Managed Care Program, available at* http://ahca.myflorida.com/ (last visited March 20, 2013).
[5] *See* http://www.buxtonlaw.com/flmedicaidplanning.shtml (last visited April 10, 2013).

that 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. Current law does not contain standards for these contracts or enable DCF to monitor or enforce them to ensure that contracted services are actually provided.[6]

Section 1924 of the Social Security Act contains provisions 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.[7] When a couple applies for Medicaid, an assessment of the couple's resources is made and a protected resource amount of $115,92014 is set aside for the community spouse and the remainder is considered available for the individual applying for Medicaid. This protected amount is known as the Community Spouse Resource Allowance (CSRA). An individual applying for Medicaid cannot be determined ineligible for assistance based on the assets of the individual's spouse when:

- The applicant assigns his or her rights to support from the community spouse 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.[8]

While federal law provides states the authority to seek financial support from the community spouse under these circumstances, DCF indicates no mechanism to recover funds from the community spouse is available in current Florida law.[9]

Federal Deficit Reduction Act of 2005

The Federal Deficit Reduction Act of 2005 (DRA)[10] contained a number of provisions that were intended to discourage the use of planning techniques and transactions which are intended to protect wealth while enabling access to public benefits.

When an individual applies for Medicaid coverage for long-term care, DCF must conduct a review, or "look-back," to determine whether the individual (or his or her spouse) transferred assets to another person or party for less than fair market value (FMV). The DRA lengthened the "look-back period" to 60 months prior to the date the individual applied for Medicaid. When individuals transfer assets at less than FMV they are subject to a penalty that delays the date they can qualify to receive Medicaid long-term care services. Previously the penalty period began with the month the assets were transferred, which created an opportunity for individuals to avoid part or all of a penalty by transferring assets months or years before they actually entered a nursing home. Under the DRA, the penalty period now begins on either the date of the asset transfer, or the date the individual enters a nursing home and is found eligible for coverage of

[6]Fla. Dep't of Children and Families, *Staff Analysis and Economic Impact- SB 1748* (on file with the Senate Committee on Children, Families, and Elder Affairs).
[7]42 U.S.C. 1396r-5(d).
[8]42 U.S.C. 1396r-(5)(c)(3)(C).
[9] *See supra* note 6.
[10] Pub. Law No. 109-171, S.1932, 109th Cong. (Feb. 8, 2006).

institutional level services that Medicaid would pay for were it not for the imposition of a transfer penalty—whichever is later.[11]

III. Effect of Proposed Changes:

Section 1 amends s. 409.902, F.S., relating to eligibility for nursing home care under Medicaid to require DCF, when determining eligibility for Medicaid, to consider a personal services contract as a transferred asset without fair compensation under the following circumstances:

- The contracted services duplicate services available from other sources or providers such as Medicaid, Medicare, or private insurance. Transportation, for example, is a service provided by Medicaid. So a personal services contract for transportation would be duplicative of the services for which the person is eligible.
- The contracted services do not directly benefit the person.
- The contract does not specify the hours worked, the specific service, and how frequently the services will be provided.
- The cost of the contracted services is more than the minimum wage or the amount typically paid in that geographic area for the same service.
- The contract is retrospective and pays for services already provided before the effective date of the bill. To avoid being considered a transfer without fair compensation, the contract would need to be in place before services are provided.
- The contract does not provide fair compensation the individual during his or her expected lifetime.

The bill does not prohibit such contracts, rather it attempts to prevent the abuse of such contracts to qualify for Medicaid.

The bill also addresses the issue of the support of the Medicaid applicant by his or her spouse. The bill states that the applicant for Medicaid shall be ineligible for Medicaid if he or she refuses to provide information about the nonapplicant spouse or does not cooperate in the pursuit of court-ordered medical support or the recovery of Medicaid expenses paid by the state on the applicant's behalf.

The bill requires DCF to pursue support from the spouse of a Medicaid recipient if the nonrecipient spouse refuses to support the recipient spouse and the recipient spouse has assigned his or her right to support to the state.

DCF is authorized to adopt rules necessary to implement the bill.

Section 2 provides an effective date of July 1, 2013.

[11]Dep't. of Health and Human Services, Centers for Medicaid and Medicare Services, *Important Facts for State Policymakers Deficit Reduction Act,* (January 8, 2008), *available at* http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/downloads/TOAbackgrounder.pdf (last visited April 10, 2013).

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Additional nursing home residents will be able to pay for their care privately. Private pay rates are higher than the Medicaid rates so this would have a positive impact on nursing homes. Persons needing nursing home care would find it more difficult to shield their assets in order to gain eligibility to Medicaid.

C. Government Sector Impact:

The bill would have a positive fiscal impact on the state's Medicaid expenditures. The amount is indeterminate.

VI. Technical Deficiencies:

The term "consideration" as used on line 73 is vague. In this context it is not clear whether it is meant to describe the required consideration for a contract, or the familial basis that typically would result in the provision of the services in the absence of a contract.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.