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"AVOIDING PAYMENT PITFALLS: BEST PRACTICES FOR ASSISTED LIVING FACILITY ADMISSIONS, DISCHARGE, COLLECTIONS AND MEDICAID"

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ASSISTED LIVING FACILITIES OVERVIEW

An assisted living facility (ALF) is defined as "a congregate residential setting that provides or coordinates personal care, 24-hour supervision and assistance, both scheduled and unscheduled, and activities and health-related services." Mont. Code Ann. § 50-5-101(7). Medicaid funding is not available to ALFs unless they meet all requirements outlined in Admin. R. Mont. § 37.40.1435. There are three categories of service: Category A, Category B, and Category C. The Administrator is the individual responsible for ensuring residents have 24-hour supervision. § 37.106.2814. The Administrator must meet all qualifications outlined in § 37.106.2814.

Home and community-based services (HCBS), including ALFs, are not generally provided under a state's Medicaid program. 42 C.F.R. §§ 440.180, 181. However, a state may offer HCBSs as an alternative to a standard nursing home by filing a waiver under section 1915(c) of the Social Security Administration Act. 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(VI), 1396n(c)(1). The state must make assurances to the Centers for Medicare and Medicaid Services (CMS) as listed in 43 C.F.R. § 441.352. The state must also provide to CMS the supporting documentation required in § 441.353.

A waiver typically comes with conditions setting out the kind of patient who qualifies and capping the number of available slots. In addition, a waiver must be "cost neutral," at least in the aggregate. A waiver is cost neutral in the aggregate if the cost that a state incurs to treat patients under the waiver, in the aggregate, does not exceed the cost the state would incur to treat the patients without the waiver. *See Lee v. Dudek*, 2012 U.S. Dist. LEXIS 190510, *5 (N.D. Fla. Jan. 3, 2012) (discussing the implications of federal Medicaid waivers).

Montana has a program called MT Big Sky (0148.R05.00). *See* https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-Roadmap/Resources/State-Federal-Relationships/1915c-Waivers-by-State.html#montana. This program allows participating ALFs to receive Medicaid funding. *See* Approved Application [hereinafter "the Application"], *available at* http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html?filterBy=Montana. As of 2009, 167 ALFs and adult foster homes participated under Montana's 1915(c) waiver.[1] The approved application, valid through June 30, 2016, indicates a maximum of 3,200 participants. *See* the Application. Medicaid beneficiaries who are residents at an ALF are referred to as "waiver participants" by the Montana Department of Public Health and Human Services.[2]

[1] Robert L. Mollica, Ed. D., *State Medicaid Reimbursement Policies and Practices in Assisted Living*, Sept. 2009, *available at* http://www.ahcancal.org/ncal/resources/documents/medicaidassistedlivingreport.pdf.
[2] Montana Medical Assistance Policy Manual, AKA Montana Medicaid Manual.

Different Levels of Service/Care

Category A offers basic living assistance. Mont. Code Ann. §50-5-226(2). Category B offers additional health services. § 50-5-226(3). Category C additionally offers mental health services. § 50-5-226(3).

Category A. The following conditions must be met to qualify a resident as Category A:

(a) The resident may not require physical or chemical restraint or confinement in locked quarters, but may consent to the use of safety devices pursuant to Title 50, chapter 5, part 12.

(b) The resident may not have a stage 3 or stage 4 pressure ulcer.

(c) The resident may not have a gastrostomy or jejunostomy tube.

(d) The resident may not require skilled nursing care or other skilled services on a continued basis except for the administration of medications consistent with applicable laws and regulations.

(e) The resident may not be a danger to self or others.

(f) The resident must be able to accomplish activities of daily living with supervision and assistance based on the following:

(i) the resident may not be consistently and totally dependent in four or more activities of daily living as a result of a cognitive or physical impairment; and

(ii) the resident may not have a severe cognitive impairment that renders the resident incapable of expressing needs or making basic care decisions. Mont. Code Ann. § 50-5-226(2).

Category B. The following conditions must be met to qualify a resident as Category B:

(a) The resident may require skilled nursing care or other services for more than 30 days for an incident, for more than 120 days a year that may be provided or arranged for by either the facility or the resident, and as provided for in the facility agreement.

(b) The resident may be consistently and totally dependent in more than four activities of daily living.

(c) The resident may not require physical or chemical restraint or confinement in locked quarters, but may consent to the use of safety devices pursuant to Title 50, chapter 5, part 12.

(d) The resident may not be a danger to self or others.

(e) The resident must have a practitioner's written order for admission as a category B resident and written orders for care.

(f) The resident must have a signed health care assessment, renewed on a quarterly basis by a licensed health care professional who:

(i) actually visited the facility within the calendar quarter covered by the assessment;

(ii) has certified that the particular needs of the resident can be adequately met in the facility; and

(iii) has certified that there has been no significant change in health care status that would require another level of care. §50-5-226(3).

Category C. The following conditions must be met to qualify a resident as Category C:

(a) The resident has a severe cognitive impairment that renders the resident incapable of expressing needs or of making basic care decisions.

(b) The resident may be at risk for leaving the facility without regard for personal safety.

(c) Except as provided in subsection (4)(b), the resident may not be a danger to self or others.

(d) The resident may not require physical or chemical restraint or confinement in locked quarters, but may consent to the use of safety devices pursuant to Title 50, chapter 5, part 12. § 50-5-226(4).

I. ADMISSIONS TO AN ASSISTED LIVING FACILITY[3]

Unlike nursing homes, ALFs are not governed by federal government but are instead state regulated.[4] The Montana Department of Public Health and Human Services (the Department) regulates ALFs in Montana.[5]

A. Admissions to ALF The state regulations are broad with respect to admissions standards and are silent as to what steps an assisted living facility may take to secure sufficient

[3] This section refers to the rules and regulations generally applicable to ALFs. However, if an ALF receives Medicaid under a state waiver program, it appears that an ALF would be cautious to apply general Medicaid rules pertaining to ALFs.

[4] For further discussion regarding the lack of federal oversight for ALFs, *see* Center for Medicare Advocacy, *Is It Time for Federal Regulation of the Assisted Living Industry?*, Sept. 10, 2013, *available at* http://www.medicareadvocacy.org/old-site/News/Archives/SNF_07_03.22.AssLivRegulation.htm.

[5] The Montana Landlord-Tenant Act does not apply to assisted living facilities. *See* Mont. Code Ann. § 70-24-104 excluding "residence at a public or private institution if incidental to detention or the provision of medical . . . service" from the arrangements the Act applies to.

payment. The regulations require an assisted living facility to "develop a written application procedure for admission to the facility which includes the prospective resident's name and address, sex, date of birth, marital status, and religious affiliation (if volunteered)." Admin. R. Mont. § 37.106.2821(1). Montana administrative rules regarding admissions do permit the collection of a security deposit and late fees. Admin. R. Mont. § 37.106.2823(1)(e) and (f). Montana's Administrative Rule on Residency Agreements is as follows:

37.106.2823. RESIDENT AGREEMENT

(1) An assisted living facility shall enter into a written resident agreement with each prospective resident prior to admission to the assisted living facility. The agreement shall be signed and dated by a facility representative and the prospective resident or the resident's legal representative. The facility shall provide the prospective resident or the resident's legal representative and the resident's practitioner, if applicable, a copy of the agreement and shall explain the agreement to them. The agreement shall include at least the following items:

(a) the criteria for requiring transfer or discharge of the resident to another level of care;

(b) a statement explaining the availability of skilled nursing or other professional services from a third party provider to a resident in the facility;

(c) the extent that specific assistance will be provided by the facility as specified in the resident service plan;

(d) a statement explaining the resident's responsibilities including but not limited to house rules, the facility grievance policy, facility smoking policy and policies regarding pets;

(e) a listing of specific charges to be incurred for the resident's care, frequency of payment, facility rules relating to nonpayment of services and security deposits, if any are required;

(f) a statement of all charges, fines, penalties or late fees that shall be assessed against the resident;

(g) a statement that the agreed upon facility rate shall not be changed unless 30 day advance written notice is given to the resident and/or the resident's legal representative; and

(h) an explanation of the assisted living facility's policy for refunding payment in the event of the resident's absence, discharge or transfer from the facility and the facility's policy for refunding security deposits.

(2) When there are changes in services, financial arrangements, or in requirements governing the resident's conduct and care, a new resident/provider agreement must be executed or the original agreement must be updated by addendum and signed and dated by the resident or the resident's legal representative and by the facility representative.

B. Admissions to Nursing Homes.

On the other hand, nursing home admissions are subject to both state and federal regulation.

Federal laws provide certain admissions requirements for nursing homes under the Nursing Home Reform Act (NHRA), 42 U.S.C. § 1395i-3; 42 U.S.C. § 1396r; corresponding regulations at 42 C.F.R. § 483 *et seq*. Montana Code adopts these federal regulations and provides other rights under the Montana Long-Term Care Residents' Bill of Rights (Mont. Code Ann. §§ 50-5-1101 *et seq*.), but the state law generally applies to residents rights during residency and does not add requirements for admission.

C. Increasing at the outset the right to future payment by an ALF.

Based upon the lack of regulation, Montana law does not specifically bar an ALF from:

- Requiring a third party guaranty as a condition of admission.
- Requiring a resident to submit a detailed financial statement. Financial information may include:
  - Bank account information
  - Asset list
  - Financial statement
  - Credit check
  - Such information could be used as a source of payment in the event the resident later refuses payment.
- Requiring a security deposit.
- Requiring a lien on assets.

D. Increasing at the outset the right to future payment by a nursing home.

On the other hand, as discussed below, skilled nursing facilities are generally:

- Not permitted to require a third party guaranty as a condition of admission.[6]

[6] 42 U.S.C. § 1396r(c)(5)(A)(ii)

- Permitted to require patients to submit detailed financial information as a condition of admission is permissible, so long as such information is not used for the purpose of discriminating against Medicaid patients.[7]
- Not permitted to require a deposit as a condition of admission for Medicaid recipients.[8] However if the resident is not qualified to have their stay covered by medicare or medicaid at the time of admission then the SNF may require a security deposit as a condition of admission, even if the resident's medicaid eligibility is pending.
- No permitted to require a lien as a condition of admission from resides qualified for Medicaid. However no language in 42 U.S.C. §1396r(c) or 42 C.F.R. § 483.12(d) appears to prohibit nursing homes from requiring such a lien from private pay residents.

What the nursing home can require of the applicant:

1. Third-party guarantees:

   Federal law expressly prohibits any nursing home participating in Medicaid from requiring guarantees as a condition of admission or extended care. "With respect to admissions practices, a skilled nursing facility must ... not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility."[9]

2. Responsible Party Provisions:

   a. Skilled nursing facilities may, however, require "an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care." [10]

   b. Otherwise, responsible party provisions must not be a requirement for admission to a Medicaid/Medicare approved facility. *Manahawkin Convalescent v. O'Neill*, 85 A.3d 947, 959 (N.J. 2014); *see also Sunrise Corp. v. Azarigian*, 821 A.2d 835, 808, (Conn. App. Ct. 2003) (holding that a responsible party provision did not violate the third-party guarantee provision because "the responsibly party does not personally guarantee or serve as surety for payment" as described by law).

   c. When a third-party signs an admission contract as a "Responsible Party" courts may or may not uphold the contract and require the third-party to pay

[7] 42 U.S.C. § 1396r(c)(5)(A)(i)
[8] Robert J. Fogg, *CMS Clarifies Resident Pre-Admission Deposit Rules*, 11 No. 11 Nursing Home Regulations Manuel Newsl. 4, (2004) (citing 42 C.F.R. 483.12 (d)(3)).
[9] 42 U.S.C. § 1395i-3(c)(5)(A)(ii); 42 U.S.C. § 1396r(c)(5)(A)(ii); 42 C.F.R. 483.12(d)(2)
[10] 42 U.S.C. § 1395i-3(c)(5)(B)(ii)

for unpaid care. *Compare* *Holloway v. Riley's Oak Hill Manor, Inc.*, 139 S.W.3d 144, 84 Ark. App. 301, 2002 WL 31259803 (Ark. Ct. App. 2002)(holding that an adult son was contractually bound to pay for elderly mother's nursing home care by signing his name on the "Responsible Party" line of the admissions document, which provided "the patient and/or responsible party agrees to pay a daily rate of [blank] and the Nursing home will accept this agreement in full consideration for care and services rendered.") *with* Special Care Nursing Services, Inc. v. Fox, 1998 Mass.App. Div. 30, 1998 WL 61902 (Mass. App. Div. 1998) (holding that an adult granddaughter was not contractually bound by signing the "Responsible Party" line even when the admission document stated "I agree to assume responsibility for and guarantee the payment of any and all sums that become due [to the extent not paid by insurance, Medicare, or Medicaid].").

3. Deposits:

    a. Deposits permitted. Nursing homes may charge deposits or require promissory notes only from a resident whose stay is not financed by Medicare or Medicaid.

    b. Deposits not permitted. Federal regulation states: "In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, **or other consideration** as a precondition of admission, expedited admission, or continued stay in the facility." 42 C.F.R. § 483.12(d)(3)(emphasis added); *see also* 42 U.S.C. § 1396r(c)(5)(A)(iii).

    c. If the resident is qualified to receive Medicaid benefits at the time of admission then a nursing facility is not allowed to require a security deposit. Robert J. Fogg, *CMS Clarifies Resident Pre-Admission Deposit Rules*, 11 No. 11 Nursing Home Reg. Manual Newsletter 4 (2004)(citing 42 C.F.R. § 483.12(d)(3)). Similarly, if a resident is eligible to have Medicare pay for a part of their stay at the time of admission the nursing facility cannot charge a deposit. *Id.* (citing 42 C.F.R. § 489.22). However, if the resident is not qualified to have their stay covered by medicare or medicaid at the time of admission then the nursing facility may require a security deposit as a condition of admission, even if the resident's medicaid eligibility is pending. *Id.*

4. No Waiver of Right to Apply for Medicaid or Medicare.

    a. The nursing home cannot "require residents or potential residents to waive their rights to Medicare or Medicaid." 42 C.F.R. § 483.12

    b. The nursing home cannot "require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits." 42 C.F.R. § 483.12

5. Collateral.

"In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission, or continued stay in the facility."[11]

Nothing in the admission requirements of either 42 U.S.C. § 1396r(c)(5) or 42 C.F.R. § 483.12(d) expressly prohibit a nursing home from requiring a lien as a condition of admission. However, the above-cited language of 42 U.S.C. § 1396r(c)(5)(A)(iii), which has been interpreted by CMS as prohibiting a skilled nursing facility from requiring a security deposit from residents qualified for medicaid, would also likely prohibit the requiring a lien if the resident is qualified for medicaid at the time of admission. However no language in 42 U.S.C. §1396r(c) or 42 C.F.R. § 483.12(d) appears to prohibit nursing homes from requiring such a lien from private pay residents.

Therefore, for a private pay resident, there is no prohibition to a nursing home requiring collateral to secure payments owed.

6. Financial information.

We have not been able to locate a specific statute or regulation that bars the nursing home from requiring a potential applicant to provide the nursing home financial information in advance of admission, provided such information is not used for acquiring assurance that the resident will not apply for or be eligible for medicaid benefits. The nursing home could use financial information to identify potential pitfalls that may be anticipated for Medicaid approval, such as assets and recent transfers.

Financial information may include:

- Bank account information
- Asset list
- Financial statement
- Credit check

Such information could be used as a source of payment in the event the resident later refuses payment.

7. Personal representative.

Federal law provides that Medicare and Medicaid qualified facilities may "requir[e] an individual, who has legal access to a resident's income or resources available to pay for

[11] 42 C.F.R. § 483.12(d)(3); *see also* 42 U.S.C. § 1396r(c)(5)(A)(iii).

care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care."[12]

Case law allows for facilities to collect from representatives that have legal access to a resident's income or resources if the representative has misappropriated the funds for personal gain. [13]

However, when a patient is receiving Medicaid assistance, Medicaid guidelines for skilled nursing facilities should be observed.

E. The Importance of Admission Agreements for ALFs.

Written admission agreements are required under state law. Requirements include:

1. the criteria for requiring transfer or discharge of the resident to another level of care;
2. a statement explaining the availability of skilled nursing or other professional services from a third party provider to a resident in the facility;
3. the extent that specific assistance will be provided by the facility as specified in the resident service plan;
4. a statement explaining the resident's responsibilities including but not limited to house rules, the facility grievance policy, facility smoking policy and policies regarding pets;
5. a listing of specific charges to be incurred for the resident's care, frequency of payment, facility rules relating to nonpayment of services and security deposits, if any are required;
6. a statement of all charges, fines, penalties or late fees that shall be assessed against the resident;
7. a statement that the agreed upon facility rate shall not be changed unless 30 day advance written notice is given to the resident and/or the resident's legal representative; and
8. an explanation of the assisted living facility's policy for refunding payment in the event of the resident's absence, discharge or transfer from the facility and the facility's policy for refunding security deposits.
9. When there are changes in services, financial arrangements, or in requirements governing the resident's conduct and care, a new resident/provider agreement must be executed or the original agreement must be updated by addendum and signed and dated by the resident or the resident's legal representative and by the facility representative.[14]

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[12] 42 U.S.C. § 1395i-3(c)(5)(B)(ii); 42 U.S.C. § 1396r(c)(5)(B)(ii); *see also* 42 C.F.R. § 483.12(d)(2) (2002).
[13] *Leonard Nursing Home Inc. v. Kay*, No. 45-1-2002-1242, 2003 WL 1571579, *2-3 (N.Y. Sup. Ct. Mar. 13, 2003); *see also Pioneer Ridge Nursing Facility Operations L.L.C. v. Ermey*, 203 P.3d 4, 7 (Kan. App. 2009).
[14] ARM § 37.106.2823.

F. Essential Elements of a Contract in Montana

1. Montana Code Annotated, § 28-2-102 requires:
    a. Identifiable parties capable of contracting;
    b. Their consent;
    c. A lawful object; and
    d. A sufficient cause or consideration.
        (1) Consideration is "[a]ny benefit conferred or agreed to be conferred upon the promisor by any other person, to which the promisor is not lawfully entitled, or any prejudice suffered or agreed to be suffered by the person, other than prejudice that the person is at the time of consent lawfully bound to suffer, as an inducement to the promisor is a good consideration for a promise."[15]

2. Ambiguity – will be construed against drafter of the contract. The ALF is the drafter.[16]

3. Adhesion Contracts/ Unconscionability - If a clause in a contract is unconscionable, it will not be enforced. *Arrowhead School District No. 75 v. Klyap*, 2003 MT 294, 318 Mont. 103, 79 P. 3d 250, (involving a liquidated damages clause when a teacher prematurely terminated his employment contract). There is a two-prong analysis as to whether a clause in a contract is unconscionable:
    a. Clause must occur in a "contract of adhesion" – i.e. the weaker party has no meaningful choice regarding acceptance of the contract provisions. No contract of adhesion, no unconscionability.
    b. If there is a contract of adhesion the contractual terms must be unreasonably favorable to the drafter, who usually has superior bargaining power.
        (1) Whether the clause is unreasonably favorable to the drafter in turn involves an inquiry into whether the clause is within the reasonable expectations of or unduly oppressive to the weaker party. In *Kortum-Managhan v. Herbergers NBGL*, 2009 MT 79, 349 Mont. 475, 204 P. 3d 693, this second prong was expanded to include, in determining "reasonable expectations", whether the clause is unduly oppressive, unconscionable or against public policy.

4. Key terms and provisions of an admission agreement:
    - Attorney fees (must be reciprocal, Mont. Code Ann. § 28-3-704)
    - Interest
    - Responsible parties

[15] Mont. Code Ann. § 28-2-801.
[16] Mont. Code Ann. § 28-3-306

- Rates
- Date of admission
- Services to be provided
- Residents rights and responsibilities
- Resident Trust Account
- Establish mental capacity of resident and guardianship
- Court jurisdiction or venue terms.
- Arbitration terms.

II. DISCHARGE FROM AN ASSISTED LIVING FACILITY

Assisted living facilities reserve the right to discharge residents upon certain circumstances. Admin. R. Mont. § 37.106.2824. ALFs are required to give residents a 30 day notice when they are requested to move out. The regulations provide that the administrator shall initiate transfer of a resident in following circumstances:

(a) the resident's needs exceed the level of assisted daily living services the facility provides;

(b) the resident exhibits behavior or actions that repeatedly and substantially interfere with the rights, health, safety or well being of other residents and the facility has tried prudent and reasonable interventions;

(i) documentation of the interventions attempted by the facility shall become part of the resident's record;

(c) the resident, due to severe cognitive decline, is not able to respond to verbal instructions, recognize danger, make basic care decisions, express needs or summon assistance, except as permitted by ARM 37.106.2891 through 37.106.2898;

(d) the resident has a medical condition that is complex, unstable or unpredictable and treatment cannot be appropriately developed in the assisted living environment;

(e) the resident has had a significant change in condition that requires medical or psychiatric treatment outside the facility and at the time the resident is to be discharged from that setting to move back into the assisted living facility, appropriate facility staff have re-evaluated the resident's needs and have determined the resident's needs exceed the facility's level of service. Temporary absence for medical treatment is not considered a move out; or

(f) the resident has failed to pay charges after reasonable and appropriate notice. *Id.*

Thus, an ALF is only required to give "reasonable and appropriate notice" of charges due before involuntarily discharging a resident.

Right to a Fair Hearing before the Department of Public Health and Human Services. A resident does have the right to a fair hearing to contest an involuntary transfer or discharge. § 37.106.2829(4). To exercise this right, the resident must mail a written request; however, the resident will be involuntary discharged or transferred during the pendency of a hearing, absent a showing of "good cause." § 37.106.2829(4)(b)-(e).

For purposes of comparison, I have provided the discharge rules that pertain to nursing homes.

DISCHARGE FROM NURSING HOMES

A. FEDERAL AND STATE REGULATIONS

Federal laws provide certain requirements for transfer and discharge from a nursing home. Montana Code adopts these federal statutes and regulations and provides other rights under the Montana Long-Term Care Residents' Bill of Rights (Mont. Code Ann. §§ 50-5-1101 *et seq.*), but the state law generally applies to residents' rights during residency and does not add requirements for discharge.

B. PROHIBITIONS TO TRANSFER OR DISCHARGE

A Medicare certified nursing home shall not transfer or seek to evict resident due to resident changing from private pay or Medicare.[17]

C. APPROPRIATE REASONS FOR DISCHARGE OR TRANSFER

1. The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;[18]

2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;[19]

3. The safety of individuals in the facility is endangered;[20]

4. The health of individuals in the facility would otherwise be endangered;[21]

[17] 42 C.F.R. §483.12(c)(1).
[18] 42 U.S.C. §1395i-3(c)(2)(A)(i); 42 U.S.C. §1396r(c)(2)(A)(i); 42 C.F.R. §483.12(a)(2)(i)
[19] 42 U.S.C. §1395i-3(c)(2)(A)(ii); 42 U.S.C. §1396r(c)(2)(A)(ii); 42 C.F.R. §483.12(a)(2)(ii)
[20] 42 U.S.C. §1395i-3(c)(2)(A)(iii); 42 U.S.C. §1396r(c)(2)(A)(iii); 42 C.F.R. §483.12(a)(2)(iii)
[21] 42 U.S.C. §1395i-3(c)(2)(A)(iv); 42 U.S.C. §1396r(c)(2)(A)(iv); 42 C.F.R. §483.12(a)(2)(iv)

5. The resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this subchapter or subchapter XVIII of this chapter on the resident's behalf) for a stay at the facility [language from 42 USC § 1396r];[22] or

6. The facility ceases to operate.[23]

D. PATIENTS RIGHTS BEFORE AND UPON DISCHARGE

1. Right to Notice:

1. Transfer or discharge must be ordered in writing by a physician, if the discharge is related to the health, welfare, or safety of the resident.[24]

2. Nursing home must give the resident, family member and legal representative advance notice of the transfer or discharge as soon as practicable.[25]

3. Any transfer or discharge requires 30 days written notice, except for when the health or safety of other individuals would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, the resident's urgent medical needs require a more immediate transfer or discharge, or the resident has resided in the facility less than 30 days.[26]

4. Notice of transfer or discharge must include:

(1) The reason for the discharge;

(2) The location to which the resident will be discharged;

(3) If the resident has developmental disabilities, the contact information of the agency responsible for the resident's protection and advocacy;

(4) If the resident is mentally ill, the contact information of the agency responsible for the resident's protection and advocacy; and

(5) A statement that the resident has the right to appeal with the name, address and telephone number of the Licensing & Certification District Office, and contact information for the long term care ombudsman.[27] In Montana, appeals of involuntary discharge are filed with the Montana Department of Public Health and Human Services, Office of Fair Hearings.[28]

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[22] 42 U.S.C. §1395i-3(c)(2)(A)(v); 42 U.S.C. §1396r(c)(2)(A)(v); 42 C.F.R. §483.12(a)(2)(v);
[23] 42 U.S.C. §1395i-3(c)(2)(A)(vi); 42 U.S.C. §1396r(c)(2)(A)(vi); 42 C.F.R. §483.12(a)(2)(vi)
[24] 42 U.S.C. §1395i-3(c)(2)(A); 42 U.S.C. §1396r(c)(2)(A); 42 C.F.R. §483.12(a)(3)
[25] 42 U.S.C. §1395i-3(c)(2)(B)(i), (ii); 42 U.S.C. §1396r(c)(2)(B)(i),(ii); 42 C.F.R. §483.10(b)(10)(i)(D), §483.12(a)(4).
[26] 42 U.S.C. §1395i-3(c)(2)(B)(i),(ii); 42 U.S.C. §1396r(c)(2)(B)(i), (ii); 42 C.F.R. §483.12(a)(4), (5); ARM § 37.106.2824.
[27] 42 U.S.C. §1395i-3(c)(2)(B)(iii); 42 U.S.C. §1396r(c)(2)(B)(iii); 42 C.F.R. §483.12(a)(6).
[28] ARM § 37.106.2824(4)(b).

2. Right to a Safe and Orderly Transfer:

A skilled nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.[29]

3. Right to Appeal:

Upon request by the resident or representative, the state must conduct appeal hearings that comply with federal requirements.[30] Montana requirements for appeal of an involuntary discharge are found in ARM § 37.106.2824.

4. Right to Preparation of Residents Prior to Transfer or Discharge:

1. Nursing home must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.[31]

2. Nursing home must develop a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.[32]

5. Right to Readmission After Hospitalization or Leave of Absence/Therapeutic Leave:

1. Right to receive a written bed-hold notice when transferred to the hospital; nursing home must offer its next available bed to resident upon hospital discharge if it doesn't comply.[33]

2. Right to pay to hold bed for up to 7 days during hospitalization and immediate readmission upon discharge.[34]

3. Resident on Medicaid has the right to be readmitted to the first available bed in a semiprivate room if the hospital stay exceeds 7 days.[35]

E. WHEN TO DISCHARGE RESIDENTS

1. Internal decisions. The nursing home should have an internal decision process to determine when it would seek to discharge a resident. Such decision process must include compliance with statutory requirements discussed above.

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[29] 42 U.S.C. § 1395i-3(c)(2)(C).
[30] 42 U.S.C. §1396r(e)(3) & (f)(3); 42 C.F.R. §483.200 et seq.; 42 C.F.R. §483.12(a)(2).
[31] 42 C.F.R. §483.12(a)(7)
[32] 42 C.F.R. §483.20(l).
[33] 42 C.F.R. § 483.12(b)(2).
[34] 42 C.F.R. 483.12(b).
[35] 42 C.F.R. § 483.12(b)(3).

2. Courts may be hesitant to approve involuntary discharge:

1. "The involuntary transfer or discharge of a nursing facility resident must be the last resort."[36]

F. WHAT TO DO WHEN NO ONE WILL TAKE RESPONSIBILITY FOR THE RESIDENT

If there is no authorized representative, such as a spouse, power of attorney or guardian and conservator, the nursing home may be compelled to take the following steps:

1. Move for the appointment of guardian and conservator. Often this will be a concerned family member.

2. If no family member will serve, Adult Protective Services may be willing to serve. At times, it may be compelled to serve as a guardian. Montana law provides:

> Mont. Code Ann. § 72-5-312(5): If the court determines that there is no qualified person willing and able to serve as guardian, the court may appoint an agency of the state or federal government that is authorized or required by statute to provide services to the person or to persons suffering from the kind of disability from which the incapacitated person is suffering or a designee of the agency, notwithstanding the provisions of subsection (4). Whenever an agency is appointed guardian, the court may also appoint a limited guardian to represent a specified interest of the incapacitated person. Whenever a limited guardian is appointed pursuant to this subsection, the specified interest of the incapacitated person is the sole responsibility of the limited guardian and is removed from the responsibility of the agency.

III. COLLECTIONS: WHAT TO DO WHEN A RESIDENT'S BILL IS NOT BEING PAID

The law provides assisted living facilities and related businesses several different tools to collect unpaid debts. From simple collection letters to lawsuits to pre-admission planning, assisted living facilities administrators should know their options to efficiently collect what is owed. This section highlights various processes that an assisted living facilities may consider in collecting past due accounts.

The likelihood of recovering on any given debt often turns on two questions: 1) Who is liable? and, 2) How strong is my claim against that person? The larger the group of potentially liable parties the greater the chance of recovery. The easier it is to establish liability, the easier it is to collect. For example, a breach of contract is easier and less expensive than establishing a

[36] *Matter of Involuntary Discharge or Transfer of J.S. by Hall*, 512 N.W.2d 604, 612 (Minn.App.,1994).

complex fraudulent transfer claim. Keeping these principles in mind pre-admission and during a resident's stay will help assisted living facilities maximize their recovery.

A. Liens

When assisted living facilities clients initially contact us about past due accounts, one common request is that they wish us to "file a lien" on a resident's property to secure the unpaid debt. Unfortunately, in Montana, there isn't a simple process for "filing a lien" without the consent of the resident.

1. No automatic liens for assisted living facilities

   Some industries receive a lien or security interest as a matter of law upon the providing of a service. A lien, or security interest, "is a charge imposed . . . upon specific property by which it is made security for the performance of an act."[37]

   For example, liens may arise as a matter of law, without the consent of the debtor, for unpaid construction projects, unpaid fertilizer and pesticide purchases and for storage of items.

   Certain health care providers are granted a lien to pay for services provided (i.e. physician, nurse, ambulance service). However, an assisted living facility is not specifically listed as a beneficiary of such lien.[38] In certain specific factual situations, assisted living facilities may be able to assert health care providers' liens, but assisted living facilities should consult legal counsel in those situations. In addition, the lien is limited to "services rendered or products provided . . . to a person injured through the fault or neglect of another."[39] Moreover, the lien only encumbers certain types of property, such a cause of action that the injured person might have, a judgment that the injured person may receive, and money paid in satisfaction of the judgment or settlement of the claim.[40]

   Unfortunately for the assisted living facilities, outside of limited situations under the health care providers' lien statutes, there is no lien that can just be filed unilaterally by the assisted living facilities. Instead, for the assisted living facilities, there are only two options for placing a lien on a resident's property: (i) a consensual lien, or (2) a judgment lien.

2. Consensual liens

   A consensual lien requires the consent of the resident (or their power of attorney/fiduciary). Consensual liens include mortgages or trust indentures to

[37] Mont. Code Ann. § 71-3-101(2).
[38] Mont. Code Ann. § 71-3-1114(1)(a).
[39] Mont. Code Ann. § 71-3-1114.
[40] Mont. Code Ann. § 71-3-1114(1)(b).

encumber land, or security interests to encumber personal property, such as cars and equipment.[41]

At or prior to admission, consider whether the resident has an interest in property and whether a lien on that property makes sense in the event of non-payment. We strongly recommend involving an attorney whenever considering asking a resident to grant a consensual lien, **especially if the resident is applying for or receiving Medicaid**.

a. Real Property (i.e. homes, condominiums, lots, etc…). For this type of property, you may be able to obtain a mortgage or trust deed granting your facility a lien. Depending on the value of the property and whether other creditors already have liens on the property, these types of consensual liens can provide significant security.

b. Personal Property (vehicles, equipment, investments). Residents can grant you a security interest in their personal property. For most types of personal property, a written document called a "security agreement" is required. The resident has to be: 1) given value for granting the security interest, 2) have rights in the collateral, and 3) sign the security agreement. The security agreement will describe the specific property you take an interest in.

Whether you are taking an interest in real property or personal property, your lien needs to be "perfected" by filing it with the appropriate governmental agency. This essentially gives notice to the world that you have an interest in the property and reserves your place in line if you have to foreclose your interest.
While holding a lien certainly provides a measure of leverage and some security for the facility, it does not automatically result in payment. To take the property or sell it, you will need to involve an attorney and "foreclose" your lien – a process that may or may not involve a lawsuit.

***Key point**: Mortgages, trust indentures and UCC security interests must be agreed to in writing by the resident. The assisted living facilities cannot force the resident to sign the lien documents. As a practical matter, consensual liens are probably best secured at or before the time of admission. Later in the relationship, the resident may feel less incentive to voluntarily grant a lien.*

3. Judgment liens

A judgment obtained from a district court in Montana acts as a lien upon real property of the judgment debtor in the county in which the judgment is filed. Generally, judgment liens are effective for a period of ten years after the entry of judgment.[42] Judgment liens are junior in priority to other liens of record at the time the judgment lien attaches to the real property, including previously recorded bank mortgages.

[41] See Uniform Commercial Code, Article 9]; Mont. Code Ann. §30-9A-101, et. seq.
[42] Mont. Code Ann. § 25-9-301(2).

Judgment debtors may make a declaration that real property is their homestead and therefore up to $250,000 in equity is exempt and out of the reach of creditors. This homestead exemption, as a practical matter, makes it difficult to sell a home to pay off a judgment. However, the judgment lien will encumber the home so that if the home is ever sold, the judgment lien will be paid at closing to the extent possible.

With a judgment, the judgment creditor can also levy upon personal property of the judgment debtor.

***Key point**: Judgments can be difficult to collect and costly to obtain. Judgments only arise after you've brought a lawsuit against the resident. We will discuss this in greater detail below. Because of Montana's high homestead exemption amount, judgments may lay dormant for many years and many often go unsatisfied.*

B. Traditional Collection Agencies

Delinquent accounts may be assigned to collection agencies.

C. Collection Letters

1. What are collection letters?

   Collection letters, also called demand letters, are letters sent to the person or persons responsible for payment of a debt. The letter should set forth the amount owed, the basis for the debt and a demand to pay.

2. Who should send?

   Initially, the assisted living facilities may wish to send its own internal collection letters. Some assisted living facilities find it helpful to engage an attorney to send a collection letter. For some recipients, the added seriousness of the lawyer's letterhead will motivate payment. An attorney's demand letter must comply with federal and state law known as the Fair Debt Collections Practices Act, which limits what can be included in the letter and requires certain disclosures pertaining to a debtor's rights. For example, threats, foul language, deadlines, and misstatements are not permitted.

3. When to send?

   The assisted living facilities should determine a policy of when it will send internal collection letters. For example, it may send a letter when payment is 60 days late and again when payment is 90 days late. Assisted living facilities typically involve an attorney after multiple efforts to collect internally are not effective. The assisted living facilities should balance the cost and effectiveness of attorney collection letters when considering when to engage an attorney to send a collection letter.

4. To whom to send?

   The collection letter should be sent to the resident and anyone liable for the care of the resident, including guardians, conservators, power of attorneys and other fiduciaries.

5. Effectiveness.

   The effectiveness of sending collection letters varies on the circumstances of the resident. Internal collection letters have little downside since they are inexpensive to produce. External collection letters sent to legal counsel, while more expensive, often produces results since it effectively shows the resident that the facility takes the matter seriously. Additionally, involving an attorney early in the process enables a facility to consider all of its collections options.

D. Third Party Liability for Unpaid Accounts

Besides the resident, other people may be liable for unpaid accounts. Each situation should be analyzed to determine if another person could be pursued for payment. A few third parties who may be potentially liable are:

- Spouse
- Child
- Power-of-attorney
- Guardian
- Conservator
- "Gift" Recipients and other Transferees

1. Admission agreement liability

   The assisted living facilities, with the assistance of legal counsel if desired, should determine whether a responsible party can be held liable under the terms of an admission agreement. **Watch out for provisions that require third-party guaranty agreements for Medicaid recipients, which are prohibited under federal law!**

   a. Fiduciary liability

      The assisted living facilities, with the assistance of legal counsel, should determine whether a power of attorney, guardian, conservator or other fiduciary may be liable.

      For example, generally a conservator is not individually liable for contracts she enters into in her fiduciary capacity. [43] However, she may voluntarily contract to be liable and may also be liable if she is personally at fault or has committed some form of tort.

[43] Mont. Code Ann. § 72-5-436.

(i.e. *Jane is conservator of her mother's estate because her mother is disabled. On behalf of her mother, Jane arranges for care at an assisted living facility and signs an admission agreement. Jane tells the assisted living facility that her mother's estate has plenty of money to pay for care. After admission, Jane leaves town with what money was left in her mother's estate. Jane may have committed fraud by telling the assisted living facility that payment would be made from her mother's assets and she could be "personally at fault" for keeping her mother at the facility when she knew there was no money to pay for care.*)

Often times in admission agreements, a "responsible party" promises to use the resident's resources to pay the assisted living facilities. If that responsible party then fails to do so, she may be liable. In one example, a daughter who acted as her mother's power of attorney, was held responsible for her mother's care.[44] Her liability did not stem from a prohibited guaranty provision in the admissions agreement, but rather from her failure to abide by her own separate promise to preserve her mother's assets for assisted living facilities care. The case serves as an example of a power of attorney being held liable.

Another example is when a guardian fails to make a timely application for Medicaid.

2. Spousal liability

Montana law permits recovery against a spouse who fails to provide for the other spouse's necessary support. Relevant statutes are:

a. Mont. Code Ann. § 40-2-103. Support of spouse.

"If a married person who is able neglects to make adequate provision for the financial support of the person's spouse, except in the cases mentioned in 40-2-104, any other person may in good faith supply the spouse with articles necessary for support and recover the reasonable value of the articles from the married person who has failed to provide support."

b. Mont. Code Ann. § 40-2-106. Liability for acts or debts of spouse.

"A husband or wife, solely on the basis of being a spouse, is not answerable for the acts of the other spouse or liable for the debts contracted by the other spouse, except that the expenses for necessities of the family and of the education of the spouses' children are chargeable upon the property of both the husband and wife, or either of them, and in relation to those expenses, the husband and wife may be sued jointly or separately."

[44] *Sunrise Healthcare Corp.* v. *Azarigian*, 821 A.2d 835 (Conn. App. Ct. 2003).

3. Child liability

Several states, including Montana, have "family responsibility statutes" that purport to hold children liable for supporting their parents. In Montana, these statutes have not been interpreted to create the "automatic" liability they suggest – particularly in regards to nursing homes. The same may hold true for assisted living facilities. However, they do support finding a child liable when he or she voluntarily promises to pay for his parent's care.

a. Mont. Code Ann. § 40-6-214. Reciprocal duties of parents and children in maintaining each other.

> "It is the duty of the father, the mother, and the children of any poor person who is unable to provide self-maintenance by work to maintain that person to the extent of their ability. **The promise of an adult child to pay for necessaries previously furnished to that parent is binding**."

In 2003, a nursing home argued that this statute required an adult daughter to be personally liable for her mother's nursing home debt.[45] The Montana Supreme Court disagreed and held that the first sentence of the statute did not create automatic personal liability for the daughter.

However, the Court did find that the daughter had verbally promised to personally make payments for her mother's care. Thus, while the nursing home couldn't force the daughter to pay the mother's debt, the nursing home could sue the daughter for breaching her own separate promise to pay, which under the statute, was binding. The lesson of this case is that it is possible to have children voluntarily agree to pay. *As a best practice, nursing homes should document conversations where children talk about payment or agree to make payments.*

b. Mont. Code Ann. § 40-6-301. Duty of child to support indigent parents.

> "It is the duty of every adult child, having the financial ability, to furnish and provide necessary food, clothing, shelter, medical attendance, and burial, entombment, or cremation costs for an indigent parent, unless, in the judgment of the court or jury, the child is excused by reason of intemperance, indolence, immorality, or profligacy of the parent."

However, this section may only be enforced by a child (against a sibling when there are multiple children), a parent that is owed the support, or by the county attorney.[46] The Montana Supreme Court has held that nursing homes cannot use this statute to seek payment.

[45] *Vencor, Inc. v. Gray*, 315 Mont. 537, ¶¶ 22 – 31, 66 P.3d 323 (2003)(unpublished opinion).
[46] Mont. Code Ann. § 40-6-303; *Vencor, Inc. v. Gray*, 315 Mont. 537, 66 P.3d 323 (2003).

4. Nursing Home Reform Act

Skilled nursing facilities (including nursing homes) accepting Medicare and Medicaid assisted residents are governed by the NHRA.[47] This federal law prohibits skilled nursing facilities from requiring a third party guarantee of payment to its facility as a condition of admission to, or continued stay in, its facility.[48] This prohibition applies to *both* Medicaid and private-paying residents. But, a facility may require an individual who has legal access to a resident's income or resources, to sign a contract (without incurring personal financial liability) to provide payment form the resident's income or resources for care.[49]

For example, you cannot condition a resident's admission on her son's promise to personally pay for care. But, you can require that son to make payment from his mother's assets if he is her guardian or her attorney-in-fact. Any personal guarantee that the son will pay for his mother's care would need to be voluntarily given. What about "responsible party" signatures in admission agreements? In some scenarios, this may extend contractual liability to third parties. However, some courts have equated "responsible party" with "guarantor." Please review your admissions agreements, paying close attention to what third parties are signing. More on this under *Admissions Agreements*.

5. Uniform Fraudulent Transfers Act.

Montana's Uniform Fraudulent Transfers Act[50] is a flexible tool that may be used to collect debts. There is a broad range of possible property interests that residents may have transferred to a family member or friend. (i.e. cash, pension income, CDs, stocks, real estate, business interests, personal property, granting a joint interest in property, etc…). Unfortunately, elderly individuals are also often fraud victims when guardians, children, or others transfer assets away.

a. Consider whether:

(1) Residents or their representatives transferred assets away from the resident without receiving a reasonably equivalent value in return;

(2) Residents actually intended to hinder, delay, or defraud the facility's collection of the debt;

(3) The resident was about to engage in a transaction (i.e. admission) and was left with an unreasonably small amount of assets in relation to the transaction after the transfer (i.e. no money to pay for care);

(4) The resident intended to incur, or reasonably should have believed that he would incur, debts beyond his ability to pay as they became due.

[47] 42 U.S.C. § 1396a(28)(a).
[48] 42 U.S.C. § 1396r(c)(5).
[49] 42 U.S.C. § 1396r(c)(5)(B)(ii); *see also* 42 C.F.R. § 483.12(d)(2).
[50] Mont. Code Ann. § 31-2-333.

b. Using Montana's Uniform Fraudulent Transfers Act to collect a debt requires litigation assisted living centers would have to prove that a transfer was fraudulent. However, in certain scenarios, the Act can be an effective tool that provides assisted living facilities several remedies. Given the prevalence of transfers as residents and their families prepare for admission and the occurrence of transfers after admission, assisted living facilities should be mindful of the Act.

E. Bringing a Legal Action

This outline focuses on collection of delinquent accounts through legal action involving residents of assisted living facilities who have gone into default on their obligations.

The assisted living facilities should determine through its internal procedures that an overdue account is appropriate for legal action. This outline assumes that the assisted living facilities has completed its internal review and has properly sent the matter to its counsel for legal action.

1. Legal Terminology

In order to avoid confusion and to aid in the proper understanding of the legal process between the assisted living facilities and its counsel, it is important to be familiar with certain terms commonly used in a legal action. The following is a non-exhaustive list of terms that will help the assisted living facilities understand the various processes and status of a legal action:

a. Plaintiff. A plaintiff is the person bringing the legal action. For purposes of this outline, the plaintiff is the assisted living facility.

b. Defendant. It is the party against whom a legal action is brought. The defendant must defend the legal action.

c. Complaint. A complaint is the original or initial pleading filed with the court by which a legal action is commenced. It is a legal document that outlines the factual background of the matter and the factual basis for a cause of action, asserts the cause of action against the defendant and makes a request upon the court to take certain action, such as entering a judgment against the defendant for a specific dollar amount.

d. Summons. The summons is an instrument issued by the court and directs the sheriff or other person qualified to effectuate service of process, requiring him to notify the defendant that a legal action has been brought against him, and that he is required to appear by a specified time to answer the allegations alleged in the complaint.

e. Service of Process. Service of process involves delivering a copy of the complaint and summons to the defendant. Typically, the complaint and summons must be personally delivered to the defendant before the court can

assume jurisdiction over the defendant and render a decision in the matter. Service of process is most often accomplished by the County Sheriff's Department or a private process server. Neither the assisted living facilities, nor its employees, nor its attorneys can serve the complaint and summons on a defendant, but must utilize a third party to accomplish service of process.

Service of process upon an incapacitated person brings its own challenges.

Mont. R. Civ. P. 4(h), - Serving an Incompetent Person.

(1) An incompetent person who has been adjudged of unsound mind by a Montana court or for whom a guardian has been appointed in Montana by reason of incompetency may be served by delivering a copy of the summons and complaint to the person's guardian, if such guardian resides in Montana, was appointed under Montana law, and is acting under Montana law. If there be no such guardian, the court must appoint a guardian ad litem for the incompetent person.

(2) When a party is alleged to be of unsound mind, but has not been so adjudged by a Montana court, process may be served personally upon that party.

(3) The court may also stay any action pending against a person on learning that such person is of unsound mind.

A power of attorney may also be the basis for service of process upon the fiduciary.[51]

f. Answer. An answer is the response by the defendant(s) to the plaintiff's complaint, and is filed with the court. The answer responds to the facts asserted in the complaint, and states the defendant's defenses.

g. Default. If a defendant fails to answer the complaint or otherwise appear and defend against the legal action within the time allowed by law (typically 21 days from the date the defendant was served with the complaint and summons), the defendant is in default. The clerk of court is authorized to enter the default of the defendant in the record. A default is not the same as a default judgment.

h. Default Judgment. A judgment entered against a defendant who has failed to appear or otherwise defend the legal action.

i. Summary Judgment: A mechanism that allows for the prompt resolution of legal action under certain circumstances. A request for summary judgment may be made after an answer is filed. A summary judgment is available where the relevant facts are not in dispute and the applicable law supports the entry of judgment in favor of one of the parties.

j. Judgment: The final decision of the trial court.

[51] See, Mont. R. Civ. P. 4(a)(2). The term "person" includes an "individual's agent or personal representative."

k. Deficiency Judgment: A judgment in favor of a creditor for the difference between the amount of the indebtedness and the amount derived from a sale held in order to satisfy the indebtedness.

l. Writ of Execution: A formal written command issued by the Clerk of District Court to satisfy a judgment from property of the judgment debtor.

m. Writ of Garnishment: A formal written command to satisfy a judgment from property of the judgment debtor that is in the possession of a third party, such as wages owing to the judgment debtor.

n. Judgment Lien. In Montana, a judgment lien automatically attaches to all real property owned by the judgment debtor located in the county where the judgment is issued and where the judgment is docketed (filed with the district court).

o. Exemptions from Execution. A privilege allowed by law to a judgment debtor, by which he may retain property to a certain amount free from all liability to levy and sale on execution, attachment and bankruptcy.

p. Satisfaction of Judgment. Once a judgment debt has been paid in full, an entry must be made in the court record indicating that the judgment has been satisfied.

2. Filing the Lawsuit

a. Initially, the assisted living facility should make a determination, through its internal procedures, of whether a matter should be referred to counsel for legal action. If the matter is referred to counsel, the assisted living facility should compile all relevant documents related to the account, including any agreements with the resident or third parties and any relevant correspondence or communications with the resident or related third parties.

b. File Review and Preparing the Complaint. The assisted living facility's file consisting of admission agreement, invoices and correspondence between the assisted living facility and the resident should be sent to counsel for review to determine if the documents are in order. If issues exist, it is better to address them prior to filing a legal action. Addressing the issues prior to the filing of a legal action may provide the only opportunity to remedy deficiencies contained in the assisted living facility's file or that are related to the claim. Additionally, counsel will need to review the file in order to prepare the complaint, and will typically attach copies of the admission agreement and invoices (redacted to protect privacy) as exhibits to the complaint.

c. Service of Defendant. Once the complaint is prepared and filed with the clerk of court and the summons is issued, counsel must send the documents to the sheriff or a process server for service upon the defendant. In order to avoid delays in service of process, it is important to have a current address for the defendant or defendants.

d. Procedure After Service of Process. Once the defendant has been served with the summons and complaint, he has 21 days to file an answer or otherwise make an appearance in the action. If the defendant fails to do so, the assisted living facility may file a request with the clerk of court for the entry of default. Once default has been entered, the assisted living facility may file a motion for the entry of default judgment against the defendant.

e. If the defendant files an answer, it should be reviewed with the assisted living facility in order to respond to the arguments and claims made by the defendant. If a counterclaim is brought by the defendant against the assisted living facility, the assisted living facility will have 21 days to file an answer to the same. Again, the counterclaim should be reviewed with the assisted living facility in order to respond to the allegations contained therein.

f. Summary Judgment. If the defendant files an answer, the legal action will have to be decided by the court based upon testimony, evidence and legal arguments. If the operative facts are not in dispute, and if case law supports the assisted living facility, a motion for summary judgment will typically be filed. A summary judgment is often considered an extreme remedy by a trial court as it deprives the parties of a trial on the merits. Summary judgment is most appropriate if there is no reasonable dispute regarding the facts of the case. The motion will be supported by affidavits of assisted living facility personnel substantiating the facts of the case. The court may require a hearing on the motion for summary judgment.

g. Discovery. If the defendant answers the lawsuit and it cannot be disposed of by summary judgment, counsel may need to conduct discovery. Discovery is the act or process of revealing facts and developing evidence by seeking the answers to questions about the defendant's defenses or counterclaims. The primary discovery devices are interrogatories, depositions, requests for admissions and requests for production. Interrogatories are written questions that the defendant is required to answer under oath. Generally, a deposition is the oral questioning of a witness by a lawyer in the presence of a court reporter, with answers given by the witness under oath. A request for admission is a written factual statement served on the other party who must admit, deny, or object to the substance of the statement. A request for production is a written request that another party provide specified documents or other tangible things for inspection or copying. The use of the subpoena power is also available to a litigant, which provides the right to require the production of documents or compel attendance at a deposition. A subpoena may be used by a party in its dealings with non-parties.

h. Disposition of the Lawsuit. The following is a non-exhaustive summary of the various processes for resolving the legal action.

(1) Default Judgment. If the defendant does not answer or otherwise appear in the legal action within 21 days of service, the assisted living facility can receive a judgment by default. This involves filing the following documents: Request for Entry of Default, Entry of Default, Affidavit of

Attorney, Motion for Default Judgment, Affidavit in Support of Attorney Fees and Costs and Judgment.

(2) Dispositive Motions. If the defendant answers the complaint, counsel will evaluate the various options available for resolving the matter. If the answer fails to deny the allegations of the complaint, the allegations are deemed admitted and counsel may file a motion for judgment on the pleadings or a motion for summary judgment.

(3) Motion for judgment on the pleadings occurs when the defendant fails to deny the allegations or answers in a way that from the face of the pleadings, taken in the light most favorable to the defendants, the assisted living facility is still entitled to judgment.

(4) A motion for summary judgment can be used only if the material facts are not contested and the assisted living facility is entitled to judgment as a matter of law. The motion is typically supported with an affidavit of the facts as prepared by the attorney and discovery responses, if needed. In Montana, a motion for summary judgment usually involves a court hearing.

3. Trial

If facts are disputed, the case cannot be resolved without a trial. The court sets a scheduling conference and sets a trial date. Unless a jury is requested by a party at the time the complaint is filed (in the case of the plaintiff) or at the time of the answer (filed by the defendant), the trial will be heard by just the judge, who will be sitting as the trier of fact and the trier of law. The assisted living facility will need to provide an appropriate witness or witnesses at trial. The witnesses will need to establish the validity of the various documents maintained in the assisted living facility's file, including the admission agreement, verify the amount owed, verify the default by the resident, and refute any allegations made by the defendant.

4. Settlement

The vast majority of disputes and lawsuits are settled prior to a trial. Often, parties will engage in alternative dispute resolution (ADR) in an effort to attempt resolution of the lawsuit. ADR encompasses many processes of dispute resolution, which includes negotiation and mediation. Mediation is a nonbinding dispute resolution process involving a neutral third party selected by the parties who assists the disputing parties to reach a mutually agreeable solution. Many, if not the vast majority, of Montana District Court judges require parties to mediate prior to the setting of a trial date.

5. Judgment

After the motion for default judgment, judgment on the pleadings, summary judgment or trial, the court enters a judgment (hopefully in favor of the assisted living facility).

The judgment gives the assisted living facility the right to collect by using the authority of the law to enforce the debt.

F. Collection of Judgment

Once judgment is entered, it is the assisted living facility's right to collect on the judgment through writs of execution and garnishment. Judgment collection may be more difficult than obtaining the judgment and is entirely dependent on the judgment debtor's ability to pay or the available assets owned by the judgment debtor. Under Montana law, the judgment creditor is tasked with the obligation to locate assets and to seize these assets to satisfy the judgment. The judgment debtor does not automatically pay a judgment. In many cases, the judgment creditor must zealously pursue its collection remedies if it ever hopes to recover any payment of the judgment.

1. The difficulty of collecting a judgment is one reason that an assisted living facility may, in making a business decision, decide not to commence legal action.

2. A writ of execution is a command from the court to the sheriff or levying officer directing that the officer seize (levy) property in the possession of the judgment debtor. A writ of garnishment is a command from the court to the sheriff or levying officer directing that the officer seize (levy) property of the judgment debtor that is in possession of a third party. Typically, the easiest assets to levy are bank accounts and wages. Wages are likely not an available asset for an assisted living facility resident. Counsel will need the name of the bank and account number, if possible, and a social security number when seeking to execute upon bank accounts. Other property a judgment creditor attempt to execute and levy upon includes real estate, vehicles and any other articles of personal property. If property is seized through execution and levy, the sheriff will sell the property at a public sale, after posting notice of sale. In Montana, a judgment lien automatically attaches to all real property owned by the judgment debtor located in the county where the judgment is issued.

3. Exemptions from Execution. Exemptions are statutory rights provided to a judgment debtor, wherein the judgment debtor may retain certain property or a fixed sum free from all liability and free from the reach of a judgment creditor. Examples of property exempt under Montana law include professionally prescribed health aids for the judgment debtor, benefits the judgment debtor has received or is entitled to receive under federal social security or local public assistance legislation, veteran's benefits, disability or illness benefits, contributions made to qualifying retirement accounts prior to the lawsuit, benefits paid or payable for medical care or which will be used for such care, maintenance and child support, a burial plot for the judgment debtor and the judgment debtor's family, and interest in any un-matured life insurance contracts.[52] A judgment debtor is also permitted to exempt certain personal property up to a certain dollar amount.[53] In addition to the exemptions provided by

[52] Mont. Code Ann. § 25-13-608.
[53] Mont. Code Ann. § 25-13-609.

Montana law, federal law places limits on the amount of wages subject to garnishment.

4. Debtor's Examinations and Post-Judgment Discovery. A judgment creditor may conduct an examination a judgment debtor concerning the location and extent of his assets. The debtor's examination is done for the purpose of identifying assets to seize under a writ of execution. The judgment creditor is able to subpoena documents such as the judgment debtor's bank and tax records. A debtor's examination requires a court order in which the court appoints a referee to oversee the debtor's exam. The referee before whom the debtor's examination is taken may be, depending on the practice of each district court, a justice of the peace, court reporter, or law clerk. The cost of the debtor's examination will also need to be taken into account as attorneys' fees will be expended for preparing the motion for debtor's examination, subpoena and conducting the examination. The fees must be compared to the possibility that assets will, or won't, be recovered to satisfy a judgment.

5. Other Collection Considerations. In a situation involving a third party responsible for the debts or obligations of a resident, there may be other considerations that should be taken into account when determining the scope or the means of attempts to collect. Bankruptcy is one of these considerations and should be analyzed prior to undertaking the first step of collection. A debtor in bankruptcy may discharge certain debts and eliminate a creditor's ability to collect. Additionally, a debtor may strip a judgment lien from real property if such liens "impair" an exemption. Impairment occurs when a debtor is unable to utilize the full extent of an exemption. For example, if there is no equity remaining after first applying the $250,000 homestead exemption, the judgment lien would have no value and could be stripped so that the effectiveness of the judgment lien would not continue after the bankruptcy.

6. Additionally, the timing of efforts to execute and attempt collection after the entry of judgment should be done with a view toward a preferential transfer action, which may be initiated by the bankruptcy trustee or the debtor in a bankruptcy proceeding. Under the United States Bankruptcy Code, a lien that attaches to property within the 90 days prior to the filing of a bankruptcy petition may be considered a preference, which means one creditor is preferred over other creditors. If the attachment of the judgment lien is found to fall within that 90 day period prior to filing, the bankruptcy court has the authority to strip the lien and render the judgment unsecured.

G. Probate Collections

When the resident passes away, the assisted living facility may be able to collect from the probate estate of the deceased resident. However, a probate estate may not be filed in all instances. For example, if the descendent left behind insufficient assets or no real estate, consultation with legal counsel can determine if a probate should have been opened and whether the assisted living facility can demand that a probate is opened.

1. Issues in collecting against a probate estate include:

a. When a probate is opened. The assisted living facility should receive a Notice to File Claims. The claim must be filed within four months of the notice date.[54] The estate will then decide whether to allow or disallow the claim. A claim that is disallowed in whole or in part by the personal representative is barred so far as it is not allowed unless the claimant files a petition for allowance in the court or commences a proceeding against the personal representative not later than 60 days after the mailing of the notice of disallowance or partial allowance if the notice warns the claimant of the impending bar. If a petition for allowance is filed, the court will proceed with a hearing and evidence related to the validity of the claim is presented by the assisted living facility. If the claim is allowed, the assisted living facility would be provided with a distribution from the estate to satisfy the claim.

b. When no probate is opened. The assisted living facility, as a creditor, is entitled to open a probate on behalf of the decedent.[55] The assisted living facility must be appointed by the court and will be required to value and distribute property. This could be a time consuming and expensive endeavor.

c. Lawsuits. Lawsuits against a probate estate must typically be filed no later than one year after death.[56] However, if a claim is disallowed, the lawsuit must be filed with 60 days of disallowance.[57]

d. Exempt assets. The decedent's estate is entitled to $48,000 in assets before the Bank would be entitled to payment. This includes $20,000 for a homestead[58], $10,000 in property and personal effects[59], and a family allowance of up to $18,000.[60]

e. Priority of creditors. If the assisted living facility is owed an unsecured debt, it will be paid after most other creditors of the estate, in the following priority (Mont. Code Ann. § 72-3-807):

(1) Costs and expenses of administration;

(2) Reasonable funeral expenses and reasonable and necessary medical and hospital expenses of the last illness of the decedent, including compensation of persons attending the decedent;

(3) Federal estate and Montana state estate taxes;

(4) Debt for a current support obligation and past-due support for the decedent's children pursuant to a support order as defined in Mont. Code Ann. § 40-5-201;

(5) Debts with preference under federal and Montana law;

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[54] Mont. Code Ann. § 72-3-801.
[55] Mont. Code Ann. § 72-3-502.
[56] Mont. Code Ann. § 72-3-801.
[57] Mont. Code Ann. § 72-3-804.
[58] Mont. Code Ann. § 72-2-412.
[59] Mont. Code Ann. § 72-2-413.
[60] Mont. Code Ann. § 72-2-414.

(6) Other federal and Montana state taxes;

(7) All other claims.

2. Probate estate recovery

a. Estate Recovery: In Montana, the Department of Health and Human Services may recover Medicaid-covered expenses, including payment for assisted living facility residents.[61] In such cases, Medicaid will file a creditor's claim against the estate of a deceased Medicaid recipient. *Id.*

b. Exemptions: Medicaid will not collect if recipient has a surviving:

(1) Spouse;

(2) Child under 21 years of age; or

(3) Child who is blind or disabled.[62]

c. DPHHS does not normally recover on property owned by joint tenants unless the property is being sold.[63]

3. Liens

The Medicaid program will place a lien, with 30 days notice, against real property owned by a Medicaid recipient who resides in a nursing home.[64]

a. Exemptions: A lien filed against a Medicaid recipient may not be enforced when the home is occupied by a:

(1) Spouse;

(2) Child under the age of 21;

(3) Blind or disabled child;

(4) Sibling who has ownership in the home and has resided in the home for at least 12 continuous months immediately prior to recipient's admittance to the nursing home; or

(5) Sibling who has resided in the home for at least 18 continuous months prior to the recipient's admittance to the nursing home.[65]

b. Amount: the total will be calculated upon recipient's death, will include the expense paid for long term service, and cannot exceed the total value of the liened property.[66]

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[61] MA 1401-1; *see* Mont. Code Ann. § 53-6-167.
[62] MA 1401-1.
[63] MA 1401-1.
[64] MA 1402-1; *see* Mont. Code Ann. § 53-6-171.
[65] MA 1402-1.
[66] MA 1402-1.

IV. APPLYING FOR MEDICAID

MA = Medical Assistance Policy Manual, a/k/a The Montana Medicaid Manual
Facility = Assisted Living Facility

A. APPLYING

1. Who is Applying?

   The patient or most likely their agent (guardian or power of attorney) should be responsible for applying for Medicaid. The Facility can assist with the application, but ultimate responsibility should rest with the resident. This point should be verbalized to the resident and their family and also made clear in the admission agreement to avoid the family claiming that the Facility is later at fault for not making a timely application.

2. Cooperation of Resident

   Because ultimate responsibility for applying for Medicaid rests with the resident or their agent, it is important that the admission agreement impress upon the resident the importance of cooperating timely with Medicaid. We see many denials issued simply because the requested explanations and documentation are not timely provided.

3. Assignment of Rights to Facility

   The admission agreement should grant the Facility the option of appealing a denial of Medicaid benefits as resident's authorized representative. This can increase the Facility's options for collecting from Medicaid after a denial, especially if denial was due to the resident's agent lack of cooperation.

4. Timing

   The "Gap" Issue:

   a. We frequently see Facilities admit residents who plan to qualify for Medicaid but are still "over resourced" upon admittance to the Facility. After a few months, the resident has spent all their remaining resources either for services at the Facility or other qualified expenses, and they have applied for Medicaid. However, several months may pass before Medicaid issues a decision, despite the MA deadline of 90 days for a decision (or 45 days if there has already been a preadmission screening that determines medical need). During this time, the Facility is providing services in hopes of being paid by Medicaid. For whatever reason, when Medicaid decides to start paying, they often decide the resident's eligibility date is later than when the

resident ran out of assets. This causes a "gap" where the Facility has no payor source. This issue is pervasive across the state and we have seen the gap be several months long.

b. An understanding of the timing issues can help eliminate the "gap" issue faced by many Facilities.

5. Application Process.

a. Resource Assessments (MA 1001-1) – Medicaid conducts a "Resource Assessment " of the assets owned individually or jointly by members of a married couple on the first day of the month of Facility admission for a continuous period of participation to determine the CSRMA.

(1) A "continuous period of participation" consists of 30 or more consecutive days of expected participation in the Waiver program, which may include days of prior hospitalization or skilled nursing facility placement.

(2) The Resource Assessment is simply a snapshot of the couples' countable assets on that date.

(3) Only one Resource Assessment will be completed for each spouse, even if a Waiver Spouse leaves the program and is later re-enrolled. However, a Resource Assessment can only be completed when one member of the couple has already begun participation.

(4) The Resource Assessment can be completed before actually completing the Medicaid application.

(5) The amount of the CSRMA is the <u>greater</u> of:

(a) One-half, not to exceed $117,240, of the couple's combined countable resources as determined by the Resource Assessment;

(b) Montana's minimum resource maintenance allowance of $23,448;

(c) An amount designated by a hearings officer; or

(d) An amount that has been court ordered.

(6) The CSRMA does <u>not</u> change after the Resource Assessment has been completed regardless of future assets accumulated or received by the Community Spouse. However, the CSIMA may be re-adjusted if the additional assets would generate income.

(7) Within 90 days after applicant has achieved eligibility, all resources which will make up the CSRMA must be legally transferred to the Community Spouse.

b. Calculating the Spend Down – In order to obtain Medicaid eligibility for the Waiver Spouse, and consequently achieve the CSRMA for the Community Spouse, the couple's combined countable resources, as determined on the Resource Assessment date, must be "spent down" until either the maximum or

minimum limits are reached. Once the CSRMA is known, the Waiver Spouse's countable resources should be calculated as follows:

Couples combined countable resources
- CSRMA
= Waiver Spouse's countable resources

The Waiver Spouse will be resource eligible when the couple's combined countable resources do not exceed the individual resource limit ($2,000) plus the CSRMA, for a maximum of $119,240.

Examples:

No. 1:	Combined countable resources	$ 30,000.00
	CSRMA	(23,448.00)
	Resources available to inst. spouse	$ 6,552.00

The Waiver Spouse will be resource eligible when combined countable resources do not exceed $25,448 (CSRMA of $23,448 plus the Waiver Spouse's $2,000).

No. 2:	Combined countable resources	$ 100,000.00
	CSRMA	(50,000.00)
	Resources available to inst. spouse	$ 50,000.00

The Waiver Spouse will be eligible when combined countable resources do not exceed $52,000 (CSRMA of $50,000 plus the Waiver Spouse's $2,000).

No. 3:	Combined countable resources	$ 250,000.00
	CSRMA	(119,240.00)
	Resources available to inst. Spouse	$ 130,760.00

The Waiver Spouse will be eligible when combined countable resources do not exceed $119,240 (CSRMA of $117,240 plus the Waiver Spouse's $2,000).

Planning Point: *Because all resources owned by revocable trusts are countable—including resources that if personally owned would otherwise be excluded (i.e. personal residence)—it may be beneficial to clients by having otherwise excludable resources in the revocable trust in order to increase the CSRMA.*

Examples:

No. 1: A couple owns a $200,000 personal residence and a cumulative $100,000 in other resources in a revocable living trust—resulting in

$300,000 of countable resources. When one spouse is admitted to a Facility, the $300,000 of countable resources owned by the trust results in maxing out the $119,240 CSRMA. After the admission to the Facility that establishes the Resource Assessment and CSRMA at $119,240, the home would be transferred to be personally owned by the community spouse—resulting in an excludable $200,000 residence and $100,000 in other countable resources. The day the $200,000 residence is changed from a countable, trust-owned property, to an excludable, personally owned property, the CSRMA has been met.

No. 2: Single residents must still complete the resource assessment, but because they are not concerned with establishing a CSRMA the resource assessment can be provided at the same time as the application during the month in which the resident is eligible.

c. Application

The Application itself again asks for a snapshot of the resident's (and spouse's) assets, but the values should be as close as possible to the date of the Application. The Application also requests information about the incomes of the resident and their spouse.

Medicaid is supposed to make an eligibility determination within 90 days for applications requiring a disability determination and within 45 days for all other applications (see below regarding importance pre-screening determination to trigger the 45 day time frame). MA 103-1, page 3. However, these time frames are for all practical purposes purely aspirational. Medicaid's failure to abide by the time frames has no negative repercussion for Medicaid. It's not like you can take your business elsewhere if Medicaid is too slow in making a decision.

The application should be heavily documented to increase the likelihood that Medicaid will make a timely decision. Every number on both the Resource Assessment and Application should have a document to support it.

The application should be submitted during the month in which the resident is eligible, or it will be denied and a new application must be submitted later. Because of the time lags involved in the application process, a resident submitting an application when eligibility will clearly be denied will result in the "gap" issue referred to above. The facility can greatly increase its chances of being paid timely by Medicaid by ensuring the applicant is eligible when they submit the application. If a resident is eligible on the last day of the month, they are eligible for the whole month.

V. DETERMINING ELIGIBILITY FOR MEDICAID

A. HOME & COMMUNITY BASED SERVICES/WAIVER PROGRAMS

The Medicaid eligibility criteria for those in assisted living facilities are substantially the same as criteria for those in skilled nursing facilities. The overarching difference being that Medicaid for individuals in assisted living facilities falls under the Home & Community Based Services Waiver Program. This program, unlike Medicaid for skilled nursing facilities, has only a limited number of slots available in each type of Waiver program.

The Waiver program that Facility residents are most likely to qualify for is the Aged Waiver. Individuals over the age of 65 who are also physically disabled may qualify the Aged Waiver. Waiver services are designed to allow elderly clients to remain in the community rather than be placed in institutional/skilled nursing facilities.

B. PREADMISSION SCREENING (MA 902-1)

The Mountain Pacific Quality Health Foundation performs a "Screening Determination" on all Medicaid applicants to determine whether an applicant is in need of long term care services. This determination is performed by a review of medical records and discussions with medical providers. The applicant is generally not personally interviewed or examined. If the Screening Determination (the form IS SLTC-61) finds that the applicant requires long-term care services, the applicant may proceed with applying for Medicaid. An applicant must enter a facility within 90 days of the Screening Determination date. A new Screening Determination must be completed if more than 90 days passes before the applicant enters a Facility.

Planning Point: *Make sure a Screening Determination is completed upon a resident's admission to the Facility. Medicaid coverage cannot be retroactive to an earlier date than the date of the Screening Determination. However, if resident obtains a Screening Determination while in a skilled nursing facility and moves directly into a Facility no new Screening Determination is Required.*

Screening Determinations for Home and Community Based care may be completed if the applicant is under the care of a Medicaid approved provider.

C. RESOURCE/ASSET TEST (MA 400)

All resources (assets) of an individual are evaluated when determining Medicaid eligibility. If a Medicaid applicant is married, the resources of both spouses are evaluated in determining eligibility for either or both spouses according to the policies of individual resource evaluation. If an individual or couple is resource eligible on any day of a month, they are considered resource eligible for the full month.

1. Maximum allowable resources (MA 005 p. 1; 903-1 p. 1-3).

    a. Unmarried individuals in a Facility ("Waiver Individuals") AND married waiver spouses ("Waiver Spouses") are allowed no more than $2,000 of countable resources.

    b. The spouse of an institutionalized individual, known as the "Community Spouse" is allowed to keep one-half of the couple's combined countable resources, subject to a maximum of $117,240 and a minimum of $23,448. This is known as the Community Spouse Resource Maintenance Allowance, ("CSRMA"). See more about how the CSRMA is calculated and timing aspects of the CSRMA below at VI. H., under strategies to qualify.

    c. For unmarried Waiver Individuals, assets must be spent down to $2,000. For married couples, simply add $2,000 to the CSRMA and any resources in excess of this will need to be spent down.

2. Resource Accessibility (MA 400) – Medicaid evaluates all "accessible" resources of an individual or married couple. A resource is considered accessible either when actually available to the individual or when the individual has a legal or equitable interest in the property or asset and has the **legal or equitable** ability to access funds or to convert non-cash property into cash, *regardless of whether the individual has the practical ability to access the funds or to convert non-cash property into cash*.

    a. Examples of Accessible Resources:

        (1) Trusts (MA 402-3) – if the applicant is a grantor or beneficiary of a trust, the trust assets could be considered an available resource. Some special types of trusts are considered non-available and are treated as excludable resources. See V. C. 4. a. (3), (10), (11) and VI (asset transfer) below.

        Planning Point: *All Resources owned by revocable trusts are Countable Resources—even if the underlying trust assets otherwise would be considered Excludable Resources. (i.e. residence, vehicle, self-employment property, burial plots, etc.)*

        (2) Business Interests – if the applicant is a shareholder of a corporation, partner of a partnership, or member of a limited liability company ("LLC"), the assets of the corporation, partnership, or LLC could be considered an available resource to the applicant in proportion to the applicant's ownership percentage.

        (3) Any other legal entity, instrument, device, or arrangement of any kind by which an applicant does not own the property but has access to the property. These rules are liberally construed by Medicaid.

3. Income as a Resource (MA 400) **–** Income received in the current month is not counted as a resource in that month. Therefore, if the income is deposited into a bank

account, it is excluded as a resource in the current month, but countable in any future months.

4. Countable v. Non-Countable/Excludable (MA 402-1) **– All assets** of the individual applicant or married couple are counted toward the individual's resource allowance or the CSRMA unless the resources are specifically excluded.

    a. Excludable Resources:

        (1) Annuity (not deferred annuities). An annuity is excludable ONLY if:

            (a) periodic payments are being made to the Medicaid recipient or eligible spouse,

            (b) the payments are being made on at least an annual basis,

            (c) the payment contract calls for equal payments,

            (d) full payout must occur during annuitant's life expectancy and,

            (e) the annuity is irrevocable and non-assignable.

            Annuities purchased or converted on or after February 8, 2006, must name the State of Montana Medicaid Program as the residual beneficiary in the following order:

                1. Community spouse
                2. Minor child
                3. Blind or disabled child
                4. State of Montana Medicaid Program

            IRA (Section 408) annuities and other annuities associated with qualified retirement plans may be excluded if other requirements are met.

            Planning Point: *The OPA will require copies of the entire contracts—whether immediate, deferred, guaranteed future annuitization, or annuitized (converted) deferred annuity policies. They will also require 3rd party written valuations of any contracts claimed to be excludable resources, compensated transfers, or inaccessible resources.*

        (2) Basic Maintenance Items. Household goods and personal effects NOT of unusual value. Examples include clothes, furniture, jewelry (one wedding ring and one engagement ring per person), computers, etc.

        (3) Burial Arrangements

            (a) Funeral Agreement/Contract or Burial Trust– Funds in an irrevocable agreement with a funeral home to provide funeral services or in a burial trust are considered an excludable resource if the agreement/trust:

                1) is signed by the applicant and funeral home representative,

                2) specifies the price of all major services,

                3) specifies the total dollar amount of the services,

4) is not signed by an applicant who is a minor or legally declared incompetent,

5) specifies in writing that the money is not refundable under any circumstances, and

6) provides that if the funeral agreement balance exceeds $5,000 any funds not expended on funeral services will be paid to Montana Medicaid. An individual cannot have both an irrevocable funeral agreement and a burial trust.

(b) Life Insurance - provided the total face value of all life insurance owned is less than $1,500.

(c) Burial Account – Any amount less than $1,500 that is in an account titled and designated "Burial Designation". However, this amount is reduced by the face value of any life insurance as well as the value of irrevocable funeral agreements and burial trusts. The amount is not reduced by the value of burial plots.

(d) Burial Plots – one plot per family member is excluded.

(4) Contract for Deed. The value of a contract for deed is an excluded resource if:

(a) written terms include at least annual payments;

(b) terms of the contract are being met;

(c) the contract does not include provisions for forgiveness or termination of the contract and;

(d) recipient assigns all interest in the contract to Montana Medicaid after death. If the written terms are not being met, the applicant must exhaust all available legal remedies to enforce the contract in order to become eligible.

(5) Principal Residence. Up to $525,000 in equity value of principal place of residence is an excluded resource if the individual plans to return in 6 months. If a spouse or dependent child is living in house, the equity limit does not apply. Contiguous land is included with the principal place of residence. One vehicle used as a home may be excluded.

Planning Point (1 Year Plan): *A life estate in a principal residence is an excluded resource if the applicant uses it as his/her principal residence for at least one full year from the date of purchase. This opens the opportunity to buy a life estate interest in the residence of a child for fair market value, move in with the child and live in the residence for at least one full year from the date of purchase, and then subsequently have the life estate interest considered an excluded resource. Currently, Montana Medicaid does not attempt estate recovery against life estates in a primary residence (sometimes referred to as non-transferable rights to occupy). However, consider that if the child sells the residence prior to the death of*

the parent, the parent would be entitled to the tabular value of the remaining life estate interest.

(6) Vehicle (MA 403-1) One vehicle is totally excluded regardless of value if it is used for transportation of the individual applicant or a member of their household. The equity values of all other vehicles are counted using NADA value.

(7) Income Producing Property. Defined as non-liquid property used in the passive production of income. It can include rental property, non-working ownership in a business, or leased land in which the owner is not actively participating in the operation and decision making of the business for at least 10 hours per week. If the income producing property produces a minimum annual net income of 6% of its fair market value, $6,000 of equity may be excluded. The 6% test and $6,000 exclusion limit do not apply to resources used to produce items for home consumption or that are part of a self-employment enterprise.

(8) Term Life Insurance Policies. These policies have no cash value.

(9) Property/Equipment Necessary for Self-Employment. Property may be excluded as necessary for self-employment if:

(a) the owner is materially participating in the self-employment business at least 10 hours per week throughout the year;

(b) claims the endeavor as self-employment;

(c) reports income on Schedules C, F, or SE; and

(d) meets definition of "self employed" in MA 503-1.

Property owned by a corporation, LLC, or partnership may not be excluded because it is owned by the business and not the applicant or applicant's spouse.

Examples of excluded self-employment resources may include:

- Tools/equipment such as those needed by carpenter, mechanic, cosmetologist, etc. ;
- Office equipment;
- Inventory;
- Machinery and equipment; or
- Business Account – Funds in a business account that are designated as necessary business capital, operating funds, or funds pro-rated as income.

Example – Farmer sells his crops in August for $12,000. The money from the sale is intended to support his family for one year. The $12,000 is prorated as income, $1,000 per month. The

$12,000 (even if put into a bank account with other funds) is excluded as a resource for the one-year period.

(10) Special Needs Trusts. There are two types of special needs trusts, both of which are excluded as resources: 1) First party trusts are created with the trust beneficiary's (applicant's) own assets, and 2) Third party trusts (also called supplemental needs trusts) are created with the assets of anyone other than the beneficiary. Assets held in both types of special needs trusts are excludable resources for Medicaid purposes. A first party trust is authorized by 42 U.S.C. § 1396p(d)(4)(A) and may only be established by a disabled individual's parent, grandparent, legal guardian of the individual, or a court, and may only receive assets of the disabled individual until the individual attains age 65. The first party trust must name Montana Medicaid to receive all amounts remaining in the trust upon the death of the disabled individual up to the total amount of medical assistance paid on behalf of the individual during his or her lifetime ("Medicaid pay-back"). The third party trust does not require Medicaid payback upon the beneficiary's death, and assets can be contributed to the trust regardless of the beneficiary's age. As a general rule, the assets in a special or supplemental needs trust can be used to supplement, but not supplant, benefits provided by Medicaid. The special or supplemental needs trust cannot be used for a beneficiary's basic needs such as food and shelter. Administering a special or supplemental needs trust without jeopardizing the beneficiary's Medicaid benefits is complicated matter. Anyone considering a special needs trust should consult professional assistance and may even consider using a professional trustee.

(11) Pooled Trusts. A pooled trust is authorized by 42 U.S.C. § 1396p(d)(4)(C) and is established and managed by a nonprofit association (the "Self Sufficiency Trust" established and managed by PLUK – "Parents, Let's Unite for Kids," in Montana). The pooled trust can contain assets of the beneficiary or third parties and must require Medicaid payback upon the beneficiary's death similar to a first-party special needs trust. In addition to the Medicaid payback, 10% of any remaining funds on the beneficiary's death must be donated to a Charitable Trust to be used by the Montana Department of Public Health and Human Services for the purpose of providing for the care and treatment of low-income persons with disabilities. Pooled trusts can be created for disabled individuals of any age. The handbook for the Self Sufficiency Trust of Montana can be found here: http://www.pluk.org/Pubs/PLUK_MSST_Handbook_2009_207k.pdf.

Pooled trusts are administered by a "trust advisor," chosen by the trust's donor, in accordance with a Lifecare Plan for the beneficiary, which is prepared and reviewed in connection with an advisory board. As a general rule, the assets in a pooled trust can be used to supplement, but not supplant, benefits provided by Medicaid. The pooled trust cannot be used for a beneficiary's basic needs such as food and shelter. Pooled trusts are

easier and can be more cost efficient to administer than a special or supplemental needs trust because the Lifecare Plan and trust advisory board act as a guide to the trust advisor. However, pooled trusts are less flexible than a special needs trust.

D. INCOME TEST (MA 1002 and 1003)

Only the applicant's income is counted in determining Medicaid eligibility. Income solely in the name of the Community Spouse is not counted toward the applicant's eligibility but is considered in determining how much of the applicant's income the Community Spouse may be entitled to keep. Income is divided into two categories: 1) Earned Income (MA 502-1) – includes wages and salaries and net earnings from self-employment; and 2) Unearned Income (MA 501-1) – all other income. Income received on a less-than-monthly basis is prorated over the period of intended use.

1. In-Kind Support and Maintenance. Non-cash items such as food and shelter received by the applicant may be considered as earned or unearned income of the applicant. Note: ALFs are not residential medical facilities. Accordingly, if a Medicaid applicant/recipient's family (or anyone else) pays an additional amount directly to the Facility to upgrade the person from a semi-private to a private room, for a "nicer" room, or for additional food (as examples), the additional charge is considered in-kind income for shelter or food. (MA 1002-1).

2. Trust Income. Income from a special needs or pooled trust is not counted as unearned income to the trust beneficiary unless actually distributed in the form of cash or for certain types of in-kind income (MA 402-3 and MA 500).

3. Income Calculations. Medicaid performs a series of calculations using the applicant's income to determine: 1) what amount of the Waiver Spouse's income must be paid to the Facility for his or her care: and 2) what amount of the Waiver Spouse's income can be retained by the community spouse.

    a. Waiver Individual Categorization (MA 1002-1 pp. 1-2) – The first step in making these determinations involves labeling the applicant as either Categorically Needy or Medically Needy by using the following formula:

Unearned Income
- General income disregard ($20)
= Countable Unearned Income

Total Earned Income
- Balance of general income disregard
- Work expense disregard ($65)
= Remainder
- One-half Remainder u
= Countable Earned Income

Countable Unearned Income
+ Countable Earned Income
= Total Countable Income

Total Countable Income
- Categorically Needy income standard ($30 for an individual living in an institution)
= "Balance"

If "Balance" is less than or equal to $0 then the applicant is Categorically Needy; otherwise, applicant is evaluated for Medically Needy coverage using the following formula:

Unearned Income
- General income Disregard
= Countable Unearned Income

Total Earned Income
- Balance of General Income Disregard
- Work Expense Disregard(s)
= Remainder
- One-half Remainder
= Countable Earned Income

Countable Unearned Income
+ Countable Earned Income
= Total Countable Income
- Medically Needy Income Limit for One ($525)
- Medically Needy Income Deduction ($100)
= "Incurment"

The Incurment obligation is the amount a recipient needs to satisfy to qualify as medically needy. Recipients may satisfy their Incurment obligation by making a cash payment to the Department equal to their Incurment obligation; incur medical expenses equal to the amount of their Incurment obligation; a combination of medical expenses and cash payment. (MA 1003-1).

b. Waiver Spouse Categorization (MA 1002-2 pp. 1-2) – The first step in making these determinations involves labelling the applicants as either Categorically Needy or Medically Needy by using the following formula:

Unearned Income
- Legally obligated child support/alimony
- General income disregard ($20)
= Countable Unearned Income

Total Earned Income
- Legally obligated child support/alimony
- Balance of general income disregard
- Work expense disregard ($65)
= Remainder
- One-half Remainder
= Countable Earned Income

Countable Unearned Income
+ Countable Earned Income
= Total Countable Income

Total Countable Income
- Categorically Needy income standard ($30 for an individual living in an institution)
= "Balance"

If "Balance" is less than or equal to $0 then the applicant is Categorically Needy; otherwise, applicant is evaluated for Medically Needy coverage using the following formula:

Unearned Income
- Legally obligated child support/alimony
- General income Disregard
= Countable Unearned Income

Total Earned Income
- Legally obligated child support/alimony
- Balance of General Income Disregard
- Blind/disabled work expenses
- Work Expense Disregard(s)
= Remainder
- One-half Remainder
= Countable Earned Income

Countable Unearned Income
+ Countable Earned Income
= Total Countable Income
- Medically Needy Income Limit for One ($525)
- Medically Needy Income Deduction ($100)
= "Balance"
- Spousal Income Maintenance Allowance
- Family Allowance
= Incurment

The Incurment obligation is the amount a recipient needs to satisfy to qualify as medically needy. Recipients may satisfy their Incurment obligation by making a cash payment to the Department equal to their Incurment obligation;

incur medical expenses equal to the amount of their Incurment obligation; a combination of medical expenses and cash payment. (MA 1003-1).

E. POST ELIGIBILITY TREATMENT OF INCOME – SPOUSAL INCOME MAINTENANCE ALLOWANCE (MA 1002-2)

If the applicant is determined through the preceding formulas to be eligible for Medicaid coverage, Medicaid then determines the applicant's liability to the Facility depending upon whether the applicant is single or married.

1. If the Waiver Spouse is **married**, the Community Spouse is allowed to receive a portion of the Waiver Spouse's income, known as the Community Spouse Income Maintenance Allowance ("CSIMA") equal to the **lesser** of:

   $2,931
   - the Community Spouse's own total gross monthly income

   OR

   Shelter expenses for the Community Spouse's principal residence that exceed the basic shelter allowance of $590
   + Basic Needs Standard of $1,967
   - Community Spouse's own total gross monthly income.

   Thus, the maximum a Community Spouse could receive in CSIMA is $2,931.

2. If other dependent family members continue to reside with the Community Spouse, a family maintenance allowance is allowed for each additional dependent family member equal to one-third of the difference between the basic needs standard of $1,967 and the family member's gross income.

3. All of the Waiver Spouse's other income, except for the disregards referenced immediately below, must be paid to the Facility.

4. The Waiver Spouse, or an individual (single) applicant must contribute all income (calculated on a monthly basis) to the Facility except:
   a. Up to $65 of gross earned income;
   b. A personal needs allowance of $50;
   c. Up to $90 in Veterans Administration Aid and Attendance benefits;
   d. Incurred medical or remedial care expenses which:
      (1) were incurred during the 3 months immediately prior to application; or
      (2) are current actual payments on expenses incurred over 3 months immediately prior to application;
   e. Court ordered child support/alimony; and

f. A Home Maintenance Allowance of $525 in the following situations:

(1) For the month of entry when the individual entered the facility from the community after the first day of the month; or

(2) For up to 6 months when the individual is certified by a physician to return home within 6 months of entry into the institution; or

(3) For the month of discharge when the individual leaves the facility before the last day of the month to reestablish residence in the community.

VI. ASSET TRANSFERS AND OTHER ELIGIBILITY ISSUES

In order to prevent people from artificially impoverishing themselves by giving away all their assets to family members in order to meet Medicaid qualification guidelines, federal and state Medicaid laws have been established to evaluate past asset transfers by Medicaid applicants.

A. WHAT CONSTITUTES A DISQUALIFYING (OR UNCOMPENSATED) ASSET TRANSFER? (MA 404-1 PP. 1, 6)

1. A disqualifying transfer of assets occurs when:

   a. Assets were transferred for less than fair market value;

   b. The transfer occurred during the look-back period, or after Medicaid eligibility has been established; and

   c. The transfer was not an exempt transfer.

2. Asset transfers are not limited to giving away property, a disqualifying asset transfer includes any action by which an applicant gives up or limits his or her rights or access to or interest in an asset. For example, entering into a shareholder agreement whereby the sale of a Medicaid applicant's stock is prohibited or severely restricted could be considered a disqualifying asset transfer. In addition, the applicant is considered to have personally made the transfer if it was made by a spouse, parent, guardian, court, or anyone acting on behalf of the applicant.

B. THE LOOK-BACK PERIOD (MA 404-1 PP. 1-2)

1. If the transfer was made prior to February 8, 2006 the look-back period is:

   a. 36 months, or

   b. 60 months for transfers to trusts; and

   c. 60 months for transfers from trusts to or for the benefit of people or entities other than the Medicaid recipients.

2. If the transfer was made on or after February 8, 2006 the look-back period is 60 months for ALL transfers.

3. The look-back date is established based on the first application while the applicant is institutionalized regardless of approval or denial. If the applicant is denied and later reapplies, the look-back date remains the same as it was in the initial application. **Thus, an application must be submitted before the look-back date can even be established.**

C. LENGTH OF PENALTY (MA 404-2 PP. 1-4)

The length of the penalty period is determined by taking the total value of the uncompensated transfer and dividing it by the average daily cost of nursing home care ($201.67 per MA 404-2). The result is the number of days that the value of the uncompensated transfer could have been used to pay for the applicant's care. This will be the length of the penalty period.

D. DETERMINING UNCOMPENSATED VALUE (MA 404-1)

An asset is transferred for less than fair market value if the compensation received by the individual is less than the fair market value of the asset on the date of transfer or contract for sale (if earlier). Fair market value means the price of the asset on the open market.

1. Compensation means money, real or personal property, food, shelter or services:

    a. Received by the applicant/recipient or spouse at or after the time of transfer in exchange for the resource IF the compensation was provided under a legally enforceable agreement in effect at the time of the transfer, OR

    b. Received prior to the transfer if they were provided under a legally enforceable agreement whereby the applicant/recipient agreed to transfer the asset or otherwise pay for such items.

2. Compensation also includes payment or assumption of a legal debt owed by the applicant/recipient in exchange for the asset. Compensation does not include services or gifts previously provided to the applicant/recipient out of love or concern without expectation and promise of payment.

3. Personal Care Contracts and payments for duplicative services are considered uncompensated asset transfers.

    Examples:

    No. 1: At 80 years of age, Betty transferred her home, in which she still lived, to Wilma, a licensed practical nurse. In exchange for the home, Wilma agreed to provide daily nursing and homemaker services. At the time of transfer, the home's market value was $50,000. Betty is expected to live another 9.09 years

(see MA 008, "Life Expectancy Table"). The services' current market value is $20,000 per year X 9.09 years = $181,800. Betty can be expected to receive more than fair market value in exchange for her home.

No. 2: As Jane's health declines, her daughters provide her with services such as grocery shopping, housekeeping and transportation, and take care of her often when she is unwell, but none of them lives with her. The services and care continue, without any promise of payment or compensation, for three years. Prior to Medicaid application, Jane transfers her certificates of deposit to the daughters. The reason given at application is for payment for the care her children provided to her over the past several years. Because the care was provided without promise of payment, the care that Jane's daughters provided to her over the past three years cannot be considered compensation for the value of the CDs.

No. 3: Fred, a nursing home resident, enters into a personal care contract with his two sons. The personal care contract states that the sons are being compensated for coming to visit Fred and monitor his care and condition, for coming to the facility to assist him in eating two meals per day, for doing his laundry weekly, and for assisting him with management of his finances. Each son will be paid $2000 per month for these services. Since the nursing home provides assistance in eating and laundry services as part of their service package, these services are duplicative and payment to the sons for these services is treated as uncompensated transfers. Since both sons live within five miles of the facility (and are thus not incurring high travel expenses in fulfilling the contract) and neither is furnishing professional CPA or social work services, $2000 per month each exceeds reasonable standards of reimbursement for services from nonprofessionals. A reasonable amount for the financial services and visitation (including documentation of the frequency of such visits not related to feeding assistance) must be established based on the number of hours they are reasonably spending on performing these activities and a reasonable hourly payment for purposes of determining the amount that will be recognized as compensation.

4. The uncompensated value of transferred property is the fair market value of the property, less any compensation received according to the policy outlined above.

5. For uncompensated asset transfers that occurred prior to February 8, 2006 the penalty period will begin on the first day of the month in which the asset was transferred.

6. For uncompensated asset transfers that occurred on or after February 8, 2006 the penalty period will not begin until the applicant has:

    a. Applied for Medicaid benefits;

    b. Is found *otherwise eligible* for benefits, **AND**

    c. Is institutionalized or awarded an available HCBS waiver slot.

E. THE RETURN OF UNCOMPENSATED TRANSFERRED ASSETS. (MA 404-2 PP. 6-7)

1. If the full value of the assets is returned, any penalty related to the transfer is eliminated. However, the applicant will now have available assets/resources that must be spent down before becoming eligible for Medicaid.

2. If only part of the value of the assets is returned, the penalty period is adjusted to reflect only the value of those assets that have not been returned. However, assuming the transfer occurred on or after February 8, 2006, the penalty period cannot begin to run until the applicant is otherwise eligible. This means that the applicant will have to spend down the returned assets to below $2,000, then wait out the entire remaining penalty period for the non-returned assets, and then be eligible for Medicaid.

F. EXEMPT ASSET TRANSFERS (MA 404-1 PP. 6-8)

1. Transfers to a spouse prior to nursing home eligibility under spousal impoverishment policies.

2. The asset was transferred from the Waiver Spouse to the Community Spouse as part of the 90-day transfer period for the CSRMA.

   Planning Point: *Post application approval, there is a 90 day period in which to remove the applicant's ownership from resources. Practically, the only remaining resources that should be owned by the applicant is the checking account into which his/her Social Security and other income is deposited, and the cash account at the nursing home. All other resources should be transferred to the Community Spouse, and the applicant should have no beneficiary or control rights in any revocable trust. The combined countable resources in the remaining checking account and the nursing home cash account need to remain under $2,000—in the month it is received, income is not considered a resource.*

3. The asset was transferred to the minor or adult child of the owner who is blind or disabled as specified by Social Security criteria. This includes transfers to special needs trusts or pooled trusts for the benefit of the blind or disabled child.

   Planning Point: *Always find out if there is an adult child on SSDI (Social Security Disability Income). The applicant may immediately make exempt transfers of all resources to this child without penalty. If there is an adult child on SSDI, determine whether the transfer of assets would make the child ineligible for benefits, whether the transfer would better be made to a special needs trust for the child, or whether the transfer is inadvisable due to the financial immaturity of the child. At the very least, knowledge of a child on SSDI opens up planning opportunities.*

4. The asset transferred is the applicant's home and title was transferred to:

a. The spouse of the owner;

b. A minor child (under age 21 in Montana) of the owner;

c. An adult child who has been determined blind or permanently disabled as specified by Social Security criteria, including transfers to special needs trusts for their benefit;

d. A child of the owner, regardless of age, who resided with the applicant for two years immediately prior to the applicant's admission to a nursing home and who provided care that permitted the applicant to reside at home, OR

e. A sibling of the owner who has an equity interest in the home and who resided in the home continuously for at least one year prior to the applicant's nursing home admission.

Planning Point (2 Year Plan): *4d above creates planning opportunities. If there is not a child who can practically move into the parent's home and care for the parent for two years in such a manner that delays nursing home admission (evidenced by a letter from the parent's doctor), consider having the parent buy an interest in the home of a child, move in with the child, and delay nursing home admission for two years. Then, after the two years, the parent makes an exempt transfer of his/her interest in the home to the child. The child could use the proceeds from the sale of the interest in the home to remodel the home, pay off the mortgage, or in other ways facilitate the in-home care of the parent.*

5. The asset was transferred exclusively for a reason other than to qualify for Medicaid, such as satisfaction of legally enforceable debts. However, a presumption exists that the asset was transferred to qualify for Medicaid. Rebutting the presumption requires the presentation of a rebuttal statement that contains convincing evidence. In evaluating such transfers, Medicaid will focus on the timing and payments of the debt. For example, if a family member suddenly remembers or decides to collect on an alleged debt that has purportedly been outstanding for years, and no convincing evidence exists that either the applicant/recipient affirmatively acknowledged the debt or attempted to work toward satisfying the debt and that the individual(s) to whom the alleged debt was owed made previous efforts to collect the debt, the validity of the debt and whether it is legally enforceable may be questionable.

6. The assets were transferred into the applicant's qualifying first party special needs trust before the applicant reaches age 65 (see V. C. 4. a.(10) above and MA 402-3).

7. The assets were transferred to the applicant's pooled trust, **regardless of applicant's age** (see V. C. 4. a.(11) above and MA 402-3). Previously, Montana imposed an asset transfer penalty on applicants age 65 and older who transferred assets to a pooled trust for their own benefit. Montana has just very recently joined the nationwide trend of not imposing asset transfer penalties for persons age 65 and older. This is creates a tremendous Medicaid planning opportunity because it allows a

potential Medicaid applicant to convert otherwise countable resources into an exempt resource by transferring the assets to a pooled trust. Of course, there are certain drawbacks to consider as well (see V. B. 4. a.(11) above). A frequent use of pooled trusts is to pay the rate differential between a semi-private room (which Medicaid pays for) and a private room at a Facility.

8. When an undue hardship exists:

As stated in Montana's Medicaid Handbook and Administrative Rules of Montana[67], an undue hardship exists when the asset was transferred as a result of fraud, misrepresentation or coercion perpetrated against the applicant/recipient or spouse, and the applicant and/or spouse have pursued all reasonable legal recourse to acquire the transferred asset or its equivalent value.

Montana law also requires the applicant to pursue all reasonable legal recourse to acquire the transferred asset. Legal recourse is not reasonable only when the cost of pursuing such recourse exceeds the value of the transferred asset, but such a determination cannot be based solely on attorney's fees due to potential pro bono or reduced fee services.

However, in *In the Matter of Agnes Graham*, Case No. 12-0933, a pending case before the Office of Fair Hearings of the Department of Public Health and Human Services, the Department has been compelled to admit that its undue hardship exception falls short of the requirements of federal law. Accordingly, current state law will need to change because it fails to meet the minimum floor for an undue hardship exception established by federal law. As of the preparation of this material, the state has verbally stated that it will be changing the undue hardship rules, though such changes have not yet been promulgated.

The federal undue hardship exception was enacted in 2006 when Congress passed the Deficit Reduction Act ("DRA"). In § 6011(d) of the DRA, Congress required states to provide for hardship waivers and defined the minimum standard for finding a hardship waiver.[68] In pertinent part, the Act provides:

> (d) AVAILABILITY OF HARDSHIP WAIVERS. -- Each State shall provide for a hardship waiver process in accordance with section 1917(c)(2)(D) of the Social Security Act[69] -
> (1) under which an *undue hardship exists when application of the transfer of assets provision would deprive the individual* -
> (A) *of medical care such that the individual's health or life would be endangered; or*
> (B) *of food, clothing, shelter, or other necessities of life*;…

[67] ARM § 37.82.417(4)(c)(iv); § 37.82.417(8)(b).
[68] *Id*. at § 6011(d).
[69] 42 U.S.C. 1396p(c)(2)(D).

(emphasis added).

Thus, the DRA established that "undue hardship" must at the very least be defined as to exist in situations where imposing a penalty would deprive an applicant of necessary medical care or deprive an applicant of necessary food, clothing, or shelter.

Under the DRA, a Medicaid applicant should be able to receive a waiver by showing that application of the penalty rules would deprive the applicant of necessary medical care or of food, clothing, shelter, or other life necessities. When determining a hardship, the DRA doesn't contain any statement that the reason an individual is without assets should matter to a reviewing authority. Rather, the reviewing authority should focus on whether the penalty would seriously endanger the applicant as set out in the DRA.

Moreover, 49 U.S.C. § 1396p(c)(2)(D)(emphasis added) provides that a penalty shall not be applied where:

> "the State determines, under procedures established by the State (*in accordance with standards specified by the Secretary*), that the denial of eligibility would work an undue hardship *as determined on the basis of criteria established by the Secretary.*"

Thus, if the Secretary establishes standards detailing how a state must administer Medicaid, the state must, at a minimum, comply with those standards. The federal agency charged with administering the Medicaid program is the Centers for Medicare and Medicaid Services ("CMS").[70]

Accordingly, under 42 U.S.C. § 1396p(c)(2)(D), standards and criteria that the CMS establishes must be incorporated into a state's program and subsequently complied with.

Here, the standards specified by the Secretary, in delegating authority to CMS, are published in § 3258.10(C)(5) of the State Medicaid Manual.[71] It provides as follows:

> Undue hardship exists when application of the transfer of assets provisions would deprive the individual of medical care such that his/her health or his/her life would be endangered. Undue hardship also exists when application of the transfer of assets provisions would deprive the individual of food, clothing, shelter or other necessities of

[70] *Arkansas Dept. of Health & Human Services v. Ahlborn*, 547 U.S. 268, 275 (2006)("[Medicaid's] administration is entrusted to the Secretary of Health and Human Services (HHS), who in turn exercises his authority through the Centers for Medicare and Medicaid Services").

[71] The State Medicaid Manual may be referenced at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html

life.[72]

Thus, in language that is near-verbatim to that of the DRA, the CMS defines "undue hardship" to include situations where penalties would deprive an applicant of necessary medical care or necessary food, clothing, or shelter.

Montana is bound to follow the standards set out by the DRA, and by application of § 1396p, the CMS's State Medicaid Manual. Consequently, Montana must recognize undue hardships whenever application of the transfer of assets provisions would deprive an applicant of necessary medical care, food, clothing, shelter, or other necessities of life. Montana must also give notice to applicants that an undue hardship exception exists. Montana's Medicaid program does not provide either required provision.

In *Agnes Graham*, the Hearing Officer has been asked to enter an order stating that Montana's current hardship rules are invalid. We are awaiting that order.

G. REBUTTING THE PRESUMPTION THAT THE ASSET WAS TRANSFERRED EXCLUSIVELY TO QUALIFY FOR MEDICAID BENEFITS (MA 404-1 PP. 12-13)

1. Notification. The applicant must be notified of any disqualifying transfers and penalty determinations **before** eligibility is approved or denied. The notice must:

    a. Inform the applicant that an uncompensated transfer has been identified;

    b. Give the value of the resource transferred, AND

    c. Inform the applicant of his or her right to rebut the presumption that the transfer was made to qualify for Medicaid.

2. Transfer Rebuttal Statement. After receiving notification, the applicant must respond within 15 days. If no response is received, the penalty will be applied. If the applicant chooses to rebut, he or she must present convincing evidence. The rebuttal statement must include:

    a. The reason(s) the asset was transferred;

    b. Documentation of attempts to sell the asset as fair market value;

    c. Documentation that fair market value was received or the reason for accepting less than fair market value;

    d. Documentation of means of self-support after the transfer; AND

    e. Statement of relationship to the person to whom the asset was transferred.

[72] Note that the State Medicaid Manual and the language of the DRA are nearly verbatim. Federal law, whether statutory or administrative, clearly sets out a minimum definition of "undue hardship" that involves situations where an applicant may be deprived of serious medical care, food, clothing, and shelter.

3. Factors that may indicate an asset was transferred for a reason other than to qualify for Medicaid:

    a. The occurrence of any of the following after the asset was transferred:

        (1) Traumatic onset of a disability;

        (2) Diagnosis of a previously undetected and disabling condition;

        (3) Unexpected loss of other resources that would have precluded eligibility for medical assistance, OR

        (4) Unexpected loss of other income that would have precluded eligibility for medical assistance.

    b. Total countable assets, including the value of the uncompensated transfer, fall below the general resource limit during each of the months comprising the appropriate look back period.

    c. The transfer was court-ordered in a contested court action.

    d. Undue hardship applies: remember undue hardship only applies if the asset was transferred out of fraud, misrepresentation, or coercion AND the applicant has taken all available legal recourse to recover the asset. The asset is considered inaccessible as long as a suit has been filed and is actively being pursued.

H. STRATEGIES TO QUALIFY

1. Maximizing the CSRMA and Calculating the "Spend Down". Refer to IV. A. 5. a. and b. above regarding how the CSRMA is established. The goal is to have the highest CSRMA possible, up to the maximum.

2. Spend Down Strategies. "Spend down" does not require that you use your resources to pay for your cost of care. There are generally speaking only two requirements to how the "spend down" is accomplished: 1) the money must be spent for the benefit of the applicant and the applicant's spouse, and 2) the transaction must be a fair market transaction. Simply giving assets away will not work. It is not a good idea to try and hide or lie about assets, this will likely result in civil or criminal charges. The following strategies are not mutually exclusive; more than one can be used. However, because the maximum resource limit for a married couple is $117,240 and only $2,000 for an individual, and because many of the spousal impoverishment rules treat many resources of married couples as exempt, many of these strategies apply only to married couples.

    a. Funeral Arrangements. This can be accomplished in three different ways.

        (1) Pre-Paid Funeral Arrangement – Purchase all funeral arrangements in advance and make sure to tell the funeral home that the arrangement needs

to be Medicaid compliant. To be Medicaid compliant in Montana it must meet the criteria described in V.C.4.a.(3)(a) above as exempt resources.

(2) Purchase Life Insurance – So long as the face value of all life insurance owned by an individual is less than $1,500 all cash surrender value is exempt.

(3) Revocable Funeral Fund or Account – In Montana the account must be designated "Burial Designation." The limit on such accounts is $1,500 and it is reduced by the value of pre-paid funeral arrangements and life insurance. Thus if option 1 or 2 is exercised, exercising 3 is unlikely.

b. Pay off the Mortgage. Because the home equity of the primary residence is in most cases exempt, paying off a mortgage will simply transfer countable resources into the excluded resource of home equity. However, if the applicant has creditor life insurance and is not expected to live very long, this may not be a good strategy.

c. Pay off Debts.

(1) Unsecured debt is not subtracted from the value of the applicant's resources. The debt is going to have to be paid off at some point anyway, so consider using countable resources to pay the debt.

(2) It will not be helpful to pay off debt that is secured with countable resources (such as an extra vehicle). Paying off this debt will only transfer a countable resource (cash) to another countable resource (equity in a non-exempt asset). For personal reasons the applicant may want to pay off the debt but it will not help qualify for Medicaid.

(3) Personal loans need to be legitimate. Medicaid is not going to fall for "time to pay my kids back for all their years of helping me out." Any type of loan with a family member or friend is going to be subject to **heavy** scrutiny.

d. Buy a Newer, Nicer, or at Least More Appropriate, Vehicle. One vehicle is exempt regardless of value. A good planning technique is to trade in old automobiles and use extra cash to purchase a newer automobile that is more suitable to the needs of either the Waiver Spouse or Community Spouse. Some couples chose to purchase specialty vans that can easily accommodate a wheelchair. However, if you are considering purchasing an unusual vehicle, there is a chance that Medicaid could consider that purchase to be an investment asset and not transportation (ex. the purchase of an expensive classic car).

e. Upgrade Household and Personal Property. Upgrading the property in the exempt home is a great way to take countable resources and turn them into exempt resources. Personal property includes items normally worn or carried by the individual, items that have an intimate significance to the individual, or items that have a religious or cultural significance. Many items around the house can be upgraded and considered exempt resources, including new TV, new furniture, or other new appliances. As with the car, one must be careful if

purchasing items that could be considered investments such as fine jewelry or original works of art.

f. Make Home Improvements. Since your home is normally an exempt resource, any money you spend to fix, repair, or upgrade your home is likely a good way to accomplish spend down. Anticipate expenses you will need to incur in the next few years and consider getting the work done now. Maybe the roof could last a couple more winters before it needs replacing, but why not get it done right now and count that as part of your spend down? That green toilet and yellow countertop are long out of style. Why not consider a remodel? Perhaps a bathroom or kitchen needs to be remodeled to make it safer or more convenient for wheel chair access. Keep in mind that large projects could take a considerable amount of time to complete. The spend-down is not finished until the checks are written and delivered.

g. Set-up the Spend Down Using Home Equity.

(1) This technique may seem counterintuitive at first. It involves "setting up" your spend down by increasing your debt immediately prior to requesting a Resource Assessment. This technique requires that a couple financially qualifies to take out a loan, and works best when the couple owns a home, with sufficient equity, that counts as an exempt resource. This technique works very well for couples whose combined countable resources are $117,920 (the maximum CSRMA) or less. The technique can also be partially effective for couples with combined countable resources less than $235,840 (twice the maximum CSRMA). The technique works as follows:

(a) Before requesting a Resource Assessment, the couple obtains a loan equal to their total amount of countable resources. The loan should not be secured against a countable resource, such as a vehicle, because that will reduce the equity value of the resource, which counts toward the CSRMA. The best, and usually most cost effective, loan to obtain is a home equity line of credit because the loan is secured against the home, an exempt resource.

(b) The couple places all the loan proceeds in their bank account.

(c) Submit a Resource Assessment to Medicaid.

(d) Medicaid will consider the loan proceeds as a countable resource because the debt is not subtracted from the assets.

(e) Medicaid will allow the Community Spouse to keep half of the combined countable resources (what is actually all the couple's assets prior to obtaining the loan) up to $117,920 and require that the remainder be spent down.

(f) Once this determination is received from Medicaid, the couple immediately pays off the loan to complete the spend down and informs Medicaid, with appropriate documentation, that the spend down is complete.

(g) If the technique is performed correctly, the Community Spouse can achieve the maximum CSRMA and allow the Waiver Spouse to become resource eligible without needing to actually spend down any of the couple's resources. The only cost is the fee to establish the loan and some interest expense while waiting to hear from Medicaid.

(2) No house, No problem. Any loan that allows you to get cash will do the trick. However, such loans will likely result in paying more in closing costs and initial interest.

(3) Timing is critical for this technique because the loan must have closed and proceeds deposited in the couple's bank account on "the first day of the month of residential medical institution admission for a continuous period of participation" for the Resource Assessment. If the Waiver Spouse enters a Facility after the first of the month, the couple might consider, if possible, taking the Waiver Spouse out of the Facility and caring for him or her at home during the loan process and then re-admitting the Waiver Spouse after the first of the next month when the loan proceeds are in the couple's bank account.

h. Set up the spend down using a revocable trust as owner of otherwise excludable resources.

i. Buy a new House. Buying a more expensive and more appropriate house is a simple way to once again convert otherwise countable assets into exempt home equity. As long as the Community Spouse, or a blind, disabled, or minor child occupies the home, it remains an exempt Resource.

(1) Remember that Montana allows unlimited home equity to be excluded for married couples.

(2) The house should be titled solely in the name of the Community Spouse, for estate planning and estate recovery purposes.

j. Medicaid Compliant Annuity ("MCA") for the Community Spouse.

(1) This is a very effective way to quickly accomplish the spend-down while not actually spending the money. What the MCA does is take otherwise countable resources and turns them into Income for the Community Spouse, and the Community Spouse's Income is never considered for the Waiver Spouse's eligibility. It does not matter that the Community Spouse's resources will continue to grow. The Community Spouse's resources are only evaluated at the time of the Resource Assessment. So long as the annuity payments are deposited in a bank account, or other financial device, that is solely in the name of the Community Spouse they will be protected. Third party valuations will be required to determine accessibility and/or value as a countable resource.

(2) A MCA, also called an Immediate Annuity, is one that (in this case) is made to the Community Spouse;

(3) Has a periodic schedule of payments on at least an annual basis;

(4) Has regular payments throughout the contract with no lump sum, deferred or balloon payments;

(5) Is actuarially sound; that is full payout is expected to occur within the lifetime of the annuitant (in this case the Community Spouse);

(a) For example, suppose $100,000 is used to purchase an annuity in the name of the Community Spouse, who is 70 years old, to be paid out in a period of 100 months (8 years and 4 months). The life expectancy of the Community Spouse is 12 years and 9 months so the annuity is actuarially sound. The $100,000 will eventually be fully recovered by the Community Spouse.

(6) Is irrevocable and non-assignable; and

(7) Names Montana Medicaid as the irrevocable first position residual beneficiary (unless the couple has a minor child or a blind or disabled child).

k. MCA for the Waiver Spouse/Individual. It is far better to create the annuity for the Community Spouse. But in the case of a single individual, or in cases such as where the couple's assets are in the form of an IRA and transfer to the spouse would result in large taxes, this may be a good option. The requirements for the annuity are the exact same as an annuity for the Community Spouse. Some or all of the income from the annuity will be used to pay for the cost of care. However, if the payments are stretched out over the course of the individual's life expectancy and in the case of a couple, if the CHIME is high enough the damage can be minimized. In addition, in Montana, if an IRA is rolled over into a MCA, Montana Medicaid does not need to be listed as the primary beneficiary assignment.

l. Medicaid Compliant Life Insurance ("MCLI"). The key here is to remember that only the cash surrender value of life insurance is considered an asset. A MCLI is one that has no cash surrender value. The face value is equal to the premium paid, thus if the individual pays $50,000, the beneficiary will eventually receive the $50,000 in the form of monthly payouts. The strategy only works if the individual is 100% sure he or she will never need the money. Once the policy is purchased, the individual will have no further access to the money. Third party valuations from viatical/life settlement companies will be required to determine accessibility and/or value as a countable resource.

m. Pay a Family Member to Provide Care.

(1) A large amount of due diligence is required with this strategy. Remember, Medicaid is very suspicious of contracts with family members. Payments subsequent to services rendered, where no contract exists, are likely not going to work.

(2) Draft a contract that is detailed and specific regarding the care that is going to be provided and the hourly rate.

(a) The rate needs to be a fair market rate. It will be necessary to do some research, and remember the cost of an individual care provider is going to be less than the cost of using an agency. It is generally all right to error on the high side so long as the rate could be considered fair market value.

(3) Make sure thorough records are kept of all work done and payments made. Payments need to be made on a regular schedule, weekly, biweekly, or monthly is probably best. If the caregiver is going to be paid at a later date, for example after the sale of property, this needs to be very well documented in the contract and the record must support that the transaction is fair market value. There is still a risk that Medicaid may not accept the delayed payment.

(4) A final thing to remember is that if the caregiver is an employee and not an independent contractor, appropriate taxes need to be deducted and there may be worker's compensation insurance and other employment related issues that should be addressed.

n. Create a Life Care Contract.

(1) This works similarly to the last strategy except that the payment is a lump sum in advance of services.

(2) The amount must not be some arbitrary figure. It must be carefully calculated based on the fair market rate of services, the amount of services provided, and the life expectancy of the applicant.

(3) MA 404-1 does not specifically declare such contracts to be an uncompensated transfer. However, some states do not recognize these contracts. In any event, the contract is likely going to be heavily examined by Medicaid.

(4) There are professionals experienced in creating Life Care Plans that should be consulted if this strategy is considered.

o. Make a Loan to a Family Member. This strategy involves drafting a promissory note that will not be categorized as a countable resource or an uncompensated transfer.

(1) In Montana, (MA 402-1 pp. 16-17) a promissory note is considered a countable resource unless it is inaccessible. In addition, making an inaccessible loan is considered an uncompensated transfer. Thus, this strategy is not likely to be effective in Montana.

(2) This involves making the promissory note very much like a MCA. The payments must be continuous, level, and actuarially sound. The note cannot be self-cancelling upon the death of lender or any other event.

(3) Ideally, the note is in the name of the Community Spouse, because if it is in the name of the Waiver Spouse much of the payments may go to nursing home payments.

(4) A variation on this strategy could work in Montana using a contract for deed. A contract for deed is an excludable resource (MA 402-1 pp. 8-9) if:

(a) The written terms include at least annual payments.

(b) The terms of the contract are being met.

(c) The contract does not include any provisions for termination or forgiveness.

(d) The Medicaid recipient shall transfer any interest to Montana Medicaid after death. (However, Montana Medicaid will not retain payments beyond the amount of care provided to the recipient.)

Therefore, if real property is available, the strategy could work using a contract for deed in place of a promissory note.

If the applicant does not have real property, but does have sufficient resources, instead of simply issuing a promissory note to a family member, one could buy some property and then issue a contract for deed to the family member.

p. Purchase Income-Producing Property. In states where income-producing property is an exempt resource, purchasing it is a great way to turn countable resources into income, especially if it can be purchased in the name of the Community Spouse. Most states that exempt income producing property, require it to be gaining at least 6% return on equity. Thus if the property is worth $200,000 one must be receiving at least $12,000 a year in income from it.

This strategy will have limited effectiveness in Montana, however, as Montana caps the amount of equity that can be exempt in income producing property at $6,000. This low figure deals a serious blow to the effectiveness of this strategy.

q. Make Exempt Transfers

(1) Gifts to a blind, disabled (SSDI), or minor child

(a) Transferring assets to a child that is blind, disabled, or a minor is an exempt transfer of assets. In Montana, a minor child is one who is under the age of 21. There is no restriction on the amount of assets that can be transferred in this manner.

1) Transfers to a blind, disabled, or minor child should be made to a third party special needs trust for the benefit of that child instead of outright.

(2) Transfer of the personal residence

(a) 2 Year Plan—transfer to an adult child of the owner who resided with the applicant for two years immediately prior to the applicant's nursing home admission, and provided care which permitted the applicant to

reside at home (a doctor's statement must confirm the care provided deferred nursing home admission).

(b) Transfer to a sibling who has equity interest in the home and continually resided in the home for at least one year prior to the applicant's nursing home admission.

r. Purchase a life estate interest in a primary residence and live there for at least one year prior to nursing home admission (1 Year Plan).

s. Purchase Self-Employment Property for the Community Spouse.

(1) Must be Schedule C, F, or SE, personally owned.

(2) Must materially participate in the business at least an average of 10 hours per week, and be involved in decision making, etc.

(3) Pass-through entities do not qualify as self-employment.

t. Make the Gift and Wait. In some situations, the best thing to do is to simply wait out either the penalty period or the look back period.

(1) For example, if the cost of the patient's nursing home care is less than the state average (in Montana the state average is $201.67 per day and $6,134.12 per month), then it may be best to just make the uncompensated transfer and pay the duration of the penalty period. Nevertheless, remember the penalty will not begin to run until the patient is BOTH otherwise eligible AND institutionalized.

(2) In other situations, especially if the uncompensated transfer has already been made, it may be best to just wait out the 5-year look back period. However, remember if taking this approach that once the Medicaid application has been turned in, the look back date is firmly established. If the waiting out the look back period strategy is being implemented, remember to NOT apply for Medicaid until 5 years after the transfer.

(3) If this strategy is pursued it is very important that the person who receives the transferred assets not spend or dispose of them. It is important that the recipient be a trustworthy person who will not put the patient in a precarious position by disposing of needed assets and there being an estate recovery issue down the road.

VII. WHAT TO DO WHEN A MEDICAID APPLICATION IS DENIED

Much of the discussion herein is make in the context of nursing homes. However, where and ALF is receiving Medicaid payments for its residents, unless indicated otherwise by context, the Medicaid appeal process would apply to ALFs.

A common scenario an assisted living facility may face is that it only learns about a denial of a Medicaid application after the fact from family members of the Medicaid applicant. In order to

protect itself and potentially its only payment source, it is important that the ALF/nursing home carefully track the status of the Medicaid application and require family members or fiduciaries to promptly advise the ALF/nursing home upon receipt of a denial.

Practice Point: *Carefully track the status of the Medicaid application. Though it may not be the ALF/nursing home's obligation to do so, Medicaid payments may be an ALF/nursing homes only realistic source of payment.*

When legal counsel is contacted by an ALF/nursing home concerning past due payments and denied Medicaid, the first goal is typically to "stop the bleeding." There may be multiple denials of past Medicaid applications with thousands of dollars owing. Attention should be focused on what needs to be done to receive Medicaid right away so that ongoing expenses are paid for. Then attention can be given to collecting past amounts.

Practice Point: *Stop the bleeding. Determine if the resident can be discharged. If not, determine what can be done as soon as possible to obtain payment and future Medicaid. Past due accounts may quickly become "sunk costs." Focus efforts on what can be done to make sure future bills do not go unpaid.*

A. STEPS TO TAKE UPON MEDICAID DENIAL

We suggest taking the following steps upon learning that Medicaid has been denied.

1. Determine why the Medicaid application was denied.

   Often the answer isn't known because only applicants, families and fiduciaries have the denial paperwork from the Office of Public Assistance ("OPA"). Copies of the denial paperwork should be obtained from the family member right away. Generally, an Alf/nursing home does not directly receive notice of a Medicaid denial.[73] However, an ALF/nursing home may submit to the county Office of Public Assistance a written request for notice of a determination of a pending Medicaid application.[74] This is important because family members and fiduciaries may not keep the ALF/nursing home properly appraised of developments with the Medicaid application.

2. Common grounds for Medicaid denial and what to do about them.

   a. Failure to Communicate with OPA. The applicant is required to respond to OPA's request for information. OPA often sends 10-day letters with a warning that benefits may be denied if communication is not made.[75] In addition, OPA is granted 45 days to approve most Medicaid applications and 90 day days for applications based upon a disability determination.[76] It is this

[73] ARM § 37.5.307(3)(c).
[74] ARM § 37.5.307(3)(c).
[75] MA 103-1, p. 1.
[76] MA 103-1, p. 4; 42 C.F.R. § 435.911.

writer's experience that OPA may wrongfully use these deadlines as cut off points to deny Medicaid by default. Instead, if the Medicaid applicant is in even minimal contact with OPA, the application should remain open.

> "The agency may not deny Medicaid to an individual simply because necessary verification is not submitted within 45 days (or 90 days, as applicable) of the application as long as the individual is making appropriate attempts to obtain verification and is maintaining on-going communication with the OPA regarding such attempts."[77] (emphasis in original).

***Practice Point**: If OPA has prematurely closed the Medicaid application, appeal may be taken to reopen it. We have had success in reopening cases where we demonstrated that the applicant made minimal contact or that the 90 deadline for disability should have been used instead of the normal 45 days.*[78]

b. Failure to Verify Assets. The Medicaid applicant generally has the duty to verify that the applicant qualifies for Medicaid, including that the applicant's resources do not exceed the maximum limit.[79]

A detailed review of the Medicaid applicant's assets should be taken, including real estate, personal property and bank accounts. A careful analysis must be taken of any exempt assets. Then, a determination must be made as to how the assets will be dealt with to get under the Medicaid limit. For a nursing home that is owed for past due accounts, excess cash should be paid over to the nursing home and, if possible liens placed on other assets in order to "zero out the equity." We recommend involving legal counsel in the determination of whether and how to secure a lien on assets of the nursing home resident. For Medicaid purposes, unsecured debts do not reduce the value of the asset for Medicaid purposes, while secured debt does reduce the value for Medicaid purposes.[80] Therefore, debt must be secured, typically by consensual liens, such as a mortgage or UCC security interest.

Example: Applicant owns a parcel of commercial property valued at $50,000. Applicant owes nursing home $50,000 for a delinquent account. Applicant will not qualify for Medicaid because the value of the commercial property exceeds the resource limit. However, if the nursing home has a lien on the property in the amount of $50,000, the asset value becomes $0 and applicant may qualify for Medicaid.

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[77] MA 103-1, p. 5.
[78] *In re Anderson*, Case No. 11-1443, p. 6 (Office of Fair Hearings, Feb. 28, 2014).
[79] MA 103-1, p. 4.
[80] *Timm v. Montana Department of Public Health and Human Services*, 2008 MT 126, ¶ 51, 343 Mont. 11, ¶ 51, 184 P.3d 994, ¶ 51.

A common problem that may arise is that the nursing home resident is too incapacitated to assist with the Medicaid application. To complicate matters, the family member or fiduciary assisting the resident may be uncertain what to do, overwhelmed with the process, incompetent or outright fiendish. At some point, the nursing home will have to decide when to involve legal counsel. We suggest sooner, rather than later, before months pass and thousands of dollars are owed.

In cases where the above-scenarios may occur, we have had to undertake the following courses of action:

(1) Gather all interested parties together for a frank and detailed discussion of what needs to be done to verify the assets. Such parties may include Adult Protective Services, guardian, conservator, family members, fiduciaries, nursing home representative and legal counsel.

(2) Appoint a guardian and conservator. This may require making a demand upon adult protective services or filing a petition for the appointment of a guardian and conservator.

(3) Having the nursing home submit the Medicaid application. At times, we have even had to file lawsuits to subpoena bank and property records in order to verify assets for Medicaid.

(4) Real estate and vehicle records can be searched online.

3. Over-Resourced with Assets. In order to qualify for Medicaid, as a general rule, a single applicant can only have $2,000 and a married couple can only have $3,000 in nonexempt assets.[81] The applicant must figure out how to spend down the resources or convert the resources to nonexempt. In theory, the applicant should pay the nursing home bill until the assets are exhausted, whereupon Medicaid can then be approved. However, sometimes demand letters and lawsuits may be required in order to obtain payment.

Practice Point: *Always look for a method to demonstrate that an asset of the Medicaid applicant is "inaccessible." See, MA 401-1. This provides a method to demonstrate that a person, for reasons beyond their control, cannot access the value of asset. Unlike other "undue hardship" issues, the provision provides that an "undue hardship" exists if the cost of accessing the value of the property exceeds the value of the property. Other reasons include: joint owner refusing possession; if jointly owned real estate, if the sale would make the joint owner homeless; or, if listed for sale and no reasonable offer (2/3rds the estimated current market value) is received. Examine these reasons closely as other standards may be applicable, such as the need for listing real estate with a broker and advertising.*

[81] MA 001.

4. Uncompensated Transfers. An applicant is ineligible for Medicaid services if, during the relevant time period, "for the purpose of qualifying for medical assistance, the client has disposed of any resource . . . for less than fair market value . . ."[82]

    a. Examples of uncompensated transfers that we have dealt with include:

        (1) Money stolen by children, friends and fiduciaries.

        (2) Property sold for less than fair market value, often to family or friends.

        (3) Payments made to service providers, often friends or family, for services provided after the fact. Examples: taking care of mom's dog or house; gas to go visit mom in the nursing home.

        (4) Gifts, or family members with access to mom's checkbook giving gifts.

        (5) Bank account records showing payments made but no verification of the purpose of those payments.

        Uncompensated transfers carry a penalty the must be served before Medicaid will be approved.[83] The penalty period is calculated by dividing the uncompensated value of the asset by the average daily cost of the nursing home care at the time of the application.[84] All too often, the nursing home must eat the penalty costs because the applicant will not be able to pay.

    b. There are several exceptions to the uncompensated transfer penalty:

        (1) Property transferred to spouse or disabled child.

        (2) Transferred exclusively for a purpose other than to qualify for medical assistance.

        (3) Denial of eligibility would cause an undue hardship.[85] This exception is often referred to as the "hardship exception."

        Presently, as the hardship exception is currently listed in the Medicaid handbook, the hardship exception in Montana is incredibly difficult to apply.

        This generally requires showing: the transfer was due to theft, exploitation and the like; all reasonable legal recourse has been explored, including criminal charges and filing a civil proceeding. "At the minimum, an applicant (or the applicant's representative" must file a report with the police and pursue a civil action." Fawn Kirkpatrick, *Medicaid Look-Backs and Undue Hardship Are the Elderly Being Denied Access to Basic Human Rights Due to Exploitation?*, 39 Mont. Law. 16 (April 2014). However, Montana undue hardship law is contrary to governing federal law. Federal law, through statute and through administrative regulation,

[82] ARM § 37.82.417.
[83] MA 404-2, p. 1.
[84] MA 404-2, p. 1.
[85] ARM § 37.82.417.

establishes the minimum definition of undue hardship that a state must use in its administration of Medicaid. 42 U.S. C. § 1396p(c)(2). In 2006, Congress passed the Deficit Reduction Act of 2005 ("DRA"). In § 6011(d) of the DRA, Congress required states to provide for hardship waivers and defined the minimum standard for finding a hardship waiver. *Id*. at § 6011(d). In pertinent part, the Act provides:

> (d) AVAILABILITY OF HARDSHIP WAIVERS. -- Each State shall provide for a hardship waiver process in accordance with section 1917(c)(2)(D) of the Social Security Act (42 U.S.C. 1396p(c)(2)(D))-
> (1) under which an *undue hardship exists when application of the transfer of assets provision would deprive the individual* -
> (A) *of medical care such that the individual's health or life would be endangered; or*
> (B) *of food, clothing, shelter, or other necessities of life*;…

Thus, the DRA established that "undue hardship" must at the very least be defined as to exist in situations where imposing a penalty would deprive an applicant of necessary medical care or deprive an applicant of necessary food, clothing, or shelter.

Under the DRA, an applicant should be able to receive a waiver by showing that application of the penalty rules would deprive the applicant of necessary medical care or of food, clothing, shelter, or other life necessities. When determining a hardship, the DRA doesn't contain any statement that the reason an individual is without assets should matter to a reviewing authority. Rather, the reviewing authority should focus on whether the penalty would seriously endanger the applicant as set out in the DRA.

Accordingly, undue hardship exists when application of the transfer of assets provisions would deprive the individual of medical care such that his/her health or his/her life would be endangered. Undue hardship also exists when application of the transfer of assets provisions would deprive the individual of food, clothing, shelter or other necessities of life. Because of Congress's express mandate in the DRA and because of §1396p(c)(2)(D)'s express requirement that states conform their medicaid programs to the standards specified by federal agencies, Montana must conform to the federal definition of undue hardship.

The Montana Department of Public Health and Human Services has conceded that Montana's hardship exception does not comply with federal

law.[86] However, as August 13, 2014, the Department has not changed the offending rule. The Office of Fair Hearings has been asked to order and declare that the hardship rules are invalid.[87]

(4) Cost to access the property exceeds the value of the property.[88]

(5) The property is not accessible. "Resources are considered accessible either when actually available to the individual or when the individual has a legal or equitable interest in the property or asset and has the legal or equitable ability to access funds or to convert non-cash property into cash, regardless of whether the individual has the practical ability to access the funds or to convert non-cash property into cash."[89] This issue has been litigated at times, but questions as to how "accessible" would be applied still remain.

(6) The property was not "transferred." For example, case law has stated that "transfer" requires a purposeful and voluntary act. Where assets are taken through a non-voluntary act of the Medicaid applicant, such as an applicant suffering from dementia, there may not be a "transfer."[90]

(7) The state can file suit again a person who receives an asset for less than fair market value when the Medicaid applicant receives medical assistance under the hardship exception. The state can recover a 100-150% penalty, plus attorney fees.[91]

B. APPEAL OF MEDICAID DENIALS

Fair Hearings. The first ground for appealing a Medicaid denial is to request a Fair Hearing.

1. Administrative Review. Upon request for a fair hearing, the Department of Public Health and Human Services first conducts an administrative review with the purpose of resolving the case and avoiding an unnecessary fair hearing. The review may be telephonic. The review is typically an informal conference and involves the review of the facts and law. A report following the administrative review is submitted by the hearing officer.[92]

2. The Role of an Attorney. Some of our nursing home clients prefer to handle fair hearings with staff members. Others prefer to involve legal counsel. The nursing

[86] See motions and briefs filed in *In the Matter of the Fair Hearing of Agnes Graham*, Case No. 12-0933 (Before the Office of Fair Hearings).
[87] *Id*.
[88] MA 401-1, p. 5.
[89] MA 401-1, p. 2.
[90] See e.g., *Lee v. St. Dept. of Public Health & Welfare*, 480 S.W.2d 305, 309 (Mo.App. 1972); *Gangloff v. Commr. of Public Welfare*, 196 N.E.2d 644 (Mass. 1964).
[91] Mont. Code Ann. § 53-6-190.
[92] ARM § 37.5.318.

home should have internal policies for involving legal counsel. Depending on the type of dispute, it is this writer's position that the attorney should be involved in the Medicaid dispute as soon as possible and prior to the request for the fair hearing.

3. The Nursing Home is Entitled to Request a Fair Hearing. "A claimant who is aggrieved by an adverse action of the department shall be afforded the opportunity for a hearing . . ."[93] A "claimant" is defined to include, "a medical assistance provider appealing an eligibility determination as a real party in interest."[94] A "medical assistance provider" is defined as "any individual or organization providing services to eligible claimants under the Montana Medicaid program . . ."[95] While "real party in interest" is not defined in Montana Administrative Rules, in other contexts it is defined as a party who will benefit from the requested relief. *Missouri, Kansas & Texas Ry. Co. v. Missouri R. and Warehouse Comm'rs,* 183 U.S. 53 (1901). This concept is very similar to what is referred to as "standing," which requires a "personal stake in the outcome" of the matter. *Greater Missoula Area Fedn. Of Early Childhood Educators v. Child Start, Inc.* 2009 MT 362 ¶23, 353 Mont. 201 ¶23, 219 P.3d 881 ¶23.

   As a practical matter, a nursing home that will be the recipient of Medicaid funds if approved has never, in my experience, been objected to as having the right to contest a Medicaid application denial[96]. In fact, under MA 1506-1, OPA notes that "State law grants any 'real party in interest' (e.g., medical providers) the right to request a fair hearing and or appeal the decision." State Administrative Rules provide that a medical assistance provider is entitled to a hearing with the same procedures as available to other claimants.[97]

   However, the nursing home is required to verify or establish eligibility.[98]

4. How a fair hearing is instituted. There is no specified formality for instituting a fair hearing request. The Department has a form. I typically use a letter. "A request for a hearing is any clear written expression by the claimant or an authorized representative to contest an adverse action . . ." [99] The request for hearing is generally due within 90 days of the notice of adverse action.[100]

5. Procedure.

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[93] ARM § 37.5.307(1).
[94] ARM § 37.5.304(5)(c).
[95] ARM § 37.5.304(12).
[96] The Montana Supreme Court has noted that a hospital is entitled to request and appear at a fair hearing, even if the beneficiary fails to appear, for "welfare reimbursement" for emergency medical treatment. *See, Montana Deaconess Hospital v. Lewis and Clark County, 149 Mont. 206, 210, 425 P.2d 316, 318*, *See also, County of Blaine v. Moorer, 174 Mont. 114, 568 P.2d 1216 (1977)*, allowed application by provider after beneficiary had incurred substantial expense.
[97] ARM § 37.5.307(3).
[98] ARM § 37.5.307(3)(b).
[99] ARM § 37.5.307(1)(a).
[100] ARM § 37.5.307(1)(c).

a. Dismissal. The fair hearing may be dismissed upon withdrawal by claimant, the claimant fails to appear at the hearing, or the request for hearing is not timely received.[101]

b. Hearing Officer. A fair hearing is conducted by a hearing officer of the Department of Public Health and Human Services. The hearing officer can:

(1) Compel the attendance of witnesses;

(2) Production of documents by a subpoena,

(3) Require compliance with reasonable and appropriate orders'

(4) Grant summary judgment.

(5) Administer oaths

(6) Receive evidence

(7) Regulate the conduct of the hearing with due process

(8) Prepare a proposal of decision containing findings of fact and conclusions of law. [102]

c. Hearing procedure:

(1) Conducted by telephone unless a party requests an in-person hearing.

(2) Notice is given in advance of hearing explaining claimant's rights and procedures.

(3) The claimant has the opportunity to examine the case file, present the case himself or with a representative, bring witnesses, advance arguments, cross examine and conduct discovery.[103]

(a) The hearing officer prepares a proposed decision consisting of findings of fact, conclusions of law and contains a statement setting forth the parties' rights to appeal.[104]

Practice Point: *The hearing officer can issue subpoenas to obtain records needed to verify assets or show uncompensated transfers. We have used subpoenas to obtain:*

- *Bank account records and cancelled checks;*
- *Land sale documents;*
- *Evidence of assets.*

[101] ARM § 37.5.313.
[102] ARM § 37.5.322.
[103] ARM § 37.5.325.
[104] ARM § 37.5.328.

(4) Notice of appeal. Appeal from the hearing officer's ruling is made to the Board of Public Assistance. It must be received within 15 days of the date of the mailing of the notice of the proposal for decision.[105]

[105] ARM § 37.5.331.

6. Board of Public Assistance Appeals.

a. Notice is usually given of the date and time for the Appeal. The Board of Public Assistance Appeals meets on the third Thursday of each even numbered month.

b. The appellant can file an optional brief in support of its appeal within 10 days of the hearing. A reply brief may be filed within five days.[106]

c. The Board may not consider or make a part of the record any evidence not admitted in evidence by the hearing officer.

Practice Point: *Make sure any evidence you want considered is presented to the hearing officer at the Fair Hearing. You may be barred from adding additional evidence.*[107]

d. Board of Public Assistance appeals can be conducted by telephone or in person in Helena.

e. It is my experience that the Board deliberates verbally, announces a decision, and then later provides a written decision.

f. Judicial Review

(1) A party who is aggrieved by a final decision may seek judicial review by filing a petition in district court within 30 days after service of the final decision[108].

Practice Point: *You must "exhaust all administrative remedies" before seeking review of the Court. In other words, if you do not argue the point at the Fair Hearing and in front of the Board of Public Assistance, you generally are not permitted to argue the issue to the Court.*[109]

(2) Petition. The petition for judicial review "must include a concise statement of the facts upon which jurisdiction and venue are based, a statement of the manner in which the petitioner is aggrieved, and the ground or grounds specified in 2-4-704 (2) upon which the petitioner contends to be entitled to relief."[110]

(3) Review confined to the record. Judicial review is generally confined to the record of the case as submitted to the hearing officer at the Fair Hearing.[111]

However, there is an exception that will allow additional evidence to be presented if the additional evidence is "material and that there were good reasons for failure to present it in the proceeding before the agency, the

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[106] ARM § 37.5.331.
[107] ARM § 37.5.331.
[108] ARM § 37.5.331; Mont. Code Ann. § 2-4-702.
[109] *Marble v. State Department of Health and Human Services*, 2000 MT 240, 301 Mont. 373, p P.3d 617.
[110] Mont. Code Ann. § 2-4-702(2)(b).
[111] Mont. Code Ann. § 2-4-704(1).

court may order that the additional evidence be taken before the agency upon conditions determined by the court."[112]

Practice Point: *Good reason "doesn't include evidence to bolster claim". Example would be when the "discovery of the evidence is beyond the control" of the party prior to the hearing – i.e. discovery of a new and unknown witness.*[113]

(4) Grounds for review:

(a) The court cannot substitute its judgment for that of agency as to the weight of the evidence on questions of fact[114].

(b) The court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because:

1) the administrative findings, inferences, conclusions, or decisions are:

a) in violation of constitutional or statutory provisions;

b) in excess of the statutory authority of the agency;

c) made upon unlawful procedure;

d) affected by other error of law;

e) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record;

f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion; or

2) findings of fact, upon issues essential to the decision, were not made although requested.[115]

Practice Point: *The latest district court statistics note that the average clearance time for civil matters from filing to final judgment is 730 days.*

C. SUPREME COURT APPEALS

1. The party that loses the judicial review may appeal to the Montana Supreme Court within 60 days after entry of judgment.[116]

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[112] Mont. Code Ann. § 2-4-703.
[113] See, *Pannoni v. Board of Trustees*, 2004 MT 130, 321 Mont. 311, 90 P.3d 438.
[114] As long as substantial credible evidence exists to support the administrative findings, the reviewing court may not overturn them. *Roeber v. State, Dept. of Institutions*, 243 Mont. 437, 440, 795 P.2d 424, 426 (1990). Substantial evidence must be more than a scintilla, but may be less than a preponderance, of evidence. *Miller v. Frasure* (1991), 248 Mont. 132, 137, 809 P.2d 1257, 1261. Look for "firsthand knowledge" of facts or "expert opinions" in order to ensure the evidence is reliable and should be considered. *See*, *Wheatland County v. Bleeker*, 175 Mont. 478, 575 P.2d 48 (1978).
[115] Mont. Code Ann. § 2-4-704.
[116] Mont. Code Ann. § 2-4-711.

2. At the Supreme Court, the appellant (the party that files the appeal) must order the record of proceedings from the cases appealed from and any transcripts. This must be done at the same time of filing the notice of appeal. The transcript is submitted to the Supreme Court within 45 days.

3. Upon submission of the transcript, the appellant must file its appeal brief within 30 days. The appellee must file a response brief within 30 days. The appellant may file an optional reply brief within 15 days.

4. The standard of review is the same as at the District Court level.[117]

5. Whether or not a rule has been interpreted properly, either at the District Court level or the agency level is "whether the interpretation is reasonable and not plainly inconsistent with the Rule's spirit[118]."

6. The Supreme Court will decide whether the full court will decide the appeal, or just a panel of five judges and whether to have oral argument or to just decide the appeal based upon the written briefs. Court decisions are usually issued within a varied degree of time. As it presently stands, most general civil matters are processed by the Montana Supreme Court in approximately 300 days.

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[117] Mont. Code Ann. § 2-4-704. *See also, Kirchner v. State*, 2005 MT 202, 328 Mont. 203, 119 P. 3d 82.

[118] *Juro's United Drug v. Montana Dept. of Public Health and Human Services*, 2004 MT 117, 321 Mont. 167, 90 P. 3d 388. In addition, the Court tries to determine the intent from the plain meaning of the words, and if the meaning of the statute or rule can be determined from the language used. In the absence of the Court does not consider any other information, such as comments or explanations from the agency. *See, Glendive Medical Center Inc. v. Montana Department of Public Health and Humans Services*, 2002 MT 131, 310 Mont. 156, 49 P. 3d 560.