House Joint Resolution 25

A report to the Children, Families, Health and Human Services Interim Committee

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MONTANA
Department of Public Health & Human Services

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INTRODUCTION

House Joint Resolution 25

In order to examine difficulties encountered by individuals during the Medicaid Long-Term care (LTC) eligibility determination process, the 61st Legislature passed House Joint Resolution 25 (HJR25)[1]. The goals of this study, as written in the language, are the following:

(1) identifying and examining difficulties experienced by those applying for Medicaid nursing home services;
(2) identifying and examining difficulties experienced by nursing facilities related to the admission and care of those applying for Medicaid assistance;
(3) identifying and examining which parts of the eligibility determination process are dictated by state or federal laws and regulations;
(4) identifying and examining which parts of the eligibility determination process are based on state interpretations, policies, and procedures;
(5) identifying and examining any possible solutions to the issues and concerns presented by consumers and providers, including but not limited to discussion of expanded use of hardship provisions, more clarity with respect to expectations, establishment of parameters for what constitutes a good faith effort to obtain information sought by the state, provision of more specific information about the legal basis for denial of eligibility, financial relief to facilities that admit residents in crisis pending eligibility determination, and ability of applicants to transfer or assign annuities, life insurance policies, and property to the state when there is a dispute about the liquidity or value of the property;
(6) identifying and examining any costs related to identified solutions; and
(7) identifying and examining any other issues and concerns considered pertinent to the study.

Workgroup

A committee consisting of Department of Public Health and Human Services (DPHHS) Medicaid and Senior and Long Term Care (SLTC) specialists, legislators, advocates, legal and health care professionals was formed to carry out a study and report to Children, Families, Health, and Human Services Interim Committee. The work group met monthly from August 2009 to September 2010. See Appendix B for a full list of committee representatives.

BACKGROUND

Nursing home care and costs in the state of Montana

There are currently over 4,700 people receiving care in 86 nursing home facilities across the state of Montana. This accounts for approximately 0.5% of the state's population of 974,989. The care that these nursing home residents receive is considered "long-term," with the average length of residency expected to be three years.

The costs of nursing home care vary somewhat depending on the type of care, but the average cost of care in 2011 to an individual is estimated to be $5,473.20 a month or $66,590.60 a year[2]. These costs are generally covered in three ways: through the personal income and resources of the nursing home

[1] See Appendix A for a copy of House Joint Resolution 25
[2] DPHHS

resident or their family members, through long-term care insurance, or through Medicaid nursing home coverage.

The role of Medicaid

Medicaid is a federal-state program which provides medical care to certain low-income individuals. While Medicare (a program which covers medical costs for all individuals over the age of 65, individuals under the age of 65 with certain disabilities, and people of all ages with End-Stage Renal Disease) pays for inpatient hospital care and some transitional services, it does not cover the costs of long-term care (LTC) services including the costs of nursing home facilities. Because of this, Medicaid plays a large role in paying for nursing home costs in the state of Montana. Of the over 4,700 nursing home residents, about 62% receive Medicaid coverage. The total amount of Medicaid spending on nursing facility care in the state of Montana was $152,492,178 for state fiscal year 2010[3].

STUDY OBJECTIVE 1: Identifying and examining difficulties experienced by those applying for Medicaid nursing home services

The committee surveyed applicants in order to identify difficulties encountered during the application and eligibility process.

Production and distribution of survey

Surveys were initially drafted on July 23, 2009 and periodically submitted to the committee for suggestions on what was to be incorporated in the survey.

Final draft of the applicant survey was submitted on 3/1/2010 to all members of the committee, and a meeting was held on 3/1/2010 to discuss the final approval of the survey. The final survey was approximately four pages long and included 13 multiple choice and short answer questions[4]. In addition, respondents were given the opportunity and asked to share as much additional information as necessary.

The population chosen to be surveyed was drawn from an initial pool of 3,902 applications from 2/1/2008 to 9/24/2009. From this pool, surveys were sent to all applicants whose application showed that it took 45 days or greater to receive a determination regarding eligibility. Because applicants often have help during the eligibility process, the survey requested that it be completed by either the applicant or the person who helped the applicant apply for Medicaid coverage ("personal representative").

A total of 1193 surveys were sent to applicants from 39 counties (Beaverhead, Bighorn, Blaine, Carbon, Cascade, Chouteau, Custer, Dawson, Deer Lodge, Fallon, Fergus, Flathead, Gallatin, Glacier, Hill, Lake, Lewis and Clark, Lincoln, Meagher, Mineral, Missoula, Musselshell, Park, Phillips, Pondera, Powell, Prairie, Ravalli, Richland, Rosebud, Sanders, Sheridan, Silver Bow, Stillwater, Sweet Grass, Teton, Toole, Valley, and Yellowstone).

[3] DPHHS

[4] See Appendix C for a copy of the final survey sent to applicants.

Surveys were mailed on March 11- March 12, 2010 with a pre-addressed, pre-paid envelope with a due-date of March 31, 2010. A total of 418 surveys from 36 counties were completed and returned (35%).

Results

Below are some of the findings based on data received from 418 applicants. See Appendix D for a complete summary of the results.

Application

Fifty-seven percent (**57.1%**) of respondents reported that they did not encounter any problems with the application.

The surveys were completed by the individual(s) who completed the application for the applicant/recipient ("personal representative"). Respondents reported the following relationship to the applicant, in order of frequency:

- Child (**48.3%**)
- Spouse (**18%**)
- Other family member (**10%**)
- Nursing facility staff (**5.9%**)
- No one helped/applicant completed the application on his/her own (**3.3%**)
- Friend (**2.4%**)

Approximately twenty-four percent (**24.1%**) of applicants/survey respondents reported that they did not receive any help with the application. The most common people assisting applicants were:

- OPA staff members (**38.3%**)
- Nursing facility staff members (**24.4%**)
- Family members (**12.7%**)

The most frequent problem applicants/survey respondents reported with the application was that it asked for information that the applicant did not have on hand (**24.8%** of respondents) such as:

- Information about assets (**30.7%** of people who experienced this problem)
- Bank statements (**30.7%**)
- Insurance information (**28.2%**)

Applicants/survey respondents who claimed to have difficulty getting access to the information they needed (**13.3%**) reported having the most difficulty gaining access to:

- Insurance information (**37.5%**)
- Information about assets (**25%**)
- Bank statements (**21.8%**)

Process

The average number of times that the applicant/survey respondent met with his or her case manger was 1.87 times, and the range was zero to ten times. The majority (**90.9%**) found that meeting with a case manager was helpful.

Of those applicants/survey respondents who reported that they did not meet with a case manager, the following reasons were given: a meeting was not offered (**35%**), the applicant did not feel that a meeting was necessary (**35%**), and a meeting was not possible due to the location or mobility of the applicant (**29%**).

The majority (**85.6%**) discussed their cases over the phone with their case managers.

The average overall customer service rating, on a scale of one to five, was 3.9.

Other

The most common difficulties reported in the eligibility process were:

- Understanding what information was needed (**22.0%**)
- Understanding how to get the information that was needed (**18.6%**)
- Getting copies of contracts from life insurance/annuity companies (**18.4%**)
- Getting proof of assets/resources (**17.4%**)
- Timeframes to submit information were too short (**12.2%**)

The majority (**87.8%**) found the notices sent by the OPAs to be clear and understandable.

The majority (**82.5%**) would be interested in a pre-qualification/pre-application process.

STUDY OBJECTIVE 2: Identifying and examining difficulties experienced by nursing facilities related to the admission and care of those applying for Medicaid assistance

The committee surveyed nursing facilities in order to identify difficulties experienced by facilities when serving Medicaid applicants/recipients.

<u>Production and distribution of surveys</u>

In order to determine what difficulties, if any, are encountered by nursing facilities when caring for residents who are applying for Medicaid, a survey was created. Surveys were initially drafted on July 23, 2009 and periodically submitted to the committee for suggestions on what was to be incorporated into the survey.

Final draft of the nursing facility survey was submitted on 11/10/2009 to all members of the committee, and a meeting was held on 12/1/2009 to discuss the final approval of survey. The final survey included

23 multiple choice and short-answer questions. In addition, facilities were given the opportunity to share specific cases in which there had been a delay in eligibility determination[5].

A total of 89 long-term care facilities were offered the opportunity to complete a survey. This population was chosen with the assistance of DPHHS Senior and Long Term Care Division who provided an initial list of current nursing facilities which was then augmented with suggestions by members of the committee.

Each facility was given a unique link to the survey which could be completed online through the program Survey Gizmo (surveygizmo.com). The link was e-mailed to facility administrators and/or personnel of each facility on January 15, 2010. Responses were monitored, and facilities which had not completed a survey were periodically sent reminders. Facilities were also given the option to return hard copies of the survey.

The survey was closed electronically on March 10, 2010. An 83% response rate was achieved. This is extremely high relative to the average expected response rate for a client survey of 10-15% and to an internal survey of 30-40%[6].

Results

Below are some of the findings based on data received from 74 nursing facilities. See Appendix F for a complete summary of the results, including the reported financial impact and short-answer responses.

Application

The facilities reported a total of 1,589 residents have applied for Medicaid coverage in the past 12 months. The majority of these applications (56.8%) were completed by the residents' families. The facilities themselves completed 35.4% of these applications.

The majority (**71%**) feels that problems are more likely to arise for newly admitted residents rather than established residents (**25%**).

The two most common problems encountered when completing the application were that the application asked for information the facility did not have on hand (experienced by **61%** of facilities) and that the application asked for information the facility did not have access to (**58%**).

Twenty percent (**20%**) of facilities reported that they did not have any problems with the application itself.

Timeliness

The facilities estimate that **47.3%** of Medicaid applications were processed within 45 days.

Of the applications which were not processed within 45 days, **44%** of facilities report that the family failure to provide information to the Office of Public Assistance (OPA) is a frequent cause for delay.

[5] See Appendix E for a copy of the final survey sent to nursing home facilities.

[6] Donna S. (2010, Jan 28). Survey Response Rates. http://www.surveygizmo.com/survey-blog/survey-response-rates/

Other

The majority of facilities (**83%**) report that they have a functional working relationship with the OPA, within the bounds of HIPAA.

Fifty-five percent (**55%**) of facilities report that they have experienced differences between the OPAs in different counties.

The majority of facilities (**93%**) would send someone to attend more seminars to provide education about Medicaid eligibility policies and processes and provide additional access to information.

The majority of facilities (**90%**) believe that a pre-application process would be used if offered, and 89% believe that a pre-application process would be helpful.

Financial impact

Nursing facilities were asked to list any cases in which they felt some financial impact which they believed were due to Medicaid eligibility processing. The facilities reported a total of 128 cases in which Medicaid was either denied or delayed. The total financial impact of these cases was **$1,958,959.07**. The range of costs per resident for these cases is from $801 to $100,000, with an average of **$15,304.37**.

STUDY OBJECTIVE 3 AND 4: Eligibility policies dictated by state or federal laws and regulations, state interpretations, policies, and procedures

Research was undertaken in order to determine the basis for Montana's current Medicaid policy regarding countable and excluded income and resources. A summary of the results is below. Please see Appendices G and H starting on page 38 for a complete table of Montana's income and resource policies, respectively.

Note: States have the option to adopt more liberal income and resource eligibility policies with approval from CMS through changes to the Medicaid State Plan under provisions of the Social Security Act Section 1902r(2). However, not all state proposals are approved, particularly if they directly conflict with new Congressional action or the intent of Congressional action, and require attachment of fiscal notes for both State General Fund and federal costs.

<u>Income</u>

Of 118 different types of income as classified by the Medicaid policy:

- 52 (**44.0%**) types are always counted when determining Medicaid eligibility,
- 48 (**40.6%**) types are always excluded when determining eligibility, and
- 18 (**15.2%**) types may be counted or excluded, depending on the circumstances of the specific income or case.

In addition:

- 110 (**93.2%**) of these policies are determined by federal rule,
- 5 (**4.2%**) are based on DPHHS interpretation, and
- 3 (**2.5%**) are based on a state option.

- Of the policies dictated by the state, 2 of the 3 (**67.7%**) were cases in which the state opted to apply a more liberal criteria than the federal rules required, allowing for more exemptions.

Resources

Of 63 different types of resources as classified by Medicaid policy:

- 25 (**39.6%**) types are always counted when determining Medicaid eligibility,
- 23 (**36.5%**) types are always excluded when determining eligibility, and
- 15 (**23.8%**) types may be counted or excluded, depending on the circumstances of the specific resource or case.

In addition:

- 53 (**85.7%**) of these policies are based on federal rule,
- 5 (**7.9%**) are based on DPHHS interpretation, and
- 5 (**7.9%**) are based on a state option.
- Of the policies dictated by the state, 4 of the 5 (**80%**) were cases in which the state opted to apply a more liberal criteria than the federal rules required, allowing for more exemptions.

STUDY OBECTIVE 5: Examining current eligibility practices, including the undue hardship exemption for uncompensated asset transfers

Eligibility process

Medicaid is a means-tested program, which determines eligibility based on both financial and non-financial criteria. There are two categories of Medicaid—"family" and "aged, blind, and disabled." Institutional Medicaid (which is responsible for nursing facility care) is paid for through the aged, blind, and disabled category. In order to qualify, an individual must prove that he or she is 65 or older, or blind according to Social Security Administration (SSA) standards, or disabled according to SSA standards.

In addition, certain income and resource standards must be met. There is no income limit, but individuals may be required to meet a deductible. Before an individual is able to receive Medicaid coverage for his or her nursing facility care, he or she must show proof of eligibility for both financial and non-financial criteria. In the eligibility determination process, it is first determined whether the applicant is categorically needy or medically needy, and the appropriate policy is applied. Next, a determination is made of financial need to calculate whether the applicant is eligible for Medicaid coverage of institutional cost of care. The applicant's total income is compared to the net Medicaid cost of care for the individual at the facility where they reside. If the applicant's income is over the cost of care, the applicant is not eligible for institutional coverage. If income is under, then the individual's contribution is determined.

The current resource limit is $2,000 for an individual. An individual's resources include, but are not limited to, any checking or savings accounts, homes, family farms, trusts, life insurance policies, and annuities. When an applicant applies for coverage, proof of the value of all resources must be provided to the case worker at the Office of Public Assistance. If an applicant has a spouse, then the spouse not

in need of nursing facility care is allowed to retain a minimum of $21,912 of the couple's combined resources, or, if more, half of their total combined resources up to a maximum of $109,560.

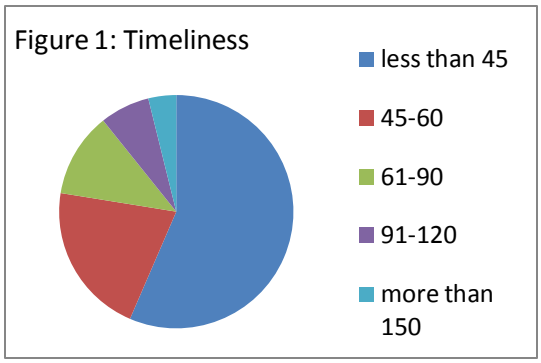
Applications for Medicaid coverage can be made in person at any OPA or by mail or fax. An online application is available at the agency's website. Face-to-face interviews with case workers are available and encouraged but are not required. Applicants and recipients are also able to reach their case workers through telephone contact.

Timeliness

The goal of DPHHS is to process all applications for nursing facility Medicaid with 45 days as set by the Code of Federal Regulations (CFR). Applicants who are actively engaged in securing documentation are allowed extensions of 10 days each from their caseworkers.

Based on a report from The Economic Assistance Management System (TEAMS), which was used to determine and track eligibility, **93%** of applications were processed in 90 or less days. The following timeliness rates were achieved for applications received between 2/1/2008 and 9/24/2009:

- less than 45 days between application date and eligibility determination: 2,591 (66.4% of total applications)
- 45-60 days: 591 (15.4%)
- 61-90 days: 439 (11.2%)
- 91-120 days: 59 (1.5%)
- Greater than 150 days: 60 (1.5%)



Uncompensated asset transfers and undue hardship[7]

An applicant is subject to a 60 month (five year) "look-back" period upon application for institutional Medicaid coverage. If it is determined that an applicant has transferred a resource (or "asset") in order to qualify for Medicaid without receiving its fair market value in return, he or she is considered to have made an uncompensated asset transfer and may be subject to a penalty. These transfers may come in the form of gifts, the creation of trusts, the purchase of annuities, waiving or failing to pursue benefits or assets one may be entitled to receive, or other forms. This penalty is determined by the value of the transferred assets, and can disqualify an individual from receiving Medicaid institutional coverage for up to five years.

If an applicant has only transferred an asset due to exploitation, he or she may be eligible for an undue hardship exemption. The policy is based on that defined by the Deficit Reduction Act (DRA) of 2005. In order to qualify, an applicant must prove not only that he or she would be deprived of necessary medical care if coverage was not instituted, but also that the asset was only transferred as a result of

[7] See MA 404-1 in Appendix I

fraud, misrepresentation, or coercion and that the exploited individual has exhausted all available legal recourse to recover the assets.

STUDY OBJECTIVE 6: Difficulties experienced and ideas for improvement

Based on the findings of this committee, the following areas have been identified along with possible solutions and the estimated costs of these solutions.

Difficulties experienced by applicants during the application process

PROBLEM: Applicants have difficulty knowing what kind of information/documentation is needed and how to provide this information.

- OPTION 1: **Provide improved educational material for applicants**. The committee has developed a prototype educational packet which addresses common difficulties applicants report encountering. This packet includes information on topics such as, but not limited to:
    - "Medicaid Step-by-Step," which gives an applicant advice on what to do both before and after the application is submitted and guides him or her through the process of applying Medicaid coverage for his or her nursing facility care.
    - "Helpful Hints When Applying for Medicaid for Nursing Home Care," which gives advice for how to make the application process go smoothly and lists the types of verification generally required from an applicant.
    - Information about annuities—both explain how they are treated as assets by the Department and explaining how to sell an annuity.
    - Information about long-term care insurance and long-term care partnerships
    - Information about Veterans benefits

  ESTIMATED COST: Printing and material cost of $1,500 for 1,000 copies. Minimal cost to make available online.

- OPTION 2: **Improve the online resources available from the Department.** The committee proposes that the website be streamlined and made more user-friendly in order to make it easier for applicants and their family members find the information they need both before and during the process. In addition, all educational materials developed should be made easily available on the website and contact information for local OPAs should be made easily accessible.

  ESTIMATED COST: $0

- OPTION 3: **Provide improved education for nursing facility providers**. It has been found that many applicants go to their nursing facilities for help during the application process. In addition, nursing facilities suffer financially when their residents are unable to complete the eligibility process in a timely manner. By providing seminars and better training materials to nursing facilities and hospitals, these providers will then be able to better serve their clients' needs.

ESTIMATED COST: $2,000 a year to attend association conferences and nursing facilities

- OPTION 4: **Promote and encourage a pre-application process for applicants.** While it has always been possible for clients to schedule an interview with a case worker prior to submitting an application, based on survey results the majority of both facilities[8] and applicants[9] are unaware that this pre-application process is available. We have included information about what applicants can do prior to their need to apply for Medicaid coverage in the educational packets (see page 12 for more information about educational packets).

  ESTIMATED COST: $0 in additional costs (see page 12 for more information about educational packet)

Annuities

PROBLEM: Acquiring information regarding annuity contracts and other information from annuity companies has often been cited as a barrier to completing a Medicaid application by the applicants, nursing facilities, and the Department.

- SOLUTION: **The Office of the Commissioner of Securities and Insurance has been informed of the difficulty that some applicants have encountered when attempting to receive proof of annuities.** Information from the Insurance Commissioner's Office about the requirement has led to annuity/insurance companies being more willing to provide applicants the documentation required to determine eligibility.

  ESTIMATED COST: $0

Uncompensated asset transfers and undue hardship

PROBLEM: Applicants have difficulty proving that they qualify for an undue hardship exemption for uncompensated asset transfers[10]. This is, in part, due to the requirement that an applicant "pursue all legal recourse" including "filing a civil court action and pursuing the civil action to its conclusion." It can be difficult for applicants of limited means who have often been exploited to find legal representation in such cases.

- SOLUTION 1: **Modify and clarify the existing hardship policy.** The committee has worked to clarify the existing policy by tempering the language and adding words such as "reasonable available legal recourse." The goal of this action is to give some discretion in cases where a civil case would be inappropriate, while still providing consistency and equal treatment. These changes are anticipated to be incorporated in the Medicaid manual by January 2011.

[8] Please see the discussion of facility surveys, pages 7-9 and Appendix F
[9] Please see the discussion of applicant surveys, pages 5-7 and Appendix D
[10] See MA 404-1 in Appendix I

ESTIMATED COST: $0

- OPTION 2: **Provide a "modest means program" in order to give applicants greater access to legal resources to pursue a civil case.** This program, Legal Representation for Seniors Filing Civilly (LRSFC), would provide legal representation at a reduced rate for applicants who otherwise qualify under the undue hardship exemption, allowing them to pursue recovery of their lost assets in civil court. See Appendix J for a draft of one proposed modest means model.

  ESTIMATED COST:
  - **Attorney fees:** $24,000.00
  - **Malpractice:** $30,000.00
  - **Paralegal Support:** $7,500.00
  - **Investigation:** $13,000.00
  - **State Bar:** $20,000.00
  - **Collection Process:** $1000.00 plus travel expenses per case
  - **LRSFC FEES:** $1000.00
  - **One Time Start-up for Mt AAA Legal Services fee**: $20,000.00

- OPTION 3: **Legislation which would put into law a penalty for the recipient of assets received in order for an applicant to qualify for Medicaid.** After reviewing hardship policies in neighboring states, it was discovered that Washington has a law which penalizes the recipient of any funds transferred in order to qualify for Medicaid coverage[11]. It is believed that a similar law in Montana could accomplish the following:
  - Act as a deterrent—encouraging those who receive assets to return them to the Medicaid applicant as is usually the case in Washington[12]
  - Reduce the need for the filing of civil suits by individual applicants
  - Provide funding for a modest means program which would help applicants pursue legal recourse against the recipients of their asset transfers, as discussed above
  - It is too late in the legislative process for the Department to pursue such legislation, but legislation could be proposed independently by a legislator.

  ESTIMATED COST: $0 to the Department

<u>Life insurance</u>

PROBLEM: Some applicants believe they must cash out their life insurance policies for amounts well below the policy's face value in order to qualify for Medicaid coverage. While there may be options other than cashing out life insurance, if the applicant takes action to cash in a life insurance policy, the delays in accessing the value in cash could cause months of ineligibility for Medicaid, which leaves the applicant without Medicaid eligibility and their nursing facility with an unpaid bill.

[11] RCW 74.39A.160 Transfer of Assets—Penalties, see Appendix K

[12] Personal correspondence with Lori Rolley, Financial Policy Analyst in WA state on August 3, 2010

- OPTION: **Allow applicants to exempt the value of their life insurance if they name DPHHS/Medicaid program as the irrevocable primary beneficiary.** The 'assigned' life insurance cash value could be excluded as a resource when determining Medicaid eligibility right away. Then, when the Medicaid recipient passed away, Medicaid would recover the face value of the policy, thereby offsetting the Medicaid costs connected with this exception. Any amount of cash value exceeding Medicaid costs would then be payable to the secondary beneficiaries such as the recipients' family members.

  The Montana Office of the Commissioner of Securities and Insurance has expressed that they believe this proposal is within state law governing insurance. As of September 23, 2010, the Centers for Medicare & Medicaid Services (CMS) has stated that they would not oppose a state plan amendment. Department expects to pursue this change in policy as quickly as possible.

  ESTIMATED COST: $0

Long-term care partnerships

PROBLEM: Long-term care insurance partnerships offer an opportunity for applicants to avoid relying on Medicaid to pay for nursing facility care and to protect their assets if they do need to apply for Medicaid. In spite of this, there is very little awareness of long-term care insurance partnerships among facilities or individuals.

- OPTION: **Create educational material promoting long term care partnerships.** The committee has included information about long-term care partnerships in its aforementioned prototype educational packet. The Department is also working with MSU to create a MontGuide to assist clients. In addition, the Office of the Commissioner of Securities and Insurance is creating a new long-term care consumer guide which will include information about long-term care partnerships to be published in the winter.

  ESTIMATED COST: $0 additional cost (see page 12 for more information about the educational packet)

Family farm/small business exemption

PROBLEM: In the course of reviewing other states' Medicaid regulations, the committee discovered a policy in Vermont that allows applicants to transfer their family farms or small business to their families without incurring a penalty for making an uncompensated asset transfer. Since there are people in Montana with farms, ranches, and other small business who might wish to be able to transfer their business to their families, the committee evaluated this as a possible option to consider.

- OPTION 1: **Institute a family farm/small business exemption in the asset transfer policy.** Similar to the policy in Vermont, this would exempt transfers of family farms and small businesses from the application of an uncompensated asset transfer penalty. This would require CMS to approve a Medicaid State Plan Amendment and probable legislation.

ESTIMATED COST: based on the number of farms and small businesses in the state of Montana and that the following number of individuals who would be on Medicaid due to such a transfer in order to meet eligibility requirements

	Number of individuals*	Cost per SFY of change, total**	General Fund estimate
Year 1	100	$3,632,400	$799,491
Year 2	400	$14,529,600	$3,197,965
Year 3	700	$25,426,800	$5,598,439
Year 4	900	$32,691,600	$7,195,421

*based on an estimate of two newly eligible applicants per county in the first year (100) and six per county (300) in each additional year and the assumption that a person will be in the nursing facility for an average of three years

**the number of individuals multiplied by the average Medicaid cost per person of $3,027

- OPTION 2: **Promote the purchase of long-term care partnership Insurance policies.** If people purchase long-term care partnership insurance policies with coverage equal to the value of their farms or businesses, they will be able to exclude the value of that property when applying for Medicaid.

  ESTIMATED COST: Minimal cost of educational materials (see pages 12 and 15)

APPENDICES

Appendix A: House Joint Resolution 25

HOUSE JOINT RESOLUTION NO. 25
INTRODUCED BY W. WARBURTON

A JOINT RESOLUTION OF THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA REQUESTING THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES TO EXAMINE ISSUES RELATED TO THE DETERMINATION OF MEDICAID ELIGIBILITY FOR NURSING HOME CARE AND TO PROVIDE A REPORT TO THE 62ND LEGISLATURE.

WHEREAS, frail elderly Montanans who need nursing home care and their families who assist them are
experiencing difficulties with the application process by which Medicaid eligibility is determined; and

WHEREAS, it is often difficult for family members to obtain all of the documentation required because
some of the original transactions occurred 30 or more years ago; and

WHEREAS, Montana nursing homes often wait months for eligibility to be determined and receive no
payment during this period of time; and

WHEREAS, the federal and state laws and regulations related to Medicaid eligibility are very complex
and subject to changing interpretation, making it difficult for those applying for Medicaid to understand and comply; and

WHEREAS, it is important that procedures and interpretations used in determining eligibility be understandable and reasonable, while at the same time ensuring that only those who meet eligibility criteria are deemed eligible to receive Medicaid benefits.

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA:
That the Department of Public Health and Human Services work in cooperation with all appropriate stakeholders, including nursing home care providers, consumers, and other interested parties, to examine the issues related to difficulties being encountered by nursing homes and those seeking medical assistance for a nursing home stay.

BE IT FURTHER RESOLVED, that the study should include but is not limited to:

(1) identifying and examining difficulties experienced by those applying for Medicaid nursing home services;
(2) identifying and examining difficulties experienced by nursing homes related to the admission and care of those applying for Medicaid assistance;

(3) identifying and examining which parts of the eligibility determination process are dictated by state or federal laws and regulations;
(4) identifying and examining which parts of the eligibility determination process are based on state interpretations, policies, and procedures;
(5) identifying and examining any possible solutions to the issues and concerns presented by consumers and providers, including but not limited to discussion of expanded use of hardship provisions, more clarity with respect to expectations, establishment of parameters for what constitutes a good faith effort to obtain information sought by the state, provision of more specific information about the legal basis for denial of eligibility, financial relief to facilities that admit residents in crisis pending eligibility determination, and ability of applicants to transfer or assign annuities, life insurance policies, and property to the state when there is a dispute about the liquidity or value of the property;
(6) identifying and examining any costs related to identified solutions; and
(7) identifying and examining any other issues and concerns considered pertinent to the study.

BE IT FURTHER RESOLVED, that the Department of Public Health and Human Services report at least
quarterly to the Children, Families, Health, and Human Services Interim Committee on the status of the study and that the Department prepare a final report, including any findings, conclusions, comments, or recommendations for the 62nd Legislature.

Appendix B: HJR 25 Workgroup

Representative Wendy Warburton (Representative, HD 34, Havre)
Rose Hughes (Montana Health Care Association)
Bob Olsen (Vice President, Montana Hospital Association)
Casey Blumenthal (Montana Hospital Association)
Linda Snedigar (Human and Community Services Division Administrator)
Kelly Williams (Senior and Long-Term Care Administrator)
Rick Bartos (Adult Protective Services Chief)
Nancy Clark (Aged, Blind, and Disabled Medicaid Eligibility Policy Specialist)
Traci Clark (Senior and Long-Term Care)
Frank Clinch (Special Assistant Attorney General DPHHS)
Barb Flamand (Medicaid Compliance Specialist)
Debrah Fosket (Medicaid Fraud Control Unit Director)
Barbara Hoffman (Special Assistant Attorney General DPHHS)
John McCrea (Legal Services Developer DPHHS Senior and Long-Term Care)
Kelly Moorse (State Nursing Home Ombudsman)
Kathe Quittenton (Public Assistance Bureau Chief)
Charlie Rehbein (Senior and Long-Term Care)
Lori Henderson (Northern Montana Care Center Administrator)
Joan Miles (Montana Hospital Association)
Lois Steinbeck (Legislative Fiscal Division)
Lou Villemez (Attorney)
Shannon Mykins (AmeriCorps VISTA)

Appendix C: Survey completed by Medicaid applicants

The 2009 Montana Legislature passed House Joint Resolution 25 requiring the Department of Public Health and Human Services to conduct a study of issues related to the determination of Medicaid eligibility for nursing home care and provide a report to the next Legislature.

The goal of conducting this survey and gathering your input is to help improve the Medicaid eligibility process and customer service. Your input is a vital part of achieving this goal. Thank you for your time and input.

The Department is asking you to provide us with your feedback about your recent experience in applying for nursing home Medicaid for «Name».

We would appreciate it if you could respond to this survey within the next 20 days-- by March 31. However, if you are unable to respond within that time period, we will welcome your feedback whenever you are able to provide it.

1. Were you the individual who completed the application and application process for Medicaid for «Name»? □ Yes □ No

   If you were, please take a few minutes to respond to the following questions. We have included a self-addressed, stamped envelope for your convenience in returning the survey.

   If you were not the individual who completed the application and process, please pass this survey on to the person who assisted with the application process for Medicaid coverage for «Name».

   Thank you for your time.

2. Please list your relationship to the applicant:

   - □ Applicant
   - □ Spouse of applicant
   - □ Adult child of applicant
   - □ Other relative
   - □ Social worker/other professional not connected with facilities
   - □ Friend
   - □ Conservator/Guardian
   - □ Power of attorney/Durable power of attorney, not related
   - □ Nursing home/hospital employee

3. Did you apply for Medicaid before or after «Name» entered the nursing home?
   □ Before □ After

4. If you experienced any problems with completing the application itself, please check the items below that apply:

- The application asked for information I didn't have on hand, such as _____
  _____
- The application asked for information I did not have access to, such as _____
  _____
- I was not sure what the application was asking me to report for questions about:
  _____
- The application was too long.
- The application asked for information that I did not think was needed, such as:
  _____
- Other: _____
  _____
- No problems.

5. If someone assisted you with filling out the Medicaid application or with the process, please indicate below who assisted you (check any that apply):

- Office of Public Assistance staff
- Nursing home social worker or other staff
- Adult Protective Services social worker
- State Health Insurance Assistance Program (SHIP) Volunteer
- Case Manager
- Other: _____
- No one helped---I did it myself.
- □ Family member
- □ Friend
- □ Area Agency on Aging staff
- □ Attorney
- □ IHS/Tribal Health employee
- □ Home health agency employee

6. If you attended at least one interview with a Medicaid eligibility case manager during the application process, please complete the following:

   a. How many times did you meet with your case manager? _____

   b. Did you feel the meetings were helpful and provided you with information?
   □ Yes □ No

7. If you did not attend at least one interview with an eligibility case manager, why did you choose not to use interviews or meetings as part of the process? _____
   _____
   _____

   Did you discuss the case with the case manager on the phone or in some manner other than through written correspondence? □ Yes □ No

8. Please rate your overall customer service experience: 1 2 3 4 5
   (poor) (very good)

   Comments: _____
   _____

9. If you experienced any difficulties during the eligibility process, what were those difficulties? Please check all that may apply.

- □ Understanding what information was needed, or instructions were unclear.
- □ Understanding how to get information that was needed.
- □ Getting proof of income.
- □ Getting proof of assets/resources, such as bank statements, property deeds, etc.
- □ Getting copies of contracts from life insurance or annuity companies.
- □ Getting offers/refusals for annuities/structured settlements.
- □ Getting proof of compensation for past asset transfers.
- □ Getting proof of citizenship or identity of the applicant.
- □ Getting proof and/or copies of trusts or contracts.
- □ Getting proof and/or copies of burial contracts or arrangements.
- □ Getting proof of health insurance payments, coverage or premiums.
- □ Getting the authority/power of attorney to access information that was needed.
- □ Getting information and proof from a spouse or spouse's children/representative.
- □ Getting information from a person who was given or took assets from the applicant during the lookback period?
- □ Filing a civil law suit in order to attempt to get transferred assets returned.
- □ The application was denied because of uncompensated asset transfers that were made in the past.
- □ Timeframes to return information were too short (10 days) and I did not ask for extensions.
- □ Timeframes to return information were too short (10 days) and I was denied extensions when I asked for them.
- □ Repeated requests from the Office of Public Assistance staff for the same information. Please list:

  _____

- □ Getting information from a third party (including family) that the third party was reluctant or resistant to providing, even though it was information the applicant was legally entitled to have. Please list:

  _____

Did you ask for help or guidance from the Medicaid eligibility case manager? □ Yes □ No

If so, did the eligibility case manager give you ideas or help you get the info? □ Yes □ No

If the eligibility case manager did give you ideas or guidance, was this helpful? □ Yes □ No

10. What information was requested by the Department to process the Medicaid application after you submitted the application?

- □ Proof of income sources and amounts
- □ Proof of resources/assets
- □ Proof of citizenship and/or identity
- □ Proof of the assets held in a trust
- □ Proof of the values of some assets
- □ Return of signed forms

□ Proof of how assets were spent or distributed during the 'lookback period' of up to 60 months
□ Proof of filing of a civil law suit to attempt to get transferred assets returned
□ Proof of compensation for assets that were transferred during a 'lookback period' of up to 60 months
□ Other: _____

□ Proof of trusts, annuities, life insurance or contracts
□ Proof that property is listed for sale at fair market value
□ Proof of income and assets of a spouse
□ Information or documentation from third parties such as trustees, payees, annuity companies, etc.

11. Were the notices the Department sent to you during this process clear and understandable? □ Yes □ No

12. If you had been offered an opportunity to go through a pre-qualification process for Medicaid, would you have taken advantage of the opportunity to get information and gather documentation before the need for Medicaid coverage arose? A pre-qualification process would include meeting with a Medicaid case worker to learn more about Medicaid policies and requirements and acquire a list of the information that would be necessary to complete the Medicaid eligibility process, as well as guidance on how to access the necessary information. □ Yes □ No

13. May we call to ask you for more information after we receive this survey? □ Yes □ No

If so, what is your daytime phone number? _____

If there is anything else you would like to tell us, please include that information below. If additional space is needed, please use the back of this survey or add additional pages as needed.

Again, thank you for your time. We appreciate your feedback in helping us improve the Medicaid application process.

Please print and sign your name below:

Name (please print): _____

Signature: _____ Date: _____

Return to:

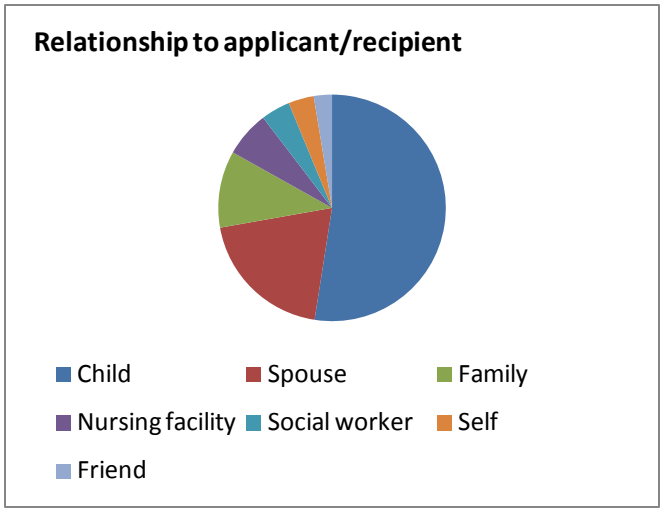
Medicaid Eligibility Survey
DPHHS
HCSD/PAB
PO Box 202925
Helena, MT 59620-2925

Appendix D: Summary of data received from applicant surveys

A total of 1193 surveys were sent to applicants from 39 counties. Of these surveys, 418 surveys from 36 counties were completed and returned (35%). This is high compared to the average expected response rate for a client survey of 10-15%[13].

Relationship to the applicant/recipient

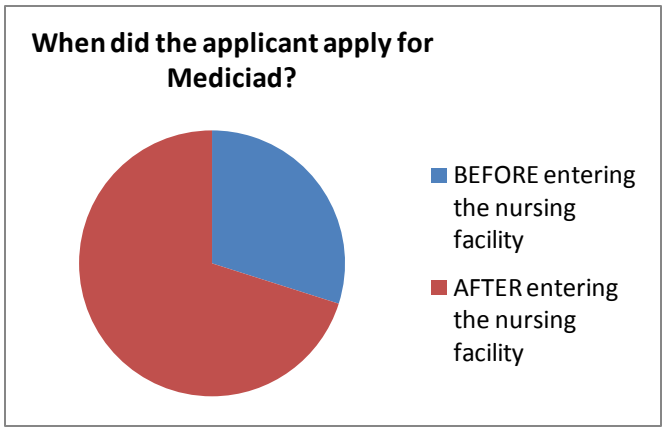
Child	202	(**48.3%**)
Spouse	76	(**18%**)
Family	42	(**10%**)
Nursing facility	25	(**5.9%**)
Social worker	16	(**3.8%**)
Self	14	(**3.3%**)
Friend	10	(**2.4%**)



When did applicant apply for Medicaid coverage?

BEFORE entering nursing home:
125/418 (**29.9%**)

AFTER entering nursing home:
293/418 (**70.0%**)



The application asked for information I didn't have on hand, such as: 104/418 (**24.8%**)

Of the 78 respondents who specified the information they did not have on hand:

Information regarding assets:	24	(30.7%)
Bank statements:	24	(30.7%)
Insurance Information:	22	(28.2%)
Information from the "Lookback" period:	12	(15.3%)
Citizenship/ID documents:	9	(11.5%)
Burial documents:	8	(10.2%)
Information regarding income:	6	(7.7%)
Military/VA benefit information:	4	(5.1%)
Information regarding annuities:	3	(3.8%)
Information about/from a spouse:	3	(3.8%)

[13] Donna S. (2010, Jan 28). Survey Response Rates. http://www.surveygizmo.com/survey-blog/survey-response-rates/

Information regarding the sale of property:	3	(3.8%)
Tax information:	2	(2.5%)
Other:	10	(12.8%)

The application asked for information I didn't have access to, such as: 56/418 (**13.3%**)

Of the 32 respondents who specified the information they did not have access to:

Insurance Information:	12	(37.5%)
Information regarding assets:	8	(25%)
Bank statements:	7	(21.8%)
Information regarding income:	4	(12.5%)
Information from the "Lookback" period:	3	(9.3%)
Information regarding citizenship/ID:	3	(9.3%)
Information about/from a spouse:	3	(9.3%)
Burial documents:	1	(3.1%)
Information regarding annuities:	1	(3.1%)
Tax information:	1	(3.1%)
Other:	4	(12.5%)

I was not sure what the application was asking me to report for questions about: 30/418 (**7.1%**)

Of the 10 respondents who specified the information they had trouble with:

Insurance Information:	3	(33.3%)
Burial documents:	1	(10.0%)
Information about retirement:	1	(10.0%)
Information about bank accounts:	1	(10.0%)
Information about prior expenses:	1	(10.0%)
Information about trusts:	1	(10.0%)
Information about a life estate:	1	(10.0%)

The application was too long: 68/418 (**16.2%**)

The application asked for information I didn't think was needed: 33/418 (**7.8%**)

Of the 20 respondents who specified the information they did not think was needed:

Insurance Information:	5	(25%)
Information about a spouse/family:	3	(15%)
Information from the "Lookback" period:	3	(15%)
Information about cash/safety deposit box:	3	(15%)
Burial documents:	3	(15%)
Information regarding citizenship/ID:	1	(5.0%)
Information regarding annuities:	1	(5.0%)
Redetermination:	1	(5.0%)
Information regarding income:	1	(5.0%)

Other 25/418 (**5.9%**)

No problems encountered with the application 239/418 (**57.1%**)

Who assisted you in filling out the application for Medicaid?

Office of Public Assistance (OPA) staff	38.3%
Nursing home staff	24.4%
No one	24.2%
Case manager at the OPA	18.8%
Family member	12.7%
Adult Protective Services worker	3.6%
Attorney	3.6%
Area Agency on Aging staff	2.9%
Friend	1.2%
Home health agency employee	0.7%
HIS/Tribal Health employee	0.2%
Other	2.6%

How many times did you meet with your case manager?

Average:	1.87
Range:	0-10
Helpful?:	90.9%

Appendix E: Survey completed by nursing home facilities

To: Facility

The 2009 Montana Legislature passed House Joint Resolution 25 requiring the Department of Public Health and Human Services to conduct a study of issues related to the determination of Medicaid eligibility for nursing home care and provide a report to the next Legislature.

The goal of conducting this survey and gathering your input is to help improve the Medicaid eligibility process and customer service. Your input is a vital part of achieving this goal. Thank you for your time and input.

The Department is asking you to provide us with your feedback about your recent experiences related to applications for Medicaid eligibility. At the end of this survey, we are asking you for the names of known applicants for whom difficulties were encountered so that we may research the situations and possibly find remedies for anything that can be resolved on a case-specific basis as well.

We would appreciate it if you could respond to this survey within the next 10 days---by January 28, 2010. However, if you are unable to respond within that time period, we would still welcome your feedback whenever you are able to provide it.

Please respond electronically. If you prefer to send in a written response, return to:

Medicaid Eligibility Survey
DPHHS
HCSD/PAB
PO Box 202925
Helena, MT 59620-2925

1. Were you the individual who completed the application and application process for Medicaid for any resident of your facility in the recent past?

( ) Yes
( ) No

If yes, please answer items 2-5, below. If no, please skip items 2-5 and proceed to item 6, below.

2. Did you apply for Medicaid before or after the applicant entered the nursing home?

( ) Before
( ) After

3. Do you believe the difficulties in locating verifications necessary to complete the Medicaid application process are more likely to arise for:

( ) an established nursing home patient, or
( ) a newly admitted patient?

4. If you experienced any problems with completing the application itself, please check all items that apply:

( ) The application asked for information I didn't have on hand, such as:

( ) The application asked for information I did not have access to, such as:
( ) I was not sure what the application was asking me to report for questions about:
( ) The application was too long.
( ) The application asked for information that I did not think was needed, such as:
( ) Other
( ) No problems.

5. In the past 12 months, how many new or established residents of your facility have applied for Medicaid?

_____

6. Of those residents, who applied for Medicaid on their behalf (please list the number for each of the categories below)?

the resident, # _____
the resident's family, # _____
your facility, # _____
Adult Protective Services social worker, # _____
other (if other, list who,if known) # _____

7. How many of the Medicaid applications do you estimate were processed (whether approved or denied) within 45 days of the date of the application? #

_____

8. Of the applications that took longer than 45 days to process, how many do you estimate were processed (whether approved or denied) within:

90 days, # _____
120 days, # _____
150 days, # _____
More than 150 days, # _____

9. Of the residents who applied for Medicaid and were not processed within 45 days, please rank each of the following circumstances that may have caused the delays. Add any additional circumstances to question 10. For each item, list the frequency for the circumstance occurring as follows: Frequently, Occasionally, Rarely, Never

Family failed to provide information to the Office of Public Assistance (OPA)

_____ _____ _____ _____
There was no one to gather information for the applicant

_____ _____ _____ _____
Applicant is unable to provide answers to questions and had no one to help

_____ _____ _____ _____
Difficulty in finding someone to assist with the process of gathering information regarding applicant's situation

_____ _____ _____ _____
Difficulty in getting Power of Attorney, guardianship, conservatorship, etc, so someone had access to needed information

_____ _____ _____ _____

Difficulty in getting documentation related to an annuity

_____ _____ _____ _____

Difficulty in getting information related to a trust or contract

_____ _____ _____ _____

Difficulty in getting documentation of other assets or their values

_____ _____ _____ _____

Difficulty in getting documentation of income, sources, or amounts

_____ _____ _____ _____

Difficulty in getting documentation of asset transfers

_____ _____ _____ _____

Difficulty in getting a civil suit filed for return of transferred assets

_____ _____ _____ _____

10. Add any additional circumstances not identified in question 9.

_____
_____
_____
_____

11. If your facility routinely monitors the progress of the Medicaid applications, how do you monitor (check all that apply):

( ) Signed release/check in with OPA
( ) Ask authorized representative/family
( ) Don't routinely monitor

12. Does your facility routinely ask new residents to sign DPHHS's HPS-402 release form in order that your facility can monitor the progress of their Medicaid applications?

( ) Yes
( ) No

13. If yes, do you update those releases annually or at least every 30 days?

( ) Yes
( ) No

14. Does your facility's admissions packet include information on:

( ) Medicaid
( ) Medicare Part D

15. Does your facility routinely assist residents in cooperating with the Medicaid eligibility determination process, including offering timely assistance in gathering documentation (before eligibility has been denied)?

( ) Yes
( ) No

16. Does your facility routinely inquire on Medicaid eligibility for your Medicaid residents on a monthly basis using Faxback or an on-line option offered by ACS/Montana Medicaid?

( ) Yes
( ) No

17. Does your facility have a functional working relationship with the Office of Public Assistance, within the bounds of HIPAA?

( ) Yes
( ) No, please explain why:

18. If you and your residents work with more than one Office of Public Assistance (OPA), have you experienced marked differences in the way the applications are processed, policy interpretation, or responsiveness between the different county OPAs?

( ) Yes, please list the different counties and the differences you have experienced:
( ) No

19. Please share any 'best practices' that your facility, the OPA ,or others have implemented to assist in the Medicaid eligibility process.

_____
_____
_____
_____
_____

20. Please share any suggestions you have that you believe may assist in expediting the Medicaid application process.

_____
_____
_____
_____
_____

21. If the Department was to offer more seminars to provide education about Medicaid eligibility policies and processes, and provided additional access to information, would you or someone from your facility attend?

( ) Yes
( ) No

22. If the Department was to offer a pre-application process, in which people could have their situations reviewed and receive guidance as to what documentation should be gathered, and an estimate as to when eligibility could potentially be established for Medicaid, do you believe people would use such a process?

( ) Yes
( ) No

23. Do you think a pre-application process could expedite the actual Medicaid application process and be beneficial to the applicants, their families, and the facilities?

( ) Yes
( ) No

24. If there have been difficulties or delays in Medicaid eligibility determinations made for residents of your facility within the last year, please list the full names of the residents, and your impression of the

nature of the difficulty in each case, in order that we may research these difficulties. If you have the last 4 digits of the individual's Social Security Number (SSN) or their date of birth, this will assist us in identifying their case records. We hope to identify issues that may assist us in making improvements to the process and/or policies.

Resident Name Date of Birth Last 4 digits of SSN Reason for delays, if known
Your estimate of any financial impact to your facility (optional) If there was a financial impact, please note whether the reason was DELAY or DENIAL of benefits.

Name _____ _____ _____ _____ _____ _____
Name _____ _____ _____ _____ _____ _____
Name _____ _____ _____ _____ _____ _____
Name _____ _____ _____ _____ _____ _____
Name _____ _____ _____ _____ _____ _____
Name _____ _____ _____ _____ _____ _____
Name _____ _____ _____ _____ _____ _____
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Name _____ _____ _____ _____ _____ _____
Name _____ _____ _____ _____ _____ _____
Name _____ _____ _____ _____ _____ _____
Name _____ _____ _____ _____ _____ _____

25. If you have any additional issues, concerns, recommendations, or information you would like to share with us, please do so below, or if sending via regular mail, please use additional separate pages as needed.

_____
_____
_____
_____
_____

Contact Information
==========

26. First Name _____

27. Last Name _____

28. Title _____

29. Company Name _____

30. Street Address _____

31. Apt/Suite/Office _____

32. City _____

33. State _____

34. Postal Code _____

35. Country _____

36. Email Address _____

37. Phone Number _____

38. Fax Number _____

39. Mobile Phone _____

40. URL _____

==========

Thank You!

==========

Thank you for your time. Your assistance will help us improve this process.

Appendix F: Summary of data received from nursing home facility surveys

Did you apply for Medicaid before or after the applicant entered the nursing home?

BEFORE	6	**(11%)**
AFTER	47	**(89%)**

Do you believe the difficulties in locating verifications necessary to complete the Medicaid application process are more likely to arise for:

Established NH patients	13	**(25%)**
Newly Admitted	37	**(71%)**
Both/Equal	2	**(3.8%)**

If you experienced any problems with completing the application itself, please check all items that apply:

The application asked for information I didn't have on hand	31	**(61%)**
The application asked for information I did not have access to	29	**(58%)**
I was not sure what the application was asking me to report	2	**(4%)**
The application was too long.	3	**(6%)**
The application asked for information that I did not think was needed	7	**(14%)**
Other	1	**(2%)**
I did not experience any problems with the application itself	10	**(20%)**

In the past 12 months, how many new or established residents of you facility have applied for Medicaid?

TOTAL APPLICATIONS REPORTED BY FACILITIES	**1589**	
RANGE OF APPLICATIONS REPORTED PER FACILITY	**2-150**	
APPLICATIONS COMPLETED BY RESIDENT	164	**(10.3%)**
APPLICATIONS COMPLETED BY RESIDENT'S FAMILY	903	**(56.8%)**
APPLICATIONS COMPLETED BY FACILITY	562	**(35.4%)**
APPLICATIONS COMPLETED BY ADULT PROTECTIVE SERVICES SOCIAL WORKER	33	**(2.1%)**
APPLICATIONS COMPLETED BY OTHER	15	**(<1%)**

How many of the Medicaid applications do you estimate were processed (whether approved or denied) within: [14]

45 days of the date of application	800	**(47.3%)**
90 days	464	**(27.4%)**
120 days	286	**(16.9%)**
150 days	84	**(4.9%)**
more than 150 days to process	56	**(3.3%)**

[14] See "Timeliness" on page 10 for data compiled from the TEAMS database.

Of the residents who applied for Medicaid and were not processed within 45 days, please rank each of the following circumstances that may have caused the delays. Add any additional circumstances to question 10. For each item, list the frequency for the circumstance occurring as follows:

Family failed to provide information to the OPA:

Frequently	28	**(44%)**
Occasionally	27	**(43%)**
Rarely	6	**(9.5%)**
Never	2	**(3.7%)**

There was no one to gather information for the applicant:

Frequently	20	**(33%)**
Occasionally	20	**(33%)**
Rarely	12	**(20%)**
Never	8	**(13%)**

Applicant was unable to provide answers to questions and had no one to help:

Frequently	18	**(29%)**
Occasionally	19	**(31%)**
Rarely	12	**(19%)**
Never	12	**(19%)**

Difficulty in finding someone to assist with the process of gathering information regarding applicant's situation:

Frequently	19	**(31%)**
Occasionally	25	**(41%)**
Rarely	9	**(15%)**
Never	8	**(13%)**

Difficulty in obtaining Power of Attorney, guardianship, conservatorship, etc. so that someone would have access to needed information:

Frequently	12	**(19%)**
Occasionally	26	**(42%)**
Rarely	11	**(18%)**
Never	13	**(21%)**

Difficulty in getting information related to an annuity:

Frequently	17	**(28%)**
Occasionally	17	**(28%)**
Rarely	16	**(27%)**
Never	10	**(17%)**

Difficulty in getting information related to a trust or contract:

Frequently	14	**(23%)**
Occasionally	19	**(31%)**
Rarely	15	**(25%)**
Never	13	**(21%)**

Difficulty in getting documentation of other assets or their values:

Frequently	20	**(32%)**
Occasionally	26	**(42%)**
Rarely	11	**(18%)**
Never	5	**(8%)**

Difficulty in getting documentation of income, sources, or amounts:

Frequently	15	**(24%)**
Occasionally	23	**(37%)**
Rarely	17	**(27%)**
Never	7	**(11%)**

Difficulty in getting documentation of asset transfers:

Frequently	13	**(20%)**
Occasionally	16	**(25%)**
Rarely	22	**(35%)**
Never	12	**(19%)**

Difficulty in getting a civil suit filed for return of transferred assets:

Frequently	4	**(6.5%)**
Occasionally	6	**(9.8%)**
Rarely	22	**(36%)**
Never	29	**(48%)**

In order to monitor the progress of MA applications, does your facility:

get a signed release/check in with the OPA	58	**(78%)**
ask authorized representative/family	55	**(74%)**

Does your facility routinely ask new residents to sign DPHHS's HPS-402 release form in order that your facility can monitor the progress of their MA applications?

Yes	40	**(54%)**
No	34	**(46%)**

If yes, do you update those releases annually or at least every 30 days?

Yes	16	**(39%)**
No	25	**(61%)**

Does your facility's admissions packet include information on:

MEDICAID	67	**(90%)**
MEDICARE PART D	39	**(53%)**

Does your facility routinely assist residents in cooperating with the MA eligibility determination process, including offering timely assistance in gathering documentation (before eligibility has been denied?

Yes	67	**(93%)**
No	5	**(7%)**

Does your facility routinely inquire on MA eligibility for your MA residents on a monthly basis using Faxback or an online option offered by ACS/MT MA?

Yes	31	**(44%)**
No	39	**(56%)**

Does your facility have a functional working relationship with the OPA, within the bounds of HIPPA?

Yes	59	**(83%)**
No	12	**(17%)**

Have you experienced differences between the OPAs in different counties?

Yes	39	**(55%)**
No	32	**(45%)**

If the Department was to offer more seminars to provide education about MA eligibility policies and processes and provide additional access to information, would you or someone from your facility attend?

Yes	67	**(93%)**
No	5	**(7%)**

If the Department were to offer a pre-application process, do you believe people would use such a process?

Yes	67	**(90%)**
No	7	**(10%)**

Do you believe that a pre-application process could expedite the actual MA process?

Yes	65	**(89%)**
No	8	**(11%)**

Additional issues, concerns, recommendations, and comments as reported by nursing facilities

01	We have had problems prior to this last year. A QI is being completed at this time for these exact reasons. We have one resident that was denied because info was not received from life insurance in a timely manner. When the life insurance was cashed out, the resident was over resource even though she owed the facility $11000.00 at the time. The fair hearing was completed and the judge agreed with the resident, but the decision was not changed. This resulted in an $11000.00 deficit to the facility.
02	We are located close to North Dakota. When a North Dakota resident chooses to reside in our facility, ND Medicaid will not pay and they must apply for Montana Medicaid. I know that neighboring states have residency requirements - why don't we. Many of the folks who have come to us from ND have never lived in Montana or paid taxes here.
03	There seems to be a lot claims that are sent in on the first of the month that are not paid. This has happened since Sept 09. They are all sent on the same date, but not all paid on the same date. This is new, and when I call, they don't know why and say they don't see any problem with the claims not paid, but they will be paid probably the next week. Too much attention is being paid to the residents who are permanent nursing home residents, and will not be going home ever. Their circumstances do not change in a NH. Now we are delayed in getting payment due to the change in paperwork and requirements, the OPA employees are overwhelmed. This is not encouraging. Facilities cannot survive if there is nonpayment.
04	Community Education from DPHHS experts would be helpful-more factual and trustworthy. Not attorney seminars. Families have not idea of the rules until the day before they are trying to admit someone.
05	While I like the idea of a prescreening process I feel that a prescreening process will only work if there are additional case workers as well as additional training for case workers.
06	Caseworkers I know are busy but a 2 minute call to Nursing homes waiting for info would be nice.
07	I would just like to say that I am so frustrated with our department of OPA that I almost refuse to call them. I understand that they are entrusted to properly award eligibility to protect the State against fraud or improper use of limited Medicaid dollars. My frustration is when the technicians insist on documentation that simply does not exist. In some cases the money that was or is in an annuity was put there back in the day when formal documentation was not a priority. In one case listed above in the difficulties/delays area--Mr. and Mrs. [name removed]: This case went to Fair Hearing and the Fair Hearing officer that heard the case was instructed to give the case to a new hearing officer and it was ultimately denied but the whole case was based on the fact that the eligibility technician could have corrected the son when he very clearly illustrated what he thought to be the correct resource level (he thought it was $3000.00 for each of his parents when it was $3,000.00 for both of them). So, of course they were over resourced. The son misunderstood the resource amount and the technician did not do anything to correct him. Where was he supposed to get the correction from if not from the technician? Thank you for opportunity to speak out. Thank you for the above questions relating to instruction and pre-admission process. I think those tools will go a long way in assisting our elderly as they plan for their future health care needs.
08	Please call me if you can, I can tell you many issues from the past, too many details to write down. Teton County is a mess and it doesn't do any good to go to the supervisors as you receive no help. I would like the form mentioned in #12.

09	Medicaid transport authorization information is often conflicting from month to month on eligibility
10	If the Medicaid applications and Re-determinations could be done on line it would save a ton of paper, time, stamps, and verification that the application was received.
11	I do feel the majority of issues at this point in time is CHIMES and maybe not always the timeliness of processing.
12	Our Lincoln County OPA workers are very pleasant and helpful
13	The length of opening a resident on Medicaid takes longer because of the new Medicaid computer system this year. Problems did not show up until 2 or 3 months. The OPA ET are over whelmed with the program. With good communications with our community offices it has helped us work through these problem areas. I am from Stillwater County and the depts. at both Stillwater & Sweetgrass county work closely with me and I am glad to have the qualified staff to work with for the benefits of the our residents.
14	All of the applications that have taken longer than the traditional 45 days are due to uncooperative insurance companies rather than a problem with the OPA caseworker. The caseworker in our county works very hard to assist families with the process and does not hesitate to assist them as much as she is able. If you keep in contact with families and assist them along the way they are usually cooperative and complete the application in a timely manner. The biggest problem our facility has is those persons that do not qualify due to many assists but not enough to pay for nursing home care.
15	Some January 2010 claims were denied because technicians were unaware they had to re-authorize for January. We would like to have the ability to print the application for LTC off of the web site.
16	We have already contacted Rick Norine with our questions regarding the above patients, my office manager is not available, you can contact us directly or Rick Norine already knows the issues.
17	After a collective number of years (34 years), facility staff did not know that the authorization form was available. Some techs make rules that are not actual rules and state that facility/resident /family must abide by them.
18	Please discontinue the use of the "Adult Single Unit". Because there are so many different people working on a case it is an absolute nightmare to try and follow up on the progress of it. The new software program seems to be a huge issue with getting cases completed in a timely manner. The case workers have told us that they are absolutely fed up with it and that the training has been very minimal. They have also said that in the past when the state brought out new software that it was piloted in a small county to work out the bugs and then gradually phased in the rest of the state, they said with this program it was just "dumped" on them and they were expected to work out the bugs as they went.
19	The ability for clients to submit applications and documentation before the resource limit is met.

20	When the OPA offices open a short term nursing home span, they will send a letter to the facility if they are covering some or all of the room and care costs but if they are applying the room & care costs to the patient's incurement, they will not notify the facility. This poses a problem as we need to know what days are Medicaid days for cost reporting. Without a letter stating that the days are approved for Medicaid (spans do not show up on MEPS), we have no way to know if the patient is responsible to pay the full rate or Medicaid rate. Hill County OPA says it is the patient responsibility to tell us they owe the days at the Medicaid rate and that it violates HIPPA to send us a letter saying they owe room and care, even if the stay is Medicaid approved.
21	Only two of our Medicaid applications appear to have been approved/denied within 45 days during 2009. It is a huge concern that we have no way of knowing for sure if someone will qualify for Medicaid prior to admission, and that once they are here it is not unusual for the turnaround time to be 2-3 months. It can be significantly longer if there are problems.
22	Due to the new eligibility requirements more & more people are qualifying for assistance. Therefore the caseworkers are being overloaded with applications. The state needs to assist in some manner with the overload of applications the local offices are receiving. Providing more staff would be beneficial.
23	I am being told by family members that they are not able to make application for Medicaid until their resources are close to $2,000.00. It is difficult to admit a Medicaid pending resident when their remaining resources are less than half of a month's care and it will take possibly 90+ days to process application. How will the balance of up to $15,000.00 be paid to the SNF if they are denied? Being able to qualify much earlier with a spend down amount is much safer for resident and family as well as facility. Also during application process residents and families should be made aware that they should not spend the residents resources which will be owing to SNF if Medicaid is approved and retro'ed back 3 months. I find it frustrating and so do family members to get a recorded message at the Medicaid office basically stating that they are too busy and will call back whenever they can but please don't call again. I feel the same way at my job sometimes but would not think of leaving a message for my consumers telling them not to call back if I don't respond in what they believe is a reasonable amount of time. I don't mean to be only negative in my comments. I actually have found the workers to be very helpful when I have had questions. The family members I have spoken to do not seem to share that opinion.
24	I had a big problem with 2 yearly redeterminations out of Beaverhead County (90+ days). One eventually was approved, but the other was denied. The reason given for the delays were that the OPA was short staffed, and the case worker had an illness. If the denial was given earlier, other arrangements could have been made with the family.
25	Use a simplified format, such as the resource assessment sheet. Eligibility specialists need training in customer service. Respect, empathy, answering all questions with integrity. This is an overwhelming task for the elderly
26	Note number we 24 - we are working with OPA for resolution on individual issues.
27	I feel the real problems now are CHIMES and there are workers who do not understand how the system works.
28	The eligibility screen could be more informative.

29	1. We have regular issues with the Pharmacist who is left hanging on these longer cases. Residents often have expensive Medication bills and pending Medicaid qualification or denial the Pharmacist is frustrated and has even threatened withholding Medications to the resident if months have gone by with no payment. Or as with the case of [name removed], the facility does not get a monthly estimated resource amount as the monies have to go to pay for the pharmacy bill. The Pharmacist will not carry an account for a year and a half. We certainly cannot blame him. It does look like this case has a high potential of being denied. The family is unsure of how the bills will be paid if it is denied. 2. Another major problem is when a resident or their family requests a screen date at the end of the month or a resident moves in at the end of the month and requests a screening. It is difficult to do the appropriate spend down in so few of days. The resident may only be a few hundred dollars over the allowed resource amount and not have enough to pay for the month. Or pre-paid funerals and other needs such as adaptive equipment cannot be purchased in time to bring the resource amount within qualifications. This puts tremendous pressure on the family/resident. In one case we could not get the insurance companies to liquidate small but over the $1500 cash out value in a timely manner. The resident received monies too late and yet did not have enough to pay the previous month's days of stay. 3. Another issues that is disturbing is when a resident on Medicaid has a spouse in the community and that spouse comes into the nursing home on a temporary basis with intent to return home within a 6 month period and is treated as a single person requiring they reach the $2000 or less resource limit as well as their spouse. This person was allowed certain assets in the community that they now needed to liquidate and in one case in an expedited way as the info was not received until the last day of the month. Therefore this person who did not have enough to pay for the month's stay was denied until the next month when they had time to spend down. This person then returned to the community and the assets that were protected before admission were now gone. 4. Families and the facility need to know where they stand within 30 days and sometimes sooner not 45 as information needed to manage the funds is often given too late. Or, if the information is given late or not requested until later in the month, they need grace periods to gain the information or do the appropriate actions as needed. The "Resources need to be below the $2000 by the end of the month" rule is often not fair. I have seen families come in to help a resident with dementia and find financial affairs in disarray to stay the least and sometimes find out that the person could have qualified sooner if the financial information was given within the expected timeframe, i.e. the end of the previous month. It becomes often too late and the funds are not in place to pay for the days of stay.
30	We enjoy our relationship with the Gallatin County Office of Public Assistance caseworkers, they are very helpful! We continue to have difficulty with processing applications due to high caseload volumes at the OPA. The delays this causes affects our ability to admit residents who are pending Medicaid approval, especially if we have current residents with delayed applications and thousands of dollars of Medicaid back-payments pending. Many patients who would qualify are being denied admission to LTC facilities due to the financial losses associated with current residents' open cases.
31	Our jobs are so demanding on the LTC end and the OPA end, to meet the goal of assisting the resident get the appropriate care they need during a Medicaid pending process is just so time consuming and difficult it makes some facilities not take them at all. Then facilities like ours who does take them to assist their communities are inundated with those and it is just frustrating.

32	I apologize for this survey not meeting the dead line of Jan. 28th. It was only sent to me just recently. We have no issues with the Medicaid process. I feel I have a good working relationship with our Dept. of Human Services. If there are delays in the process it is generally related to another source of income.
33	I have had a couple residents when they've filled out applications that have boats, cars etc, still in their names that they no longer have or no longer are in any kind of working order. Here if we have questions we usually call the OPA that is handling the application to see where it's at. Another problem I've seen over the years, is when some family members receive the recertification forms they don't fill them out and send them in. I like and appreciate the shorter forms. Develop an application specific to nursing home residents, there aren't usually someone attending school or pregnant or pay child support.

Cost to nursing facilities

OVERALL (128 cases)

Total:	$1,958,959.07
Max:	$100,000.00
Min:	$801.00
Average:	$ 15,304.37

DELAY (88 cases)

Max:	$100,000.00
Min:	$801.00
Average:	$12823.67

DENIAL (26 cases)

Max:	$70,000.00
Min:	$2,400.00
Average:	$ 14856.25

Both DELAY and DENIAL: (15 cases)

Max:	$100,000.00
Min:	$6,000.00
Average:	$31,729.50

Appendix G: Income Policies

Note: States have the option to adopt more liberal income and resource eligibility policies with approval from CMS through changes to the Medicaid State Plan under provisions of the Social Security Act Section 1902r(2). However, not all state proposals are approved, particularly if they directly conflict with new Congressional action or the intent of Congressional action, and require attachment of fiscal notes for both State General Fund and federal costs.

Some items may be either countable or excluded based on the specific circumstances of the individual income source. These circumstances are outlined in the Montana Medicaid manual, starting in section 500.

Policy	Countable	Excluded	DPHHS Interpretation	State Option	Federal Rule	Notes
Active Corps of Executives payments		X			X	
Adoption Subsidies (Title IV)	X				X	
Advances on wages	X				X	
Agent Orange Settlement Fund payments		X			X	
Agent Orange VA payments	X				X	
Agricultural Stablilization and Conservation Service	X				X	
Aid and Attendance		X			X	
AmeriCorps	X				X	
AmeriCorps *VISTA		X			X	
Annuity payment	X	X		X		More liberal than federal requirement
Asbestos settlement payments	X		X			
Attendent care payments	X				X	
Bankruptcy			X			

Bartered income	X	X		X		
BIA General Assistance	X				X	
Bonus pay	X				X	
Capital gains	X		X			
Charitable donations	X		X			
Child Care Block Grant		X			X	
Child support	X				X	
Child support arrearage	X				X	
Child Tax Credit refund		X			X	
CIP payments from CSA		X			X	
Commissions	X				X	
Community Services Administration		X			X	
Complimentary assistance program benefits		X			X	
Contract for Deed	X	X				
Contractual income	X			X		More liberal than federal requirement
Contributions	X				X	
Corporation income	X		X			This is driven by a Montana Supreme Court decision on *Hofer et al v. DPHHS*
Crime Victim Compensation		X			X	
Crisis intervetion program		X			X	
Disaster Relief Act payments		X			X	
Displaced homemaker	X				X	
Dividend income	X				X	

Earned income of children	X	X			X	
Earned Income Tax Credit payment/refund		X			X	
Educational income		X			X	
Energy payments (e.g. Section 8/HUD)		X			X	
Factor XIII or IX Concentrate Blood Products payments		X			X	
Family Subsistence Supplemental Allowance	X				X	
FEMA funds (non-Disaster Relief)	X				X	
Forest Service Income for the elderly		X			X	
Foster Care payments	X				X	
Foster Grandparent Program payments		X			X	
Garnishments from income	X				X	
Gifts (infrequent)		X			X	
Government training allowances	X	X			X	
Home Equity Conversion Sale Leaseback Program	X				X	
Home Equity loan		X			X	

Homeowners Credit		X			X	
Income Tax refund/credit		X			X	
In-Kind income	X				X	
In-Kind Support and Maintenance (ISM)	X	X			X	
Interest income	X	X			X	
Irregular/infrequent income	X	X			X	
Jury duty compensation payments	X	X			X	
Lease income (non-Native American)	X				X	
Loan (given to household)		X			X	
Loan (repayments to household)		X			X	
Lump sum payments	X	X			X	
Military Basic Allowance for Housing	X				X	
Military pay	X				X	
Military reenlistment bonus	X				X	
Money drawn from Individual Development Account (IDA)		X			X	
Native American income	x	X			X	
Patronage dividends paid to a self-employment enterprise	X				X	

Payments from projects funded under the Older Americans Act	X				X	
Payments from *Susan Walker v. Bayer Corp* settlement fund		X			X	
Payments of Wartime Relocation		X			X	
Payments to children of Vietnam veterans for spina bifida		X			X	
Payments to disabled children of female Vietnam veterans		X			X	
Payments to victims of Nazi persecution		X			X	
Pension payments	X				X	
Per-capita income (Native)		X			X	
Plan for Achieving Self Support (PASS) Payments		X			X	
Radiation Exposure Compensation Act payments		X			X	
Railroad retirement	X				X	
Real Property Acquisition Policies Act of 1970 payments		X			X	

Recoupment for prior overpayments	X	X			X	
Reimbursements		X			X	
Rental income	X				X	
Renters/Homeowners Credit refund		X			X	
Reverse Annuity Mortgage (RAM)		X			X	
Royalty income	X				X	
RSDI/SSDI (SSA Title II)	X				X	
Sale of a resource	X	X			X	
Sale of blood/blood plasma	X				X	
Savings Offer Success (SOS) payments		X			X	
Self-employment income	X				X	
Senior Companion Program payments		X			X	
Severance pay	X				X	
Sick Leave	X				X	
Spouse's income	X	X			X	
SSI (SSA Title XVI)	X	X			X	
SSP	X	X			X	
State Displaced Homemaker Program payments	X				X	
Striker income (income received during strike)	X				X	
Supportive service payments		X			X	

TANF	X				X	
TANF Work Support Payments	X				X	
Temporary disability insurance	X				X	
Tips	X				X	
Title II Retired Senior Volunteer Program (RSVP) payments		X			X	
Title III Service Corps of Retired Executives (SCORE) payments		X			X	
Tribal TANF	X				X	
Trust income	X	X			X	
Unemployment compensation	X				X	
Uniform Relocation Assistance payments		X			X	
Vacation Pay	X				X	
Vendor payments	X	X			X	
Veterans benefits (excluding Aid and Attendance)	X				X	
Wages from employment	X				X	
Wages paid to temporary census workers		X			X	
Women Infants and Children (WIC)		X			X	
Work study income		X			X	

Workers compensation	X				X	
Workforce Investment Act (WIA) payments		X			X	
Work-Study income		X			X	

Appendix H: Resource Policies

Note: States have the option to adopt more liberal income and resource eligibility policies with approval from CMS through changes to the Medicaid State Plan under provisions of the Social Security Act Section 1902r(2). However, not all state proposals are approved, particularly if they directly conflict with new Congressional action or the intent of Congressional action, and require attachment of fiscal notes for both State General Fund and federal costs.

Some items may be either countable or excluded based on the specific circumstances of the individual resource. These circumstances are outlined in the Montana Medicaid manual, starting in section 400.

Policy	Countable	Excluded	DPHHS Interpretation	State Option	Federal Rule	Notes
Alien's Sponsor's resources	X				X	
Annuities	X	X		X		State opted to apply a more liberal criteria to how annuities are counted. However, options for annuities are severely limited by the Deficit Reduction Act of 2005
Basic maintenance items		X			X	
Bonds	X				X	
Burial accounts	X	X		X		State opted to apply a more liberal criteria to allow many burial contracts to be excluded.
Burial contracts	X	X		X		State opted to apply a more liberal criteria to allow many burial contracts to be excluded.
Burial plot		X			X	
Business checking account		X			X	
Business/farm equipment	X	X			X	
Camper (RV)	X				X	
Cash on hand	X				X	
Certificate of Deposit (CD)	X				X	

Contract for deed	X	X		X		State exercised SS Act Section 1902r(2) to enact a more liberal rule that allows many contracts for deeds to be excluded as resources
Credit union accounts	X				X	
Current month's income		X			X	
Disaster/Emergency assistance		X			X	
Disqualified/ ineligible member's resources	X				X	
Educational income		X			X	
EITC		X			X	
Employment-related retirement accounts (post-retirement)	X				X	
Employment-related retirement accounts (pre-retirement)		X			X	
Energy assistance		X			X	
Fee patent land (Indian)	X				X	
Fire/Casualty Insurance proceeds	X	X			X	
Funds prorated as income		X			X	
Home and surrounding property/lot		X			X	

Income producing property	X	X			X	
Indian land		X			X	
Individual Development Account (IDA)		X			X	
Individual Indian Money (IMM) accounts	X	X			X	
Individual Retirement Account (IRA)	X				X	
Items of unusual value	X				X	
Keogh Plans	X				X	
Land in Conservation Resource Program (CRP)	X	X			X	
Life estate	X	X			X	
Life insurance ("whole-life" or "straight life")	X	X			X	
Life insurance (term)		X			X	
Limited Liability Companies (LLC)	X			X	X	If LLC shares were to be excluded, then corporation shares (IBM, Microsoft, as well as S-Corporations, etc.) would all have to be excluded as well; Rules based on Montana Supreme Court ruling in Hofer et al v. DPHHS
Livestock		X			X	
Medicaid Qualifying Trust	X				X	
Native American resources	X	X			X	

Non-home real property	X				X	
Oil and Mineral Rights	X	X			X	
Patient trust account	X				X	
Personal checking account	X				X	
Pooled Trust		X			X	
Prepayment of mortgage		X	X			
Prepayment of rent	X		X			
Promissory note/Loans given by the household	X				X	
Property in probate		X	X			
Property listed for sale	X				X	
Property/equipment necessary for employment		X			X	
Resources of a corporation		X	X			Resources of a corporation are not individually owned by the shareholders. They are owned by the corporation. The corporate shares are owned by the stockholders.
Resources used as collateral	X				X	
Savings account	X				X	
Security deposits		X			X	
Settlements and restitution	X	X			X	

Special Needs Trust		X			X	
Stocks and mutual fund shares	X		X		X	If corporate shares were to be excluded, then all corporation shares (IBM, Microsoft, as well as S-Corporations, etc.) and LLC interests would all have to be excluded as well; Rules based on Montana Supreme Court ruling in *Hofer et al v. DPHHS*
Trailers (including 5th wheels)	X				X	
Trust	X	X			X	
Vehicles	X	X			X	

Supersedes: MA 404-1 (07/01/06)

►References: 42 U.S.C. §1396p (c)(1)(F) through (I) and 42 U.S.C. 1396p (e); ARM 37.82.101 and .417; P.L. 109-171; P.L. 109-432

GENERAL RULE--An otherwise eligible Medicaid applicant or recipient is restricted from receiving Medicaid coverage of institutionalized or Home and Community Based Service/Waiver (HCBS/waiver) services if a disqualifying transfer of assets has occurred. A disqualifying transfer of assets occurs when:

1. Assets were transferred for less than fair market value,
2. The transfer occurred during the look-back period, or after Medicaid eligibility has been established, and,
3. The transfer was not an exempt transfer described in "Exempt Asset Transfers" below.

In addition to selling and giving away property, disqualifying asset transfers may include, but are not limited to, actions such as:

- Establishing a trust,
- Forgiving a debt without obtaining fair market value,
- Decreasing the extent of ownership interest in an asset,
- Forfeiting or assigning the right to a stream of income,
- Making an unsecured loan,
- Any other action by which an individual gives up or limits his or her rights to or interest in an asset, or in some instances,
- Purchasing an annuity.

►LOOK-BACK PERIOD From the day an institutionalized or HCBS waiver individual (single or married) requests Medicaid coverage, the look-back period for transfers made from 8/11/1993 through 2/7/2006 is:

1. Thirty-six (36) months; or
2. Sixty (60) months for transfers to trusts;
3. Sixty (60) months for transfers from trusts to or for the benefit of people or entities other than the Medicaid applicant/recipient(s).
   Example: Gladys set up a trust in 1999, for which she and her adult children are the beneficiaries. The trust was set up with her funds. In 2006, Gladys applies for Medicaid. The trust allows for

payments to be made from principal for either her (Gladys') benefit, or for her children. In 2002, the trust paid $100,000 as a down payment for a son's home. Even though the trust was set up in 1999, the payment from the trust for the benefit of someone other than Gladys (who is the grantor of the trust) that was made within 60 months of the Medicaid application is treated as an uncompensated asset transfer that will result in a penalty period, unless she submits a successful rebuttal.

► From the date an institutionalized or HCBS/waiver individual (married or single) requests Medicaid coverage, the look-back period for transfers made on or after 2/8/2006 is 60 months for ALL transfers, including payments from trusts to or for the benefit of people or entities other than the Medicaid applicant/recipient(s).

NOTE: Asset transfers for less than fair market value made after application are also subject to penalty.

The look-back date is established based on the first application for Medicaid while an individual is also institutionalized or pursuing waiver, regardless of whether the application is approved or denied (for any reason, including failure to verify information). Only one look-back date is established for each applicant, regardless of multiple periods of institutionalization or multiple applications. Once the look-back date is established, all transfers of assets after that date are subject to evaluation and penalty.

If retroactive coverage is requested, the lookback period is calculated from the first of the retroactive month for which the Medicaid application is submitted, regardless of in which month the application is submitted (i.e., an application is submitted 10/15/05 and retroactive benefits are requested for July 2005--- the lookback period for this application will begin 7/1/02, or 36 months prior to the first month of requested coverage). The penalty period for a transfer made on or after 2/8/06 may begin in the retroactive month if all of the criteria to begin the penalty period are met in the retroactive month. (See MA 404-2.)

ASSETS Assets include all income and resources the applicant/ recipient and/or his/her spouse:

1. owns;

2. is entitled to receive;
3. is entitled to receive the benefit of (such as being a beneficiary of a trust);
4. would be entitled to receive except for some action or inaction that results in failure to obtain the asset.

NOTE: Those assets that comprise the individual's general resource allowance ($2,000 limit) are **NOT** subject to the asset transfer provisions.

PURCHASE OF AN ANNUITY

The purchase of an annuity by either an applicant/recipient or by a community spouse may be considered to be an uncompensated transfer of assets in certain circumstances.

► An annuity purchased or converted on or after February 8, 2006 by a Medicaid applicant or recipient or community spouse will be considered an uncompensated asset transfer (subject to rebuttal) when determining eligibility for nursing home or HCBS waiver services unless:

1. The annuity payments are made to the Medicaid applicant/recipient or community spouse;
2. The periodic scheduled payments are required to be paid on at least an annual basis;
3. The annuity requires equal payments throughout the contract (e.g., no deferred or balloon payments at any point during the payment period);
4. The payment schedule is actuarially sound (the equal period payments are based on expectation of a full payout of the contract within the annuitant's life expectancy);
5. The annuity is irrevocable;
6. The annuity is non-assignable; AND
7. The State of Montana Medicaid Program is named as the irrevocable first position residual beneficiary of the annuity.

► This assignment of irrevocable residual beneficiary requirement applies to any annuity that is purchased or converted (see Annuities, MA 402-1) on or after 2/8/2006.

► An annuity is converted if the annuity contract is changed. Examples of conversion include, but are not limited to, actions such as annuitizing a previously un-annuitized annuity or changing an annuity from one type of annuity to another. Automatic events such as the start of pre-arranged payments or other actions taken by the annuity company that are not

voluntary on the part of the annuity owner are not considered conversions.

The Medicaid applicant/recipient may name a community spouse, a minor child, or a blind/disabled adult child as the primary beneficiary before the State of Montana Medicaid Program. The community spouse can name only a minor child or blind/disabled adult child as the primary beneficiary before the State of Montana Medicaid Program. However, if such an individual is named as a beneficiary in a position primary to the State of Montana Medicaid Program, the State of Montana Medicaid Program must be named as the first position beneficiary if the spouse or child disposes of any remainder for less than fair market value. In other words, the State of Montana Medicaid Program becomes entitled to the remaining balance of the annuity if the spouse or child attempts to liquidate or transfer their remainder interest in the annuity for less than fair market value.

► An individual retirement annuity [subsection (b) of section 408 of the IRS Code of 1986], a qualified employer plan annuity [subsection (q) of section 408 of the IRS Code of 1986], or purchase of an annuity with an IRA, employer or employee association account, or a qualified salary reduction arrangement [section 408(a), (c), or (p) of the IRS Code of 1986] or a simplified employee pension [within the meaning of section 408(k) of the IRS code if 1986] will not be considered an uncompensated asset transfer (provided the payments are made to the owner of the above-named account or arrangement) or require beneficiary assignment to the State of Montana Medicaid Program. If an individual alleges one of these situations, gather documentation and request assistance from the regional policy specialist in determining whether the criteria are met.

An annuity purchased by a Medicaid recipient or community spouse after eligibility has been determined must report the purchase of the annuity under normal change reporting requirements, and must amend the annuity to meet the above requirements in order to continue to meet Medicaid eligibility requirements. If a community spouse refuses to amend his/her annuity to make the State of Montana Medicaid Program the primary remainder beneficiary, the purchase of the annuity will be considered an uncompensated asset transfer and will result in a penalty being applied to the nursing home spouse, regardless of any other provisions excepting penalties for asset

transfers made by the community spouses after Medicaid has been established by the nursing home spouse.

► Other circumstances may cause an annuity to be considered an uncompensated asset transfer, regardless of the annuity meeting #1-7 above. Circumstances such as taking an action to cause an annuity to be inaccessible (as opposed to irrevocable/non-assignable) would be treated as an uncompensated asset transfer, aside from #1-7 above.

TREATMENT OF JOINTLY OWNED ASSETS

When an asset is held in sole ownership, in common with another via joint tenancy, tenancy in common, joint ownership, or a similar arrangement, the asset (or portion of the asset) is considered to be transferred when any action is taken that reduces the individual's ownership or control of the asset.

Example 1: A daughter's name is included on Jim's checking account. The account still belongs to Jim. If the daughter withdraws funds for any purpose other than to provide for Jim, she has removed the funds from Jim's control. Thus, there is an asset transfer.

Example 2: A daughter's name is placed on Tom's home title, which limits Tom's right to sell or otherwise dispose of the home. Because the addition of daughter's name on the title requires daughter's agreement to the home sale or disposal where no agreement was necessary before, adding daughter's name to the title constitutes an asset transfer.

Example 3: During the 90-day period during which assets allocated to the community spouse are to be transferred from the nursing home spouse to the community spouse, the community spouse removes the nursing home spouse's name from their home and from a joint CD. In place of the nursing home spouse's name, the community spouse adds his daughter's name. The substitutions of the daughter's name for the nursing home spouse's name on the deed to the home and on the bank's CD records are uncompensated asset transfers. The community spouse must simply remove the nursing home spouse's name so the community spouse has full

ownership. Substituting another's name is a transfer of the nursing home spouse's assets to a third party.

WHO TRANSFERRED ASSET

An asset transfer by the applicant/recipient and/or his/her spouse must be evaluated as if the applicant/recipient made the transfer. Additionally, assets will be considered transferred by the applicant/recipient or his/her spouse when they are transferred by:

1. A parent;
2. A guardian;
3. A court; or
4. Anyone acting on behalf of, or at the direction of, the applicant/recipient or his/her spouse (e.g., an attorney).

NOTE: Assets refused by the applicant/recipient, spouse, etc. are considered to be transferred assets. Examples include waiving pension income, waiving the right to inherit, not accepting or accessing an injury settlement, or a surviving spouse's failure to seek his/her elective share of a deceased spouse's estate (see MA 906-1).

EXEMPT ASSET TRANSFERS

Do <u>not</u> evaluate asset transfers when:

1. The asset was transferred to a spouse prior to establishment of nursing home or waiver eligibility under spousal impoverishment policies.

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2. The asset was transferred from the institutionalized or HCBS/waiver spouse to a community spouse during the 90-day transfer period after approval of institutional or HCBS/waiver coverage and was part of the Community Spouse Resource Maintenance Allowance.
3. The asset was transferred to a minor or adult child who is blind or disabled according to Social Security criteria.

4. The asset transferred is the applicant/recipient's home <u>and</u> title to the home is transferred to:

   a. The spouse;

   b. A child under age twenty-one (21);

c. An adult child who has been determined to be blind or permanently disabled according to Social Security criteria;

d. A child (regardless of age) who:

► (i) Resided with the applicant/recipient for two years immediately prior to the applicant/ recipient's nursing home admission; and

► (ii) Provided care which permitted the applicant/recipient to reside at home (a doctors statement must confirm the care provided deferred nursing home admission); or

e. A sibling who:

(i) Has equity interest in the home; and

(ii) Continually resided in the home for at least one (1) year prior to the applicant/recipient's nursing home admission.

► 5. The asset was transferred exclusively for a purpose other than qualifying for medical assistance, such as satisfaction of <u>legally enforceable</u> debts.

The timing of payments of “debts” should be considered. 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.

► **NOTE:** Estate planning is a process designed to help manage and preserve a person's assets while alive and to conserve and control their distribution after death. For purposes of the determination of Medicaid eligibility, "estate planning" actions must be considered as specifically for preserving assets from long term care costs through achieving Medicaid eligibility.

6. The asset(s) was transferred into the individual's Special Needs Trust (see MA 402-3).

7. The asset was transferred by the community spouse, was an asset allowed to the community spouse as part of the Community Spouse Resource Maintenance Allowance, and was transferred AFTER Medicaid was approved and opened for the institutionalized spouse. (If assets are transferred by community spouse via a will and the community spouse predeceases the institutionalized spouse, see MA 906-1). Or,

   NOTE: Transfers of any assets that are made by the community spouse prior to spousal impoverishment policies being applied to the couple will be evaluated for uncompensated transfer against the spouse who is the Medicaid applicant/recipient.

8. Denial of coverage or eligibility would cause an undue hardship. An undue hardship exists only when:

   (a) The asset was transferred as a result of fraud, misrepresentation or coercion perpetrated against the applicant/recipient and/or his/her spouse; and

   (b) The applicant and/or his/her spouse have exhausted all legal recourse to recover the transferred resource. Exhausting all legal recourse includes, but is not necessarily limited to, filing a civil court action and pursuing the civil action to its conclusion. The requirement to exhaust all legal recourse is not satisfied by the filing of criminal charges against the person who received the assets by means of fraud, misrepresentation or coercion.

DETERMINING UNCOMPENSATED VALUE

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.

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

1. 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

2. 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.

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.

The value of compensation in the form of a promise of future services, food, or shelter is based on fair market value for the length of time the applicant/recipient can reasonably be expected to receive such support or maintenance from the date of the transfer or contract, whichever is earlier (see MA 008, "Life Expectancy Table").

► Services provided through a personal care contract cannot duplicate services that are being provided or are available as part of another existing contract, or encompassed by the package of services provided by a nursing home, assisted living facility, or adult foster home in which the individual is residing. For example, since a nursing home provides dietary services, including assistance in eating when necessary, a separate service contract for payment to a third party for the third party to provide assistance eating is not considered a valid expense in a personal care contract. Contracts and payments for duplicative services are considered uncompensated asset transfers.

Example 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.

Example 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 live 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.

► Example 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 laymen. 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.

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

The fair market value of a stream of income is considered to be the amount of the annual payments multiplied by the life expectancy of the person upon whose lifetime the payments are based.

Example: Guido is entitled to payments of $300 per month for the remainder of his life from an annuity. Guido is 85 years old. The value of this "stream of income" is $300/month X 12 months X 5.27 (Guido's life expectancy per MA 008), or $18,972.

NOTIFICATION

The applicant must be advised of any disqualifying transfer penalty determination **before eligibility is approved or denied**. The advising notice must:

1. Inform the individual that an uncompensated transfer has been identified;

2. Give the value of the resource transferred; and

3. Explain the applicant/recipient's right to rebut the presumption that the transfer was made to qualify for assistance.

If the applicant/recipient does not respond to the notification within fifteen days, the eligibility case manager must assume that no rebuttal will be received, and proceed with establishing and applying the asset transfer penalty.

TRANSFER REBUTTAL STATEMENT

The applicant/recipient may rebut the presumption that a resource was transferred for the purpose of establishing eligibility for Medicaid. In that case, it is the applicant/ recipient's responsibility to present convincing evidence that the asset was transferred exclusively for some other reason. The rebuttal statement must include and be accompanied by:

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

2. Documentation of attempts to sell the asset at fair market value;

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

4. Documentation of means of self-support after the transfer; and

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

CONVINCING EVIDENCE

Factors that may indicate a transfer was not made to qualify for assistance include:

1. The occurrence of one of the following after the asset has been transferred:

   a. Traumatic onset of disability;
   b. Diagnosis of a previously undetected disabling condition;
   c. Unexpected loss of other resources which would have precluded eligibility for medical assistance; or
   d. Unexpected loss of income that would have precluded eligibility for medical assistance.

2. Total countable assets (including the uncompensated value of the transferred asset) fall below the general resource limit during each of the months comprising the appropriate lookback period;

3. The transfer was court-ordered in a <u>contested</u> court action; or

4. The asset was transferred as a result of fraud, misrepresentation or coercion perpetrated against the applicant and/or the applicant's spouse, and the applicant and/or the applicant's spouse have exhausted all legal recourse to recover the transferred resource. Exhausting all legal recourse includes, but is not necessarily limited to, filing a civil court action and pursuing the civil action to its conclusion. The requirement to exhaust all legal recourse is <u>not</u> satisfied by the filing of criminal charges against the person who received the assets by means of fraud, misrepresentation or coercion.

   NOTE: The transferred property is considered inaccessible as long as the civil suit has been filed with a court of competent jurisdiction and is

pending but is being actively pursued.

PROCEDURE: **EVALUATING ASSET TRANSFER REBUTTALS**

Responsibility	**Action**
►Eligibility Case Manager	1. Upon identifying a potentially uncompensated asset transfer or transfers, send the applicant/recipient a notice advising them of the potentially disqualifying asset transfer, the value of the resource transferred, and explaining the right to rebut the transfer within 15 days of the notice.
Applicant/Recipient/ Representative	2. Provide the county office with a rebuttal statement regarding transferred asset(s).
Eligibility Case Manager	3. Evaluate the rebuttal statement and documentation.
	4. Recommend accepting or rejecting the rebuttal statement to the county director. **NOTE:** A recommendation to accept the rebuttal must be based on evidence that the transfer was exclusively for some purpose other than to establish Medicaid eligibility.
County Director	5. Review the eligibility case manager's recommendation.
	6. Accept or reject the rebuttal statement; case note decision. Assistance can be requested from the Regional Policy Specialist.
Eligibility Case Manager	7. When the rebuttal statement is: a. **Accepted,** the transfer will be considered exempt; or b. **Rejected,** a penalty period must be imposed (see MA 404-2). ► **NOTE:** A rebuttal may be partially accepted and partially rejected, in that the rebuttal may contain information that would reduce the ineligibility period without completely exempting it.
	8. Notify applicant of determination via system notice.

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Modest Means Model

The Legal Service Developer was requested by the HJ 25 Committee to develop a Modest Means Model to assist nursing homes in addressing collection of debt based on lack of payment for nursing home services. The Modest Means Program is currently an expansion of services provided by Mt AAA Legal Services to provide Modest Means services to persons sixty and older. This would be an extension of their service to meet the expectation of the Hardship Rule for Medicaid and address the collection of nursing home debt. Mt AAA Legal Services is currently recognized as an entity who has worked with persons sixty and older and is currently collaborating with the State Bar of Montana for Pro bono and Modest Means program. It is an expectation that this service may be funded based on the interest and support of the nursing homes who have been in need of legal representation to accomplish Medicaid eligibility and collection of debt owed for services provided by the nursing homes throughout Montana.

Collection Process

This memo will briefly summarize the procedure for filing a civil collection action to regain property from a person who obtained it from another either through fraud, exploitation or undue influence. Specifically, this memo contemplates a victim who is in need of Medicaid, but would be ineligible for Medicaid due to the uncompensated transfer of assets. This memo does not pretend to encompass all of the possible scenarios that could arise in these cases.

1. Plaintiff. The Plaintiff is the party to the lawsuit who is suing to recover lost property. The Plaintiff must be the victim who has lost the money. A long term care facility, state or other agency cannot step in as the Plaintiff. If, however, the victim is incapacitated, then a Durable Power of Attorney or Guardian may be able to sue on behalf of the victim.

2. Defendant. The Defendant is the person sued by the Plaintiff. The Defendant is accused of wrongfully misappropriating property from the Plaintiff.

3. Plaintiff's Attorney. Unless suing in small claims court, the Plaintiff will almost certainly need an attorney to represent them. Ethical rules require that the Plaintiff pay for their own attorney unless they consent in writing to allow another person/entity to pay their attorney fees. If actual collection of money is probable, attorneys often work on a

contingency fee basis; collecting as their fee 20-33% of the money collected from the Defendant. If collection is uncertain, attorneys will work on an hourly basis, usually requiring an advance payment called a retainer.

4. Complaint. A Complaint is the lawsuit is filed by the Plaintiff against the Defendant in District Court. Normally the Complaint is filed either where the Defendant lives or where the misappropriation occurred. The Complaint must state a claim that the property was wrongfully taken, and there are several such claims allowed under Montana law, including fraud, exploitation, undue influence, conversion, and violation of fiduciary duty.

5. Civil Procedure. The Defendant must be personally served (unless they cannot be located and then they may be served by other means). The Defendant normally has 20 days to answer the Complaint or file a motion to dismiss. Then each party may request information from the other, called 'discovery', and other motions may be filed. Eventually the court will set a trial on the Complaint, which may either by Judge or Jury. This process can take anywhere from several months to several years, depending on the issues and fight of the Defendant.

6. Collection. Assuming the Complaint is successful, the end result will be a Judgment against the Defendant. The Judgment is signed by the Judge and states the amount owed by the Defendant. There is a statutory interest rate of 10% on court judgments until paid. The Defendant may pay the entire judgment or make arrangements to make payments. If the Defendant is not so cooperative, or is unable to pay, then there are several methods of collecting on judgments. The Plaintiff may use writs of execution to garnish the Defendant's bank account or paychecks. If the Defendant has income which is not exempt (e.g.: SSA benefits are exempt), garnishment is not difficult, although it may take some time and fees. The Plaintiff may also place liens on the Defendant's real property. If the Defendant has real property other than their home, then placing a lien is not difficult (though actual collection does not occur until the property is transferred such as through a sale). If, however, a Defendant does not have non-exempt income or other cash, and does not have real property, then collection may be difficult.

Modest Means Program

Legal Representation for Seniors Filing Civilly (LRSFC)

The Modest Means Program will serve persons 60 and older who are eligible for Medicaid services. The standard for eligibility for modest means case for LRSFC will be the client's monthly income less than the Medicaid rate for the facility in which the client resides (normally would be the facility's Medicaid rate times 31 days). Those with income over this amount are not eligible for Medicaid coverage of nursing home care.

An individual will not be eligible for the Modest Means program unless the following criteria is met: a) Medicaid gives the "green light" for the hardship rule to apply, allowing a case to be referred to the LRSFC program. The "green light" allows the attorney to proceed with the case unrestricted. Once the determination has been made, the Modest Means Program must meet all three of the following objectives: a) Pursuing collection of resident's assets b) Assure Medicaid coverage is provided while pursing collection of assets c) Attorney is paid for services. A case will not be accepted by LRSFC without a copy of the Medicaid records.

In order for the LRSFC program to succeed, there will need to be a source(s) of funding. It is suggested the funding be obtained from the legislature and in combination with funds from the nursing homes to pursue collection of cases. The Legal Service Developer will coordinate attorneys for the LRSFC program and the collection process.

Types of cases:

A referral must be sixty and older to be eligible for the LRSFC program.

Cases referred by the Nursing home when a resident's funding is not secured and/or has been exploited.

Cases referred by the Family members when funding was not secured and/or has been exploited.

Referrals from other entities may be accepted by LRSFC in conjunction with Public Assistance Bureau.

Appendix K: Washington state's RCW 74.39A.160 (Transfer of assets—Penalties)

Transfer of assets — Penalties[15].

(1) A person who receives an asset from an applicant for or recipient of long-term care services for less than fair market value shall be subject to a civil fine payable to the department if:

(a) The applicant for or recipient of long-term care services transferred the asset for the purpose of qualifying for state or federal coverage for long-term care services and the person who received the asset was aware, or should have been aware, of this purpose;
(b) Such transfer establishes a period of ineligibility for such service under state or federal laws or regulations; and
(c) The department provides coverage for such services during the period of ineligibility because the failure to provide such coverage would result in an undue hardship for the applicant or recipient.

(2) The civil fine imposed under this section shall be imposed in a judicial proceeding initiated by the department and shall equal (a) up to one hundred fifty percent of the amount the department expends for the care of the applicant or recipient during the period of ineligibility attributable to the amount transferred to the person subject to the civil fine plus (b) the department's court costs and legal fees.

(3) Transfers subject to a civil fine under this section shall be considered null and void and a fraudulent conveyance as to the department. The department shall have the right to petition a court to set aside such transfers and require all assets transferred returned to the applicant or recipient.

[15] Available online http://apps.leg.wa.gov/RCW/default.aspx?cite=74.39A.160