

**COMMENTS OF THE INDIANA CHAPTER OF THE NATIONAL ACADEMY  
OF ELDER LAW ATTORNEYS CONCERNING THE PROPOSED MEDICAID  
RULE (LSA DOCUMENT #08-325) TO IMPLEMENT THE DEFICIT REDUCTION  
ACT AND TO MAKE SEVERAL OTHER CHANGES IMPACTING  
MEDICAID ELIGIBILITY**

These comments are presented on behalf of the Indiana Chapter of the National Academy of Elder Law Attorneys (NAELA). NAELA is a non-profit association established in 1987 that assists lawyers, bar organizations and others who work with older clients, people with special needs, and their families. The Indiana Chapter of NAELA consists of approximately 100 Indiana attorneys who advise and represent Hoosiers concerning Medicaid eligibility and other elder law matters. Its members are very familiar with the problems and needs of their clients, with the Medicaid program, and with the requirements of the Deficit Reduction Act of 2005 (DRA), Public Law No. 109-171. These comments are being presented on behalf of elderly and disabled Hoosiers, or those who may be in the future, as most of them are not aware of these rules and their potential impact on their lives.

We are aware that FSSA must implement the provisions of the DRA, and we appreciate the opportunity to comment on the regulation. After waiting for almost three years to implement the Act, implementing it retroactively to apply to transactions that occurred on or after February 8, 2006, will result in tragic and unexpected results for many Hoosiers. It would be much more humane to implement the Act prospectively only. We had hoped that the undue hardship exception to transfer penalties would help to alleviate much of the harshness of the DRA provisions, but the exception is written so narrowly and stringently that it will rarely apply. Even then, the proposed rules forces persons to choose between seeking an exception or appealing the penalty, and if one chooses to file for an exception, FSSA will not commit that it will act on the exception, as it will deem the request denied if not ruled upon within 30 days. This is unfair and

contrary to federal law. Our detailed comments on these and other provisions of the proposed regulation follow.

**I. IT IS UNFAIR AND UNREASONABLE TO RETROACTIVELY APPLY THE PROVISIONS OF THE DRA WHERE IT HAS TAKEN INDIANA ALMOST THREE YEARS TO IMPLEMENT THE ACT.**

The DRA was signed into law on February 8, 2006, and many provisions of the Act state that they apply to transfers made on or after that date. NAELA members are aware of these provisions and have advised their clients of the possibility that the rules could be applied retroactively once implemented. However, there are thousands of elderly and disabled Hoosiers who have not contacted knowledgeable elder law attorneys and who are not aware of the DRA provisions. If a person was contemplating making a transfer and attempted to research the Medicaid rules by looking at the regulations in the Administrative Code and/or looking at the transfer rules in the on-line Program Policy Manual (also referred to as the ICES Manual), that person would only be aware of the pre-DRA rules, as no warning was ever placed in the IAC or in the ICES Manual that these rules were subject to change once the DRA was implemented. The DRA and the FSSA regulation make dramatic changes in the transfer penalty rules, as transfers that would not result in any problem under the pre-DRA rules, due to rounding down or due to the penalty period starting to run the month after penalty, or due to the 36-month limit on look back, may well under the new rules result in significant penalty periods that have not yet begun to run. In light of how long it is taking for FSSA to implement the DRA, the only reasonable way to implement it is prospectively, and to only apply it to transactions occurring after the effective date of the rule. We are aware that Florida has chosen to apply the DRA rules prospectively only, and the Center for Medicare and Medicaid Services (CMS) has to-date not

objected. In light of the unreasonableness of applying it retroactively, there is no reason to believe that CMS will object to only applying the rules prospectively.

This unfairness is a particular concern for Hoosiers who are vulnerable, frail, elderly and disabled (the population needing Medicaid assistance). Most of these individuals will not have hired attorneys to advise them, and they will not be aware of the potential problems under the DRA. Those who do consult with attorneys will only do so when nursing home admission is imminent. Increasing the look back period to five years, even for transfers made in 2006, will require record keeping and documentation that is far beyond the ordinary practices of the elderly, especially poor and chronically ill elders. The look back period has been 36 months for so long that it is a common understanding, and a change should not be made without advance notice and an opportunity for one to change one's plans and expectations.

Nursing homes will be especially hard-hit by the retroactive impact of the proposed new rule, especially when it is coupled with the draconian nature of the proposed guidelines for the undue hardship exceptions. If a nursing home resident expends all of his available funds and then applies for Medicaid assistance, only to find out that he is ineligible for Medicaid for two months due to some small gifts he made to his grandchildren four-and-a-half years before, the nursing home will suffer by not receiving Medicaid payment for the two-month penalty period. The resident will typically not have any means to pay the bill, so the nursing home will likely not get paid for those two months. If this happens several times to the same nursing home, as it likely will, the nursing home may have difficulty paying for necessary staffing and services for its residents, plus it will be reluctant to accept prospective residents as Medicaid pending. Persons unable to privately pay who need nursing home care may find it difficult, or maybe even impossible, to find a nursing home that will accept them.

It is important to note that the federal Medicaid law is not self-implementing. When the federal Medicaid law changes, it is really a matter of the federal government telling the individual states that they must change their state Medicaid laws to come into compliance with the requirements of the new Federal laws. As a result, Hoosiers could not have known how Indiana would choose to implement the various parts of the DRA.

We thus request and propose that the proposed regulation be modified by making the new provisions effective “for transfers on or after January 1, 2009.” This is the effective date of the regulation, which is 30 days after the final rule is published.

**II. THE CRITERIA FOR OBTAINING A HARDSHIP WAIVER PROVIDED IN THE PROPOSED REGULATION IS MUCH MORE RESTRICTIVE THAN THAT SET FORTH IN THE DRA, WHILE THE PROCEDURES FOR PROCESSING WAIVER REQUESTS AND APPEALS OF WAIVER DENIALS VIOLATE DUE PROCESS AND FEDERAL LAW.**

Section 6011(d) of the DRA requires that a hardship waiver be granted when:

application of the transfer of assets provision would deprive the individual--

(A) of medical care such that the individual’s health or life would be endangered; or

(B) food, clothing, shelter, or other necessities of life. . .

Indiana’s proposed rule adds several additional requirements for granting an undue hardship exception, some of which go beyond clarifying the federal standard and instead are more restrictive than the federal standard. The rules require the applicant to submit documentation (on an approved state form) that proves **all** of the following:

1. The applicant would have been otherwise eligible for Medicaid. This is redundant. An applicant would not receive a notice regarding the hardship

exception unless the applicant were otherwise eligible and a transfer penalty imposed.

2. The applicant has no other assets or income that could be used to pay for the care required by the applicant. This requires more specificity. “Other income” should not include income that is needed for a community spouse and which would be protected as a community spouse income allocation if the applicant were approved for Medicaid coverage of nursing home care. “Other assets” should not include certain exempt assets, such as the residence of the community spouse, one vehicle and at least a portion of the community spouse resource allowance. (North Carolina says 60%).
3. The applicant has attempted to regain control of the transferred asset using any and all legally valid methods. The regulation does not specify what is intended by “all legally valid methods.” Further, the applicant is required to “fully cooperate” with the state in efforts to recover the transferred asset, and upon request, to assign the applicant’s rights to recover the asset to the state Medicaid agency. These requirements are above and beyond what the DRA calls for. Although at first glance they may seem reasonable, to require an applicant to “fully cooperate with the state” is too vague to provide helpful guidance. What if the applicant has limited capacity to cooperate? The applicant may have no right to recovery of the asset, and if not, should not be penalized for not being willing to assign non-existent rights.
4. A transfer was made to a person who used illegal means to gain the resource and the applicant (A) has filed a police report; and (B) is using legal recourse to regain

the resource. This part of the rule says demonstrate “all” of the following, so this reads as if the only situation where an application can show hardship is where illegal means were used. This reduces the hardship exception’s helpfulness to almost zero, and it is a requirement beyond what the DRA requires. Also, what if the applicant cannot afford to pursue legal recourse (hire an attorney, pay court costs, etc.) or does not have the capacity to do so? That should not be a determinant of being able to obtain a hardship exception.

Indiana’s rules go even further beyond the DRA by listing specific circumstances where an undue hardship does not exist. This is problematic. If one of these circumstances exist BUT the applicant can demonstrate the requirements of the DRA (deprive the individual of medical care such that the individual’s health or life would be endangered; or food, clothing, shelter, or other necessities of life), will the undue hardship exception be granted?

1. For example, “the individual transferred assets under a violative personal services contract, including an oral personal services contract,” yet the imposition of the penalty period will demonstrably “deprive the individual of medical care such that the individual’s health or life would be endangered”. To summarily say that a hardship exception does not exist, simply because the transfer was due to an oral services contract, goes beyond the provisions of the DRA.
2. The rule provides that an undue hardship exception shall not exist when the imposition of the transfer of assets provisions (A) merely causes the applicant inconvenience; or (B) such imposition might restrict the applicant’s lifestyle but not put the applicant at risk of serious deprivation. This is redundant since the

DRA does not support an undue hardship exception for mere inconvenience or restriction to an applicant's lifestyle.

3. The proposed rule provides that an undue hardship exception shall not exist when an individual is required to sell an asset in an arm's length transaction, which would result in a sale of the asset that is less than the current fair market value. Selling an asset for less than fair market value is itself a transfer, so this just sets up another potential for a transfer penalty to be imposed. It is not clear in this section by whom or what the individual is being required to sell the asset. It seems this provision was written in response to a specific circumstance that is not clear.
4. The proposed rule refers to the undoing of a transfer that causes adverse tax consequences or penalties, interest, or other contract damages and says that where such penalties, interest, and contract damages are incurred in a contract between members of the same family (including step- and half- family members) the penalties, interest, and damages shall be considered transfers for inadequate consideration. This seems redundant, as the DRA does not support a hardship exception just because not transferring funds or undoing the transfer causes adverse financial consequences. The DRA has a specific standard for when a hardship exception is appropriate. It is also not clear whether an applicant can obtain a hardship waiver from the penalty period which the rule says can be applied for the penalties, interest, and damages.

5. The proposed rule does not allow a hardship waiver when a dissolution of marriage will result. Although this situation may be rare, by foreclosing it the state would seem to be encouraging divorce.
6. The proposed rule automatically denies a hardship waiver for penalties resulting from gifts to charitable organizations. This exception is not supported by the federal statute. Further, the agency should consider the impact of this provision on charitable giving. Once this provision is common knowledge, financial advisors and others will advise seniors, particularly those far advanced in age or with health problems, to refrain from making charitable gifts. Even if the individual can convince the division that the transfer was for purposes other than to qualify for Medicaid, this process is cumbersome and usually involves hiring an attorney to assist with getting the transfer approved, particularly if a formal appeal is involved. We know this process takes months, during which time the individual receives no Medicaid coverage for their long term care. The new regulation provides that a decision on hardship waiver must occur within 30 days, much shorter than the appeal period. Charitable gifts are important for many reasons that do not need to be elaborated here. The agency should not punish an individual who makes contributions to their church or favorite charity by threatening them with long term care costs.

The proposed rule sets up procedural roadblocks that are contrary to federal law. The proposed rule provides that any request not approved within 30 days is deemed denied. Notice of adverse decisions is required by federal law. To the extent this provision allows no notice to be sent and no reasons to be given when an undue hardship exception is denied, this provision

violates federal law. Further, applicants are entitled to appeal such adverse determinations and are entitled to notice of such appeal rights. It is not acceptable to allow an undue hardship exception request to simply sit in the agency's new computer system or on a caseworker's desk for longer than 30 days and therefore be denied. In reality, it usually takes the agency longer than 30 days to do most things. This provision reads like an "out" for the agency to simply fail to act on an exception request. If there is to be any deeming for non-action, the deeming should be that an exception not acted upon would be deemed approved. That would provide a real incentive for the agency to act upon waiver requests.

The rule also sets up an impermissible choice of remedies roadblock, as the rule provides that one cannot both appeal and seek a waiver. Appeal rights cannot be interfered with in this way. The constitutional right to due process provides that an applicant is entitled to appeal and receive a fair hearing on the merits of their determination for public benefits. Concurrently applying for a hardship waiver, in case they are unsuccessful in their appeal, does not forfeit these rights. Federal regulations require the agency to grant a hearing to any applicant who requests it because his claim for services is denied. 42 CFR § 431.220. Federal law now requires the state agency to provide for an undue hardship exception to the transfer penalty rules and a process for making a determination about whether an undue hardship exists. 42 U.S.C. §1396p(c)(2)(D). The two processes cannot be mutually exclusive. Further, the provision's time lines interfere with appeal rights. Even if an appeal request could mean you waive your right to apply for a hardship exception (or vice versa), applicants have 30 days to make a decision about appealing. However, Indiana's rule requires the hardship exception to be filed in 20 days. This forces applicants to shorten their appeal rights time line. This is also not permissible.

The proposed rule allows various persons to apply for a waiver, including an “applicant’s personal representative.” A personal representative is only authorized to act after death. The wording should be changed to “authorized representative.” Indiana’s Health Care Consent Act (Ind. Code 16-36-1-5) provides that, if there is not a guardian or a health care representative named, then the spouse, parent, adult child, or adult sibling can act for the person. Such persons should specifically be included within the meaning of an “authorized representative.”

The proposed rule provides that an applicant has 20 days from the date they are notified that they are denied Medicaid benefits to apply for the hardship exception. It would be useful to clarify if the usual rule of adding three additional days for mailing applies.

**III. FSSA CANNOT ESTABLISH TRANSFER PENALTIES THAT ARE MORE EXTENSIVE THAN THE TRANSFER PENALTIES PROVIDED IN 42 U.S.C. § 1396p(c).**

Parts of the proposed regulation simply implement language in the DRA, while other parts of the proposed regulation, as explained in detail in the Sections that follow, go beyond the language of the DRA to impose different or additional provisions that are not provided in the DRA. While a state can choose whether to participate in the Medicaid program, once it decides to participate, it must conform its provisions to the requirements of federal law. *Indiana Dep’t of Pub. Welfare v. Payne*, 622 N.E.2d 461, 466 (Ind. 1993). The Nebraska Supreme Court applied this principle in ruling that Nebraska could not apply a longer look back period than is provided in 42 U.S.C. § 1396p(c). *Wilson v. Nebraska Dep’t of Health & Human Services*, 718 N.W. 2d 544 (Neb. 2006) (state could not apply a 60-month look back period for a type of trust transfer for which federal statute only provided a 36-month look back period). Similarly, a United States District Court in Pennsylvania ruled that a state cannot penalize a transfer which fits an

exception set by the federal statute simply because the state believed the transfer was made with the purpose of qualifying for Medicaid. The Court emphasized that the provisions of the federal law controlled. *Mertz v. Houstoun*, 155 F Supp. 2d 415 (E.D. Pa. 2001). The regulations proposed by FSSA must thus comply with and not go beyond 42 U.S.C. § 1396p(c). In every area where the proposed regulation establishes more stringent rules with respect to transfer penalties than is set in federal law, the regulation should be modified to conform with the provisions of the federal law.

**IV. THE PROPOSED REGULATION SHOULD CLEARLY DEFINE THE COMMENCEMENT DATE OF THE PENALTY PERIOD IN A WAY THAT IS CONSISTENT WITH THE DRA, WITHOUT CREATING INCENTIVES FOR EARLY NURSING HOME PLACEMENTS.**

405 IAC 2-3-1.1 (c) concerns the date on which a penalty period begins. This date has a huge impact on how a transfer of assets is treated under the Medicaid laws. The proposed language regarding the start date of a penalty period is unclear as written and should provide better guidance to those interpreting and advising others on this important rule. Also, clearer language will be more easily transferred to the ICES Manual. Finally, the language should eliminate any incentive to place an individual in a nursing home to begin the penalty period. This result would be catastrophic since the individual will be out of money to pay for nursing home care and facing a period of ineligibility for Medicaid coverage. This could also have the effect of forcing seniors into nursing homes prematurely, which is contrary to Indiana's initiative towards "aging in place." We suggest the following changes to the proposed language in 405 IAC 2-3-1.1(c)(2):

For transfers occurring on or after **[the date of implementation of the DRA in Indiana]**, ~~February 8, 2006~~ the period of ineligibility shall begin on the later of the first ~~date~~ **day** of

the month in which assets have been transferred for less than fair market value, or the date on which the individual **is in need of institutional level of care, as would be eligible for services** described in subsections (e) and (f) based on an approved application for such assistance a determination that the individual is eligible for Medicaid assistance, without regard to any penalty periods, whichever is later, and which does not occur during any other period of ineligibility. **A determination that the individual is eligible for Medicaid on the date of the transfer can be made at the time of the filing of the Medicaid application once the penalty period has expired.** Multiple penalties shall be served consecutively.

“Date” in line two needs to be changed to “day” to follow the language of the DRA. This appears to be a typographical error.

The above proposed language allows for the start of a penalty period with the least amount of involvement by FSSA at a time when the agency does not need to be involved as no public benefits are being sought at this time. This language sets out a practical solution for determining what is required to start a penalty period and how this rule will be implemented by the caseworkers. In addition, such language eliminates the possibility of bogging down an already overworked system with the possible need for filing and processing of two separate Medicaid applications for each applicant who has made transfers within the look back period. The new system could work in the same way that Medicaid applications are currently processed for purposes of determining whether pre-DRA asset transfers have been made and imposing penalty periods on those transfers **after the fact**. This system is also currently in place for determining the value of assets for a Resource Assessment in a spousal impoverishment case, often many years after the fact. Ideally, at the time of the transfer, individuals will submit to a

medical screening such as the Pre-Admission Screening Program established under Indiana Code 12-10-12 and 460 IAC 1-1, or the Assessment for Combined Case Management under 405 IAC 1-3. However, to require such a screening in order to start a penalty period will unjustly penalize those individuals who are as unaware of this requirement as they are that any transfer of assets to a family member will disqualify them for Medicaid at some point in the future. Also, to require such screening to start a penalty period would put an undue burden on the caseworkers administering such screenings. This would require the screening of individuals who are being cared for at home and who may never even apply for Medicaid assistance or enter a nursing home.

An example of the proper implementation of the law consistent with the language and intent of the DRA is as follows:

John is 85 years old and in good health. He gives \$10,000 to his grandson to pay for college tuition on September 1, 2008. On September 18, 2012, John has a stroke. John is totally incapacitated per his medical records and in need of an institutional level of care as defined in 42 U.S.C. § 1396(c)(1)(C). John's assets are below \$1,500. On October 1, John's daughter inquires at a local nursing home about John's potential placement. The nursing home carefully questions her about past transfers, she reports the gift to the grandson, and the nursing home tells her that John will not be eligible for Medicaid payment of his nursing home bill for the first two months of his placement, because of the gift to the grandson for his college tuition. Neither John nor daughter has funds to pay the nursing home, so his daughter provides full-time care to John at home. Two months later, on December 1, John is admitted to the nursing home and files a Medicaid application.

Under the language of the DRA, as of September, 2012, John "is eligible for medical assistance under the State plan and would otherwise be receiving institutional level of care ... based on an approved application for such care but for the application of the penalty period." But for the looming penalty period, he would have applied for pre-admission screening, been approved for placement in a nursing home, applied for Medicaid, and been found eligible for full

Medicaid for September, 2012, and forward. This is a better result for all parties involved, including the State of Indiana, than if John has to actually enter the nursing home in order to start a penalty period, or has to file a Medicaid application to start the penalty period, when he is not actually seeking Medicaid coverage at this time.

**V. THE LANGUAGE DISALLOWING A PARTIAL RETURN OF GIFTS IN ORDER TO REDUCE A PENALTY PERIOD SHOULD BE REMOVED.**

Disallowing the proportionate reduction of a transfer penalty when there is a partial return of the transferred assets is not a part of the DRA and should not be a part of these proposed rules. Indiana has always applied the return of assets exception to a penalty period to allow a partial return of gifts in order to reduce a penalty period. There is no public policy or change of law reason to change this practice, which is supported in the CMS State Medicaid Manual and the ICES Manual. CMS State Medicaid Manual 3258.10(C)(3) states in relevant part “When only part of an asset or its equivalent value is returned, a penalty period can be modified but not eliminated,” and ICES Manual 2640.10.35.10 states “When only a portion of the property or its equivalent value is returned, the penalty period is to be reduced proportionately.”

An individual who has received property should be encouraged to return at least part of the gift, even if that person is unable or unwilling to return all of the property. The ability to shorten the penalty period and allow the individual access to funds that can be used toward the cost of his/her care is a positive act that the State should be encouraging. To deny a person this option is unreasonable. The following example assists in clarifying this point:

Jean is 85 and in good health. Jean gives \$25,000 to her grandson for college tuition in January 2009. Jean has a stroke and needs nursing home care in January 2013. Jean is out of funds and unable to pay for the cost of her care. Jean’s daughter inquires at a local nursing home about Jean’s potential placement and is told that Jean will not be eligible for Medicaid payment of

his nursing home bill for the first five months of her placement because of the gift to her grandson four years ago for his college tuition. Jean's grandson is out of college and has a job. Grandson is able to return \$15,000 of the gift, which would reduce the penalty period by three months and allow Jean to private pay for her care during this time. He is unable to return the entire \$25,000.

In the above example, if a partial return of the original gift will not result in a reduction of the penalty period, there is little reason for the grandson to return the \$15,000. Jean has no funds to private pay and is ineligible for Medicaid for five months and is not eligible for a hardship waiver. What will happen to Jean? What benefit does the State gain by refusing to allow individuals to attempt to recover funds that have been gifted and requiring that the **entire gift** be recovered? What if the grandson can return \$24,000 but not \$25,000? This proposed change to our current rules is absurd and benefits no one.

**VI. GRANTING THE DIVISION COMPLETE AUTHORITY TO DETERMINE WHAT PROOF OF VALUE WILL BE ACCEPTED WOULD ALLOW THE DIVISION TO ACT ARBITRARILY WITHOUT ANY ASCERTAINABLE STANDARDS.**

Proposed new section (p) of 405 IAC2-3-1.1 provides that an applicant or recipient can be required "to produce proof from a reliable source, **as determined by the division**, of the fair market value" of an asset (emphasis added). The proposed language sets no guidelines for the division to determine what is a reliable source. It appears to give complete discretion to the division and would allow the division to refuse to accept proof from appropriate sources. Courts have consistently held that agencies must act pursuant to previously-stated, ascertainable standards. *Community Care Centers, Inc. v. Indiana Dep't of Public Welfare*, 523 N.E.2d 448, 450 (Ind. App. 1988); *Mugg v. Stanton*, 454 N.E.2d 867 (Ind. App. 1983). The phrase "as

determined by the division” should be deleted from the regulation because it allows for arbitrary and capricious action.

It is unclear why this language is needed. The ICES Manual already has several sections detailing what information is acceptable to verify resource values. See, *e.g.*, ICES Manual § 2605.25.05 concerning vehicle valuations and § 2605.25.10 concerning real property valuation. In addition, the Manual gives caseworkers general guidance in determining what verifications are acceptable. ICES Manual § 2025.10.00 states in part:

Good judgment is required on the part of caseworkers when determining what, if any, verifications can be furnished by the applicant or authorized representative. The caseworker will accept any reasonable evidence and will be primarily concerned with how adequately the evidence proves the statements on the application.

There is no need to give the Division more authority than it already has.

Because the ICES Manual already gives the Division all the authority it needs to obtain reliable sources of valuation and because the proposed language fails to set ascertainable standards, the phrase “as determined by the division” should be deleted from the regulation.

**VII. THE REQUIREMENT THAT THE PURCHASER MUST OF A LIFE ESTATE MUST RESIDE IN THE HOME FOR A CONTINUOUS YEAR IS MORE RESTRICTIVE THAN THE FEDERAL STATUTE.**

The proposed new section 405 IAC 2-3-1.1(d)(1)(H) provides that there is no transfer and no transfer penalty where a purchaser “resides in the home for a period of at least one **continuous** year” (emphasis added), while the federal statute at 42 U.S.C. § 1396p(c)(1)(J) requires only that a purchaser must reside “in the home for a period of at least one year.” The state regulation adds a “continuous” requirement that is not in the federal statute. For example, suppose a purchaser resided in the home for six months, broke a hip and entered a hospital and

nursing home for two months, and then returned to the home for another seven months before permanently entering a nursing home. That purchaser would have resided in the home for a period of at least one year, thus satisfying the federal statute, but would not have resided in the home for at least one “continuous” year. The word “continuous” must be removed from the state regulation so that it is not more restrictive than the federal statute.

**VIII. THE PROPOSED RULES ON PERSONAL SERVICE AGREEMENTS ARE NOT REQUIRED BY THE DRA, ARE UNDULY HARSH, AND SHOULD BE DELETED FROM THE REGULATION.**

The State of Indiana should encourage, not discourage, Personal Service Agreements. The Indiana plan of Aging in Place uses Medicaid Waiver programs to pay family members to care for an elderly or disabled person at home because it is cheaper than providing the same service in a nursing home. The same logic applies to Personal Service Agreements where a parent privately pays a child to care for them. The proposed rule will cause an institutional bias for nursing home placement of individuals needing care at a time when the administration has made it a stated goal to reduce institutionalization of individuals and to allow one a greater opportunity to remain in the home.

The DRA does not mention Personal Service Agreements. Indiana is not required to enact rules governing Personal Service Agreements. The proposed rules will punish the elderly and disabled who do not seek or cannot afford legal advice. The new rules outlaw oral agreements for personal services. The proposed rules apply to all Medicaid applications processed after December 1, 2008. The new rules retroactively penalize oral personal service agreements that were valid contracts under Indiana contract law when the child agreed to provide services. This is not fair. Indiana cannot and should not adopt an administrative rule that

punishes its citizens for conduct that was in compliance with its laws when the services were performed. The proposed rule prohibits all but the wealthiest of individuals from paying for extra care for themselves in the nursing home. Nursing homes want their residents to pay others to help with their care if they are able. This allows the nursing home staff to concentrate their overworked staff on providing care for other residents. Residents with involved family members receive better care, and compensation for services can encourage or allow family members to stay involved. The burden is placed on the resident to prove the services being provided by a paid caregiver are not duplicative of the services provided by a nursing home. Certain services, such as laundry, cannot be paid for. It is common for family members to do a resident's laundry, because the facility loses clothes or because the resident is dissatisfied with the results of the facility's industrial washers and dryers, or possibly because the resident is allergic to or dislikes the detergent used by the facility. It is not unreasonable to compensate family members for doing a resident's laundry. Also, does this mean a Medicaid recipient in a nursing home can not use the service of a dry cleaner?

The requirement that an individual must sign a Personal Service Agreement and that a personal guardian of or an attorney-in-fact for the individual can not sign are in direct violation of the guardian statutes and power of attorney statutes of the State of Indiana. The guardian has the obligation of caring for the needs of a protected person. The guardian often needs to hire a caregiver for the protected person. The creation of a guardianship requires a finding that the protected person does not have the capacity to enter into a contract. The new rules create a situation where the guardian is required by law to arrange for the care of the protected person but prohibited by rule from entering into a contract for the protected person's care.

The major reason a person signs a power of attorney is to help when the person becomes incapacitated and no longer has the capacity to make decisions on his or her own behalf. Then, the attorney-in-fact acts to substitute his or her judgment for the incapacitated individual so long as that incapacity continues. The irony of the new proposed rule is the attorney-in-fact can use the power of attorney to sell a business, pay bills, admit the individual to a nursing home, and sundry other actions, but not to arrange personal services that will keep the incapacitated individual out of a nursing home. In such manner, this proposal will encourage institutional bias in compelling an individual to enter a nursing home for care that could have been rendered by a loving and compensated family member at home, but for the inability of the attorney-in-fact to contract for such care. It is a base denial of equal protection rights under state and federal laws for a disabled, incapacitated person to be unable to transact his or her affairs under power of attorney as any person of capacity is able to do. Note also that Ind. Code 30-5-9-9(a) provides that one who refuses to accept the authority of an attorney-in-fact is liable for treble damages and attorney fees. This shows that the legislature intends that a power of attorney be honored.

I, Keith Huffman, represent a husband who is severely incapacitated with Alzheimer's Disease and a spouse who is his caregiver. She has promised to keep her husband at home as long as she is able. Her son lives next door and the son's wife quit her job to help with Dad's care. Mom is glad to pay her daughter in law to help to replace part of the income she lost in order to keep her promise to her beloved husband. Dad would qualify for Medicaid in the nursing home now; however, since all payments made to the daughter-in-law will be considered a transfer subject to a penalty because he could not sign the Personal Service Agreement, he will not qualify for Medicaid in two years when he must go to a nursing home when he is no longer

ambulatory. This real client scenario will be needlessly played out in countless homes throughout the State of Indiana.

The new rule calls for tax forms I-9 and W-4 to be filed with the applicable taxing authorities. These forms are not filed with a taxing authority. The employer retains the I-9 and W-4 forms.

The proposed rules prohibit payment for services that are considered love and affection. How are the Indiana Medicaid caseworkers going to decide if a hired caregiver is providing needed services or services that are considered love and affection? The main reason for a Personal Service Agreement is to have a person visit more often and provide essential services because of the needs of a disabled or elder individual.

The proposed rule with respect to a Personal Service Agreement would prohibit a parent from getting paid for services provided to a minor child. This is particularly harsh. Take the example of a child severely injured in an accident caused by a drunk driver. Mother now has to quit her job to care for the child at home. Mom is not allowed to be paid for providing services to the child at home out of the proceeds from any insurance settlement. Mom could, however, continue to work and hire anyone else in the world to care for her child. Once again, the State of Indiana would be needlessly and punitively forcing the mother to work outside the home, and forcing the care to be provided by someone other than the mother, without any compelling rationale for doing so.

The worst provision is the provision in 405 IAC 2-3-24(e)(7) stating that defective Personal Service Agreements are never grounds for allowing a penalty to be withdrawn because of an undue hardship. The State will be judging the terms of the Personal Service Agreement years after services are provided, and the failure to “dot an ‘i’ or cross a ‘t’” will lead to long-

term adverse consequences. The new rules penalize transfers unless every penny transferred is returned to the person applying for Medicaid. Imagine a Personal Service Agreement where dad pays daughter to keep him at home for three years, correctly paying all employment taxes, but daughter is also paid for services deemed loved and affection by the State three years later. This determination would require daughter to return all the funds to dad, including the taxes paid to the State of Indiana, or dad becomes ineligible for Medicaid for nursing home care for the entire time all the funds paid to the daughter and the State would pay for his care in the nursing home. This is not rational and has no compelling demonstrated reason to be implemented into the law.

For these reasons, the proposed rules on Personal Service Agreements should be deleted from the proposed regulation.

**IX. THE PROPOSED RULES ON SPECIAL NEEDS TRUST PAYMENT FOR PERSONAL SERVICES ARE NOT REQUIRED BY THE DRA AND ARE CONTRARY TO INDIANA CASE LAW AND TRUST LAW.**

The new rule would mandate that the trustee of a special needs trust deny all claims due to the rendering of personal services, if those claims are made at or after the time of the trust beneficiary's death, or in anticipation of the trust beneficiary's impending death. The new rule would also prohibit the trustee of a special needs trust from ever paying a parent to provide services to the trust beneficiary, if that trust beneficiary is a minor child.

The DRA does not provide a basis for this new Rule, as the DRA does not include any provisions regarding special needs trusts.

The new Rule is in contravention of the holding of the Indiana Court of Appeals in the 2007 case of *Hammans v. The State of Indiana*, 870 N.E.2d 1071 (Ind. App. 2007), and therefore the new Rule cannot be enforced.

The new Rule is against Indiana trust law. Ind. Code 30-4-3-2 prohibits transfers to trusts to defraud creditors. If the trustee of the special needs trust enters into a valid contract with a provider of personal services for the benefit of the beneficiary of the trust, and that provider agrees to bill the trustee on a monthly basis, there is a very good chance that the final bill of that provider will come to the trustee after the death of the beneficiary of the trust. After all, unless the beneficiary of the trust happens to die on the very day that the provider submits a bill, the provider will provide some services between the billing date and the death of the trust beneficiary, and the new Rule will prohibit the trustee from paying for these additional services, since they occurred after the death of the trust beneficiary. In fact, even if the provider rushes to provide a bill when the provider can see that the trust beneficiary is not doing well and might die, the Rule still prohibits the trustee from paying the provider, since the provider anticipated the trust beneficiary's impending death. The provider is a legitimate creditor of the trust, and the Indiana trust law requires that he be paid. It may even be difficult for the trustee to find health care providers for the trust beneficiary, because these providers can never be sure that they will be paid for all of their services.

The new Rule is unreasonable and unfair. Trustees should be allowed to pay parents for some of the care that they provide to their minor children with disabilities. It is typical for Medicaid to pay for no more than about 30% of the care that these children need. This leaves the parents to put in 16-hour shifts every day Monday through Friday, and sometimes 24-hour shifts on Saturday and Sunday. Often, one of the parents must stop working outside of the home in order to become a full-time caregiver for the child at home. The situation is much more difficult if it involves a single parent. In any case, there will be many days when the home health care

agency calls to say they can't send anyone out that day, and then the parent or parents will pull a 40-hour shift before the next help arrives.

If a trustee can pay the parent or parents something for some of the care they are providing to the trust beneficiary, this may well mean the difference between keeping that child at home and resorting to nursing home placement. Parents obviously don't want to be put in this position.

Indiana must allow payments from a special needs trust to caretaker parents, because the State's policy must be comparable to the policy of the Federal Supplemental Security Income (SSI) program, and no more restrictive. The Social Security Administration (SSA) has, by its National Appeals Council, accepted without question that a special needs trust could make distributions by way of a stipend to the mother of the disabled trust beneficiary for caring for the child, consistent with SSI law respecting special needs trusts. *Calef v. JoAnne B. Barnhart, as Commissioner of Social Security*, 309 F.Supp.2d 425 (E.D. NY 2004). Even in a 209(b) state like Indiana, where Medicaid eligibility is not tied directly to SSI eligibility, the State Medicaid program may be more liberal, but may not be more restrictive than the Federal SSI program. 42 U.S.C. 1396a(f). Indiana will violate this Federal law if it implements the new Rule forbidding a trustee to pay parents as caregivers, because this would clearly be more restrictive than the Federal SSI rules.

**X. THE PROPOSED RULE ON ANNUITIES GOES BEYOND THE REQUIREMENTS OF THE DRA.**

With respect to the changes suggested in Section 1 of the proposed rules, regarding 405 IAC 2-1-2(I), the proposed changes will require applicants or recipients to disclose annuity ownership for the individual or community spouse during the application or recertification

process. The applicant or owner must then sign a statement agreeing to name the State as the remainder beneficiary. The State will also notify the issuer of its rights as a preferred remainder beneficiary. Contrary to the DRA, this rule will apply to all situations, regardless of when the annuity was purchased or changed. It appears to apply to **any** annuity during any application or redetermination after December 1, 2008. Section 6012(d) clearly provides that the State will only have a beneficial interest in annuities purchased after February 8, 2006.

In addition, this proposed rule ignores the exclusions and restrictions found in the changes suggested to 405 IAC 2-3-1.2(g), exempting certain qualified and irrevocable annuities from the requirement of naming the State as a beneficiary.

Enactment of this rule, as proposed, would effectively impose an indefinitely retroactive requirement on individuals who purchased annuities prior to February 8, 2006. For example, an individual who purchased an annuity in January, 2000, and applied for Medicaid assistance in March, 2002, would be required to disclose the annuity at the time of his next redetermination interview. As this rule is written, the state would then notify the annuity issuer of its rights as a remainder beneficiary when, pursuant to the state's own rules, in accordance with federal law, it has no such right.

The language in this proposed rule change should be edited to reflect that the State shall notify the issuer *of any annuity which meets the requirements of 405 IAC 2-3-1.2 for which the State may have an interest as a remainder beneficiary.*

The text of 405 IAC 2-3-1.2(g), which refers to “an annuity described in subsection (f) is not an asset for purposes of section 1.1 of this rule . . .,” does not make it clear that the intention of the subsection is to exempt the types of annuities described from the requirement that the State be named as a remainder beneficiary. We would suggest modifying this language to read “*an*

*annuity described in subsection (f) is not subject to the requirements of subsection (h) below if:”*

There is an obvious error in 405 IAC 2-3-1.2(h), as it refers to February 8, 2005 rather than to February 8, 2006, which is the correct effective date of the DRA.

**XI. DEFINING REAL PROPERTY TRANSACTIONS AS EQUIVALENT TO AN ANNUITY IS BEYOND LOGIC AND REASON.**

**A. Real Property Law and Financial Instruments Such as Annuities are Grounded in Two Different Areas of Law.**

The context of real property is founded under common law principles and concepts derived from the long-standing history of property ownership dating back to feudal times in England. Rather than creating an entirely new system of real property law, the United States of American and its respective States, including the State of Indiana, borrowed those common law principals as the basis of their real property law. The foundations of the laws of financial transactions and instruments, on the other hand, are largely the product of much later statutory developments.

Property laws are based upon a significantly different legal scheme than those of other areas of law. By borrowing from the history of common law, rather than starting from scratch, those government bodies intended real property law to be treated much differently than other areas. When legal issues develop in the context of real property ownership, those disputes are typically settled under historical common law principals, rather than a set of new real property laws developed after the inception of Federal or State government.

Analyzing the treatment of real property ownership under statutes and regulations is contrary to the historical treatment of property law. To analyze real property ownership under the statutory scheme of another area of law is incongruous to Indiana law. Thus, property law

ownership should only be analyzed under Indiana property law and not that of the statutory-based laws of financial transactions.

B. Federal Medicaid Law Recognizes the Distinction between Real Property Law and Financial Transactions Law.

The treatment of real property and financial transactions are outlined in separate areas of Federal Medicaid law. Even Federal Medicaid law recognizes that property law ownership should and must be analyzed under State property common law, rather than statutes designed to analyze other ownership of other types of assets.

C. The Indiana Code Already Contains an Independent Section Defining Annuities with Heavy Regulations under Insurance and Securities Statutory Principles.

Indiana Code 27-1-12.5 and 27-1-12.6 and 760 IAC 1 already define annuities and specify very strict and detailed standards for annuity contracts. This definition and the standards found in the Indiana Code and Indiana Administrative Code do not include or contemplate real property ownership as an annuity. To re-define annuity contracts under Indiana Medicaid regulations creates an ambiguous result under the same statutory framework. Citizens should be able to rely on those already-defined standards regarding what comprises an annuity contract in those areas of Indiana law dedicated to annuity contracts, without concern that such assets are re-defined in other areas of Indiana law that are not dedicated to determining the ownership of such assets.

D. The Annuity Rules Rely on a Structure that is Irrelevant and Incompatible to Real Estate Ownership.

Annuities are purchased in order to grant payments, usually for life, based on the actuarial life expectancy of the annuitant. When the payments are completed, the asset is gone. Rental property arrangements do not have a similar diminishing value standard. The real

property owner will always hold value as long as he or she holds title to the real property.

Although this value may vary depending upon economic and market conditions, the real property will never diminish to zero value like in a typical annuity contract. Furthermore, the lease on the real property is designed to be a means to receive a return on the owner's investment. When the lease expires, the real property owner continues to own the asset, unlike an annuity which ends with its last payment. Annuities are an intangible asset, while real estate is very much tangible.

Unlike traditional annuities, rental real estate cannot be actuarially sound. The term "actuarially sound" contemplates that payments from the annuity will terminate and the existence of the annuity will cease prior to the owner's death. Leases are a return on an investment for a period of years. Leases can be fixed for a period of time, but the value of the underlying asset, the real property itself, never ends. Rental real property ownership will never terminate upon some future date. Further, when a lease ends with a current tenant of the real property, the real property owner will always have the option of entering into a new lease with another owner. Traditional annuities simply do not have this ability to "renew" the return on the initial investment.

- E. Applying the Deficit Reduction Act of 2005's Annuity Restrictions to Income-Producing Real Property is Redundant, as the State Already has Strict Provisions in Place Regarding Transfers Involving Income-Producing Real Property and Income Earned by Such Property and Has the Ability to Implement Estate Recovery With Regard to Such Property.

The state already has strict restrictions in place regarding the transfer of income-producing real property and its income. If a Medicaid applicant or recipient rents income-producing real property for less than fair market value, the applicant or recipient may be subject to a transfer of assets penalty. 405 IAC 2-3-1.1(d)(1)(E). The amount transferred is the difference between the fair market rental value and the amount of rent received, multiplied by

the person's life expectancy based on life expectancy tables published by the office. 405 IAC 2-3-1.1(k). This severe result is inflexible and does not account for the length of the lease agreement in violation of this regulation, nor whether the applicant or recipient continues to own the property for the rest of his or her life.

The state also has statutes and regulations in place that permit Medicaid estate recovery with regard to income-producing real property following the sale of such property or the death of the recipient. The State receives the benefit of income earned by the owner of income-producing real property since the recipient's spend down or liability increases, thereby decreasing costs paid by Medicaid. Further, with current lien (405 IAC 2-10) and estate recovery statutes and regulations (405 IAC 2-8-1), the State may recover costs from real property following the sale or death of a recipient.

F. Ownership is Repetitious and Unnecessary in the Rule Structure.

405 IAC 2-3-1.2(f) of the proposed rule states:

An annuity shall also include an *ownership* of a share of income-producing real property where a majority of the following factors are present:

(1) The individual has an *ownership* interest in the property. (*emphasis added*)

...

The rule structure adds ownership as a factor in determining whether income-producing real property is an annuity, yet ownership of income-producing real property is what requires the analysis of such property under the factor test. This repetition of ownership is an illogical structure to the rule. Since ownership is what requires analysis under the factor test, factor (1), requiring that the individual have an ownership interest in the property, should be deleted.

**XII. THE PROVISION ON CONVERTING FUNDS TO PURCHASE A PROMISSORY NOTE, LOAN, OR MORTGAGE IMPERMISSIBLY CONTAINS PROVISIONS BEYOND THOSE PROVIDED IN THE FEDERAL STATUTE.**

The proposed new section 405 IAC 2-3-1.1(d)(G) tracks the language in 42 U.S.C. § 1396p(c)(1)(I), except that it adds two subsections, (iv) and (v), that are not included in the federal statute. Particularly troublesome is the language in subsection (iv) requiring the borrower to pledge real or personal property or anticipated future income. An arrangement may be completely legitimate without being secured by property. It is not clear what would be required to “pledge” future income; would it be sufficient for one to agree to pay out of future income? Please keep in mind that in most Medicaid situations all but \$52 each month of income will go to pay for the nursing home resident’s care. Congress determined that the requirements of subsections (i), (ii), and (iii) are sufficient to insure that these instruments are not abused. Subsections (iv) and (v) are not provided in the federal statute and therefore cannot be added to the state’s regulation.

**XIII. THE HOME EQUITY LIMIT SECTION FAILS TO DEFINE WHAT IS A “BREAK IN LONG-TERM CARE ELIGIBILITY.”**

Section 6014(b) of the DRA provides that the home equity limit applies to “individuals who are determined eligible for medical assistance with respect to nursing facility services or other long-term care services based on an application filed on or after January 1, 2006.” The new section 405 IAC 2-3-15(c)(3) implements this effective date, but it makes an exception for a person who has a “break in long-term care eligibility” without defining what is a “break.” In a similar situation concerning applying an effective date, FSSA determined that the spousal impoverishment resource provisions would apply to a married resident who entered a nursing home before September 30, 1989, unless that resident was absent from the institution for at least

30 consecutive days. ICES Manual § 2635.10.10. If FSSA finds it necessary to refer to break in long-term care eligibility, FSSA should clarify in the regulation that a break is considered to be an absence of at least 30 consecutive days. The regulation should be revised to state: “unless the individual does not receive nursing facility services or other long-term care services for at least 30 consecutive days.”

Note also that the word “who” in section (c)(3) is extraneous and should be deleted.

#### **XIV. CONCLUSION.**

The proposed rules go well beyond what is required to implement the DRA. We ask that those provisions that go beyond what is required to implement the DRA be eliminated from the rule.

We also request that the rules not be implemented retroactively, as that will cause harsh and unexpected consequences for many Hoosiers. We continue to be willing to meet with FSSA to discuss regulatory changes that are consistent with federal law and not unduly harsh.

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