

Applied Income Workgroup Report

As Required by Special Provision 49, Senate Bill 1, 83rd
Legislative Session, 2013

September 2014

Table of Contents

Introduction and Charge.....	1
Workgroup Summary.....	1
Applied Income Background.....	2
Incurred Medical Expenses.....	3
Process and Current Options.....	4
Medicaid Estate Recovery Program.....	6
Representative Payees.....	7
Survey Findings.....	7
Workgroup Recommendations.....	9

Introduction and Charge

The 2014-15 General Appropriations Act, Senate Bill 1 (S.B. 1), 83rd Legislature, Regular Session, 2013 (Article II, Health and Human Services Commission, Special Provision 49), established a workgroup on nursing facility residents' applied income.

Special Provision 49, S.B. 1, requires that the Health and Human Services Commission (HHSC) appoint members to the workgroup, including representation from the Office of the Attorney General, the Department of Aging and Disability Services (DADS), Texas Health Care Association, Texas Silver Haired Legislature, and the Texas Senior Advocacy Coalition. The workgroup was tasked with developing recommendations that would more effectively manage applied income payments to ensure those funds are used for their intended purposes. This report is intended to fulfill that requirement and is respectfully submitted to the Senate Health and Human Services Committee and House Human Services Committee.

The workgroup reviewed a range of topics related to applied income. Focus areas included incurred medical expenses, identification and discussion of responsibilities from varying entities (individual, family member, nursing facility, state agency, and managed care organizations (MCO)), as well as representative payee and organizational payee information from the Social Security Administration (SSA). The workgroup also administered a survey to nursing facility administrators and long-term care ombudsman staff. The survey was used to gain a better understanding of the prevalence of unpaid applied income, and also to learn more about the current issues and concerns surrounding uncollected applied income from the perspective of nursing facility administrators and ombudsman staff.

This report includes a summary of workgroup activities and findings. Recommendations reflect the views and opinions of a majority of the workgroup's membership.

Workgroup Summary

Special Provision 49 workgroup members were appointed by HHSC Executive Commissioner Kyle Janek. HHSC staff contacted appropriate professionals within each stated entity in Special Provision 49, S.B. 1, including government relations specialists, acting chairs, and executive vice presidents. These points of contact coordinated with their membership to identify individuals to represent their organizations on the workgroup.

HHSC staff also identified other organizations whose representation on the workgroup would provide valuable input. Those organizations include the Texas Association of Health Plans, Leading Age Texas, and AARP. Members of the applied income workgroup are listed below.

- Barbara Aydlett, Health & Human Resources Committee Chair, Texas Silver Haired Legislature
- Ronnie Evans, Autumn Winds Retirement Lodge, Representing Texas Healthcare Association
- Amanda Fredriksen, Director of Advocacy, AARP
- Carl Kidd, Vice President of Government Contracts, Molina, Representing Texas Association of Health Plans

- Kelly Longhofer, Vice President of Provider Network Services, Amerigroup, Representing Texas Association of Health Plans
- Alyse Meyer Director of Public Policy, Leading Age Texas
- Tom Plowman, Director of Rate and Financial Analysis, Texas Health Care Association
- Derek Price, HMG Healthcare, Representing Texas Healthcare Association
- David Solyom, Director of Business Integration, United Healthcare, Representing Texas Association of Health Plans
- Betty Streckfuss, Speaker Pro Tem, Texas Silver Haired Legislature
- David Thomason, Chair, Texas Senior Advocacy Coalition
- Betty Trotter, Deputy Speaker Pro Tem, Texas Silver Haired Legislature

State agency representatives include:

- Trish Burkett, Claims Management Systems, Department of Aging and Disability Services
- Dee Church, Office of Social Services, Health and Human Services Commission
- Rick Copeland, Medicaid Fraud Control Unit, Office of Attorney General
- Gloria Salinas, Consumer Protection Division, Office of Attorney General

The applied income workgroup met three times beginning in March 2014. Workgroup members participated via phone and in person. A professionally diverse group of individuals were selected to serve on the workgroup, representing varying interests. Subject matter experts were invited to provide information to the workgroup, including individuals from HHSC, DADS, Department of Family and Protective Services (DFPS) and the Social Security Administration (SSA). The workgroup discussed a variety of options to encourage the collection of applied income, including actions the nursing facility can take independently, proposing legislative changes that would mandate repercussions for persons that do not pay applied income, and the development of standard information from a state agency to explain current options and provide guidance in the collection of applied income. A majority of the information presented and discussed during workgroup meetings is summarized below.

Applied Income Background

Applied income is the amount that a nursing facility resident who is Medicaid eligible has to pay for nursing facility services. This is sometimes called a co-payment. Applied income is calculated based on the individual's income and after determination of Medicaid eligibility. Federal regulations require reducing the person's amount to pay a nursing facility by deducting items from the person's total income in the order listed below¹.

- Personal needs allowance – Federal regulations require states to allow nursing facility residents to keep at least \$30 of their own income for personal needs. In Texas, residents get to keep \$60 of their income. A personal needs allowance is defined as an amount that is reasonable for clothing and other personal needs of an individual while they are in an institution.
- Guardianship fees – This is required by Texas law. Court ordered guardianship fee deductions may include the following²:
 - Monthly guardianship fees up to \$175
 - Costs to establish the guardianship up to \$1,000

¹ 42 CFR 435.725

² Estates Code Sec. 1155.202

- Costs to terminate a guardianship up to \$1,000
- Administrative costs up to \$1,000 over a three-year period
- Maintenance needs of spouse – This deduction is for an individual with only a spouse at home. Federal guidelines establish ceilings for the highest amount of income able to be deducted. In Texas, this amount is up to \$2,931 and is reduced by the amount of the spouse’s own income. For example, if the spouse has a monthly income of \$2,000, the deduction in the applied income calculation would be \$931.
- Maintenance needs of the family – This amount is for minor dependents and adult dependents that have a disability. The allowance for a dependent living with the spouse is \$1,939. When the dependent is not living with the spouse, the allowance is \$721. The amount must take in to account the financial needs of the family and is adjusted for the number of family members living in the home.
- Home maintenance – This optional deduction is allowed if an individual provides a physician’s certification on the likelihood that the individual will return home and provides proof of expenses needed to maintain the home. This deduction is limited to six months upon admission to a nursing facility.

For state fiscal year 2013, 75 percent of all individuals receiving Medicaid nursing facility services made an applied income payment. The average applied income payment in calendar year 2013 was \$24.36 per day, or \$741 per month. The total amount of applied income payments for calendar year 2013 was \$498.2 million. For state fiscal year 2013, roughly a quarter of Medicaid nursing facility residents had no applied income payment, while 21 percent of residents paid less than \$600 monthly. A little over half of Medicaid nursing facility residents paid \$600-\$2100 of applied income monthly.

Except for the personal needs allowance of \$60 per month, nearly all of an individual’s income goes to pay for nursing facility care. Nursing facility residents over 65 who receive Medicaid are likely to have higher applied income amounts than individuals who are under 65. This is because people under 65 are not as likely to have incomes from Social Security or other sources.

Incurred Medical Expenses

Incurred Medical Expenses (IME) is another form of deduction from the income of a Medicaid eligible person in a nursing facility. These deductions are made from the person’s income so that they may pay insurance premiums and other healthcare expenses. The person’s attending practitioner must attest in writing that the item or service is medically necessary. The medically necessary requirement is defined as the need for medical services in an amount and frequency sufficient, according to accepted standards of medical practice, to preserve health and life to prevent future impairment. For dental services, the practitioner attests that the dental services are not medically contraindicated for the patient. If HHSC determines the amount of medical expenses for the person prospectively, that period may not exceed six months. The basis for projection may include medical expenses incurred in the preceding six months.

Payment arrangements are made between the health care provider and the individual. Once an individual has IME applied to their income, it is up to that individual or their responsible party to pay the healthcare provider as agreed.

Reasonable limits on IMEs are specified in the Medicaid State Plan. The following are examples of non-allowable IMEs:

- Items covered by the nursing facility rate (including, but not limited to, diapers, sitters, durable medical equipment, dietary supplements or physical, speech or occupational therapy);
- Covered services that are beyond the amount, duration and scope of the Medicaid state plan;
- Services covered by the Medicaid state plan but delivered by non-Medicaid providers;
- Expenses for medical services received before the applicant's medical effective date;
- Premiums for cancer or other disease-specific insurance policies, income maintenance policies or general health insurance policies with benefits that cannot be assigned;
- Health care services provided outside of the U.S.;
- Expenses incurred during a transfer of assets or home equity penalty (including, but not limited to nursing facility bills);
- Expenses for eyeglasses, medically necessary contact lenses, hearing aids, services provided by a chiropractor or a podiatrist (these are covered through the Medicaid program);
- Specialized augmentative communication device systems, also referred to as speech-generating device systems (a nursing facility is reimbursed if purchased by the facility for a Medicaid recipient); and
- Expenses incurred by Medicaid-eligible recipients 21 years of age and older requiring mental health and counseling services provided by a licensed psychologist, licensed professional counselor, licensed clinical social worker or a licensed marriage and family therapist.

Other allowable deductions include health insurance expenses, such as vision and dental premiums, and deductibles and co-insurance. Allowable IME deductions for durable medical equipment are based on the Medicare durable medical equipment fee schedule. Allowable IME deductions for dental services on the Texas dental IME Schedule are based on the American Dental Association Survey of Fees at the 90th percentile for the West South Central Region, General Dentistry.

Process and Current Options

The applied income, or copayment, amount is determined by HHSC Medicaid Eligibility staff. In some cases, there is not enough income to cover the allowable deductions appropriate for the person's circumstances. When this happens, the individual does not have an applied income amount to pay the nursing facility each month. Applied income eligibility is reviewed at least once per year and more frequently when expenses are anticipated to change. If a recalculation increases the individual's applied income owed, the person is given advance notice and the right to appeal the decision.

Once the applied income amount has been calculated at HHSC, it is entered in the Texas Integrated Eligibility Redesign System, or TIERS. TIERS sends this information to DADS staff for further processing. DADS uses this information to adjudicate the nursing facility claim, or determine how much to reimburse the facility, and how much of the payment will be the responsibility of the nursing facility to collect from the individual. The nursing facility receives a notification from DADS stating

how much the resident or family member is responsible for paying as a daily rate. Due to the inclusion of nursing facilities in managed care, effective March 1, 2015, DADS will send this notification to an MCO, which will in turn send the applied income information to the nursing facility. The nursing facility does not have access to view the deductions the individual receives.

The following methods to collect unpaid applied income were identified during workgroup meetings and are presently available to nursing facility administrators and business office managers:

- **Contact ombudsman staff or a volunteer ombudsman**

Congress amended the Older Americans Act in 1978 to establish the Long-Term Care Ombudsman program to serve residents in long-term care facilities. In Texas, the Office of the Long-term Care Ombudsman operates within DADS. Ombudsman staff and volunteers advocate for individuals in nursing facilities by addressing complaints, providing information, and advocating for systems changes to better serve residents. Ombudsman staff are located throughout the state at all 28 Area Agencies on Aging (AAA). They may help to educate the individual or family member about applied income or help to establish a payment plan or arrangement between the family and the facility.

- **Request to be the representative payee for the individual through a local SSA office**

When a nursing facility becomes a representative payee for an individual's funds, the SSA pays the facility that person's Social Security benefits to use on the individual's behalf. When the SSA receives this request from the nursing facility, a letter is sent to the family member asking for approval of the request for the nursing facility to become the representative payee. Family members then have an opportunity to deny the request. If the family member does not respond to the letter at all, the nursing facility may become the representative payee for that individual's funds.

In order to help reduce the amount of time it takes to process a representative payee request, the SSA recommends that each nursing facility become familiar with their local SSA office. Nursing facility administrators should keep the name, phone number, e-mail, and fax number of a contact at each local SSA office. Normally, a face to face interview is required to become a representative payee, however, if a nursing facility is determined to be the representative payee, the request may be completed on a paper basis. Before a nursing facility is appointed as representative payee, the SSA reviews the facility's history for any previous instances of becoming a representative payee, past grievances against the facility, or indicators of fraudulent behavior. If an individual does not have a payee of any kind, the SSA may refer the individual to an organizational payee. Organizational payees may charge a fee of up to \$39 per month.

- **Effective March 1, 2015, ask the individual's MCO for assistance**

Senate Bill 7 (S.B. 7), 83rd Legislature, Regular Session, 2013, states an MCO providing services under the Medicaid managed care program shall assist in collecting applied income for recipients. This may entail the MCO contacting the resident or family member by phone, or sending letters requesting payment. These efforts are documented by the MCO, and are not intended to subrogate the nursing facility's existing responsibilities to collect applied income.

- **If appropriate, contact APS and report suspected financial exploitation**

In cases of suspected financial abuse, neglect, or exploitation, the nursing facility may make a referral to Adult Protective Services (APS). During fiscal year 2013, APS spent approximately \$430,000

assisting with nursing facility placements. Of that amount, a small percentage was used to assist with applied income payments for persons in a state of abuse, neglect, or exploitation. APS typically does not get involved with investigations due to non-payment unless there is a threat of imminent eviction. When financial mismanagement or malfeasance are the root cause of abuse, neglect, or exploitation, APS may also work with the individual or responsible party for payment to help identify a financial plan going forward.

Other actions the nursing facility may take include:

- Work directly with the individual or responsible party for payment to see if a payment arrangement can be made;
- Send collection letters from the nursing facility business office, or call the responsible party for payment;
- Ask the individual or party responsible for payment to set up a direct deposit account with the nursing facility;
- Remind the party responsible for payment they could be violating Section 32.45 of the Penal Code, which could be considered a misdemeanor or felony offense, depending on the amount of applied income withheld;³
- Utilize an attorney to send a letter to the responsible party for payment; and/or
- Send the uncollected applied income amount to a collection agency.

If none of the above actions result in payment of applied income, many nursing facilities end up absorbing the cost of care for that individual.

Medicaid Estate Recovery Program

Federal law requires states to recover costs of certain Medicaid long-term care services and supports.⁴ In order to meet this requirement, Texas implemented the Medicaid Estate Recovery Program, or MERP, effective March 1, 2005. After an individual receiving Medicaid long-term care services passes away, the state of Texas may ask for some of the individual's funds back to help pay for their long-term care costs. In some cases, the state may not file a claim or ask for any funds back. Texas Estates Code, Chapter 355, Section 102 specifies the priority of claims payment against a person's estate as:

- Unpaid expenses for funeral and any expenses of final illness, up to \$15,000;
- Unpaid expenses from estate administrator for managing the estate, or for keeping the estate intact, and any expenses of a guardian who is appointed while the individual is alive;
- Unpaid secured claims and tax liens filed against the home;
- Unpaid child support debts owed;
- Unpaid state and local taxes owed;
- Unpaid expenses from a correctional institution; and
- Repayment of medical assistance payment made by the state under Chapter 32, Human Resources Code.

The Texas Estates Code lists claims for repayment of the state's medical assistance at the bottom of the list of priorities for which claims are to be paid from an individual's estate. Due to the payment priorities before it, MERP collections usually end up being close to 1 percent of an individuals' estate,

³ Texas Penal Code Sec. 32.45 <http://www.statutes.legis.state.tx.us/Docs/PE/htm/PE.32.htm#32.45>

⁴ 42 USC 1396p(b)(1)

if anything. DADS then has to pay the federal government 60 percent of the MERP claim, leaving the state with a little less than 0.5 percent of the claim.

Since the amount returned to the state under MERP is fairly low, the workgroup decided amending the Estates Code with an additional claim specifically for recoupment of applied income would not have a significant impact on funds that could be returned to nursing facilities.

Representative Payees

When an individual is no longer able to manage their own finances, a representative payee may be appointed by the SSA. Representative payees are usually a close friend or family member of the individual and are paid the person's social security benefits to spend on that person's behalf. Representative payees may not collect a fee from the individual they are acting on behalf of, unless they have certain authorizations from the SSA to do so. Individuals designated as representative payees must utilize the individual's benefits to ensure their day-to-day needs are being met. Priority is given to food and shelter needs. Medical and dental costs not covered by health insurance are then paid, followed by personal needs and recreation. For individuals in nursing facilities, funds should be used to pay charges for care. In Texas, an additional \$60 should be set aside for the individual's personal needs.⁵⁵

Organizations may also serve as representative payees, including nursing facilities. If this is the case, the organization may place funds in a single checking or savings account, called a "collective account". There are specific requirements from the SSA that these accounts must meet. The funds in a collective account must show they belong to the beneficiary and not the organization, the account must be separate from the organization's operating account, and any interest earned in the account must belong to the beneficiary, not the organization.⁶ Organizational payees must abide by resident's rights as prescribed in the Statement of Resident Rights found in Title 40, Texas Administrative Code §19.401(b).⁷ Residents must retain the right to manage their own finances or choose to delegate that responsibility to another person, and also must have access to their history of financial transactions with the nursing facility.

Survey Findings

In an effort to learn more about common challenges faced by nursing facilities, and strategies used to collect applied income, a survey was developed and distributed to nursing facility administrators through a DADS listserv. Nursing facility associations also publicized and encouraged their members to complete the survey. A total of 113 nursing facilities submitted responses. A similar survey was developed and distributed to long-term care ombudsman staff at DADS.

The survey addressed a variety of issues, including number of involuntary discharges due to failure to pay applied income, total revenue lost due to failure to pay, identified strategies used by the nursing

⁵ Additional information on becoming a representative payee through the SSA can be found online at <http://www.ssa.gov/pubs/EN-05-10076.pdf>

⁶ Additional information about organizational payees can be found online at <http://www.ssa.gov/payee/NewGuide/toc.htm>

⁷ A list of Nursing Facility resident's rights is available online at http://www.dads.state.tx.us/handbooks/nfr-lmc/res/19_401%20attachment.pdf

facility to help encourage payment of applied income, and estimates on applied income administrative costs to facilities. There were several identified themes from survey responses.

Survey responses indicated nursing facility Medicaid beds remained in arrears for unpaid applied income an average of five months. Most often, an individual's son or daughter was the responsible party for payment, followed by the individual residing in the facility. The average revenue lost on applied income by survey respondents for calendar year 2013 was roughly \$63,000, with a reported average of \$10,900 spent during calendar year 2013 on administrative costs to collect applied income. When asked about the number of involuntary discharges due to failure to pay applied income, 43% of facilities stated they had none for calendar year 2013, while 37 percent stated they had up to five involuntary discharges for that year. Involuntary discharges are typically an option of last resort. It is worth noting that an involuntary discharge can be disruptive to the individual's treatment and way of living, can be an onerous process for the facility, and is not the desired approach to resolving non-payment.

The most popular strategy to collect applied income was to work with the individual or responsible party for payment directly. The second most popular strategy was to request to be a representative payee through the Social Security Administration, and the third was sending the uncollected applied income amount to a collection agency. The most effective method of collecting applied income was overwhelmingly reported to be requesting to become a representative payee through the SSA.

The survey also asked nursing facility respondents to suggest one reform to increase the collection of applied income. Common themes were as follows:

- Mandate the nursing facility to be the representative payee for all residents on Medicaid;
- Give the nursing facility more control over the resident's income;
- Increase communication with the family or responsible party for payment; and
- Provide more applied income education for the resident or family member.

The survey for DADS ombudsman staff addressed similar issues and concerns with the collection of applied income. Over half of the ombudsman staff submitted responses. According to survey results, 85 percent of ombudsman staff in calendar year 2013 assisted with an issue related to applied income. Most often, ombudsman staff responded that the primary cause for non-payment of applied income was lack of response from the responsible party, as opposed to payment withheld from a dispute on a bill, the individual found not eligible for Medicaid, or the individual using funds for other needs.

Non-payment was most often resolved with an involuntary discharge from the nursing facility. The second most common resolution was the person responsible for payment eventually paying the facility. Other common responses for non-payment include the resident voluntarily moving, the facility and individual working together to arrange a payment plan, and facilities waiving all or some of the charges.

When asked what steps should be taken to help prevent non-payment to a facility, ombudsman staff suggested an increase in educational opportunities to individuals and family members, having the nursing facility become the representative payee, and letting the resident or responsible party for payment know the ombudsman is available to help. Ombudsman staff also suggested presenting

information on applied income separately from the admission paperwork, when individuals may be feeling overwhelmed with information. Nearly 80% of staff agreed that providing individuals and families with education or literature on Medicaid and applied income would help to avoid non-payment issues. Many stressed the information should be in terms that are easily understood, presented face-to-face and also in writing, and available in English and in Spanish with contact information for the ombudsman clearly presented.

Workgroup Recommendations

Recommendations considered by some workgroup members, but not officially endorsed by the workgroup as a whole, included more stringent mandates for nursing facilities to become representative payees for every Medicaid resident's social security benefits. Some workgroup members suggested this should be an automatic process upon admission to the nursing facility. However, this practice is prohibited according to state policy found in DADS regulations.⁸

Another recommendation that was considered would have proposed legislation to place stricter penalties on individuals and family members for not paying their applied income, such as mandating a referral to a collections agency. This recommendation was not officially adopted because current statute does not prevent the nursing facility from making this referral voluntarily. Leaving statute as is allows the nursing facility to remain as autonomous as possible.

The applied income workgroup recommends the following to more effectively manage applied income payments to ensure those funds are used for their intended purposes.

Recommendation 1: Establish a state-wide organizational representative payee housed within a state agency.

The organizational payee should be set up in such a way that alleviates nursing facilities from having to maintain representative payee paperwork and reporting requirements.

Recommendation 2: Develop and maintain a one page explanation of applied income, to be included with an individual's application for nursing facility Medicaid.

The document should inform the responsible party for payment of possible repercussions for not paying applied income, including possible referral to a collections agency or, in cases of suspected abuse, neglect, or exploitation, a referral to APS. The responsible party for payment should sign the document to acknowledge receipt of information.

Recommendation 3: HHSC and health and human services agencies should create and publicize a three-pronged approach to applied income education for nursing facilities and residents.

⁸ Nursing Facility Requirements for Licensure and Medicaid Certification Handbook §19.404, Protection of Resident Funds: <http://www.dads.state.tx.us/handbooks/nfr-lmc/E/index.htm#r19.401>

Health and human services agencies should include the following in their development of this educational approach to applied income awareness:

- a. Encourage nursing facilities to provide clear, easily understood information to the individual at a time other than admission, when individuals and families are easily overwhelmed;
- b. Publicize the ombudsman's role to help educate the individual and mediate between the nursing facility and the individual as able; and
- c. Encourage nursing facilities to utilize the managed care organization involved in the individual's care for any assistance they may be able to provide.

Recommendation 4: The state should develop standard documents and information for nursing facility operators and business office managers.

This standard information should be written in clear, concise language and should detail what options are available to nursing facilities for the collection of applied income, including, but not limited to:

- a. Working directly with the person or their responsible party;
- b. Contacting the SSA to request becoming the representative payee;
- c. Asking the MCO to help educate the individual or family member;
- d. Utilizing an attorney to send a letter requesting payment;
- e. Referring the responsible party to a collections agency or liens for non-payment; and
- f. In suspected cases of abuse, neglect, or exploitation, making a referral to APS.