

# CASE NOTES AND COMMENTS

## PROTECTING THE NURSING HOME INDUSTRY AND THE ELDERLY FOLLOWING THE DEFICIT REDUCTION ACT OF 2005

### I. INTRODUCTION

In 2008, ninety-nine-year-old Cordelia Robertson received an eviction notice from the assisted living facility where she had lived for the past decade: her savings had run out, and the facility had altered its policies, choosing to decline Medicaid as payment.<sup>1</sup> Describing his mother as “happy” but “frail,” Cordelia’s son worried that a move would result in confusion and devastation for his eighty-pound elderly mother.<sup>2</sup> Evictions such as these have brought the owner of Cordelia’s facility, Assisted Living Concepts, under careful scrutiny.<sup>3</sup> But while elders and their families have been frustrated by eviction notices, Assisted Living Concepts has been concerned with its solvency, noting that certain states’ Medicaid reimbursement rates have not kept up with inflation.<sup>4</sup>

As Cordelia’s son feared, researchers have indeed confirmed that such evictions can take their toll on the health of the elderly<sup>5</sup> and that this is not an isolated problem. In 2006, more than seven million elders like Cordelia Robertson received long-term care in America<sup>6</sup>—a figure that is expected to double by 2020.<sup>7</sup> The increasing number of Americans dependent on long-term care warrants a closer look at the regulations and actual practices that define the long-term care industry, the industry’s solvency, and mechanisms in place to ensure that elders will be able to afford the care they need. Regulations should balance the interests of the consumer, the taxpayer, and the industry to ensure (1) that the costs of long-term care are subsidized in a way that makes care accessible and protects the elderly from dangerous evictions, (2) that taxpayers do not become responsible for long-term care costs that middle-class consumers would be able to cover themselves, and (3) that the long-term care industry remains financially solvent in spite of additional protections afforded to its consumers.

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1. Joseph Shapiro, *Assisted Living Firm Rejects Medicaid, Evicts Elderly*, NPR, Aug. 11, 2008, <http://www.npr.org/templates/story/story.php?storyId=93260987>.

2. *Id.*

3. *Id.*

4. *Id.*

5. See *infra* Part II.B.2 for a discussion of the transfer trauma theory.

6. STEPHEN A. FELDMAN, *STEVE FELDMAN ON LONG-TERM CARE PLANNING* 24 (2006).

7. U.S. GEN. ACCOUNTING OFFICE, *GAO-95-26, LONG-TERM CARE: DIVERSE, GROWING POPULATION INCLUDES MILLIONS OF AMERICANS OF ALL AGES* 8 (1994), available at <http://www.gao.gov/archive/1995/he95026.pdf>.

This Comment seeks to strike a balance between these three competing objectives in the arena of nursing home care. First, the Overview discusses recent and existing legislation. Part II.A describes the Deficit Reduction Act of 2005<sup>8</sup> (“DRA” or “the Act”), which may contribute to increased evictions and an increased financial burden on nursing homes. This first part focuses on the ways in which the Act has created both expansions and restrictions in access to Medicaid coverage for long-term care.

Part II.B focuses on the financial difficulties that individuals such as Cordelia face when attempting to plan for and pay for long-term care. This part also examines the effect of nonpayment evictions on elderly individuals by discussing the theory of transfer trauma and its triggers.

Next, Part II.C considers the same event—nonpayment—from the perspective of the nursing facility. Part II.C discusses three options available to the facility when a resident doesn’t pay: (1) retention, (2) obtaining a hardship waiver, and (3) eviction. This section also gives thorough treatment to federal and state regulations governing the circumstances under which residents may be evicted.

The Discussion section evaluates potential results of the DRA, and proposes a solution to benefit all parties. Part III.A predicts the effects of the DRA, positing that the individual may face increased incidence of eviction accompanied by heightened risk of transfer trauma, and the facility may encounter financial hardships resulting from the Act’s provisions.

Finally, Part III.B proposes a three-part solution aimed at protecting the individual from transfer trauma and inappropriate discharge or transfer, and protecting the nursing industry from financial devastation, while still exhibiting sensitivity to the DRA’s objectives.

## II. OVERVIEW

### A. *The Deficit Reduction Act of 2005*

The government intended for the Deficit Reduction Act of 2005<sup>9</sup> to slow the growth of Medicare, Medicaid, and Social Security, which the government foresaw

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8. Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (codified as amended in scattered sections of 20 U.S.C., 42 U.S.C.).

9. Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (codified as amended in scattered sections of 20 U.S.C., 42 U.S.C.). The Act was passed in February of 2008; however, several states didn’t begin to implement the Act until many months later. *See* SELFHELP COMTY. SERVS., INC., MEDICAID RULES ON THE TRANSFER OF ASSETS, WITH CHANGES BY THE DEFICIT REDUCTION ACT OF 2005, at Introduction (2010), <http://wnylc.com/health/download/37/> (stating that DRA went into effect in New York on August 1, 2006); Archive of Maine Elder Law Updates: Law Office of Patricia A. Nelson-Reade, <http://www.pnr-elderlaw.com/archive.php> (last visited Oct. 1, 2010) (describing implementation of DRA in Maine taking place April 1, 2007); *Federal Changes in Medicaid Law*, PAELDERLAW.NET, [http://www.paelderlaw.net/library/Pennsylvania\\_Medicaid\\_Act\\_42.asp](http://www.paelderlaw.net/library/Pennsylvania_Medicaid_Act_42.asp) (last visited Oct. 1, 2010) (explaining Pennsylvania did not apply DRA to Medicaid applications until March 3, 2007); Susan H. Levin, *New MassHealth Regulations Implement the Deficit Reduction Act of 2005* (July 5, 2006), [http://www.rfglawyers.com/new\\_developments/54/](http://www.rfglawyers.com/new_developments/54/) (citing July 1, 2006 as the effective date for DRA provisions in Massachusetts).

would account for about sixty percent of the federal budget by the year 2030.<sup>10</sup> In exchange for these cuts, the government expected that each taxpayer would save about \$300 per year over the next five years.<sup>11</sup> The Act represents a number of dramatic changes to Medicaid law.<sup>12</sup> One commentator used the adage “what one hand takes, the other gives back” to describe the implications of the DRA on Medicaid planning.<sup>13</sup> Consistent with this idea of give-and-take, the Act provides for both coverage extensions and eligibility restrictions that will affect who gets care, and what sort of care is covered.

## 1. Medicaid Coverage Expansions Under the DRA

### a. *Expanded Access to Community- and Home-Based Care*

Two provisions of the DRA tend to expand Medicaid coverage. First, the DRA provides for increased access to Medicaid funds to pay for at-home and community-based long-term care by eliminating the requirement that states seek waivers from the federal government before granting recipients Medicaid coverage for care in noninstitutionalized settings.<sup>14</sup> Originally, the federal government excluded coverage for in-home and community care options.<sup>15</sup> In the 1980s,<sup>16</sup> the federal government authorized Home and Community-Based Services “waivers” as a method by which states could request that the federal government waive the requirement that covered care take place in an institutionalized setting.<sup>17</sup> Before a waiver could be approved, the state needed to show that the recipient required the “level of care provided in a hospital or a nursing facility”<sup>18</sup> and that community-based care would be cost-neutral or cost-saving when compared with institutionalized care.<sup>19</sup> Forty-eight states and the District of Columbia implemented waiver programs;<sup>20</sup> however, availability of waivers

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10. Press Release, Office of the Press Secretary, Fact Sheet: President Bush Signs the Deficit Reduction Act (Feb. 8, 2006), [http://www.aging.sc.gov/NR/rdonlyres/360FCDED-8B87-4B5A-B516-B1883BB209C3/0/FactSheetPresidentBushSigns\\_theDeficitReductionAct.pdf](http://www.aging.sc.gov/NR/rdonlyres/360FCDED-8B87-4B5A-B516-B1883BB209C3/0/FactSheetPresidentBushSigns_theDeficitReductionAct.pdf).

11. *Id.*

12. ROBERT C. GERHARD, III, *PENNSYLVANIA MEDICAID: LONG-TERM CARE*, at xi (2008).

13. Lawrence A. Friedman, *New Medicaid Program: Protecting Savings and Funding Long-Term Care*, N.J. LAW.: WKLY. NEWSPAPER, June 23, 2008, at 7.

14. 42 U.S.C. § 1396n(i) (2006 & Supp. II 2008); see Press Release, Office of Senator Evan Bayh, Congress Passes Bayh’s Long-Term Care Initiatives (Feb. 2, 2006), <http://bayh.senate.gov/news/press/release/?id=e90bf399-850a-4025-b9f9-6973293d9532> (praising DRA for making greater use of community-based care, which is often less expensive and more desirable to recipients).

15. Thomas Day, *About Medicaid and Long Term Care*, LONGTERMCARELINK.NET, [http://www.longtermcarelink.net/eldercare/medicaid\\_long\\_term\\_care.htm](http://www.longtermcarelink.net/eldercare/medicaid_long_term_care.htm) (last visited Oct. 1, 2010). Medicaid is a partnership between federal and state governments, and for every state, both bodies have a hand in Medicaid administration and funding. *Id.* The federal government sets minimum standards for eligibility and establishes basic services which must be covered in order for federal funding to be granted. *Id.*

16. Mindy Morrell & Laurie S. Frank, *Community Care for Long-Term Care Needs: Medicaid Home and Community Based Waivers*, MD. B.J., Mar.–Apr. 2008, at 5.

17. 42 U.S.C. § 1396n(c).

18. *Id.* § 1396n(c)(1).

19. *Id.* § 1396n(c)(2)(D).

20. U.S. Dept. of Health & Human Servs., HCBS Waivers—Section 1915 (c), [http://www.cms.gov/MedicaidStWaivProgDemoPGL/05\\_HCBSWaivers-Section1915\(c\).asp](http://www.cms.gov/MedicaidStWaivProgDemoPGL/05_HCBSWaivers-Section1915(c).asp) (last visited Oct. 1, 2010).

remained “widely restricted.”<sup>21</sup> One commentator suggested the waiver programs were impractical because many states imposed a stricter income requirement for waiver candidates, making it easier to qualify for nursing home care than community care.<sup>22</sup> At the same time—and by contrast to Medicaid nursing home coverage—waivers excluded the cost of room, board, and utilities.<sup>23</sup> States had not adequately allowed for retention of assets sufficient to meet these living costs while still meeting strict financial eligibility requirements.<sup>24</sup> Additionally, states capped the number of allowable waiver participants, resulting in waiting lists as long as ten years in some states.<sup>25</sup> However, under the DRA, states are no longer required to seek waivers from the federal government.<sup>26</sup> Instead, states may now choose to include home- and community-based care as an optional Medicaid benefit.<sup>27</sup>

*b. Expansion of Long-Term Care Insurance Partnership Programs*

A second extension of coverage is the Act’s authorization of long-term-care insurance partnership programs between the government and private insurers.<sup>28</sup> Partnership programs aim to encourage individuals to purchase private insurance to cover the cost of long-term care.<sup>29</sup> After the private insurance benefits have been exhausted, individuals may use Medicaid funds to pay for the cost of continuing care.<sup>30</sup> While a typical Medicaid recipient must spend down his or her assets before becoming Medicaid-eligible, recipients who participate in the partnership program will be able to add the value of benefits under the private insurance policy to the amount of assets they are permitted to retain, or transfer without penalty, while receiving Medicaid.<sup>31</sup>

2. Medicaid Coverage Restrictions Under the DRA

By contrast, other sections of the DRA limit Medicaid eligibility. Applicants not receiving Supplemental Security Income (“SSI”) must meet certain income standards in order to be eligible to receive Medicaid coverage for long-term care. To be eligible, the

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21. Day, *supra* note 15.

22. *Id.*

23. 42 U.S.C. § 1396n(c)(1).

24. Day, *supra* note 15.

25. See Press Release, Office of Senator Evan Bayh, *supra* note 14 (noting that under law prior to enactment of DRA, states had to limit number of people who received home-based care, resulting in waiting lists as long as ten years in Indiana and other states).

26. 42 U.S.C. § 1396n(i).

27. *Id.*

28. *Id.* § 1396p(b)(1)(C). Prior to the DRA’s passage, the partnership program existed as a trial in California, Connecticut, Indiana, and New York. A Guide to Long-Term Care for State Policy Makers: The Long-Term Care Partnership Program, <http://www.ncsl.org/IssuesResearch/Health/TheLongTermCarePartnershipProgram/tabid/14490/Default.aspx> (last visited Oct. 1, 2010). In anticipation of a change in federal law, several states enacted legislation facilitating their ability to move forward quickly in offering partnership program benefits to their residents. *Id.*

29. A Guide to Long-Term Care for State Policy Makers, *supra* note 28.

30. *Id.*

31. Jim DeBrosse, *Long-Term Care in Ohio: Is Changing New Spend-Down Limits on Medicaid Will Allow Seniors to Keep More of Their Assets; Forum to Explain Changes*, DAYTON DAILY NEWS, Aug. 18, 2006, at A1.

Social Security Act provides that an individual must possess less than \$2,000 in resources, and a couple needing care must possess less than \$3,000.<sup>32</sup> This creates an incentive for some individuals to artificially impoverish themselves in order to qualify for Medicaid coverage. Federal Medicaid law combats these attempts by dictating that if an individual has made a transfer of assets for less than fair market value during a specified “look-back” period, the individual will face a penalty period.<sup>33</sup> During the penalty period, an institutionalized individual is ineligible for (1) Medicaid coverage of nursing facility services, (2) a “level of care in any institution equivalent to that of nursing facility services,” or (3) home- or community-based services under a waiver.<sup>34</sup> Significantly, the DRA increases the length of the look-back period for asset transfers at less than fair market value, and alters the start date of the associated penalty period in a manner unfavorable to potential Medicaid recipients.<sup>35</sup>

Congress has repeatedly attempted to limit the frequency of artificial impoverishment tactics by increasing the length of the look-back period.<sup>36</sup> The DRA lengthens the look-back period from three years to five years.<sup>37</sup> Therefore, to avoid incurring a penalty period under the new look-back policy, an individual must not have made a transfer of assets for less than fair market value within the five years prior to the date on which the individual is institutionalized and has applied for Medicaid. So, for example, a woman who donates \$50,000 to her church in 2003, becomes ill in 2007, and enters a nursing home that same year will not be eligible for Medicaid under the new look-back rules.<sup>38</sup>

In conjunction with lengthening the look-back period, the DRA changes the start date of the penalty period during which the institutionalized individual will be ineligible for coverage.<sup>39</sup> When an individual is determined to have made an asset transfer for less than fair market value within the look-back period, the number of months during which the individual will face the ineligibility penalty is calculated by dividing the uncompensated value of the transferred assets by the average monthly cost

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32. Social Security Act, § 1611, 42 U.S.C. § 1382(a)(1)–(3). The definition of resources for Medicaid eligibility is the same as the definition for SSI eligibility, except that the home is included in the resources of an institutionalized individual. CTRS. FOR MEDICARE & MEDICAID SERVS., THE STATE MEDICAID MANUAL § 3257, available at <http://www.cms.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=1&sortOrder=ascending&itemID=CMS021927&intNumPerPage=10> (click on “Chapter 3” and open the first file) (last visited Oct. 1, 2010). Resources include things owned that could be converted to cash and spent on food and shelter. Social Security Administration, *Understanding Supplemental Security Income*, <http://www.ssa.gov/ssi/text-eligibility-ussi.htm> (last visited Oct. 1, 2010). Some assets, such as burial spaces and funds set aside for funeral expenses, are excluded from resources. 42 U.S.C. § 1382b.

33. 42 U.S.C. § 1396p(c)(1)(A).

34. *Id.* § 1396p(c)(1)(C)(i).

35. *Id.* § 1396p(c)(1).

36. FELDMAN, *supra* note 6, at 207 (noting that Congress has repeatedly tried to reduce occurrence of asset transfers for less than fair market value by extending look-back period).

37. D. Chalgian & A. Tripp, *The Deficit Reduction Act of 2005 and Medicaid Eligibility for Long Term Care*, MPLP NEWSL. Q., Winter 2006, <http://www.mplp.org/Resources/mplpresource.2006-03-31.2448310> 210/.

38. See Sylvia Hsieh, *Medicaid Changes to Turn Estate Planning on Its Head*, MICH. LAW. WKLY., Mar. 13, 2006 (offering similar illustration of look-back period concept).

39. Chalgian & Tripp, *supra* note 37.

of nursing home care in the individual's state.<sup>40</sup> Formerly, the penalty period began to run when the transfer was made,<sup>41</sup> but the new provisions dictate that the penalty period in most cases will not begin until the individual would otherwise be eligible for Medicaid.<sup>42</sup> That is to say, the individual must be institutionalized and have spent down nearly all of his or her resources to the point of qualifying for Medicaid before the period of ineligibility begins.<sup>43</sup> Before the passage of the Act, individuals were generally able to wait out the penalty period by paying for care themselves before Medicaid was really needed, but the new rules trigger the beginning of the penalty period only after the need for Medicaid arises, and therefore create a greater challenge for avoiding the penalty.<sup>44</sup>

### 3. Hardship Waiver Provision Under the DRA

As a safety net to the harsh look-back and penalty period changes, the DRA requires that each state develop a process of offering hardship waivers to penalized applicants.<sup>45</sup> These waivers preserve Medicaid eligibility by waiving the penalty period associated with an asset transfer in cases of hardship.<sup>46</sup> The provision defines hardship as an application of the penalty period that "would deprive the individual (A) of medical care such that the individual's health or life would be endangered; or (B) of food, clothing, shelter, or other necessities of life."<sup>47</sup> A state is required to provide notice that an undue hardship exception exists, a timely determination of whether the waiver will be granted, and a process for appealing its decisions.<sup>48</sup> Additionally, the DRA grants a nursing home the ability to file undue hardship waiver applications on behalf of its residents with their consent.<sup>49</sup> The actual utility of the hardship waiver provision, however, has been harshly criticized.<sup>50</sup>

#### B. *Issues Stemming from Financial Challenges Facing the Nursing Home Resident*

Information on demographics and Medicaid spending indicates that the DRA will have repercussions on the long-term care and long-term care planning of a growing number of individuals. In 2006, seven million elderly individuals received long-term care.<sup>51</sup> By 2020, projections indicate that number could be as high as fourteen million, and as high as twenty-four million in 2060.<sup>52</sup>

Projections indicating an increase in the number of long-term care recipients are likely influenced by demographic data showing that the population is aging while life

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40. 42 U.S.C. § 1396p(c)(1)(E)(i).

41. Chalgian & Tripp, *supra* note 37.

42. 42 U.S.C. § 1396p(c)(1)(D).

43. FELDMAN, *supra* note 6, at 242.

44. Chalgian & Tripp, *supra* note 37.

45. 42 U.S.C. § 1396p, note (Availability of Hardship Waivers).

46. *Id.* § 1396p(c)(2)(D).

47. *Id.* § 1396p, note (Availability of Hardship Waivers).

48. *Id.*

49. *Id.* § 1369p(C)(2).

50. See *infra* Part II.C.2 for the positions of the hardship waiver's critics.

51. FELDMAN, *supra* note 6, at 24.

52. U.S. GEN. ACCOUNTING OFFICE, *supra* note 7, at 8.

expectancy continues to increase.<sup>53</sup> Since the need for long-term care increases with age, and longer life expectancies will result in more age-related disabilities, it follows that demand for long-term care will increase.<sup>54</sup> A projected increase in the eighty-five and older population<sup>55</sup> is particularly telling because in 2004, 45.2% of nursing home residents were over the age of eighty-five.<sup>56</sup> Stated another way, approximately 13.87% of all Americans over age eighty-five<sup>57</sup> and only 3.63% of those over age sixty-five were cared for in nursing homes in the same year.<sup>58</sup> Not surprisingly, these figures indicate that the likelihood of requiring nursing home care appears to increase with age, adding credibility to the projections of an increase in the need for long-term care.

#### 1. Individuals' Struggles to Plan for the Cost of Care

Medicaid will be an important source of funding for the aging population as it faces the need for long-term care. In 2000, nearly 4.79 million individuals aged sixty-five and over received Medicaid assistance of some sort.<sup>59</sup> Around the same time, Medicaid paid the bills of approximately two-thirds of nursing home residents,<sup>60</sup> and paid for 47.5% of annual expenditures on U.S. nursing home care.<sup>61</sup>

For many of those requiring long-term care in a nursing facility, significant planning will be required to avoid "potential financial devastation."<sup>62</sup> In 2007, the average annual rate for a paying resident in a private nursing home room was

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53. FELDMAN, *supra* note 6, at 25. Projections based on U.S. census data estimate that by the year 2010, people aged sixty-five and over will make up 12.97% of the population. Population Div., U.S. Census Bureau, Percent Distribution of the Projected Population by Selected Age Groups and Sex for the United States: 2010 to 2050 (Aug. 14, 2008), <http://www.census.gov/population/www/projections/files/nation/summary/np2008-t3.xls>. By 2050, that number will grow to 20.17%. *Id.* As life expectancy increases, from a projected 78.3 years in 2010 to 83.1 in 2050, Population Div., U.S. Census Bureau, Projected Life Expectancy at Birth by Sex, Race, and Hispanic Origin for the United States: 2010 to 2050 (Aug. 14, 2008), <http://www.census.gov/population/www/projections/files/nation/summary/np2008-t10.xls>, the population over age eighty-five is also expected to increase. Population Div., U.S. Census Bureau, Percent Distribution of the Projected Population by Selected Age Groups and Sex for the United States: 2010 to 2050, *supra*. By 2010, those eighty-five and over will account for 1.85% of the population, and by 2050, will account for 4.34%. *Id.*

54. FELDMAN, *supra* note 6, at 25.

55. Population Div., U.S. Census Bureau, Percent Distribution of the Projected Population by Selected Age Groups and Sex for the United States: 2010 to 2050, *supra* note 53.

56. Nat'l Ctr. for Health Statistics, Ctrs. for Disease Control & Prevention, 2004 National Nursing Home Survey Tables – Estimates – Demographics tbl.1 (2008), [http://www.cdc.gov/nchs/data/nnhsd/Estimates/nhhs/Estimates\\_Demographics\\_Tables.pdf](http://www.cdc.gov/nchs/data/nnhsd/Estimates/nhhs/Estimates_Demographics_Tables.pdf).

57. *Id.*

58. *See id.* (setting forth rate of nursing home residents per 10,000 members of general population).

59. CTRS. FOR MEDICARE & MEDICAID SERVS., PROGRAM INFORMATION ON MEDICAID & STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) 14 (2004), [http://aspe.hhs.gov/medicaid/jul/InfoMedicaid\\_schip.pdf](http://aspe.hhs.gov/medicaid/jul/InfoMedicaid_schip.pdf).

60. *Nursing Home Bankruptcies: What Caused Them?: Hearing Before the S. Spec. Comm. on Aging*, 106th Cong. 3 (2000) [hereinafter *Nursing Home Bankruptcies*] (statement of Steven Pelovitz, Director, Survey and Certification Group, Health Care Financing Administration, U.S. Department of Health and Human Services), available at <http://aging.senate.gov/events/hr57sp.pdf>.

61. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 59, at 49.

62. *See* GERHARD, *supra* note 12, at 12 (discussing importance of elder law attorneys in helping clients comply with Medicaid rules).

\$77,745.<sup>63</sup> That comes to about \$213 per day. Medicaid planning via an elder law attorney is one method used to anticipate and manage the cost of long-term care.<sup>64</sup> Medicaid planning involves the “allocation and structuring” of an individual’s assets in order to make the individual eligible for Medicaid earlier than would have been possible otherwise.<sup>65</sup> At the same time, Medicaid planning aims to preserve wealth, allowing an individual who could otherwise pay for his or her own care to retain assets while qualifying for a program designed to assist the indigent.<sup>66</sup>

Congress’s intent in passing the DRA was to substantially eliminate certain Medicaid planning techniques, therefore holding the middle class accountable for the cost of its long-term care.<sup>67</sup> This agenda is suggested by an exception to the ineligibility period contained within the Code, which excludes asset transfers made “exclusively for a purpose other than to qualify for medical assistance” from triggering ineligibility for Medicaid assistance and benefits,<sup>68</sup> although the presumption is that the transfer has been made for Medicaid planning purposes.<sup>69</sup>

The presumption that asset transfers are made for the purpose of qualifying for Medicaid is difficult to rebut.<sup>70</sup> Residents can rebut this presumption only by a showing that the asset transfer was intended to be in exchange for fair market value or other valuable consideration, or was intended “exclusively for a purpose other than to qualify for” Medicaid.<sup>71</sup> However, a Massachusetts study tracking residents’ success rates in rebutting the disqualifying presumption indicates that those wishing to do so may face increasing difficulty.<sup>72</sup> The study shows residents were successful at a rate that dropped from 42% in 2004 and 2005 before the DRA was passed, to 25% and 21% in 2006 and 2007 respectively.<sup>73</sup>

Critics have noted that the presumption effectively “slams the door shut on a lot of the loopholes” and will reduce flexibility, particularly for middle class “11th hour Medicaid planners.”<sup>74</sup> This is especially true of the most significant changes the DRA creates with respect to Medicaid planning—the amendments to the look-back and penalty periods.<sup>75</sup> Some planning opportunities still exist under the new rules. For example, an individual can prepay funeral expenses or invest in annuities, the insurable

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63. *Private and Semi-Private Nursing Home Room Rates Increase 3% in 2007*, BUS. WIRE, Oct. 2007, available at <http://www.allbusiness.com/health-care/health-care-facilities-nursing/5290583-1.html>.

64. See GERHARD, *supra* note 12, at 12 (noting that elder law attorneys can help clients limit financial impact of nursing home placement).

65. FELDMAN, *supra* note 6, at 241.

66. *Id.*

67. *Id.* at 242.

68. 42 U.S.C. § 1396p(c)(2)(C)(ii) (2006).

69. See William J. Brisk & Kathalene C. MacPherson, *Fair Hearing Decisions on Medicaid “Hardship” and “Intent” Claims*, 4 NAT’L ACAD. ELDER L. ATT’YS J. 83, 90 (2008) (stating that in most cases, applicants must prove another exclusive purpose).

70. See *id.* at 92 (stating that in 2007 only 21% of applicants in Massachusetts rebutted presumption).

71. 42 U.S.C. § 1396p(c)(2)(C)(i)–(ii).

72. Brisk & MacPherson, *supra* note 69, at 92.

73. *Id.*

74. George O’Brien, *A Big Problem—for the Long Term*, BUSINESSWEST, Mar. 6, 2006, at 38, 38, 54.

75. FELDMAN, *supra* note 6, at 252.



may purchase long-term care insurance under partnership programs, and those who are able may plan gifts five years before care is needed.<sup>76</sup>

## 2. Eviction for Nonpayment and its Effects on the Individual

Residents who are unable to pay the bills for the care they receive may face eviction.<sup>77</sup> Though there is no nationwide tally of nursing home evictions, it is telling that complaints about nursing home discharge practices have doubled between 1996 and 2006, making discharge complaints the second most populated category of complaints tracked by the Federal Administration on Aging.<sup>78</sup> Involuntary discharge from a facility can create physical and emotional problems for residents.<sup>79</sup> Such issues, brought on by the stress of relocation, are referred to as transfer trauma.<sup>80</sup> Some studies suggest that the elderly may experience a decline in health, and even hastened death, as a result of involuntary transfer or discharge.<sup>81</sup>

Researchers have posited a number of factors contributing to transfer trauma and its mitigation, which may offer insight into the negative effects of a move. First, discharge and transfer break the social networks built up by residents within their nursing facilities, upon which they rely for cognitive and other support.<sup>82</sup> Residents develop virtual family units among other residents and staff members, which are broken in a move.<sup>83</sup> These are especially important for residents whose families do not

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76. *Id.* at 252, 257–58.

77. See *infra* Section II.C.3 for a discussion of the circumstances under which a nursing home may evict a resident.

78. See Theo Francis, *To Be Old, Frail and Evicted: Patients at Risk*, WALL STREET J., Aug. 7, 2008, at D1 (reporting that 8,500 complaints were received concerning nursing home discharge practices in 2006 and suggesting increase is likely due to financial motivations of nursing homes).

79. Marlys J. Bratteli, *Transfer Trauma Following a Community Evacuation of the Institutionalized Elderly*, at xii (Dec. 2003) (unpublished Ph.D. dissertation, University of North Dakota) (on file with Temple Law Review).

80. Violette King, Op-Ed., *Keep Spotlight on Assisted Living Facilities*, S. FLA. SUN-SENTINEL, Feb. 19, 2008, at 21A.

81. See C.K. Aldrich & E. Mendkoff, *Relocation of the Aged and Disabled: A Mortality Study*, 11 J. AM. GERIATRICS SOC'Y 185, 188 (1963) (finding death rate for transferred patients more than three times higher than would otherwise be expected for first three months following transfer); Terri D. Keville, *Studies of Transfer Trauma in Nursing Home Patients: How the Legal System Has Failed to See the Whole Picture*, 3 HEALTH MATRIX: J. L. MED. 421, 423–30 (1993) (analyzing previously conducted transfer trauma studies); Francis, *supra* note 78 (describing closure of small Oklahoma nursing home which left ten of its sixteen relocated residents dead within about six months); David Richie, *Some Seniors Die After Home Is Shut: 'Transfer Trauma' May Have Claimed Elderly, Former Operator Says*, SACRAMENTO BEE, Apr. 2, 2006 (suggesting transfer trauma may be cause of death for five seniors who died within a month after 180 residents were involuntarily transferred from nursing home). Other studies have not found evidence of the phenomenon. See Bratteli, *supra* note 79, at 114–15 (describing decline in health and eventual death of ten out of ten respondents in study of effects of involuntary move on long-term care residents); Neal Krause, *Exploring the Impact of a Natural Disaster on the Health and Psychological Well-Being of Older Adults*, 13 J. HUM. STRESS 61, 66 (1987) (finding somatic effects of stressors on elderly dissipate with time). *But see* Keville, *supra*, at 431–36 (criticizing methodology of studies failing to confirm existence of transfer trauma); Anson B. Levitan, *Nursing Home Dilemma? Transfer Trauma and the Noninstitutional Option: A Review of the Literature*, 13 CLEARINGHOUSE REV. 653, 654, 658 (1980) (determining after review of existing literature that evidence indicates existence of transfer trauma and increased mortality).

82. Bratteli, *supra* note 79, at 89.

83. *Id.*

visit.<sup>84</sup> Breaking these family units through involuntary transfer without offering counseling to deal with the resultant loss can lead to "isolation and despair" and even diminished long-term survival.<sup>85</sup>

Second, the effects of transfer trauma can be mitigated when residents perceive they have control over their situations.<sup>86</sup> Thus, involuntary transfers or discharges are more likely to have a negative impact on a resident than voluntary moves.<sup>87</sup> Internal locus of control is important to the health of elderly individuals in general.<sup>88</sup> Internal locus of control refers to our belief that we have the inner strength to overcome challenges, as contrasted with a belief in luck or fate.<sup>89</sup> When others make decisions on behalf of an elder, such as care decisions, the decision to relinquish the elder's driver's license, or that the elder should be transferred involuntarily, an elder experiences a decrease in this vital mechanism.<sup>90</sup> By contrast, control is maximized by giving the resident decision-making power in the matter, and by providing options that meet the individual's independence expectations and needs.<sup>91</sup> Control can also be enhanced by moving the resident, her possessions, and her records at the same time.<sup>92</sup>

Third, effects of involuntary transfer can be mitigated by maximizing predictability over the move for the resident.<sup>93</sup> Predictability can be increased by taking steps to familiarize the resident with the new facility, providing notification, providing counseling, and otherwise "alleviating the resident's fear of the unknown."<sup>94</sup>

Fourth, and similarly, an individual's own characteristics, including her belief that she will be able to adapt to the new environment, are somewhat determinative of the effect the move will have on the individual.<sup>95</sup> Emotional adjustment before and after being informed of the impending transfer may play a role in post-transfer mortality.<sup>96</sup> General traits of impaired cognitive function,<sup>97</sup> psychosis, depression, and anger<sup>98</sup> or a reaction to the news of transfer that exhibits denial, anger, anxiety, regression, or

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84. *Id.*

85. *Id.*

86. Janet M. Robert, Comment, *Involuntary Relocation of Nursing Home Residents and Transfer Trauma*, 24 ST. LOUIS U. L.J. 758, 760 (1981).

87. See Norman Bourestom & Leon Pastalan, *The Effects of Relocation on the Elderly: A Reply to Borup, J.H., Gallego, D.T., & Heffernan, P.G.*, 21 GERONTOLOGIST 4, 5-6 (1981) (determining effect of move depends on three factors, including whether move was voluntary); J.K. Eckert, *Dislocation and Relocation of the Urban Elderly: Social Networks as Mediators of Relocation Stress*, 42 HUM. ORGS. 1, 39, 44 (1983) (asserting there is little impact on health and well-being when elders are able to move to facility of their choice); Robert, *supra* note 86, at 760 (explaining transfer trauma may be alleviated if transfer is both voluntary and occurs after significant preparation).

88. Bratteli, *supra* note 79, at 92.

89. *Id.*

90. *Id.*

91. Robert, *supra* note 86, at 760.

92. *Id.* at 760-61.

93. *Id.* at 760.

94. *Id.* at 761.

95. See Bourestom & Pastalan, *supra* note 87, at 5-6 (noting physical and mental characteristics of relocatee are essential in understanding effect of move).

96. Aldrich & Mendkoff, *supra* note 81, at 189-90.

97. Levitan, *supra* note 81, at 655.

98. Aldrich & Mendkoff, *supra* note 81, at 189.

depression tend to indicate increased morbidity to varying levels.<sup>99</sup> An individual may develop a more positive outlook if she is familiar with her new environment, and perceives the new environment as stable and enduring.<sup>100</sup>

Finally, the new environment likely plays a role in an individual's success or failure within it.<sup>101</sup> More specifically, preexisting formal and informal social structures within the new facility may hinder the recently transferred resident in developing new social networks.<sup>102</sup>

### C. Options Available to Nursing Facilities When Dealing with Nonpayment

Residents are not the only parties at risk when Medicaid coverage is denied. While evicted residents face health concerns, the evicting facilities take on related financial and legal problems. When residents are unable to pay their bills, nursing homes must either compromise their profitability or address legal (and social) issues that stem from eviction.<sup>103</sup>

#### 1. Retaining the Resident in Spite of Nonpayment

A first option for nursing homes is to retain the patients who find themselves unable to pay, and simply absorb the additional cost. Due to financial pressure faced by the industry,<sup>104</sup> this option may be very unattractive to nursing homes struggling to maintain their solvency. As mentioned previously, Medicaid dollars account for nearly half of the money spent on nursing home care.<sup>105</sup> Therefore, nursing home profitability is often somewhat dependent on the vagaries of Medicaid reimbursement policy.<sup>106</sup> On average, the shortfall in Medicaid reimbursement in 2000 was nearly ten dollars per day for each Medicaid patient.<sup>107</sup> While revenues have slowed or decreased, nursing homes' costs have been on the rise due to labor shortages in the health field, increases in insurance and utility costs, and heightened emphasis on quality and measuring

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99. *Id.* at 190.

100. See Mats Ekström, *Elderly People's Experiences of Housing Renewal and Forced Relocation: Social Theories and Contextual Analysis in Explanations of Emotional Experiences*, 9 HOUSING STUD., 369, 383 (1994) (listing these among other factors contributing to trust and security in home and neighborhood).

101. Bourestom & Pastalan, *supra* note 87, at 5.

102. See Bratteli, *supra* note 79, at 98 (explaining that new facility's formal structure as well as residents' cliques and reluctance to socialize with those in different levels of care may result in difficulty for recently transferred resident).

103. O'Brien, *supra* note 74, at 40.

104. See CONN. GEN. ASSEMBLY, OFF. OF PROGRAM REV. & INVESTIGATIONS, *Introduction to NURSING HOME MEDICAID RATE-SETTING SYSTEM* (2001), available at [http://www.cga.ct.gov/pri/archives/2001nhrepo\\_rintro.htm#P15\\_1007](http://www.cga.ct.gov/pri/archives/2001nhrepo_rintro.htm#P15_1007) (noting financial pressures facing nursing homes in Connecticut and nationwide).

105. See CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 59, at 49 (providing Medicaid data for 2001).

106. Day, *supra* note 15.

107. BDO SEIDMAN, LLP, A BRIEFING CHARTBOOK ON SHORTFALLS IN MEDICAID FUNDING FOR NURSING HOME CARE I (2002), available at <http://nescso.org/files/seidmanstudy0207.pdf>; see also Francis, *supra* note 78 (reporting estimate that Medicaid reimbursements for 2007 fell \$4.4 billion short of actual cost of care for Medicaid patients).

patient outcomes.<sup>108</sup> In 2000, approximately 1,600 U.S. nursing homes operated under Chapter 11 bankruptcy protection.<sup>109</sup>

As a second option, in some cases, nursing homes may choose to raise the price for private-pay patients in order to compensate for the loss of retaining nonpaying residents.<sup>110</sup> In at least two states, however, facilities are forbidden from charging private-pay residents more than Medicaid residents are charged, making this an unlikely option for recovering the lost income.<sup>111</sup> Furthermore, the number of private-pay residents in nursing homes has been decreasing due to the availability of other, more attractive, long-term care options such as assisted living facilities and in-home care,<sup>112</sup> making this technique a less viable option to recover the requisite sums.

A third method for a nursing home to retain a nonpaying resident is to sue the resident's adult children for payment. Though this option is rarely exercised by nursing homes, thirty states hold adult children responsible for the care of their indigent parents, sometimes including reimbursement to nursing homes for care costs within the scope of that responsibility.<sup>113</sup> Twenty-one states allow civil actions against adult children for support or reimbursement, twelve prescribe criminal penalties for failure to support aged parents, and three allow for both criminal and civil actions.<sup>114</sup>

Finally, nursing homes may retain nonpaying residents by compensating for financial losses in other ways. Historically, when profitability is compromised, nursing homes have attempted to recover losses by converting to day care centers or prisons—strategies which relocate residents.<sup>115</sup> Others have put their licenses in jeopardy, cutting costs by skimping on the quality of care, resorting to overcrowding, or failing to comply with safety standards.<sup>116</sup>

## 2. Seeking Hardship Waiver on the Resident's Behalf

Another option should a resident become unable to pay for care during a penalty period is for the facility (or resident) to file an application for a hardship waiver on the resident's behalf. The DRA establishes a hardship waiver which permits states to waive the penalty period imposed for asset transfers in cases where the penalty would endanger the health or welfare of the resident, or the resident would be without the

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108. CONN. GEN. ASSEMBLY, OFF. OF PROGRAM REV. & INVESTIGATIONS, *supra* note 104.

109. *Nursing Home Bankruptcies*, *supra* note 60 (testimony of Steven Pelovitz, Director, U.S. Dep't of Health and Human Servs.). Under Chapter 11 protection, the nursing homes continue to operate while the companies that own them undergo financial restructuring. *Id.* However, as illustrated by the closing of three Texas facilities, Pelovitz's testimony indicates that a facility's financial instability may lead to the facility's closing, requiring relocation of its residents. *Id.* Because the DRA was implemented fairly recently in some states, post-DRA financial trends aren't yet available. See *supra* note 9 for a discussion of when various states implemented the DRA.

110. Day, *supra* note 15.

111. *Id.*

112. CONN. GEN. ASSEMBLY, OFF. OF PROGRAM REV. & INVESTIGATIONS, *supra* note 104.

113. MATTHEW PAKULA, NAT'L CTR. FOR POL'Y ANALYSIS, THE LEGAL RESPONSIBILITY OF ADULT CHILDREN TO CARE FOR INDIGENT PARENTS 1 (2005), <http://www.ncpa.org/pdfs/ba521.pdf>.

114. *Id.* at 2.

115. Robert, *supra* note 86, at 763–64.

116. *Id.* at 764.

necessities of life such as food or shelter.<sup>117</sup> In theory, this provides nursing homes with a potential remedy when the resident and the resident's family refuse or are unable to pay for the resident's care and fail to file for the hardship waiver for the resident.<sup>118</sup> However, the DRA's critics dismiss the hardship waiver as unlikely to provide more than theoretical protection for a number of reasons.<sup>119</sup> First, the burden to apply for the waiver typically has fallen on an individual who is already facing financial and health problems.<sup>120</sup> Second, though the DRA strengthens the notice requirements for the waiver, waiver provisions already exist and are "virtually never" used or granted.<sup>121</sup> Third, an assessment of whether an individual faces true hardship would depend on a subjective evaluation of the strength of the individual's entire support network for the duration of the penalty period.<sup>122</sup> Critics argue that resources do not exist for this kind of evaluation.<sup>123</sup> Finally, critics contend that the process will fail to account for the potential burden on family members in the resident's support network when determining to whom to grant a waiver.<sup>124</sup> One Massachusetts study revealed that while the number of applicants for hardship waivers appears to have increased since the passage of the DRA, none of the twenty-three waiver applications filed between 2004 and 2007 were granted.<sup>125</sup> The study describes at least two cases where nursing homes were granted standing to file applications, which were later denied, on behalf of their residents pursuant to the DRA.<sup>126</sup> In one of the cases, the nursing home's application for retroactive benefits to cover \$170,000 in unpaid bills was deemed moot since the resident had died.<sup>127</sup> These cases and criticisms suggest that the hardship waiver is a tool which is infrequently used in practice.

### 3. Evicting the Resident

Finally, a nursing home may choose to evict a resident for nonpayment. In order to receive Medicaid funds, nursing facilities must abide by federal and state regulations which govern, among other things, residents' rights and the process by which a resident may be transferred or discharged.<sup>128</sup> The federal regulations impose penalties of \$1,000 to \$10,000 per instance of noncompliance<sup>129</sup> based on a nursing facility's degree of

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117. 42 U.S.C. § 1396p(c)(2) (2006).

118. See Brisk & MacPherson, *supra* note 69, at 83 (reviewing all hardship applications received by Massachusetts Medicaid program for three years and finding that none were fully approved).

119. See *Proposed Changes to Medicaid Transfer of Asset Rules from the Budget Reconciliation Conference Report*, EYE ON ELDER ISSUES (Nat'l Acad. of Elder Law Att'ys, Vienna, Va.) Dec. 2005, [http://www.naela.org/App\\_Themes/Public/PDF/Media/Eye%20On%20Elder%20Issues/Vol2No7Dec2005.pdf](http://www.naela.org/App_Themes/Public/PDF/Media/Eye%20On%20Elder%20Issues/Vol2No7Dec2005.pdf) (arguing that hardship waiver is not practical solution).

120. *Id.*

121. *Id.*

122. *Id.*

123. *Id.*

124. *Id.*

125. Brisk & MacPherson, *supra* note 69, at 91.

126. *Id.* at 87 n.22.

127. *Id.*

128. 42 C.F.R. §§ 483.1(b), .10(b)(11) (2009).

129. *Id.* § 488.438(a)(2).

culpability, history of noncompliance, and other factors.<sup>130</sup> Denial of Medicaid reimbursement is another possible consequence of noncompliance.<sup>131</sup>

*a. Federal Regulations Governing Resident Eviction*

Under federal regulations, transfer refers to “moving the resident from the facility to another legally responsible institutional setting,” while discharge refers to “moving the resident to a non-institutional setting when the releasing facility ceases to be responsible for the resident’s care.”<sup>132</sup> In general, the Code requires that nursing homes refrain from transferring or discharging residents.<sup>133</sup> However, a resident may be transferred or discharged in six specific circumstances including where “[t]he resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.”<sup>134</sup> Conversion from a private-pay rate to a Medicaid rate does not constitute nonpayment for purposes of discharge,<sup>135</sup> and nonpayment has not occurred as long as the resident has submitted all paperwork to a third party in order for the nursing home bills to be paid.<sup>136</sup> Nonpayment does occur, however, if the third party, including Medicaid, turns down the claim, and the resident does not take responsibility for the amount owed.<sup>137</sup>

Once a nursing home establishes that an individual is eligible for discharge based on nonpayment (or for another qualifying reason), the facility owes the resident two additional relevant duties: to provide notice and orientation.<sup>138</sup> First, with regard to notice, the Code provides that “[a] facility must immediately inform the resident; consult with the resident’s physician; and if known, notify the resident’s legal representative or an interested family member when there is . . . [a] decision to transfer or discharge the resident from the facility.”<sup>139</sup> The Code requires this notice to be communicated at least thirty days prior to discharge unless certain exceptions, including urgent medical needs, apply.<sup>140</sup> The notice must occur in a language and manner that the recipients can understand,<sup>141</sup> and must include the reason for the transfer or discharge, the effective date, and the location to which the resident is being transferred or discharged.<sup>142</sup> In addition, the notice must advise of the resident’s right to

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130. *Id.* § 488.438(f).

131. *Id.* § 488.406(a)(2)(i), (ii).

132. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., STATE OPERATIONS MANUAL, 41 (rev. 2009), [http://cms.hhs.gov/manuals/Downloads/som107ap\\_pp\\_guidelines\\_ltc\\_f.pdf](http://cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltc_f.pdf).

133. 42 C.F.R. § 483.12(a)(2).

134. *Id.* § 483.12(a)(2)(v). The other five circumstances are when: (1) the facility is unable to meet the resident’s needs, (2) the resident’s health has improved to the point where he no longer requires the facility’s care, (3) retention of the resident creates a safety hazard, (4) retention of the resident creates a health hazard, or (5) the facility closes. *Id.* § 483.12(a)(2).

135. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 132, at 45.

136. *Id.*

137. *Id.*

138. 42 C.F.R. § 483.12(a)(4), (7).

139. *Id.* § 483.10(b)(11).

140. *Id.* § 483.12(a)(5)(i).

141. *Id.* § 483.12(a)(4)(i).

142. *Id.* § 483.12(a)(6).

appeal the discharge under the state process, and provide contact information for the state long-term care ombudsman.<sup>143</sup> Finally, notice must include contact information for other appropriate agencies if the discharged resident is mentally ill or developmentally disabled.<sup>144</sup>

Second, to fulfill its duty of orientation, a facility must provide “sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.”<sup>145</sup> The Centers for Medicare and Medicaid Services have provided nursing homes with interpretive guidance concerning a facility’s responsibilities under this standard through its Operations Manual (the “Manual”).<sup>146</sup> The Manual defines “sufficient preparation” as “inform[ing] the resident where he or she is going and tak[ing] steps under its control to assure safe transportation.”<sup>147</sup> The document provides further examples of steps a facility should undertake in order to comply with the “orientation” regulation:

The facility should actively involve, to the extent possible, the resident and the resident’s family in selecting the new residence. Some examples of orientation may include trial visits, if possible, by the resident to a new location; working with family to ask their assistance in assuring the resident that valued possessions are not left behind or lost; orienting staff in the receiving facility to resident’s daily patterns; and reviewing with staff routines for handling transfers and discharges in a manner that minimizes unnecessary and avoidable anxiety or depression and recognizes characteristic resident reactions identified by the resident assessment and care plan.<sup>148</sup>

Within the realm of orientation, federal regulation mandates that facilities prepare a transfer or discharge summary and a post-discharge plan of care before a resident is relocated.<sup>149</sup> The post-discharge plan of care is to be developed with the resident or her family, and is designed to assist the resident with her transition to her new living environment.<sup>150</sup>

The courts have provided little additional insight to serve as a guide to what constitutes proper orientation and preparation upon discharge or transfer under the federal requirements. One decision determined there was no violation of the regulations when a facility discussed discharge plans with a resident and wife the day before the discharge, taught the resident and his wife how to administer the resident’s medications, and elicited verbal confirmation from the resident of his understanding.<sup>151</sup> By contrast, in another case, a nursing facility was found to have violated the regulation requiring orientation and preparation when it discharged an aggressive patient to a

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143. *Id.*

144. *Id.*

145. *Id.* § 483.12(a)(7).

146. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 132, at 48–49 (listing examples of assistance facilities should give when discharging or transferring residents).

147. *Id.* at 48.

148. *Id.* at 48–49.

149. 42 C.F.R. § 483.20(l).

150. *Id.*

151. *Carehouse Convalescent Hosp. v. Health Care Fin. Admin.*, Decision No. 1799, App. Div. No. A-01-54 (Dep’t of Health & Human Servs. Nov. 28, 2001), <http://www.hhs.gov/dab/decisions/dab1799.html>.

hospital without arranging for the patient to have a Farsi translator which he needed to communicate.<sup>152</sup> The facility's poor communication with the hospital, evidenced by the hospital's attempt to discharge the patient back to the nursing facility that same day, also contributed to the court's decision that discharge preparation was insufficient.<sup>153</sup>

Finally, in a highly illuminating opinion, the Massachusetts Appeals Court held that to comply with the orientation and preparation requirement, the facility's notice of discharge must present not only the location to which the resident will be discharged, but also a proposal for *safe* discharge.<sup>154</sup> In that case, Charlwell House, a skilled nursing facility, decided to discharge resident Thomas Columbo for nonpayment. Columbo, a man of ninety-seven years, had resided at Charlwell since 1993, and had several physical and cognitive impairments.<sup>155</sup> The notice of discharge, sent to Columbo's guardian with thirty days' notice, proposed release of the resident into the care of his two nephews, neither of whom had been consulted by the facility.<sup>156</sup> The facility also proposed that it would provide a week's worth of free post-discharge nursing care.<sup>157</sup> At the time of notice, however, one of the nephews to whom Columbo was discharged had been deceased for two years, and the other was seventy-one years old and already caring for two ailing family members.<sup>158</sup> The court determined that the inadequate planning set forth in the discharge notice constituted a violation of the federal regulation requiring that facilities "provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge."<sup>159</sup> The court held that to fulfill its obligation to create a "safe and orderly transfer or discharge," a nursing facility is required to "set forth its plans to accomplish that transition in its notice of discharge."<sup>160</sup> As Charlwell would have discovered had it contacted the nephew before issuing the notice, its plan to release a "completely dependent, immobile, totally incontinent, choking, psychotic, multi-stroke victim"<sup>161</sup> into the care of a deceased relative or that of an elderly nephew who already cares for two other relatives cannot be considered safe as it created a health risk for Columbo.

This case illustrates the difficulty a nursing home may have in evicting a resident for nonpayment. It would appear that in order to avoid incurring monetary penalties or even loss of Medicaid reimbursement, a facility must not only propose a new placement for the discharged resident thirty days before the transfer,<sup>162</sup> but also ensure

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152. *Kindred Nursing Ctrs. W., LLC v. Cal. Health & Human Servs. Agency*, No. D044215, 2005 WL 1460714, at \*5 (Cal. Ct. App. June 22, 2005) (unpublished opinion).

153. *Id.*

154. *See Centennial Healthcare Inv. Corp. v. Comm'r of the Div. of Med. Assistance*, No. 03-P-879, 2004 WL 2026813, at \*2 (Mass. App. Ct. Sept. 10, 2004) (unpublished opinion) (imposing regulatory obligation for safe and orderly discharge).

155. *Id.* at n.2.

156. *Id.* at \*1.

157. Appellee's Brief, *Centennial Healthcare*, No. 03-P-879, 2004 WL 2026813, 2003 WL 24890174, at \*6.

158. *Centennial Healthcare*, 2004 WL 2026813, at \*1.

159. *Id.* (citing 42 C.F.R. § 483.12(a)(7)).

160. *Id.* at \*2.

161. Appellee's Brief, *supra* note 157, at \*7.

162. *CTRS. FOR MEDICARE & MEDICAID SERVS.*, *supra* note 132, at 48; *see, e.g., In re Baxter*, SDS-D-T9208 (Or. Dep't of Human Res. July 2, 1992), summarized in 26 CLEARINGHOUSE REV. 667-68 (1992)



that the proposed placement will not be detrimental to the resident.<sup>163</sup> If the receiving facility chosen lacks the knowledge or resources the patient requires, the courts seem to place a burden on the discharging facility to fulfill those requirements.<sup>164</sup> Finding a feasible placement may be a difficult task in the case of residents who do not have known family or whose family situations would not provide appropriate environments for an elder requiring extensive care.

*b. State Regulations Governing Resident Eviction*

The federal government prescribes that each state must establish a central agency to create and administer Medicaid within the state, and that the nursing facility must at least meet the minimum standards for certification laid out in the federal regulations.<sup>165</sup> As a result, the regulations of some states include more detailed descriptions for meeting the federally imposed orientation requirement.<sup>166</sup> The regulations of Connecticut, Illinois, Wisconsin, and Missouri provide examples of the disparity among state laws.

Connecticut regulations clearly state that the discharging nursing home “shall be responsible for assisting the patient in finding *appropriate* placement,”<sup>167</sup> and forbid any discharge that is “medically contraindicated.”<sup>168</sup> Connecticut requires notice of discharge to be accompanied in most circumstances by a “discharge plan,” drawn up by either the patient’s physician, or by the facility’s medical director with input from the nursing director, social worker, or other health care provider.<sup>169</sup> When considering alternate placements, the plan must seek to minimize disruption to the resident by evaluating the desires of the resident and his or her relatives, as well as proximity of the new placement to the resident’s relatives.<sup>170</sup> The plan must state the expected effects of discharge on the patient, what will be done to minimize those effects, and what sorts of care and services the resident will receive at his or her new placement.<sup>171</sup>

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(holding nursing home had duty to retain resident since no other facility would take him due to his ability to cover only \$475 of \$2,555 monthly cost of meeting his extensive care needs); *In re Stonebraker*, 94-0074 (Cal. Dep’t of Health Servs. Dec. 22, 1993), *summarized in* 28 CLEARINGHOUSE REV. 62 (1994) (requiring nursing home readmit and maintain resident it had discharged without indicating where she would be relocated).

163. *Centennial Healthcare*, 2004 WL 2026813, at \*1.

164. See *Kindred Nursing Ctrs. W.*, 2005 WL 1460714, at \*5 (holding discharging facility must arrange for Farsi translator to assist discharged patient at new placement); *Carehouse Convalescent Hosp. v. Health Care Fin. Admin.*, Decision No. 1799, App. Div. No. A-01-54 (Dep’t of Health & Human Servs. Nov. 28, 2001), <http://www.hhs.gov/dab/decisions/dab1799.html> (finding discharging facility had fulfilled its duty when it passed on information about administration of patient’s medication to new placement).

165. 42 U.S.C. § 1396a(a)(5), (a)(28)(A) (2006). See Part II.C for information concerning federal regulations governing resident eviction.

166. See generally Kathleen Knepper, *Involuntary Transfers and Discharges of Nursing Home Residents Under Federal and State Law*, 17 J. LEGAL MED. 215, 236 (1996) (discussing differing state regulations regarding transfer and eviction of nursing home residents).

167. CONN. GEN. STAT. ANN. § 19a-535(g) (West 2003) (emphasis added).

168. *Id.* § 19a-535(f).

169. *Id.* § 19a-535(e).

170. *Id.*

171. *Id.*

Illinois's transfer and discharge procedures, in contrast to federal law,<sup>172</sup> require only twenty-one days' notice before a discharge.<sup>173</sup> However, Illinois provides a more detailed description of the nursing home's orientation duties by mandating that a facility offer the resident counseling services before discharge.<sup>174</sup> Illinois further provides assistance to discharged residents via additional orientation requirements imposed not upon the nursing homes, but rather upon the Illinois Department of Public Aid.<sup>175</sup> In advance of discharge, the Department must create a discharge plan to ensure "safe and orderly" discharge of the resident, protecting the resident's "health, safety, welfare, and rights."<sup>176</sup> Additionally, the Department is required to provide relocation assistance including information on available placements.<sup>177</sup> The resident is permitted three visits to alternative placements before discharge.<sup>178</sup>

Wisconsin provides that a resident shall not be discharged until an alternative placement is secured, and also places specific orientation obligations on the facility.<sup>179</sup> At least fourteen days prior to discharge, a facility must hold a planning conference with the resident, her guardian, appropriate county agencies, and any persons designated by the resident.<sup>180</sup> Some purposes of the conference are to assess the effect of discharge on the resident, discuss placement, and develop a "relocation plan."<sup>181</sup> The relocation plan must include plans to counsel the resident about the discharge, arrangements for the resident to visit at least one alternative placement option, assistance with moving to the new placement, and assurance that the resident will continue to receive her medications and treatments during the move.<sup>182</sup>

In contrast with states that clarify notice and orientation requirements, Missouri's transfer and discharge procedures are similar to federal law, and require thirty days' notice including the location to which the resident is being discharged.<sup>183</sup> They impose no additional "orientation" requirements.<sup>184</sup>

### III. DISCUSSION

#### A. *Likely Repercussions of the DRA*

Without proper reforms, the DRA will result in a number of problems for the nursing home industry and its consumers. Though the Act was passed in early 2006, in some states, the changes did not take effect until the states' legislatures passed enabling

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172. See *supra* notes 138–44 and accompanying text for a summary of federal law notice requirements.

173. ILL. ADMIN. CODE tit. 77, § 300.3300(d) (2009).

174. *Id.* § 300.3300(k).

175. See *id.* § 300.3300(s), (t) (outlining various assistance requirements upon discharge).

176. *Id.* § 300.3300(t).

177. *Id.* § 300.3300(s).

178. *Id.*

179. WIS. ADMIN. CODE DHS § 134.53 (2009).

180. *Id.* § 134.53(4)(a).

181. *Id.* § 134.53(4)(c)(2).

182. *Id.* § 134.53(4)(c)(3).

183. MO. CODE REGS. ANN. tit. 19, § 30-82.050(4)(B) (2008).

184. *Id.*

legislation.<sup>185</sup> Therefore in many instances, the DRA did not go into effect until significantly after the Act was passed.<sup>186</sup> As a result of the Act's recency, the full extent of its effects are still unknown. Nevertheless, its potential problems are apparent.

In light of the reported rise in complaints before 2006 of what were likely financially motivated evictions,<sup>187</sup> the increased likelihood of transfer trauma affecting those evicted under the penalty period,<sup>188</sup> and the financial stress that the DRA may place on nursing homes,<sup>189</sup> proper legislative safeguards should be put in place to protect the elderly from involuntary discharge practices that may result in transfer trauma. At the same time, successful solicitation of hardship waivers by nursing homes should be made feasible in order to protect the industry in cases where tightened discharge restrictions result in retention of a nonpaying resident.

### 1. Repercussions for Individuals

When considering the potential effects of the DRA on individuals, it is important to keep in mind the massive number of elders whose lives will be impacted by this legislation due to the aging of the population as a whole.<sup>190</sup> For many of these individuals, planning for the high cost of long-term care presents a difficulty,<sup>191</sup> which will only be exacerbated by the new restrictive provisions of the DRA. The DRA leaves fewer tools available for care planning.<sup>192</sup> Successful use of advance asset transfers following the DRA is limited by the reality that the start date and extent of care required are impossible to definitively predict five years in advance of need.<sup>193</sup> Furthermore, in order to employ effective preservation of wealth, the new rules encourage elders to protect assets by passing them to family members at the expense of impoverishment and dependence upon others for support long before the need for care is on the horizon.<sup>194</sup>

The DRA's harsh new look-back provision will result in more denials of Medicaid coverage.<sup>195</sup> This may be the case even for those not intending to employ Medicaid planning techniques. For instance, a Massachusetts study indicates that in recent years

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185. Uncle Sam Tightens Noose on Long Term Care: The Deficit Reduction Act of 2005, <http://www.prepsmart.com/medicaid-dra2005.html> (last visited Oct. 1, 2010).

186. See *supra* note 9 for dates of implementation of the DRA in several states.

187. See Francis, *supra* note 78 (reporting that 8,500 complaints were received concerning nursing home discharge practices in 2006 and suggesting increase is likely due to financial motivations of nursing homes).

188. See *infra* text accompanying notes 202–05 for an analysis of why those evicted under the penalty period are more likely to suffer from transfer trauma.

189. See *infra* Part III.A.2 for a discussion of projected consequences of the DRA for nursing facilities.

190. See *supra* Part II.B for projections concerning the population's age and need for long-term care.

191. See *supra* Part II.B.1 for a discussion of the costs associated with nursing home care and Medicaid planning techniques developed to meet the financial burden.

192. See *supra* note 76 and accompanying text for tools left available for long-term care planning following the DRA.

193. The new look-back period for asset transfers at less than fair-market value is five years. Chalgian & Tripp, *supra* note 37.

194. See *supra* Part II.B.1 for a discussion of new difficulties in long-term care planning.

195. *The Deficit Reduction Act of 2005: Congress Targets Beneficiaries for Cuts*, HEALTH ADVOC. (Nat'l Health Law Program, Los Angeles, Cal.), Spring 2006, at 1, 7, available at <http://www.healthlaw.org/images/stories/issues/newsletter.062306.pdf>.

it has been more difficult for individuals to rebut the presumption that their asset transfers were made for purposes other than to qualify for Medicaid.<sup>196</sup> Thus, even individuals who transfer funds for legitimate purposes may have difficulty rebutting the presumption. Meanwhile, by expanding the look-back period, the DRA makes it more difficult for an elder to foresee whether long-term care will be needed within that period at the time a gift is made. Therefore, penalty periods may be imposed on elders who innocently gave gifts to family members or made donations to churches and charities before their health deteriorated.<sup>197</sup>

A potential result, and serious concern, arising from a foreseeable increase in penalty periods will be residents' inability to pay their nursing homes. The DRA's critics have already begun to speculate that the DRA will result in increased improper discharge of nursing home residents who are unable to pay.<sup>198</sup> When private funds are exhausted, and no family members are willing or available to cover a resident's costs, Medicaid ineligibility may result in a nursing home's attempt to evict the resident.<sup>199</sup> This potential increase in evictions raises the problematic issue of transfer trauma.<sup>200</sup> Transfer trauma may be especially likely to result from discharges made for nonpayment due to ineligibility under Medicaid penalty periods because such situations implicate several transfer trauma risk factors. First, researchers have determined that involuntary transfer or discharge is more likely to result in transfer trauma than voluntary transfer or discharge.<sup>201</sup> Presumably, an individual being discharged for inability to pay would prefer to remain in the facility and pay her bills if able, and thus the discharge suffered is involuntary. A resident being discharged for nonpayment during the penalty period moves not because she wants to, but because neither the resident, the government, nor the resident's family members are assuming financial responsibility for the resident's care.

Second, an individual evicted on account of nonpayment as a result of the DRA's penalty period may experience a diminished internal locus of control and sense of control over the move. Internal locus of control and a sense of control over the discharge or transfer are essential to the well-being of the elderly, and to mitigating the effects of transfer trauma,<sup>202</sup> and both are compromised when an individual feels that fate, luck, or other outside forces, rather than the individual's own actions, factor prominently in an outcome.<sup>203</sup> When a discharge is involuntary, and a resident is unable

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196. Brisk & MacPherson, *supra* note 69, at 92.

197. *Id.*

198. See *The Deficit Reduction Act of 2005: Congress Targets Beneficiaries for Cuts*, *supra* note 195, at 8–10 (predicting increase in penalty periods imposed against residents which will result in increase in lawsuits against nursing homes for improper discharge).

199. See *Centennial Healthcare Inv. Corp. v. Comm'r of the Div. of Med. Assistance*, No. 03-P-879, 2004 WL 2026813, at \*1 (Mass. App. Ct. June 16, 2004) (concerning implications of nursing home's attempt to evict resident when his guardian ceased making payments).

200. Transfer trauma refers to the detrimental health effects brought on by stress of relocation. See *supra* Part II.B.2 for a discussion of transfer trauma research.

201. Bourestom & Pastalan, *supra* note 87, at 5.

202. See *supra* text accompanying notes 86–92, which explains that internal locus of control is vital to the health of the elderly. See also Robert, *supra* note 86, at 760 (describing control as one mechanism for mitigating transfer trauma following involuntary transfer).

203. Bratteli, *supra* note 79, at 92.

to pay, a resident will feel helpless and reliant upon external factors. In contrast, a resident's sense of control over a move is increased when the resident is given options that meet his or her needs and given decision-making power in the process.<sup>204</sup> For a Medicaid-eligible resident with no ability to pay her bills, however, alternative placements (and therefore options and opportunities to choose among them), may be severely limited. Besides the loss of control inherent in being discharged involuntarily, residents who face eviction from nursing facilities for nonpayment face the lack of control that comes with being impoverished. Some residents facing the penalty period may have transferred a small amount of their wealth and have since spent down their assets to the point of qualifying for Medicaid, while others may have relinquished their assets to family members or others as many as five years or more before the discharge. Abandonment of control over personal matters such as one's finances is a loss that leads to detrimental feelings of lack of control.<sup>205</sup>

## 2. Repercussions for the Nursing Home Industry

Some have speculated that the DRA will result in financial difficulties for nursing homes.<sup>206</sup> The new legislation seems to assume that when an institutionalized individual faces a penalty period for having transferred assets, the transferee will step in and pay for the cost of care.<sup>207</sup> This becomes problematic when the transferee does not take responsibility for the elder's care bills. Considering the imminence of this scenario, the difficulty that nursing homes have discharging residents under the federal regulations, and the fact that the DRA transfers the duty to pay for uncompensated care from the government to the long-term care industry, the DRA's characterization by critics as the Nursing Home Bankruptcy Act<sup>208</sup> seems fitting.

### B. Proposed Solutions

The DRA's potential negative impact on nursing homes and elders can be mitigated through the implementation of several changes. First, individuals and their attorneys should minimize use of financial planning techniques that would be likely to result in imposition of a penalty period.<sup>209</sup> Second, federal legislation governing resident discharge should impose new restrictions to combat transfer trauma, therefore protecting residents against the negative effects of an anticipated increase in discharge rates.<sup>210</sup> Finally, requirements for attaining hardship waivers should be revamped in

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204. Robert, *supra* note 86, at 760.

205. Bratteli, *supra* note 79, at 92.

206. See *The Deficit Reduction Act of 2005: Congress Targets Beneficiaries for Cuts*, *supra* note 195, at 8, 9–10 (predicting hardship to nursing home industry will be more likely than hardship to residents).

207. See O'Brien, *supra* note 74, at 40 (quoting Massachusetts attorney opining that “[a]pparently, the government expects that the person to whom the gift was made will pay for . . . care in the nursing home”).

208. *Id.* See *supra* note 109 and accompanying text for information regarding an influx in industry Chapter 11 filings occurring shortly before the passage of the Act.

209. See *supra* notes 64–66 and accompanying text for a discussion of Medicaid planning techniques.

210. See *supra* notes 196–99 and accompanying text for a forecast regarding increased nonpayment and discharge in the wake of DRA implementation.

order to protect the nursing home industry from financial ruin stemming from inability to find suitable alternative placements for nonpaying residents.<sup>211</sup>

### 1. Adopting Alternative Care Planning Techniques

Due to the potentially disastrous results of the new look-back provision and penalty period start-date to both the nursing home industry and to individuals, asset transfer should no longer be advocated as a Medicaid planning technique. Instead, seniors should take advantage of annuities and long-term care partnership programs.<sup>212</sup> Of course the inadvisability of the asset transfer strategy cannot be expected to deter well-intentioned gift giving, or persistent attempts at Medicaid planning by those who are in good health at the time of transfer, but suffer an unanticipated deterioration of health within the elongated look-back period. Therefore, to counteract the effects of the DRA,<sup>213</sup> additional steps must be taken.

### 2. Amending Federal Residents' Rights Legislation to Protect the Individual from Transfer Trauma

Attempted discharge should be the first step when a resident faces the penalty period and is unable to pay. Clearly, it is in the best interests of a facility to discharge residents who are not paying their bills. It is also fairer to taxpayers, and in most cases consistent with the DRA's purpose of cutting federal spending by refusing to lend Medicaid dollars to those who would have been able to pay for their own care,<sup>214</sup> to require such individuals to be transferred to placements where they receive care without the need for Medicaid.

Current federal regulation of involuntary discharge addresses some of the causative factors of transfer trauma. Federal regulations require a facility to provide residents with thirty days' notice of the discharge and orientation services.<sup>215</sup> First, notice requires a clear<sup>216</sup> communication of the reason for the discharge, the discharge date, and the safe location to which the resident is being discharged.<sup>217</sup> The facility must also advise the resident of her right to appeal the discharge and provide contact information for relevant agencies.<sup>218</sup> Additionally, the regulations have been interpreted to require safe transportation to the new placement.<sup>219</sup> When possible, a facility must "actively involve . . . the resident and [her] family" members in the selection of an

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211. See *supra* text accompanying notes 163–65 for the conclusion that the transferring facility owns the burden of finding a suitable alternative placement, and Part II.C.2 for a discussion of hardship waivers and their current shortcomings.

212. See FELDMAN, *supra* note 6, at 252 (discussing alternative Medicaid planning techniques).

213. See *supra* Part II.B for predictions of the effects of the DRA for individuals and the nursing industry.

214. See FELDMAN, *supra* note 6, at 242–43 (discussing intent of DRA to prevent "Medicaid planning" techniques perceived by some as "gaming the system").

215. 42 C.F.R. § 483.12(a)(4), (5), (7) (2009).

216. *Id.* § 483.12(a)(4)(i).

217. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 132, at 47. See *supra* notes 154–62 and accompanying text for elaboration of the requirement that the notice contain a plan for safe discharge.

218. 42 C.F.R. § 483.12(a)(6).

219. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 132, at 48.

alternative placement.<sup>220</sup> The Operations Manual suggests that to comply with orientation requirements, facilities might allow the resident to visit the new placement when feasible, work with family to assure the resident's possessions are moved, provide the new facility with information about the resident's routine, train staff in conducting discharges to minimize adverse reactions, and train staff to recognize those adverse reactions.<sup>221</sup> According to research on transfer trauma, however, the current regulations and guidelines may not go far enough to mitigate the stress of a move.<sup>222</sup> The following changes to federal discharge regulations would help to alleviate the effects of transfer trauma.

*a. Facilitating Social Networking*

While the federal regulations do provide a number of safeguards for discharged residents, some causes of transfer trauma are ignored or not addressed to the extent possible. First, researchers have found that the loss of the social network established in the old nursing facility can contribute to distress and diminished long-term survival for a discharged resident.<sup>223</sup> The federal regulations and accompanying guidelines are primarily forward-looking, concentrating on preparing residents for their futures in the new placements, and ignore the prospect of facilitating continuing relationships between a discharged resident and the residents and staff members who remain at the facility.<sup>224</sup> This may be an oversight, or it may be a choice made after balancing the interests of the resident with those of the discharging facility. It would be economically detrimental to require that a facility attempting to cut responsibility for expensive care to a nonpaying resident provide continuing service to the resident, or provide the resident with the means to visit her former social network.<sup>225</sup> If, however, researchers are correct in asserting that loss of social networks is a contributor to transfer trauma,<sup>226</sup> then programs for maintaining old social networks or infiltrating new ones should be provided by the discharging facility. This duty can be read into the court decisions requiring the discharging facility to provide resources that the new placement lacks in order to facilitate safe transfer of the discharged patient.<sup>227</sup> If a severing of social networks results in safety concerns for the resident, as researchers posit it may,<sup>228</sup> the discharging facility has a continuing responsibility in this arena in order to guarantee resident safety.

Loss of social networks can be somewhat mitigated by incorporating Connecticut's requirement that the decision regarding the resident's new placement

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220. *Id.*

221. *Id.* at 48–49.

222. See *supra* notes 82–102 and accompanying text for a discussion of the causative and mitigating factors of transfer trauma.

223. See Bratteli, *supra* note 79, at 89 (discussing studies showing link between intactness of resident's support system and her life expectancy and quality of living).

224. 42 C.F.R. § 483.12 (2009).

225. See *supra* notes 104–09 and accompanying text for a discussion of the already precarious financial position of the nursing home industry.

226. Bratteli, *supra* note 79, at 89.

227. See *supra* note 165 and accompanying text for decisions imposing such a duty on the discharging facility.

228. See Bratteli, *supra* note 79, at 89 (discussing potential risk of severing social networks).

consider proximity to family members,<sup>229</sup> which should at least increase the odds of the resident retaining support from family during the move. When a resident faces a Medicaid penalty period, however, discharge only occurs if nobody pays the resident's bills.<sup>230</sup> Although in some cases the resident's family may simply be unable to pay the high cost of care,<sup>231</sup> in others the resident may have no family, or the resident may be estranged from her family. To benefit residents, particularly in these cases, the regulation might be expanded to include consideration of proximity to the old facility as well, therefore potentially increasing the likelihood of preservation of ties to both family members (if available) and to the resident's old social network. Additionally, the discharging facility might assist the discharged resident in compiling the phone numbers of friends who will be left behind. Requiring that the nursing home provide more extensive services, such as facilitating visits or interaction with staff members after the resident has been moved, may be prohibitively costly and intrusive upon a facility that receives no remuneration for services tendered to the resident.

*b. Maximizing Resident Control*

Second, maximization of control is somewhat addressed by the federal regulations. Research indicates that control is maximized by offering residents options that suit their needs and allowing them to make decisions on their own.<sup>232</sup> Moving the resident at the same time as all of her belongings also maximizes the resident's feelings of control.<sup>233</sup> The aforementioned Operations Manual suggests that a facility must assist the resident in moving her belongings.<sup>234</sup> Furthermore, the Manual provides that a facility must involve the resident and her family in the selection of the new placement whenever possible,<sup>235</sup> and include the new placement in the discharge notice.<sup>236</sup> These requirements are beneficial to the resident in that they encourage the resident to be an active decision maker in the selection of her new placement. The regulations clearly place a burden on the facility to identify and present the resident with at least one new proposed placement in order to have something to include in the discharge notice.<sup>237</sup> However, it is not clear that the facility is required to identify more than one potential placement, thereby giving the resident a meaningful choice and leading to greater control. In order to maximize the patient's control, federal regulations should require the discharging facility to provide the patient with more than one acceptable alternative placement whenever possible.

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229. CONN. GEN. STAT. ANN. § 19a-535(e) (West 2003).

230. See 42 C.F.R. § 483.12(a)(2) (2009) (setting out very narrow instances where resident may be discharged, including nonpayment).

231. Recall, a private room in a nursing home costs \$213 a day on average. *Private and Semi-Private Nursing Home Room Rates Increase 3% in 2007*, *supra* note 63.

232. Robert, *supra* note 86, at 760.

233. *Id.* at 760–61.

234. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 132, at 48–49. See *supra* note 216–22 and accompanying text for a discussion of the Operations Manual and its interpretation of the federal regulations for involuntary discharge.

235. *Id.* at 48.

236. *Id.*

237. *Id.*



c. *Maximizing Predictability*

A third transfer trauma mitigation technique, the maximization of predictability,<sup>238</sup> is also somewhat addressed by the regulations. Predictability is increased by taking steps to familiarize the resident with the new facility, providing notification of the discharge, and otherwise reducing fear of the unknown.<sup>239</sup> The Manual suggests that facilities can comply with the federal orientation requirement in part by providing the resident with visits to the new facility.<sup>240</sup> The regulations also provide the resident with thirty days' notice.<sup>241</sup> According to Janet Robert, such steps would serve to enhance predictability.<sup>242</sup>

Illinois improves upon maximization of predictability. In Illinois, the Department of Public Aid is required to provide relocation assistance including information on available placements, and the resident is permitted three visits to alternative placements before discharge.<sup>243</sup> Because predictability is maximized when the resident is familiarized with the new facility,<sup>244</sup> the specific Illinois requirements may be preferable in that respect. Similar to Illinois's regulations,<sup>245</sup> Wisconsin increases predictability by requiring that a resident be able to visit at least one alternative placement option.<sup>246</sup>

The federal regulations should be amended to increase predictability. Considering the severity of the potential consequences to a crudely discharged resident, the Manual's guidelines stating that "orientation may include" visits to potential new placements<sup>247</sup> are weakly worded. Compliance with this important suggestion may be increased if it were more forcefully worded and incorporated into the resident's rights regulations. The Illinois and Wisconsin statutes, which require three visits and at least one visit respectively,<sup>248</sup> provide excellent examples which may be incorporated into the federal legislation. As an alternative, when a visit is truly undesired by the resident, impractical economically, or detrimental to the resident's well-being, the resident's rights legislation could require provision of other specific types of information on the new placements, which would serve to dispel "fear of the unknown."<sup>249</sup>

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238. See Robert, *supra* note 86, at 760 (identifying control and predictability as two effective mitigation techniques for adverse effects of involuntary transfer).

239. *Id.* at 761.

240. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 132, at 48.

241. 42 C.F.R. § 483.12(a)(5) (2009).

242. Robert, *supra* note 86, at 760–61.

243. ILL. ADMIN. CODE tit. 77, § 300.3300(s) (2009).

244. Robert, *supra* note 86, at 761.

245. ILL. ADMIN. CODE tit. 77, § 300.3300(s).

246. WIS. ADMIN. CODE DHS 134.53(c) (2009).

247. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 132, at 48.

248. ILL. ADMIN. CODE tit. 77, § 300.3300(s); WIS. ADMIN. CODE HFS § 134.53(c) (2009).

249. Robert, *supra* note 86, at 761.

Additionally, lengthening the notice requirement from thirty days' notice to allow more time would improve predictability for the resident,<sup>250</sup> and is an option that should be considered as research in the area develops.

*d. Minimizing Negative Effects of Individual Characteristics*

To counter the role an individual's characteristics play in transfer trauma,<sup>251</sup> the Manual recommends that staff be trained to monitor a resident for negative reactions to the discharge.<sup>252</sup> Regulations do not attempt to ensure that the resident views the new environment as stable and enduring, a factor which could increase her belief in her ability to adapt, and therefore improve her outcome in the new facility.<sup>253</sup>

Wisconsin's requirement that a relocation plan be developed to make arrangements to counsel the resident about the discharge<sup>254</sup> may assist in alleviating and identifying personal traits such as anxiety, depression, and anger which are indicative of increased likelihood of mortality following a discharge.<sup>255</sup> Additionally, Connecticut's discharge plan requirement generally, though not with much specificity, addresses the role the individual's characteristics have on transfer trauma by requiring determination of the expected effects of discharge on the particular patient, and what will be done to minimize those effects.<sup>256</sup> This requirement could be effective if the patient's health care provider required to draw up the plan<sup>257</sup> is familiar with the patient's characteristics as well as with the suspected causes of transfer trauma.<sup>258</sup>

In addition to providing for diligent monitoring of a patient for negative effects of stress, federal regulations should also require a plan for counseling the resident, particularly when indicators of susceptibility to transfer trauma have been detected.<sup>259</sup>

*e. Considering Characteristics of the New Placement*

Finally, the federal regulations consider only some aspects of the new facility itself which may contribute to transfer trauma. The regulations require that the new

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250. See Krause, *supra* note 81, at 61, 66 (suggesting physical effects of stressful experience to elderly individuals may take more than sixteen months to subside); Robert, *supra* note 86, at 761 (stating that providing notice increases predictability).

251. See Bourestom & Pastalan, *supra* note 87, at 5–6 (discussing evidence supporting claim that individual characteristics play role in relocation outcomes).

252. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 132, at 49.

253. See Ekström, *supra* note 100, at 383 (positing security and trust in new environment requires that environment appear stable and enduring).

254. WIS. ADMIN. CODE DHS § 134.53(c) (2009).

255. Levitan, *supra* note 81, at 655–56.

256. CONN. GEN. STAT. § 19a-535(e) (2008).

257. *Id.* Such health care providers may include the patient's physician, or the facility's medical director, nursing director, or social worker. *Id.*

258. See *supra* Part II.B.2 for a review of available literature discussing suspected causes of transfer trauma.

259. See *supra* text accompanying notes 95–100 for a list of traits indicating an individual is prone to adverse affects of transfer trauma.

placement be safe for the resident,<sup>260</sup> but they do not consider the important factors of whether the formal and informal social structures of the facility will be easy for the resident to infiltrate.<sup>261</sup>

In many cases, a resident facing the penalty period may be discharged to a family member's home rather than transferred to another facility.<sup>262</sup> However, in such cases where the resident is moved to a different facility,<sup>263</sup> further steps may be taken to decrease the negative effects of inability to adjust to formal and informal social structures within the new placement. In order to increase likelihood of a good social fit, the regulations could require consideration of similarity between residents' routines and level of care required by residents at each facility.<sup>264</sup> The transferring facility could work in conjunction with potential placement facilities to determine where a resident might fit in best.

### 3. Retooling Hardship Waivers to Protect Nursing Homes from Anticipated Financial Difficulty

Tight discharge regulations required to mitigate transfer trauma would place significant burdens on nursing homes when there are truly no acceptable alternative placements for a resident facing a DRA penalty period.<sup>265</sup> In order to protect the financial solvency of the nursing home industry,<sup>266</sup> as well as avoid creating incentives to cut corners on the quality of care,<sup>267</sup> a comprehensive solution must provide a safety valve for nursing homes that are unable to discharge a nonpaying resident.

In order to comply with the purpose of the DRA,<sup>268</sup> attempted transfer or discharge should be a facility's first step when a resident faces a penalty period and no alternative method of payment is apparent.<sup>269</sup> However, in some circumstances,

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260. See *Centennial Healthcare Inv. Corp. v. Comm'r of the Div. of Med. Assistance*, No. 03-P-879, 2004 WL 2026813, at \*1 (Mass. App. Ct. Sept. 10, 2004) (citing 42 C.F.R. § 483.12(a)(7) (2009)) (finding federal regulation requiring safe transfer forbade transfer to unsafe location).

261. See Bratteli, *supra* note 79, at 98 (discussing impact of social structures on institutionalized elderly).

262. See, e.g., *Centennial Healthcare*, 2004 WL 2026813, at \*1 (addressing discharge of patient into nephews' care); *Carehouse Convalescent Hosp. v. Health Care Fin. Admin.*, No. 1799, App. Div. No. A-01-54 (Dep't of Health & Human Servs. Nov. 28, 2001), <http://www.hhs.gov/dab/decisions/dab1799.html> (addressing discharge of patient into wife's care).

263. "'Transfer' is moving the resident from the facility to another legally responsible institutional setting." CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 132, at 42.

264. See Bratteli, *supra* note 79, at 98 (identifying formal and informal social structures of receiving facility as instrumental in causing transfer trauma).

265. See *supra* Part II.C.1 for a discussion of consequences to nursing homes as a result of retaining a nonpaying resident.

266. See *supra* text accompanying notes 104–09 for a discussion of financial pressure facing the industry.

267. See *supra* text accompanying note 116, indicating that nursing homes have skimmed on quality to protect their bottom lines.

268. One purpose of the DRA is to hold the middle class accountable for the cost of its long-term care. FELDMAN, *supra* note 6, at 242.

269. See *supra* Part II.C.3 for a discussion of the discharge process.

feasible alternative placements may not be clearly available.<sup>270</sup> The second course of action most consistent with the DRA's purpose would be a requirement that a facility bring a civil action against the offspring-transferee under filial responsibility statutes in states where the remedy exists.<sup>271</sup> Though enforcement of these statutes may raise concerns for adult children in the thirty states where they are enacted, the adult child should still be able to rebut the presumption that the asset transfer was made for purposes of qualifying for Medicaid, and therefore refute the validity of the penalty period.<sup>272</sup>

This solution has limitations. Not every state has the required filial responsibility legislation, litigation can be costly and lengthy, transferred assets may already have been depleted, or assets may have been transferred to someone other than a child. Retooling access requirements for hardship waivers to make their attainment feasible and not merely theoretical will serve to protect both the residents' health and safety as well as the nursing home's financial interests. The first obstacle in using hardship waivers to protect nursing homes in these situations is that the language of the DRA indicates that waivers only consider the hardships faced by the resident, not by the nursing home.<sup>273</sup> The provisions require an individual to face deprivation of medical care that would endanger life or health, or otherwise deprive the resident of "food, clothing, shelter, or other necessities of life" before receiving a hardship waiver.<sup>274</sup> If residents' rights regulations work as designed, however, an individual would never be eligible for a hardship waiver.<sup>275</sup> Federal regulations require a nursing home to retain a resident unless it finds a suitable placement.<sup>276</sup> Therefore, if no suitable new placement exists, a facility would be unable to discharge the resident.<sup>277</sup> As long as facilities comply with these restrictive transfer and discharge regulations, a penalty period

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270. See, e.g., *Centennial Healthcare Inv. Corp. v. Comm'r of the Div. of Med. Assistance*, No. 03-P-879, 2004 WL 2026813, at \*2 (Mass. App. Ct. Sept. 10, 2004) (finding against facility whose two alternative placement suggestions were deemed inappropriate). Additionally, the limited universe of acceptable alternative placements for a particular resident is likely to further contract when the additional considerations of severance of social ties and ease of social adaptation are considered. See *supra* Parts III.B.2.a and III.B.2.e for a discussion of characteristics of an alternative placement that make it less likely to create transfer trauma in the resident.

271. See *supra* notes 113–14 and accompanying text for information concerning filial responsibility laws.

272. See 42 U.S.C. §§ 1396p(c)(2)(C)(i)–(ii) (Supp. II 2010) (enumerating methods for challenging rebuttable presumption that asset transfer at less than fair market value was for purposes of qualifying for Medicaid). Of course, there is also a debate as to whether nursing homes will or should begin to enforce the filial responsibility statutes against any adult children, regardless of to whom the asset transfer was made. See Allison E. Ross, Note, *Taking Care of Our Caretakers: Using Filial Responsibility Law to Support the Elderly Beyond the Government's Assistance*, 16 *ELDER L.J.* 167, 185–90 (2008) (providing several arguments in favor of enforcing often ignored filial responsibility laws).

273. See 42 U.S.C. § 1396p(c)(2)(D) (discussing application for hardship waiver by facility on behalf of individual).

274. *Id.* § 1396p, note (Availability of Hardship Waivers).

275. See ElderLawAnswers.com, *The Impending Medicaid Transfer Rule Changes: An Analysis*, <http://www.elderlawanswers.com/resources/ArticleAtty.asp?id=5141&section=3&state=> (last visited Oct. 1, 2010) (explaining there may be no hardship to resident if facility is unable to evict).

276. *CTRS. FOR MEDICARE & MEDICAID SERVS.*, *supra* note 132, at 47.

277. See *supra* note 163 for examples of cases requiring nursing homes to retain residents when no suitable alternative placement was offered.

should never put a resident in the perilous circumstance contemplated by the hardship waiver requirements. Given this analysis, it is not surprising that hardship waivers are rarely granted.<sup>278</sup> To overcome this obstacle, hardship waivers should be granted to patients when a nursing home can make a showing that no suitable alternate placement exists—in other words, that the facility is required to retain the patient, and that but for that retention, the patient would suffer the deprivations outlined in the code. By removing the economic burden a facility would take on by retaining a nonpaying resident, adoption of this proposal would allow a facility to afford more weight to a resident's best interests rather than its own financial motives when considering a potentially dangerous discharge.

The hardship waiver process has been criticized as too scant to evaluate a resident's entire support network for the duration of the penalty period in order to accurately predict whether an individual would truly face deprivation in the absence of a waiver.<sup>279</sup> This criticism becomes moot, however, when a nursing home applies for a hardship waiver on a resident's behalf, since in many cases the nursing home may actually prefer to discharge the resident rather than retain her while collecting Medicaid reimbursement.<sup>280</sup> Though the process required to discharge a resident would result in considerable expense, on average, nursing homes lose money on each Medicaid patient daily.<sup>281</sup> Therefore, in many cases, the nursing home would have the motivation to perform a diligent search for an alternative placement before seeking the waiver.

#### IV. CONCLUSION

The Deficit Reduction Act of 2005<sup>282</sup> is poised to place some strain on the nursing home industry's bottom line and to jeopardize the living situations and health of American seniors.<sup>283</sup> As the demand for long-term care increases,<sup>284</sup> and as time passes since the DRA's implementation, the extent of the Act's fallout will become increasingly apparent. A three-step plan, if implemented, will protect the health of the residents and the financial stability of the nursing home industry while remaining true to the DRA's objective of holding the middle class responsible for the costs of its own care.<sup>285</sup>

First, individuals and their attorneys must recognize that the DRA's longer look-back period and amended penalty period start-date are more likely to subject individuals to untimely penalty periods and evictions when asset transfer for less than

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278. See *Proposed Changes to Medicaid Transfer of Asset Rules from the Budget Reconciliation Conference Report*, *supra* note 119, at 2 (explaining reasons why hardship waivers rarely granted).

279. See *supra* text accompany notes 119–27 for a discussion of criticisms of the hardship waiver process.

280. See *supra* note 107 and accompanying text describing the shortfall of Medicaid reimbursement.

281. ELJAY, LLC, A REPORT ON SHORTFALLS IN MEDICAID FUNDING FOR NURSING HOME CARE, at ii (2008), [http://www.ahcancal.org/research\\_data/funding/Documents/2008%20Medicaid%20Shortfall%20Report.pdf](http://www.ahcancal.org/research_data/funding/Documents/2008%20Medicaid%20Shortfall%20Report.pdf).

282. Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006).

283. See *supra* Part III.A for an argument that the DRA will have serious repercussions on both individual consumers and the long-term care industry.

284. U.S. GEN. ACCOUNTING OFFICE, *supra* note 7, at 8.

285. See FELDMAN, *supra* note 6, at 242 (interpreting Congress's intent as avoiding taxpayer responsibility for middle-class long-term care).

fair market value is employed as a Medicaid planning technique.<sup>286</sup> In order to minimize the likelihood of incurring a penalty period and resultant eviction for nonpayment, individuals and their attorneys need to make use of more advisable planning techniques, such as use of annuities and partnership programs.<sup>287</sup>

Second, the above suggestion may not always be heeded, and innocent gift-giving will continue to be presumed to be disqualifying. Therefore, legislative protection is still needed to safeguard residents from the effects of transfer trauma—health risks developing after transfer or discharge of an elderly resident.<sup>288</sup> To protect the individual, residents' rights regulations, which restrict nursing facilities' ability to transfer and discharge residents, should be tightened in accordance with our understanding of the causative factors of transfer trauma.<sup>289</sup>

Finally, because enacting increased protections against discharge or transfer for a nonpaying resident will necessarily result in a financial burden for the retaining facility, a safety valve must be developed for the industry. A facility retaining a Medicaid-ineligible, nonpaying resident should be permitted to apply for a hardship waiver to receive Medicaid funds on the disqualified resident's behalf upon a showing that other legal options for discharge or payment have been exhausted and that but for the retention, the patient would suffer deprivations of "food, clothing, shelter, or other necessities of life."<sup>290</sup> Making these three practical and legislative changes will mitigate the coverage restrictions imposed by the DRA, while protecting taxpayers and consumers, and stabilizing an industry of growing importance<sup>291</sup> in our nation.

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286. See *supra* part III.A.1 which argues that the DRA will result in a greater number of penalty periods and evictions.

287. See FELDMAN *supra* note 6, at 257–58 (describing alternate planning opportunities which survive DRA).

288. See *supra* Part II.B.2 for a discussion of transfer trauma and its causative factors.

289. See *supra* Part III.B.2 for a discussion of specific suggestions of portions of the federal residents' rights regulations that should be amended to mitigate transfer trauma and suggested portions of state regulations that may be used as a guide.

290. 42 U.S.C. § 1396p (Supp. II 2010). See *supra* Part III.B.3 for a discussion of suggested revisions to hardship waiver requirements in order to make them attainable as a practical matter.

291. See *supra* note 52 and accompanying text for projections of increasing reliance on the long-term care industry.

