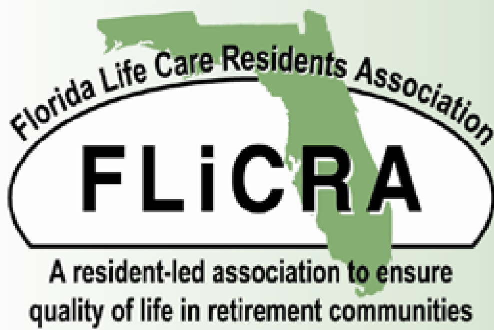

The Resident CONNECTION

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"A Resident-Led Association to Ensure Quallity of Life in Retirement Communities"

President's Message

We have pride in what has been accomplished in this first year of FLiCRA's next 25 years. We begin with a positive outlook as we move forward, fully appreciating the trust and confidence our members rightfully place in FLiCRA.

For 26 years, FLiCRA has endeavored to maintain this success through demonstrating a clear mission that is understood by our members in continuing care retirement communities (CCRCs). FLiCRA makes clear to the state legislators and regulating agencies our mission to promote and protect the rights of CCRC residents. This position of strength and respect paid off again with the successful adoption in the 2015 Legislative Session of our FLiCRA/ LeadingAge-sponsored omnibus bills.

Positive comments have been coming in on the overall success of the FLiCRA 2015 Annual Meeting in November. The agenda focused on issues of concern to members, first, from the informative address by Professor Katherine Pearson, noted authority on elder law, who also teaches courses on nonprofit organizations law; and concluding with the presentation by Executive Director Bennett Napier with an outlook on the 2016 Florida Legislative Session ahead. FLiCRA has already begun tracking bills filed to date.

Following the impact on membership of the effects on CCRC occupancy from the economic downturn lasting several years, FLiCRA has recovered membership numbers and is on a sound fiscal basis as shown in our financial reports.

The Board of Directors is aware of reports that there are some CCRCs still in recovery mode with some still experiencing financial difficulties. Analyses of these situations opens the possibility of the need for measures to address the ongoing issues. In spite of the bills just passed that amended Chapter 651, Florida Statutes (the law that regulates CCRCs), every eventuality couldn't be predicted during the drafting of these important protective measures.

This means the Board will follow through with the realistic planning needed for any action to take place. We can begin to open discussions during this time when problems have become perceptible and, where possible, before they reach crisis proportions. The positions of LeadingAge, the provider organization, and the Office of Insurance Regulation should be taken into consideration. FLiCRA's experience has shown the value of employing a strategy of collaboration and the logic of collective action before initiating a process with the legislative body. A start date of January 12 for the 2016 Legislative Session makes it unlikely for bills in this regard to be filed until the 2017 Legislative Session.

Such timing, however, does provide the Board with more ability to address practical reasons for the timing of action or inaction, and by all means to allow data, facts, and logic to dictate any decisions. Some language to be introduced in any new bills could be based on the awaited resolution of a case now moving through the courts. More than a few residents have voiced a need to address ways for CCRC regulations to “have more teeth” concerning enforcement.

We are positive we can navigate the challenges in the year and years ahead. As a mission-driven association, we want the emphasis to stay on the mission with the outcomes that can show the value received.

Pat Arends, FLiCRA President

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Are You "Good to Go"

Oak Hammock at the University of Florida residents regularly help neighbors, who have become family, probably the same as in your CCRC. One significant situation that comes up after the death of a spouse; the surviving spouse is in distress and essentially lost not knowing what to do. They do not know where to find necessary documents, passwords, access to financial records, required contacts, etc. The deceased spouse had taken care of EVERYTHING. There are also instances when the second spouse has passed and completely uninformed family members arrive, not knowing last wishes for the deceased and find they are unable to access the apartment and have no record of safe deposit boxes or financial accounts.

For several years we have been creating memos and worksheets designed to help fellow residents and their families prepare for incapacitation or death. We are pleased to invite all FLiCRA CCRC residents to view our work and encourage you to visit the Oak Hammock Residents Website at infoh.us or go directly to the documents at **http://infoh.us/good-to-go-documents** - no password required. This material is not confidential and includes disclaimers relative to consulting a financial advisor and an attorney. All of our documents are in Word and PDF formats and are editable. Some of the most popular worksheets that have been distributed are:

- My Wishes for the Final Celebration
- Summary of Assets
- Are You Ready Checklist
- Safe Deposit Box Inventory
- Automatic Deposits
- Online Accounts Inventory

Hopefully all can realize the value of being "Good to Go".

Submitted by: Wayne Forehand – Oak Hammock at the University of Florida

The official mail address to contact the Good-To-Go group at the Oak Hammock is ru.gud.to.go@gmail.com.

FLiCRA Past President, Gertrude Johanson, Passes Away

Gertrude Johanson, a past president of FLICRA passed away on November 15th at the age of 103. She was a resident of University Village in Tampa. Mrs. Johanson was a president of FLiCRA in the 1990's.

She was instrumental in FLiCRA's success achieving the homestead exemption for residents in for profit CCRC's. She worked closely with then State Representative Victor Crist for 5 years to get the proposal through the Legislature. It became law in 1998.

During her service, she was recognized by Governor Lawton Chiles with "Gertrude Johanson Day in Hillsborough County". She was also a member of the Florida Silver Haired Legislature.

Many state legislators knew Gertrude as she traveled to the capitol on a number of occasions and always wore her "Red Hat" along with a FLiCRA button.

During Gertrude's service on the board, she helped launch the formation of what FLiCRA now knows as Regions. Even after her time on the board had concluded, many resident leaders in FLiCRA sought her counsel on public policy due to her keen understanding of the political process. She will be missed by all who knew her.

New York Court Addresses "Medicaid Transfer" Issue in Context of Continuing Care Community (CCRC)

On November 6, 2015 the appellate division of New York's Supreme Court addressed an issue long brewing in some states, whether Continuing Care Retirement Communities (CCRCs) can insist on "private pay" for skilled nursing care despite a resident's "eligibility" for Medicaid under state and federal laws. In Good Shepherd Village at Endwell, Inc. v. Yezzi, the unanimous panel affirmed summary judgment in favor of the CCRC on the payment question.

The decision highlights Congressional DRA action in 2005/6 that amended federal Medicaid law to expressly permit CCRCs to offer contracts that require residents to "spend on their care resources declared for the purposes of admission before applying for medical assistance." The DRA amendment was a response to the industry's lobbying efforts, following a 2004 decision by a Maryland appellate court in Oak Crest Village, Inc. v. Murphy that held such a contractual provision violated the federal Nursing Home Residents' Bill of Rights, viewed as prohibiting nursing homes from conditioning admission on guarantees of private pay.

In the New York case history, the couple apparently signed two separate documents, beginning with a "contract" at the time of their entrance into the CCRC that required them to pay both an entrance fee ($143,850) and "basic monthly fees" of approximately $2,550 to cover the cost of independent living. Any need for skilled nursing care would be assessed "an additional charge." That contract provided that residents could "not transfer assets represented as available" for less than fair market value. When the wife needed skilled care, the couple signed a second document, referred to in the case as an "admission agreement," for treatment in the CCRC's skilled nursing unit. The "admission agreement" reportedly required the Yezzis to "pay for, or arrange to have paid for by Medicaid" all services provided by the CCRC.

After the wife entered the skilled nursing facility at the CCRC, the couple notified the CCRC of their application for Medicaid and their transfer of some $750,000 dollars of joint assets into the husband's name. The Medicaid application was approved for the wife. (New York law on the size of permitted spousal transfer appears to be more generous than in other states, depending on what assets were involved.) In any event, this is not a case where the spousal transfer violated Medicaid rules or triggered a penalty period; however the CCRC took the position that it was still entitled to higher private pay rates, regardless of the apparent lawfulness of the intra-spousal transfer for Medicaid purposes, as the transfer breached the couple's contract with the CCRC.

The appellate division wrote:

[W]e agree with plaintiff [CCRC] that the contract could require a resident to first spend the resources identified upon admission before applying for Medicaid, in compliance with both state and federal law. As [the New York court's trial division] recognized, the essence of the CCRC financial model requires a tradeoff between the resident and the facility, in which the resident must disclose and spend his or her assets for the services provided, while the facility must continue to provide those services for the duration of the resident's lifetime even after private funds are exhausted and Medicaid becomes the only source of payment. With this long-term commitment, the facility necessarily must evaluate the financial feasibility of accepting a resident in the first instance....

Although, as defendants correctly contend, the contract does not affirmatively state that the Yezzis must expend the private resources identified in their application, it does expressly preclude the transfer of such resources without fair consideration.

In conclusion, the court ruled that (1) the Yezzis' actions breached the "contract" (discussed briefly in an interesting interpretation of the apparent inconsistency in payment provisions in the "contract" versus the "admissions agreement") and (2), that the transfer was a "fraudulent conveyance" under state law.

The appellate panel did not address certain other issues or facts. For example, apparently the CCRC declined or refused to submit bills to the state agency for the authorized Medicaid payments for the wife's care. Could the couple have been required to pay "only" the portion of the wife's private pay rate that exceeded the available Medicaid payments? The lower court noted that the CCRC would have had to certify that it was accepting Medicaid payments in "full satisfaction" of pending charges. That question becomes important, given that another issue apparently raised by the Yezzis, but not addressed in the appellate opinion, was whether it was proper to treat the 1984 New York Medicaid statute on eligibility as somehow "incorporating" the later, 2005 federal DRA provision regarding CCRCs.

The dollar difference between the CCRC's private pay rate and the Medicaid rate is not spelled out in the appellate opinion, although the payment sought by the CCRC totaled between "over $106,000" (appellate opinion) and $137,000 (trial opinion) for care between October 2012 and January 2014, when the wife passed away. The lower court also awarded "reasonable attorneys' fees, plus costs and disbursements" to the CCRC.

My thanks to Pennsylvania Elder Law attorney Rob Clofine for sending us this interesting ruling. This case is a reminder that individuals and families may benefit from advice before making the decision to move in, especially from attorneys who understand both CCRC contracts and Medicaid rules.

By Katherine C. Pearson, Dickinson Law, Penn State

FLiCRA 2015 - 2016 State Board of Directors

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Congress Changes Billing Rules for Hospital 'Observation Care'

Congress has changed the laws about observation care, a problem that's been vexing seniors for years because the laws are unclear. This has forced millions of seniors to face huge unexpected medical bills when they get home from short hospital stays. The new law recently signed by the President is called the NOTICE Act, short for "Notice of Observation Treatment and Implication for Care Eligibility.

Under legislation that passed the Senate recently and was approved earlier this year by the House of Representatives, hospitals are now required to tell Medicare patients when they enter the hospital under "observation care" status, instead of being actually admitted to the hospital.

According to the most recently available data from Medicare, total claims of observation patients increased 91 percent since 2006, to 1.9 million in 2013.

Most patients do get all the services of being admitted as a patient, but instead of actually being admitted, they are billed differently. Inevitably, they get home from their brief stay and find out that the experience cost them a fortune, what Sen. Susan Collins, R-Maine, described at a congressional hearing as a "devastating" monetary effect on many seniors because, in most cases, these bills come as a total surprise.

The new law doesn't get rid of observation care. Instead it requires patients be notified 24 hours after they have received observation care. For many patients, that will be too little, too late. In addition, the new law requires that patients get an explanation why they had not been admitted and what their financial responsibilities are.

To qualify for Medicare's nursing home coverage, beneficiaries must first spend three consecutive midnights as an admitted patient in a hospital, and observation days don't count.

At a U.S. Senate Special Committee on Aging hearing during the summer, lawmakers peppered Sean Cavanaugh, a deputy administrator at the Centers for Medicare & Medicaid Services, about how Medicare would handle the issue.

"There is an assumption if [patients] are being wheeled into a hospital bed," and they are getting treatment, then they have been admitted, Sen. Claire McCaskill, a Missouri Democrat, told Cavanaugh.

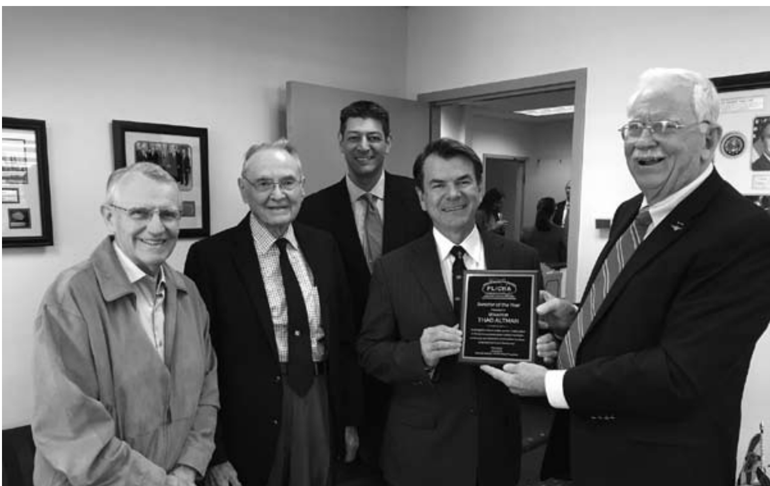
The big problem that remains for seniors is that while it's better to know you are on observation status, there's really nothing you can do about it. Toby Edelman, a senior policy attorney at the Center for Medicare Advocacy, told Kaiser Health News recently that there is no set process for challenging observation care while in the hospital, unlike issues such as disputing a discharge order when admitted patients feel they are not ready to leave.

The only way to switch from observation to admitted status is to persuade a physician or the hospital to make the change, Edelman says. And that decision doesn't apply to the time the patient has already spent on observation. After leaving the hospital, challenging observation care is inevitably frustrating since Medicare appeals judges may decide that a patient's condition did not require inpatient-level care – even when they received care that could have been provided nowhere else but a hospital.

A Medicare beneficiary who is admitted on an inpatient basis to a hospital for at least three nights is normally entitled to Medicare benefits post-discharge for skilled care in a rehabilitation center or nursing home. Part A can cover nursing home rehab or skilled care 100% of the first 20 days and all but $157.50 per day for up to an additional 80 days of treatment, but this benefit is only available after an "inpatient" hospital stay for the required three nights.

Source: Washington Watch

Recent FLiCRA Events



Top: NaCCRA Meeting on State Associations, October 2015, Boston, MA

Middle Left: Region 7 Meeting

Middle Right: FLiCRA Annual Conference Keynote Speaker, Katherine C. Pearson, Dickinson Law, Penn State

Bottom: FLiCRA Senator of the Year Presentation

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New EPA Proposed Rule

The Environmental Protection Agency has published a proposed rule that would impose stringent regulations regarding how healthcare facilities, including long-term care facilities, dispose of pharmaceuticals classified as hazardous waste. Presently, while pharmaceutical hazardous waste in long-term care facilities is regulated by the agency, it is subject to the agency's less-stringent household hazardous waste standard. In the proposed rule, however, the EPA argues that long-term care facilities more closely resemble hospitals and thus should be subject to more stringent requirements.

A long-term care facility is defined under the proposed rule as a "licensed entity that provides assistance with activities of daily living, including managing and administering pharmaceuticals to one or more individuals at the facility." The rule states that it applies, but is not limited, to assisted living facilities, hospices, nursing homes, skilled nursing facilities, and the assisted living and skilled nursing care portions of continuing care retirement facilities. The agency is seeking public input on the definition, the overall appropriateness of classifying long-term care facilities as health care facilities rather than households, and the extent to which long-term care facilities will pass the cost of compliance on to their "customers."

Specifically, the proposed rule seeks to:

- Prohibit long-term care facilities (among others) from disposing of hazardous waste pharmaceuticals by flushing them down the toilet or into a drain.
- Subject long-term care facilities to more stringent requirements regarding on-site management of "creditable" (i.e., those medications for which the provider is eligible to receive manufacturer's credit for return to reverse distributors) and "non-creditable" hazardous waste pharmaceuticals.
- Impose new tracking requirements for shipping of creditable hazardous waste pharmaceuticals to pharmaceutical reverse distributors.
- Regulate the disposal of hazardous waste pharmaceutical residues remaining in containers after use.