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Nursing Home Resident's Attorney-in-Fact Has No Duty to Ensure Continued Medicaid Eligibility

Connecticut's appeals court rules that a nursing home resident's attorney-in-fact has no duty to assist the nursing home in securing the continuation of the resident's eligibility for Medicaid. Kindred Nursing Centers East, LLC v. Morin (Conn. App. Ct., No. 31176, Nov. 23, 2010).

While a resident at a nursing home operated by Kindred Nursing Centers, Medicaid recipient Charles Sclafani executed a document naming Arthur Morin as his attorney-in-fact. The State Department of Social Services subsequently questioned Mr. Sclafani's continued eligibility for Medicaid when it learned of a bank account jointly owned by Mr. Sclafani and his sister. A Kindred employee asked Mr. Morin to withdraw the balance of the account, which, after consulting with Mr. Sclafani, Mr. Morin did, keeping the proceeds of $2,671.20 in an uncashed bank check. But Mr. Morin declined to use the proceeds to reduce Mr. Sclafani's net worth to less than the $1,600 asset threshold for continued Medicaid eligibility because Mr. Sclafani never authorized him to do so.

As a result, Mr. Sclafani's Medicaid eligibility was terminated. Kindred filed a complaint charging that Mr. Morin negligently failed to cooperate in the determination of Mr. Sclafani's continued Medicaid eligibility. Concluding that an attorney-in-fact had no such duty, the trial court granted Mr. Morin's motion for summary judgment, and Kindred appealed.

The Appellate Court of Connecticut affirms, holding that the State's power of attorney statute "contains not one provision holding an attorney in fact accountable to anyone other than his principal," and the court also rejects Kindred's argument that an attorney-in-fact should be subject to the same duties as a conservator.

Editor's Note: Although I agree with the Court's legal analysis, two questions remain. Why didn't the agent under the POA spend down the money—what was he trying to accomplish by holding on to it other than creating this legal mess. Secondly, it is possible for an agent to be "tagged" with liability under other legal theories, such as detrimental reliance or promissory estoppel, although the agent would have to hold himself out to the facility as acting in a personal capacity, but the distinctions can be easily blurred.

Court Rules Lack of Progress Is No Reason to Stop Medicare SNF Coverage

A federal district court rules that Medicare should not have stopped payments to a beneficiary in a skilled nursing facility simply because she was not improving, holding that skilled care may be required to preserve current functioning or prevent further decline. Papciak v. Sebelius (U.S. Dist. Ct., W.D. Pa., No. 09-1354, Sept. 28, 2010).

On June 3, 2008, 81-year-old Wanda Papciak was admitted to a skilled nursing facility for rehabilitative care following hip surgery. Medicare paid for Ms. Papciak's care for about a month, at which time it determined that she no longer needed skilled care and had reached her maximum potential for therapy. The agency denied payment for services provided between July 10, 2008 and July 19, 2008, concluding that during that time Ms. Papciak received only "custodial care" and not the skilled care covered by Medicare. A final agency decision upheld the denial.

Ms. Papciak appealed to the federal district court, arguing that the agency considered only whether her condition would improve with additional skilled nursing care and should have also considered whether she required skilled nursing care to maintain her current level of functioning. Ms. Papciak and the agency filed cross motions for summary judgment.

The Federal District Court in Pennsylvania finds that the agency's decision was based on Ms. Papciak's lack of improvement and failed to consider whether Ms. Papciak required skilled nursing care as part of a maintenance plan. The court grants Ms. Papciak's motion and remands the matter to the agency to calculate and award benefits. The court notes that Medicare regulations state that "[t]he restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities."

Editor's Note: The question of when Medicare may deny payment has always been a concern. Under Federal law it is clear that Medicare should not stop just because the resident is not showing signs of improvement or making forward progress in their rehabilitation, but nursing homes have routinely used this as an excuse to cut off benefits. This court got it right and my advice to family members and patient advocates is to insist on coverage if you feel it provides any benefit and if coverage is still denied, to then appeal the denial to the administrative law judge.

Applicant Transferred Funds for Purpose Other Than to Qualify for Medicaid

A New Jersey administrative law judge finds that a Medicaid applicant who was healthy at the time he transferred funds to his daughter transferred the funds for a reason other than to qualify for Medicaid. R.C. v. Division of Medical Assistance and Health Services and Hudson County Board of Social Services (N.J. Office of Administrative Law, Hudson County, OAL DKT. NO. HMA 08047-10, Oct. 22, 2010).

While R.C. was healthy he transferred $100,000 to his daughter to help with her financial problems. A year later, R.C. suffered a stroke and his health began to deteriorate. He was eventually admitted to a nursing home.

R.C. applied for Medicaid benefits. The state denied benefits, finding that R.C. had made an uncompensated transfer of assets to his daughter. R.C. requested a hearing.

The administrative law judge (ALJ) reverses, finding that the transfer was made exclusively for a purpose other than establishing Medicaid eligibility. The ALJ concludes that because R.C. was employed and in good health when the transfer occurred and the stroke was unexpected, R.C. provided convincing evidence that he did not transfer the money in order to qualify for Medicaid.

Editor's Note: Connecticut continues to be very strict in this regard. Although the Connecticut regulation states that any transfer made within the look-back period (5 years) is presumed to have been made for the purpose of qualifying for Medicaid unless the applicant can prove by clear and convincing evidence that the transfer was made for another purpose, the Connecticut Department of Social Services interprets this regulation in a manner that makes it virtually impossible for an applicant to meet their burden of proof.

National Average Cost of Nursing Home Care Tops $83,000 a Year

Nursing home and assisted living rates rose significantly from 2009 to 2010, according to the 2010 MetLife Market Survey of Long-Term Care Costs. Private room nursing home rates rose 4.6 percent to $83,585 a year or $229 a day, while assisted living facility costs climbed 5.2 percent on average to $39,516 a year or $3,293 a month.

The average cost of home health care aides and adult day care were unchanged, after having jumped about 5 percent the year before. Home care aides still average $21 per hour and adult day care services remain at an average $67 per day.

The survey also reports on the cost of a semi-private room in a nursing home, which increased 3.5 percent to $205 a day, or $74,825 a year. The cost of a semi-private room in an Alzheimer's wing actually dropped, from an average of $75,920 to an average of $75,190 annually.

Once again, the highest rates for a private nursing home room in 2010 were found in Alaska, where the cost is now $687 a day on average. The lowest rates were found in Louisiana (with the exception of Baton Rouge and the Shreveport area), at $138 a day.

The cost of assisted living was the highest in the Washington, D.C., area, at $5,231 a month and the lowest in Arkansas (except for Little Rock) at $2,073 a month. Average home health care aide services ranged from a high of $30 an hour in Rochester, Minnesota, to $14 and hour in the Shreveport area of Louisana. Adult day care services were highest in Vermont at an average of $140 a day and lowest in the Montgomery, Alabama, area, at $31 a day.

Editor's Note: Based on State averages, Connecticut retains its number two ranking. Nursing homes in Connecticut cost $376 per day on average. For the complete report go to: http://www.metlife.com/assets/cao/mmi/publications/studies/2010/mmi-2010-market-survey-long-term

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IRS Data Shows Steep Decline in Estates Owing Tax Over Last Decade

Only 0.6 percent of those dying in the U.S. in 2008 owed any estate tax, according to new data released by the IRS. This means that 99.4 percent of estates were too small to pay an estate tax, which the Republican party and some wealthy individuals have been fighting to repeal entirely.

The data also show that the number of estates filing taxes decreased from more than 108,000 in 2001 to fewer than 34,000 in 2009. As Julie Garber writes in her Wills & Estate Planning Blog, "[I]t doesn't take a rocket scientist to figure out why." It is due to an increase in the filing threshold called for in the tax law President Bush signed in 2001, which increased the threshold from $675,000 in 2001 to $3.5 million in 2009. The number of estates that ended up paying any tax after filing a return dropped from 51,700 in 2001 to 14,700 in 2009.

The estate tax was temporarily repealed for 2010 but Congress recently approved a $5 million exemption for 2011 and 2012.

The federal government took in about $20.6 billion in tax payments in 2009 from the estates of those dying in 2008. (Estate taxes are usually filed the year after the year of death.) Of the millionaires who died in 2008 and had an estate tax liability, an average of 20.4 percent of their estates went to the federal government, 2.5 percent went to the state, 8.6 percent went to charity and more than 68 percent went to heirs, according to calculations based on the IRS data. The estate tax liability threshold was $2 million in 2008.

Editor's Note: In 2009, the federal estate tax exemption increased from $2 million in 2008 to $3.5 million, so it is very likely that even fewer estate tax returns were filed for 2009 deaths than for 2008 deaths. There is still much uncertainty concerning the estate tax because Congress only approved the increased exemption for two years.