State of New Jersey

OFFICE OF ADMINISTRATIVE LAW

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A copy of the administrative law judge's decision is enclosed.

This decision was mailed to the parties on APR 14 2008

State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION
SUMMARY DECISION
CONSOLIDATED

O.B.,

Petitioner,

v.

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES AND MIDDLESEX COUNTY BOARD OF SOCIAL SERVICES,

Respondents.

OAL DKT. NO. HMA 6519-07

E.B.,

Petitioner,

v.

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES AND OCEAN COUNTY BOARD OF SOCIAL SERVICES,

Respondents.

OAL DKT. NO. HMA 8059-07

E.A.F.,

Petitioner,

v.

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES AND MONMOUTH COUNTY BOARD OF SOCIAL SERVICES,

Respondents.

OAL DKT. NO. HMA 8310-07

J.B.,

Petitioner,

v.

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES AND MONMOUTH COUNTY BOARD OF SOCIAL SERVICES,

Respondents.

OAL DKT. NO. HMA 3219-08

R.M.,

Petitioner,

v.

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES AND GLOUCESTER COUNTY DIVISION OF SOCIAL SERVICES,

Respondents.

OAL DKT. NO. HMA 6952-07

John W. Callinan, Esq., for petitioners O.B., E.B., E.A.F., and J.B.

Jerold E. Rothkoff, Esq., for petitioner R.M.

Zoe J. McLaughlin, Deputy Attorney General, for respondent Division of Medical Assistance and Health Services (Anne Milgram, Attorney General of New Jersey, attorney)

Record Closed: April 8, 2008 Decided: April 9, 2008

BEFORE **JOSEPH PAONE**, ALJ:

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

Petitioners O.B., E.B., E.A.F., J.B. and R.M. each appeal their denial of Medicaid eligibility. Each filed for a fair hearing and the Division of Medical Assistance and Health Services (DMAHS) transmitted the contested cases to the Office of Administrative Law between August 15, 2007, and February 27, 2008. N.J.S.A. 52:14B-1 through -15; N.J.S.A. 52:14F-1 through -13. Their respective cases were consolidated at the request of their attorneys because the cases presented a common question of law. (Second Amended Order, dated April 8, 2008). Petitioners contend that when an applicant for a Medicaid waiver program makes an uncompensated transfer of an asset during the look-back period, the penalty period begins to run the month the transfer is made and the applicant is otherwise eligible for Medicaid benefits but for the application of the penalty period. Respondent DMAHS posits that a penalty period never commences in such a situation.

All parties moved for summary decision and submitted initial briefs and multiple reply briefs. Oral argument was heard on March 17, 2008. Upon receipt of the final stipulation of facts, related to the R.M. case, on April 8, 2008, the record closed.

STATEMENT OF FACTS

The parties have stipulated to the following relevant **FACTS**:

1. Petitioners are each elderly individuals within the meaning of the regulations governing the Medicaid program.

2. Petitioners have each applied for benefits under a community-based services Medicaid waiver program established pursuant to 42 U.S.C.A. § 1396n(c). O.B. applied for benefits on December 8, 2006; E.B. applied on May 1, 2007; E.A.F. on April 16, 2007; J.B. on January 29, 2007; and R.M. on June 4, 2007

3. Petitioners have each made certain uncompensated transfers of assets after February 8, 2006. O.B. transferred $34,400.66 on July 27, 2006, and $7,527.15 on August 18, 2006. E.B. transferred $80,000 on March 2, 2007. E.A.F. transferred $115,447 on April 11, 2007. J.B. transferred $128,986.26 between November 2, 2006, and January 25, 2007. R.M. transferred $47,817.25 on March 22, 2007.

4. Petitioners have each been denied Medicaid benefits under their respective community-based services Medicaid waiver program as a result of the transfers.

5. But for the uncompensated transfer of assets, petitioners were each eligible for benefits under a community-based services Medicaid waiver program.

CONCLUSIONS OF LAW

Since it is undisputed that petitioners are otherwise eligible for a community-based services Medicaid waiver program but for an uncompensated transfer of assets made after February 8, 2006, and during the look-back period, and are each subject to a period of ineligibility for those services as a result of the transfer, there are no genuine issues of material fact. Therefore, pursuant to N.J.A.C. 1:1-12.5(b) and Brill v. Guardian Life Insurance Co. of America, 142 N.J. 520, 523 (1995), the matter is ripe for summary decision.

The Medicaid Act was established in 1965 pursuant to Title XIX of the Social Security Act. 42 U.S.C.A. §§ 1396 et seq. The joint federal-state program provides medical assistance to "aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical care." 42 U.S.C.A. § 1396. These individuals are known as the "categorically needy." Although participation is not obligatory, if a state chooses to participate in the program, it must submit a state plan to the Secretary of the United States Department of Health and Human Services for approval, which must comply with the comprehensive requirements provided in 42 U.S.C.A. § 1396a. The Medicaid Act also allows a participating state to offer coverage to a class of individuals known as "optionally needy." 42 U.S.C.A. § 1396a(a)(10)(A)(ii)(I) to (XVIII). Individuals eligible for community-based waiver services (42 U.S.C.A. § 1396a(a)(10)(A)(ii)(VI)), as well as individuals residing in a nursing facility for at least thirty consecutive days (42 U.S.C.A. § 1396a(a)(10)(A)(ii)(V)), are included in this category. As a participant in the program offering coverage to the optionally needy, the State of New Jersey is responsible for enforcement of the Medicaid Act in New Jersey. N.J.S.A. 30:4D-1 et seq. Medicaid eligibility is based upon an applicant's income and resources. When it is determined that an applicant has transferred a resource for less than fair market value during a specified period of time known as a "look-back period," a penalty period arises. 42 U.S.C.A. § 1396p(c)(1). Compare N.J.A.C. 10:71-4.7(a); N.J.A.C. 10:72-4.5(b)(3). A penalty period is a measurable period of time during which the applicant is ineligible for an institutional level of services. 42 U.S.C.A. § 1396p(c)(1).

The Deficit Reduction Act of 2005 (DRA) modified the Medicaid Act by increasing the look-back period from three to five years. The State of New Jersey has not enacted any statute or regulation implementing the DRA. The DRA provides that the look-back begins on the "first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State plan." 42 U.S.C.A. § 1396p(c)(1)(B)(ii)(I). Accordingly, "if an institutionalized individual . . . disposes of assets for less than fair market value on or after the look-back date . . . the individual is ineligible for medical assistance services described in subparagraph (C)(i) . . . during

the period beginning on the date specified in subparagraph (D) . . . ." 42 U.S.C.A. § 1396p(c)(1)(B)(i). The length of the period of ineligibility is governed by 42 U.S.C.A. § 1396p(c)(1)(E), and is not an issue in dispute in this case. 42 U.S.C.A. § 1396p(c)(1)(C)(i) lists the following medical assistance services:

> (I) Nursing facility services.
>
> (II) A level of care in an institution equivalent to that of nursing facility services.
>
> (III) Home or community-based services furnished under a waiver granted under [42 U.S.C.A. § 1396n(c) or (d)].

42 U.S.C.A. § 1396p(h)(3) defines an "institutionalized individual" as one

> who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in [42 U.S.C.A. § 1396(a)(10)(A)(ii)(VI)].
>
> [Emphasis added.]

42 U.S.C.A. § 1396a(a)(10)(A)(ii)(VI) adds that an institutionalized individual is one

> who would be eligible under the State plan under [42 U.S.C.A. §§ 1396 et seq.] if [she] were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community based services described in [42 U.S.C.A. § 1396n(c),(d), or (e)] [she] would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under [42 U.S.C.A. § 1396n(c), (d), or (e)].
>
> [Emphasis added.]

Petitioners additionally urge consideration of N.J.A.C. 10:71-4.7(b)(3) and N.J.A.C. 10:71-4.10(b)(2), which the parties agreed in their Joint Stipulation were enacted to implement 42 U.S.C.A. § 1396p(c)(1)(B), and which also define an

institutionalized individual as "a person seeking benefits under a home or community care waiver program" (emphasis added). Neither the federal statute nor the State regulation requires the actual receipt of home- or community-based services in order for a person to be characterized as an institutionalized individual. Therefore, I **CONCLUDE** that petitioners' applications seeking community-based waiver services are sufficient to classify petitioners as institutionalized individuals.

Since the parties have stipulated that each petitioner made an uncompensated transfer of an asset within months, and in E.A.F.'s case days, of their respective applications seeking community-based waiver services, I **CONCLUDE**, as the parties agreed during oral argument, that the uncompensated transfers of assets in question were each made during the look-back period. And I further **CONCLUDE** that as institutionalized individuals, the petitioners must each be subject to a penalty period or period of ineligibility for community-based services furnished under a waiver.

The issue in dispute in this matter is at what point the penalty period begins when an applicant for a Medicaid waiver program has made an uncompensated transfer of an asset during the look-back period. While the DMAHS agrees with petitioners that they are subject to a penalty period, the DMAHS contends that a penalty period can never begin because an applicant seeking community-based waiver services must await the expiration of the look-back period before she can seek those services. Petitioners, however, contend that if an applicant is otherwise eligible for Medicaid benefits but for the transfer of assets, the penalty period must start the month the uncompensated transfer of the asset is made.

The DRA added 42 U.S.C.A. § 1396p(c)(1)(D)(ii), a new subclause, to the Medicaid Act. Prior to enactment of the DRA, the penalty period resulting from an uncompensated transfer of assets commenced the month that the applicant made the uncompensated transfer, irrespective of what resources remained in the applicant's name. Since the parties have stipulated that the transfers were made after February 8, 2006, their periods of ineligibility must commence

> the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) [a community-based waiver service] based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.
>
> [42 U.S.C.A. § 1396p(c)(1)(D)(ii) (emphasis added).]

Petitioners persuasively argue that according to the plain-language canon, the statute means what it says "and no further search is necessary or appropriate in the absence of clear ambiguity." In re M.G., 307 N.J. Super. 348, 354 (App. Div. 1998), certif. denied, 154 N.J. 607 (1998). This cardinal doctrine of statutory construction directs that the penalty period assessed against an applicant must begin when the applicant 1) is eligible for medical assistance under the state plan, and 2) would otherwise be receiving home- or community-based services furnished under a waiver based on an approved application for such care, 3) but for the application of the penalty period. Simply stated, the penalty start date is the point in time when the applicant is eligible and would otherwise be receiving services, but for the penalty period. Petitioners submit that the insertion of "would otherwise be" and "but for" in the statute creates the grammatical tense known as the "present unreal conditional," which is used to express what one would do in an unreal or imaginary situation. They urge that the application of this grammatical analysis to the statute makes it apparent that the statute intends that the penalty period begins when "an applicant for Medicaid benefits would otherwise be receiving services furnished under a waiver but for the fact that the applicant made an uncompensated transfer." The applicant, however, isn't really receiving those services.

The DMAHS argues that the penalty period for an uncompensated transfer cannot start against an applicant for community-based waiver services until she is eligible for medical assistance under the State plan and is actually receiving community-based waiver services. But, as the DMAHS's reasoning continues, such an

applicant cannot actually receive waiver services because the uncompensated transfer of assets prohibits receipt of waiver services. In reaching this circuitous position, the DMAHS relies on an enclosure that accompanied a letter to the State Medicaid Director from the Centers for Medicare and Medicaid Services (CMS), dated July 27, 2006. The CMS enclosure provides that

> [f]or transfers of assets made on or after February 8, 2006, the period of ineligibility will begin with the . . . date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level of care services (based on an approved application for such services) that, were it not for the imposition of the penalty period, would be covered by Medicaid.
>
> [Emphasis added.]

The CMS enclosure, however, misquotes the statute, and the DMAHS's reliance on it is, thus, misplaced. In order to accommodate the language of the CMS enclosure, the DMAHS is obligated to take an inherently contradictory position. While the DMAHS deems petitioners "institutionalized individuals" in determining the look-back period start date, it denies that petitioners are "institutionalized individuals" for purposes of determining the penalty period start date. The DMAHS reasons that an applicant must be receiving waiver services in order to be denominated an institutionalized individual. Otherwise, the penalty period cannot commence. But, as had been previously noted, an "institutionalized individual" is not only an inpatient in a nursing facility or medical institution, but also, as the federal statute provides, one who would be eligible for community-based waiver services if she were in a medical institution, or, as State regulations allow, is seeking those services. 42 U.S.C.A. § 1396p(c)(1)(D)(ii) does not require that one actually receive institutional-level care as respondent contends. The statute merely demands that one "would otherwise be receiving institutional level care . . . but for the application of the penalty period."

Petitioners proffer that the Congressional Record refutes the DMAHS's construction. A proposed House Bill had provided that the beginning date for a period of eligibility be

> [t]he date on which the individual is eligible for medical assistance under the State plan and is receiving services described in subparagraph (C) based on an approved application for such care but for the application of the penalty period.
>
> [151 Cong. Rec. H10571 (daily ed. Nov. 17, 2005) (emphasis added).]

But the "is receiving services" language in the proposed legislation was later changed by Conference Agreement to the present text — "would otherwise be receiving institutional level care." Id. at H12709-H12710. Petitioners point out that the use of the present participle "is receiving" would have suggested that the applicant must actually be receiving waiver services. But the verb tense change made during Conference Committee demonstrates that Congress was aware that an applicant for benefits under a community-care waiver program, who had made an uncompensated transfer of an asset, could not be receiving waiver services before applying for those services.

The purpose of the DRA is to deter self-impoverishment in order to qualify for Medicaid by penalizing those who transfer assets for less than fair market value. There is no evidence in the legislative record cited by the DMAHS that Congress intended to eliminate community-based waiver services completely to those who made such transfers. Application of the DMAHS's tortured construction of the DRA, however, would entirely eliminate the imposition of a penalty period and require anyone making uncompensated transfers within a look-back period and seeking waiver services to wait up to five years from the date of the transfer before an application could be made for home- or community-based waiver services. While the DMAHS suggests that its interpretation is consistent with the DRA's objective, which was to lighten the taxpayers' burden, its interpretation would actually encourage placement in a nursing facility over less-costly waiver services and undermine the impetus for the DRA's enactment.

The plain meaning of 42 U.S.C.A. § 1396p(c)(1)(D)(ii) is clear and the DMAHS's strained interpretation is conflicting, contrived and inconsistent with the statute's legislative history. I, therefore, **CONCLUDE** that the penalty period for an applicant for

a Medicaid waiver program who has made an uncompensated transfer of an asset during the look-back period begins on the date on which she is otherwise eligible for Medicaid waiver services based on an application that would be approved, but for the transfer of assets. Thus the penalty period for each petitioner should commence on the date each petitioner submitted her application for community-based waiver services.

ORDER

Accordingly, I hereby **ORDER** that a penalty shall be assessed against each petitioner as a result of her uncompensated transfer of an asset and that the start date of the penalty period shall be the date on which the application for waiver services was made after the uncompensated transfer.

I hereby **FILE** my initial decision with the **DIRECTOR OF THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES** for consideration.

This recommended decision may be adopted, modified or rejected by the **DIRECTOR OF THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES**, the designee of the Commissioner of the Department of Human Services, who by law is authorized to make a final decision in this matter. If the Director of the Division of Medical Assistance and Health Services does not adopt, modify or reject this decision within forty-five (45) days and unless such time limit is otherwise extended, this recommended decision shall become a final decision in accordance with N.J.S.A. 52:14B-10.

Within seven (7) days from the date on which this recommended decision was mailed to the parties, any party may file written exceptions with the **DIRECTOR OF THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, Mail Code #3, P.O. Box 712, Trenton, New Jersey 08625-0712**, marked "Attention: Exceptions." A copy of any exceptions must be sent to the judge and to the other parties.

April 9, 2008
DATE

JOSEPH PAONE, ALJ

Date Received from Agency:

4-14-08

Mailed to Parties:

APR 14 2008
DATE

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