NOT FOR PUBLICATION WITHOUT THE
APPROVAL OF THE APPELLATE DIVISION

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-2669-13T3

E.A.,

Petitioner-Appellant,

v.

DIVISION OF MEDICAL ASSISTANCE
AND HEALTH SERVICES and HUNTERDON
COUNTY BOARD OF SOCIAL SERVICES,

Respondents-Respondents.

Argued May 26, 2015 – Decided July 20, 2015

Before Judges Sabatino, Simonelli and Gilson.

On appeal from the Division of Medical Assistance and Health Services.

Gaetano M. De Sapio argued the cause for appellant (Law Offices of Gaetano M. De Sapio, attorneys; Mr. De Sapio, of counsel and on the brief).

Jennifer L. Cavin, Deputy Attorney General, argued the cause for respondent Division of Medical Assistance and Health Services (John J. Hoffman, Acting Attorney General, attorney; Melissa H. Raksa, Assistant Attorney General, of counsel; Ms. Cavin, on the brief).

Shana L. Taylor, Hunterdon County Counsel, attorney for respondent Hunterdon County Board of Social Services joins in the brief of respondent Division of Medical Assistance and Health Services.

PER CURIAM

Appellant E.A. appeals from the December 20, 2013 final agency decision of the Division of Medical Assistance and Health Services (DMAHS), which adopted the initial decision of an Administrative Law Judge (ALJ) affirming the decision of the Hunterdon County Board of Social Services (HCBSS) that E.A. was eligible for Medicaid benefits subject to a 936-day period of ineligibility for transferring assets for less than fair market value in violation of N.J.A.C. 10:71-4.10(a). For the reasons that follow, we affirm.

We begin our analysis with a review of the relevant authority and factual background.

Medicaid is a federally-created, state-implemented program that provides "'medical assistance to the poor at the expense of the public.'" Estate of DeMartino v. Div. of Med. Assistance & Health Servs., 373 N.J. Super. 210, 217 (App. Div. 2004) (quoting Mistrick v. Div. of Med. Assistance & Health Servs., 154 N.J. 158, 165 (1998)), certif. denied, 182 N.J. 425 (2005); see also 42 U.S.C.A. § 1396-1. Although a state is not required to participate, once it has been accepted into the Medicaid program it must comply with the Medicaid statutes and federal regulations. See Harris v. McRae, 448 U.S. 297, 301, 100 S. Ct. 2671, 2680, 65 L. Ed. 2d 784, 794 (1980); United Hosps. Med.

Ctr. v. State, 349 N.J. Super. 1, 4 (App. Div. 2002); see also 42 U.S.C.A. § 1396a(a) and (b). The state must adopt "'reasonable standards . . . for determining eligibility for . . . medical assistance [that are] consistent with the objectives' of the Medicaid program," Mistrick, supra, 154 N.J. at 166 (quoting L.M. v. Div. of Med. Assistance & Health Servs., 140 N.J. 480, 484 (1995)), and "provide for taking into account only such income and resources as are . . . available to the applicant." N.M. v. Div. of Med. Assistance & Health Servs., 405 N.J. Super. 353, 359 (App. Div.) (internal quotation marks omitted), certif. denied, 199 N.J. 517 (2009); see also 42 U.S.C.A. § 1396a(a)(17)(A)-(B).

New Jersey participates in the federal Medicaid program pursuant to the New Jersey Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 to -19.5. Eligibility for Medicaid in New Jersey is governed by regulations adopted in accordance with the authority granted by N.J.S.A. 30:4D-7 to the Commissioner of the Department of Human Services (DHS). DMAHS is the agency within the DHS that administers the Medicaid program. N.J.S.A. 30:4D-5, -7; N.J.A.C. 10:49-1.1. Accordingly, DMAHS is responsible for protecting the interests of the New Jersey Medicaid Program and its beneficiaries. N.J.A.C. 10:49-11.1(b).

In this case, E.A. applied for institutional level Medicaid benefits while she was residing in a nursing home. DMAHS provides such benefits to pursuant to the Medicaid Only program, N.J.A.C. 10:71-1.1 to -9.5. Among other eligibility requirements, an individual seeking such benefits must have financial eligibility as determined by the regulations and procedures. See N.J.A.C. 10:71-1.2(a). The local county welfare agencies evaluate eligibility. N.J.S.A. 30:4D-7a; N.J.A.C. 10:71-1.5, -2.2(c). Through those county agencies, DMAHS serves as a "gatekeeper to prevent individuals from using Medicaid to avoid payment of their fair share for long-term care." W.T. v. Div. of Med. Assistance & Health Servs., 391 N.J. Super. 25, 37 (App. Div. 2007).

An individual who is already receiving institutional level services but who is not yet eligible for Medicaid benefits, such as E.A., shall be deemed ineligible for those services if the individual "has disposed of assets at less than fair market value at any time during or after the [sixty-]month period immediately before . . . the date the individual applies for Medicaid as an institutionalized individual" (the look-back period).[1] N.J.A.C. 10:71-4.10(a)(2); see also N.J.A.C. 10:71-

[1] On February 8, 2006, the Deficit Reduction Act of 2005 enlarged the look-back period from thirty-six months to sixty (continued)

4.10(b)(9)(ii). "Fair market value" is defined as "an estimate of the value of an asset, based on generally available market information, if sold at the prevailing price at the time it was actually transferred. Value shall be based on the criteria for evaluating assets as found in N.J.A.C. 10:71-4.1(d)."[2] N.J.A.C. 10:71-4.10(b)(6). If the applicant transferred assets during the look-back period, the fair market value . . . of the asset shall be ascertained and fully documented. N.J.A.C. 10:71-4.10(c).

The transfer of an asset for less than fair market value during the look-back period raises a rebuttable presumption that the asset was transferred for the purpose of establishing Medicaid eligibility. H.K. v. State, 184 N.J. 367, 380 (2005) (citing N.J.A.C. 10:71-4.10(j)); see also 42 U.S.C.A. § 1396p(c)(1). To rebut that presumption, the applicant must present "convincing evidence that the assets were transferred exclusively (that is, solely) for some other purpose." N.J.A.C. 10:71-4.10(j). The presumption "shall be considered

---

(continued)
months. Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006); see also 42 U.S.C.A. § 1396p(c)(1)(B)(i).

[2] N.J.S.A. 10:71-4.1(d) defines "value" as "the price that the resource can reasonably be expected to sell for on the open market in the particular geographic area minus any encumbrances (that is, its equity value)."

successfully rebutted only if the applicant demonstrates that the asset was transferred exclusively for some other purpose." N.J.A.C. 10:71-4.10(l)(1). "If the applicant had some other purpose for transferring the asset, but establishing Medicaid eligibility appears to have been a factor in his or her decision to transfer, the presumption shall not be considered successfully rebutted." N.J.A.C. 10:71-4.10(l)(2).

"In determining whether or not an asset was transferred for fair-market value, only tangible compensation, with intrinsic value shall be considered." N.J.A.C. 10:71-4.10(b)(6)(i). A transfer for "love and affection" is not considered a transfer for fair market value. Ibid. "In regard to transfers intended to compensate a friend or relative for care or services provided in the past, care and services provided for free at the time they were delivered shall be presumed to have been intended to be delivered without compensation." N.J.A.C. 10:71-4.10(b)(6)(ii). "Thus, a transfer of assets to a friend or relative for the alleged purpose of compensating for care or services provided free in the past shall be presumed to have been transferred for no compensation." Ibid. The applicant may rebut the presumption

> by the presentation of credible documentary evidence preexisting the delivery of the care or services indicating the type and terms of compensation. Further, the amount

> of compensation or the fair market value of the transferred asset shall not be greater than the prevailing rates for similar care or services in the community. That portion of compensation in excess of the prevailing rate shall be considered to be uncompensated value.
>
> [Ibid.]

The regulations are clear that the applicant bears the burden of proof to rebut the presumption by presenting credible documentary evidence of the fair market value of the transferred assets. N.J.A.C. 10:71-4.10(j).

If it is determined that the applicant transferred an asset for less than fair market value during the look-back period, to become eligible for Medicaid institutional level services, the applicant will be subject to a period of Medicaid ineligibility to be imposed once he or she is otherwise eligible for Medicaid benefits. N.J.S.A. 30:4D-3(i)(15)(b); N.J.A.C. 10:71-4.10(c)(4). The period of ineligibility, determined in accordance with 42 U.S.C.A. § 1396p(c)(1)(E),

> shall be the number of months equal to the total, cumulative uncompensated value of all assets transferred by the individual, on or after the look-back date, divided by the average monthly cost of nursing home services in the State of New Jersey[.]
>
> [N.J.A.C. 10:71-4.10(m)(1).]

The period of ineligibility begins on the later of the first day of the month during or after which the individual transferred

the assets for less than fair market value or the date on which the he or she is eligible for medical assistance and would be receiving institutional level services but for the penalty period. 42 U.S.C.A. § 1396p(c)(1)(D)(ii). An institutionalized individual who is ineligible for payment for long-term care services because an asset transfer precluded him or her from eligibility "shall be entitled to ancillary services if otherwise eligible." N.J.A.C. 10:71-4.10(m).

The record in this case reveals that E.A. began residing in B.C.'s home in September 2004, when she was ninety-five years old. From September 2004 to June 2005, B.C. received no compensation for any caregiver services or lodging provided to her mother. From June 2005 to September 2006, B.C. received E.A.'s Social Security benefits of approximately $1500 per month to offset the cost of caring for her mother.

Approximately one year before the start of the look-back period in this case,[3] E.A., then ninety-seven years old, executed a document whereby B.C. would receive $3600 per month from September 15, 2006 to September 15, 2007 (the care agreement). The care agreement permitted B.C. to withdraw the funds directly from E.A.'s bank accounts. The sum of $3000 was for E.A.'s room

[3] E.A. applied for institutional level Medicaid benefits on December 5, 2012. Thus, the look-back period began December 5, 2007.

and board, which included care for E.A. and her dog, and $600 was for E.A.'s "additional medications, various items of food and drink, or any other additions." To justify the $3600 payment, E.A. compared the new amount to the $18.50 per hour rate or $179 daily rate for live-in caregiver services charged by a private company, and the $3500 to $5000 monthly rate charged by a private nursing home "without a dog."

In April 2008, E.A. updated the care agreement to increase the monthly payment to $4300, effective March 2008. The care agreement specified that E.A. was "in no need of nursing care, but only [needed] supervision and her daily needs taken care of: laundry, food, cleaning, transportation and oversight." To justify the increase, B.C. compared her monthly rate to the $6665 monthly rate for live-in caregiver services charged by a private company, Comfort Keepers, and the monthly rates charged by two private nursing homes. B.C. also testified that the new rate accounted for her increased gas expenditures from driving home from work periodically to check on her mother.

In June 2009, E.A. updated the care agreement to increase the monthly payment to $5100, effective March 2009. The care agreement noted that the $800 monthly increase was for an "increase in [E.A.'s] board." To justify the increase, B.C. again compared her rate to the $6665 monthly rate for live-in

caregiver services charged by Comfort Keepers and the monthly rates charged by two private nursing homes.[4]

In early August 2012, E.A. was hospitalized and then discharged to a nursing home, where she remains. She paid the costs from her remaining funds. On December 5, 2012, B.C. applied for institutional level Medicaid benefits on E.A.'s behalf. B.C. submitted the care agreement and E.A.'s bank account statements from November 2008 to December 2012.[5]

Although B.C. was to receive a set monthly amount under the care agreement, HCBSS's review of E.A.'s bank account statements revealed that E.A. and B.C. did not generally abide by the agreement. For example, B.C. was to receive $4300 per month under the April 2008 updated care agreement; however, she made two larger monthly withdrawals. Under the June 2009 updated care agreement B.C. was to receive $5100 per month from March 2009 onward; however, in 2009, she made three larger

[4] Throughout this matter, E.A. insisted that B.C.'s monthly rates also compared to the monthly rates charged by two private nursing homes. E.A. has abandoned that position on appeal and, instead, argues for the first time that DMAHS erred in relying on the nursing home rates to uphold the period of ineligibility. We conclude that E.A. invited the error and is now barred from raising this argument for the first time on appeal. See N.J. Div. of Youth & Family Servs. v. M.C. III, 201 N.J. 328, 340-42 (2010).

[5] The record on appeal does not reveal why B.C. did not submit E.A.'s bank statements beginning in December 2007, when the look-back period commenced.

withdrawals; in 2010, she made seven larger withdrawals; in 2011, she made ten larger withdrawals; and in 2012, she made four larger withdrawals from January to September. According to HCBSS's calculations, the larger withdrawals totaled almost $101,000 more than that to which B.C. was entitled under the care agreement. All of these larger withdrawals occurred during the look-back period.

In addition, although E.A. was living in a nursing home in August 2012, B.C. withdrew $6100 in August 2012, and $5100 in September 2012. Furthermore, there were many monthly withdrawals that B.C. identified as payments for a home health aide; however, her monthly payments were not reduced accordingly.

B.C. had no records of the services she or others provided to her mother, and she did not report any of the money she received under the care agreements as ordinary income on her tax returns. Instead, she reported the income as rental income without distinguishing the rental income she received from her mother from the rental income she received from renting a soccer field. B.C. also did not distinguish the amount she listed on her tax returns as rent from her mother from the amount relating to the caregiver services provided to her mother.

On January 23, 2013, HCBSS determined that E.A. was eligible for Medicaid benefits, effective January 1, 2013. However, HCBSS found that E.A. had transferred a total of $244,510 to B.C. during the look-back period for less than fair market value, and thus, imposed a 936-day period of ineligibility from January 1, 2013 to July 25, 2015. HCBSS determined that E.A. was entitled to ancillary Medicaid benefits during the period of ineligibility, which E.A. has been receiving since January 1, 2013, and will continue receiving until the end of the period of ineligibility.

B.C. requested a hearing on E.A.'s behalf, and the matter was transferred to the Office of Administrative Law as a contested case. B.C. testified about the types of general services provided to her mother and also submitted a list of services provided in 2005 and 2006. B.C. acknowledged that her sole responsibility was not to provide full-time care to her mother, as she conducted several business from her home and managed her husband's soccer business.

For several reasons, the ALJ rejected the care agreements as constituting credible documentary evidence. First, the ALJ found that E.A. and B.C. did not comply with the care agreements, as evidenced by B.C.'s numerous larger withdrawals. Second, the ALJ found that Comfort Keeper's monthly rate was not

equivalent to B.C.'s monthly rate because Comfort Keeper's rate reflected services provided by bonded, insured and trained care providers who provided extensive services to patients and whose sole responsibility was to accommodate the patient's needs. The ALJ determined that because B.C. was not trained or licensed and had responsibilities other than caring for E.A., she was not entitled to the higher rates charged by Comfort Keepers. Third, the ALJ found that the care agreement did not specify the types of services and terms of compensation for each service provided. The ALJ also rejected B.C.'s examples of services provided in 2005 and 2006, before the start of the look-back period.

Although the ALJ acknowledged that B.C. had provided substantial services to E.A., citing N.J.A.C. 10:71-4.10(b)(6)(i), he emphasized that it was customary for children to provide many of these services to their parents out of love and affection for no compensation. Citing N.J.A.C. 10:71-4.10(b)(6)(ii), the ALJ found that B.C. failed to present credible documentary evidence establishing that the fair market value of the transferred assets was not greater than the prevailing rates for similar care or services in the community. The ALJ concluded that B.C.'s failure to provide details of the types of services provided under the care agreement, the time

expended on those services, and the comparable value of those services, rendered a finding on fair market value impossible.[6]

The ALJ concluded that E.A. failed to present convincing evidence that the assets were not transferred for the purpose of establishing Medicaid eligibility, or credible documentary evidence preexisting the delivery of care and services indicating the type and terms of compensation or that the amount of compensation or fair market value of the transferred assets was not greater than the prevailing rates for similar care in the community. Accordingly, the ALJ upheld HCBSS's decision.

In a December 20, 2013 final agency decision, DMAHS Director adopted the ALJ's initial decision in its entirety. The Director additionally emphasized that E.A. "used licensed, professional rates to justify transfers that did not correspond to the scope and breath of services provided under those rates." The Director concluded that

[6] We note that B.C. submitted her tax returns as evidence that the care agreement "was an arm's length transactions and not a gift or a transfer to her." The ALJ found that the tax returns established that E.A. and B.C. often disregarded the care agreements, and thus, did not constitute credible documentary evidence rebutting the presumption in N.J.A.C. 10:71-4.10(b)(6)(ii). Contrary to E.A.'s argument in her reply brief, neither the ALJ nor the DMAHS Director held that N.J.A.C. 10:71-4.10(b)(6)(ii) requires persons providing care under a care agreement to show that they accurately reported income derived from the agreement on their income tax return.

> [t]he record demonstrated that [B.C.] was employed and working outside the home. There [was] no clear delineation of time afforded to [E.A.'s] care, as [B.C.] would "attend to her own personal and business affairs" while being compensated to provide care to her mother. Rather[,] the [care] agreement used lump sum amounts to transfer funds to [B.C.] that did not reflect fair market value.

On appeal, E.A. argues that: (1) DMAHS erred in not recognizing care agreements;[7] (2) DMAHS erred in failing to accept the comparison of B.C.'s services and rates to the services and rates charged by Comfort Keepers, and in requiring B.C. to be licensed to provide services; (3) DMAHS's decision was contrary to the weight of the evidence; and (4) DMAHS failed to calculate the worth of B.C.'s services, resulting in the imposition of an excessive period of ineligibility.

Our review of an agency decision is limited. R.S. v. Div. of Med. Assistance & Health Servs., 434 N.J. Super. 250, 260-61 (App. Div. 2014). "An administrative agency's decision will be upheld 'unless there is a clear showing that it is arbitrary, capricious, or unreasonable, or that it lacks fair support in the record.'" Id. at 261 (quoting Russo v. Bd. of Trs., 206 N.J. 14, 25 (2011)).

---

[7] E.A. relies on unpublished opinions to support this contention. However, those opinions do not constitute precedent or bind us. R. 1:36-3; Trinity Cemetery Ass'n v. Twp. of Wall, 170 N.J. 39, 48 (2001).

In determining whether agency action is arbitrary, capricious, or unreasonable, our role is restricted to three inquiries:

> (1) whether the agency action violates the enabling act's express or implied legislative policies; (2) whether there is substantial evidence in the record to support the findings upon which the agency based application of the legislative policies; and (3) whether, in applying the legislative policies to the facts, the agency clearly erred by reaching a conclusion that could not reasonably have been made upon a showing of the relevant factors.
>
> [Ibid. (quoting H.K. v. Div. of Med. Assistance & Health Servs., 379 N.J. Super. 321, 327 (App. Div.), certif. denied, 185 N.J. 393 (2005)).]

"'Deference to an agency decision is particularly appropriate where interpretation of the [a]gency's own regulation is in issue.'" Ibid. (quoting I.L. v. N.J. Dep't of Human Servs., Div. of Med. Assistance & Health Servs., 389 N.J. Super. 354, 364 (App. Div. 2006)). "Nevertheless, 'we are not bound by the agency's legal opinions.'" A.B. v. Div. of Med. Assistance & Health Servs., 407 N.J. Super. 330, 340 (App. Div.) (quoting Levine v. State Dep't of Transp., 338 N.J. Super. 28, 32 (App. Div. 2001)), certif. denied, 200 N.J. 210 (2009). "Statutory and regulatory construction is a purely legal issue subject to de novo review." Ibid.

Applying the above standards, we discern no reason to disturb DMAHS's decision, as it is amply supported by the record. Contrary to E.A.'s argument, DMAHS did not refuse to recognize the care agreement. Rather, DMAHS accepted the ALJ's initial decision in its entirety. The initial decision included the ALJ's analysis of and reasons for rejecting the care agreement. The record supports the ALJ's determination that E.A. failed to present convincing evidence that the assets were not transferred for the purpose of establishing Medicaid eligibility, or credible documentary evidence preexisting the delivery of care and services indicating the type and terms of compensation or that the amount of compensation or fair market value of the transferred assets was not greater than the prevailing rates for similar care in the community.

The mere existence of a pre-existing care agreement for services does not automatically establish that the services were rendered for fair market value. See E.S. v. Div. of Med. Assistance & Health Servs., 412 N.J. Super. 340, 352-53 (App. Div. 2010). Notwithstanding a care agreement, the applicant still bears the burden to establish the types of care or services provided, the type and terms of compensation, the fair market value of the compensation, and that the amount of compensation or the fair market value of the transferred asset

is not greater than the prevailing rates for similar care or services in the community. <u>N.J.A.C.</u> 10:71-4.10(b)(6)(ii) and (j). The care agreement in this case fell short of meeting that burden.

We disagree that B.C. proved that she provided care and services similar to Comfort Keepers. As the ALJ and DMAHS properly found, care providers at Comfort Keepers must undergo mandatory and specialized training and they provide full-time care to patients. B.C. did not provide full-time care; she attended to her personal and business affairs and was not providing constant care equivalent to that of the licensed professionals at Comfort Keepers, whose sole responsibility is to care for their patients.

In addition, contrary to E.A.'s argument, DMAHS was not establishing a disqualifying condition that only trained/bonded/licensed caregivers may validly receive compensation under a care agreement. Rather, DMAHS found that B.C. was not entitled to the rate charged by Comfort Keepers because she did not provide the same full-time services that Comfort Keepers provides.

Finally, we reject E.A.'s argument that DMAHS failed to calculate the worth of B.C.'s services, resulting in the imposition of an excessive period of ineligibility. E.A., not

DMAHS, bore the burden to establish the fair market value of the transferred assets, which she failed to do. <u>N.J.A.C.</u> 10:71-4.10(j). Even if DMAHS should have performed a calculation, E.A. provided insufficient details of the types of services actually provided under the care agreement, the actual time expended on those services, or an appropriate or the comparable value of those services, making a calculation virtually impossible. Given that E.A. already had a full and fair opportunity to present that evidence to DMAHS, as well as B.C.'s repeated disregard of the terms of the agreement in collecting monetary withdrawals and in her tax filings, principles of equity do not require a remand in this case for a potential recalculation.

We are satisfied there is sufficient credible evidence in the record supporting DMAHS's decision and the decision is not arbitrary, capricious or unreasonable.

Affirmed.

I hereby certify that the foregoing
is a true copy of the original on
file in my office.

CLERK OF THE APPELLATE DIVISION