State of New Jersey

OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION

3 OAL DKT. NO. HMA 1856

Agency Final Decision9-16

B.K.,

Petitioner,

v.

MONMOUTH COUNTY DIVISION OF

SOCIAL SERVICES AND DIVISION OF

MEDICAL ASSISTANCE AND

HEALTH SERVICES,

Respondents.

Gary Garland, Esq., appearing for petitioner

Lourdes Martin, Fair Hearing Liaison, appearing for respondent pursuant to N.J.A.C. 1:1-5.4(a)(3)

No appearance on behalf of respondent Division of Medical Assistance and Health Services

Record Closed: April 3, 2017 Decided: April 24, 2017

BEFORE **SUSAN M. SCAROLA**, ALJ:

STATEMENT OF THE CASE

Petitioner, B.K., appeals the denial of eligibility for Medicaid Managed Long Term Care Special Services Program (MLTSS) by respondent, Monmouth County Division of Social Services (Division), because her resources exceed the eligibility limit as the result of a private pay agreement (contract) in effect at the nursing facility in which she resides. She contends that eligibility has been met because she is resource eligible, and that any transfer penalty to be imposed should run at the same time as she complies with the private pay agreement.

PROCEDURAL HISTORY

3 On October 31, 2016, petitioner commenced the Medicaid application process with the Division of Medical Assistance and Health Services and the Division. On November 17, 2016, the petitioner was found to be ineligible for benefits, including ancillary services.[1] The petitioner filed a timely request for a hearing, and the matter was transmitted to the Office of Administrative Law, where it was filed on December 9, 2016. N.J.S.A. 52:14B-1 to -15; N.J.S.A. 52:14F-1 to -13. A hearing was held on March 10, 2016, and the record remained open until April 3, 2017.

FINDINGS OF FACT

The facts are not in dispute, and, accordingly, **I FIND**:

> 1. On or about June 1, 2016, the petitioner, then age eighty-seven, entered the nursing facility. She executed a contract dated June 1, 2016, which indicated that she would privately pay for services at the nursing facility through at least May 31, 2018.[2] The facility indicated in "Exhibit 3" of the Contract, "Medicaid

Waiver Addendum," that it would not consider accepting Medicaid benefits for the petitioner until twenty-four months after admission and private pay.[3]3 Prior to May 31, 2018, the petitioner was personally responsible for the facility's monthly charges. The petitioner agreed to these terms and executed the "Medicaid Waiver" to the contract.

2. On October 31, 2017, the petitioner (through her authorized representative) applied for Medicaid benefits. As part of the application process, it was determined that the petitioner had sold her home in August 2016 for approximately $209,000, and that these funds had been placed in the petitioner's account, which had a total account balance on August 5, 2016, of $225,958.32.[4] A portion of these funds was withdrawn and used to pay for the petitioner's care at the facility from her admittance.

3. On or about October 28, 2016, $163,238.04, was transferred out of the petitioner's account. On that same day, another $10,500 was withdrawn, leaving a zero balance.

4. Because the petitioner's assets were less than $2,000, petitioner felt she was eligible to commence receipt of MLTSS benefits, except for the calculation of the penalty period,[5] which she acknowledged must be imposed. She sought immediate eligibility so that the penalty period could run as the nursing facility was being paid during the "private pay" period. The petitioner was not seeking immediate payment of Medicaid benefits; rather, she was seeking immediate eligibility for benefits to permit the transfer penalty to run. Clinical eligibility for Medicaid was established on December 13, 2016.

5. The Division made inquiry at the nursing facility and was advised that the petitioner had a contract to pay for twenty-four months of care before the facility would accept Medicaid payment, and that it would not presently accept any Medicaid payment for the benefit of the petitioner. Further, there was no guarantee that when the twenty-four-month period had expired, a Medicaid bed would be available for the petitioner.

6. The Division considered that the private pay agreement/contract between the petitioner and the facility was a resource available to her, and consequently denied Medicaid eligibility. It indicated that once the petitioner actually needed Medicaid benefits, she could re-apply, and if a transfer penalty were to be imposed, it would commence running from the date of eligibility that would then be determined.

LEGAL ANALYSIS AND CONCLUSION

Congress created the Medicaid program under Title XIX of the Social Security Act (the "Act"), 42 U.S.C.A. §§ 1396 to 1396w-5. The program is funded by the federal government and administered by the states, including New Jersey. A.K. v. DMAHS, 350 N.J. Super. 175 (App. Div. 2002).

New Jersey participates in Medicaid through the New Jersey Medical Assistance and Health Services Act. N.J.S.A. 30:4D-1 to -19.5. The Commissioner of the Department of Human Services has promulgated regulations implementing New Jersey's MLTSS Medicaid programs to include income and resource eligibility standards for all applicants and recipients. N.J.A.C. 10:71-4.1 to 5.9; N.J.A.C. 10:70-4.1 to 5.4. A "resource" is "real or personal property . . . which could be converted to cash to be used for [the individual's] support and maintenance." N.J.A.C. 10:71-4.1(b); N.J.A.C. 10:70-5.3(a). Unless specifically excluded, all liquid and non-liquid resources are considered "countable" resources in determining eligibility for participation in the Medicaid Only and Medically Needy Medicaid programs. N.J.A.C. 10:71-4.1(b); N.J.A.C. 10:71-4.2(a); N.J.A.C. 10:70-5.3(a). The resource must also be "available." A resource is deemed "available" to an individual when "[t]he person has the right, authority, or power to liquidate real or personal property, or his or her share of it." N.J.A.C. 10:71-4.1(c)(1); N.J.A.C. 10:70-5.3(a).

An applicant's Medicaid eligibility is postponed until all of the available assets, except those that are exempt, have been "spent down" to the eligibility limits. N.J.A.C. 10:70-6.1(a). Participation in the MLTSS program must be denied or terminated if the total value of an individual's resources exceeds $2,000. N.J.A.C. 10:71-4.5(c). Resource eligibility is generally determined as of the first moment of the first day of each month for which eligibility is sought to be established. N.J.A.C. 10:71-4.5(a)(1).

Pursuant to the Deficit Reduction Act (DRA) of 2005 (enacted February 8, 2006), if an applicant transfers assets for less than fair market value during the look-back period, then those assets are included in the eligibility analysis as funds available to the applicant, and a period of ineligibility is assessed. See 42 U.S.C.A. § 1396p(c)(1); N.J.A.C. 10:71-4.10(a). This period of ineligibility is known as a transfer penalty. 42 U.S.C.A. § 1396p(c)(1)(A) and (E); N.J.A.C. 10:71-4.10(a).

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 transferred. Value is based on the criteria for evaluating assets as found in N.J.A.C. 10:71-4.1(d). N.J.A.C. 10:71-4.10(b)(6). The transfer penalty is calculated by dividing the uncompensated portion of the transferred resource by the monthly average cost of nursing home care in New Jersey. N.J.A.C. 10:71-4.10(m)(1).

The penalty period in the case of a transfer of assets made on or after the date of the enactment of the DRA begins to run on the later of three dates: the first day of a month during which assets have been transferred for less than fair market value; the first day of a month after which assets have been transferred for less than fair market value; or the date when the individual becomes eligible for medical assistance and would be receiving institutional-level care based on an approved application if not for the penalty. 42 U.S.C.A. § 1396p(c); E.B. v. DMAHS, HMA 2289-07, Initial Decision (August 23, 2007), adopted, Director (November 19, 2007), <http://njlaw.rutgers.edu/collections/oal/>. The penalty does not begin when the applicant is merely financially eligible or merely medically eligible, but rather when the applicant meets all the requirements for Medicaid eligibility under the State plan, including medical eligibility.

Here, the petitioner presents the most intriguing issue: presuming she has resources below the eligibility limit and is otherwise clinically eligible for Medicaid benefits, should she not be considered eligible for MLTSS benefits and ancillary services while the penalty period runs during the two-year period of private pay at the nursing facility? The petitioner contends that this would happen if she had remained in the community, and that she is being penalized because she entered the facility. She contends that if she were found eligible for Medicaid while in the community, the penalty period would be running concurrently to the use of any funds transferred out of her account (and being used for her care). Simply because the facility will not accept Medicaid payment now, does not mean that she is not otherwise eligible for

benefits. Further, she contends that Medicaid should not be entirely denied during a private pay period, meaning she would be eligible for ancillary services.

The Division contends that since the facility will not take any Medicaid benefit until after two years of private pay and since the petitioner personally guaranteed payment for those two years before she could apply for a Medicaid bed at the facility, the contract and the resources it represents must be considered as a resource in excess of the maximum available to the petitioner.

The Division also contends that there can be no finding of "present future eligibility" with the running of the penalty period concurrently with the private pay agreement/contract, as that would defeat the purpose of the penalty period. Parties could divest themselves of their assets and yet use them for their care as the penalty ran to ensure eligibility for a Medicaid bed at a facility with limited Medicaid availability. This petitioner does not want Medicaid now; she just wants the penalty period to run, and to receive ancillary services. The Division also contends that since this facility does not accept Medicaid payments in the presence of the two-year private pay contract, the Division has no one to pay, and, therefore, eligibility cannot exist without a recipient for the Medicaid payment. She is not eligible because she has no need for Medicaid.

The Division cites to N.J.A.C. 10:71-4.5(c), which provides that the resource maximum for an individual for participation in the program shall be denied or terminated if the total value of an individual's resources exceeds $2,000, and N.J.A.C. 10:71-3.14(a), which provides for institutional eligibility to "[p]ersons who are otherwise eligible for Medicaid Only receive medical coverage while receiving patient care in eligible medical institutions. Such coverage shall be provided through the appropriate payment mechanism of the Division of Medical Assistance and Health Services."

In response, the petitioner cites N.J.A.C. 10:71-4.1(b), which defines resources as "any real or personal property which is owned by the applicant (or by those persons whose resources are deemed available to him or her, as described in N.J.A.C. 10:71-4.6) and which could be converted to cash to be used for his or her support and maintenance. Both liquid and nonliquid resources shall be considered in the determination of eligibility, unless such resources are specifically excluded under

the provisions of N.J.A.C. 10:71-4.4(b).” A resource is considered available to an individual when the person has the right, authority or power to liquidate real or personal property or his or her share of it; or it has been deemed to him; or it arises from a third-party claim or action. N.J.A.C. 10:71-4.4(c)(1). Resource eligibility is determined as of the first moment of the first day of each month. N.J.A.C. 10:71-4.5(a)(1). The petitioner contends that in no way can a contract to pay an obligation be considered a resource; rather, it is a liability. Further, she suggests that there is a “huge distinction” between not accepting Medicaid payment for a period of time versus not being entitled to it.

What has happened here? The petitioner moved into a nursing facility; signed a contract obligating her to pay for two years; sold or transferred her resources; stripped herself of her financial assets; applied for Medicaid; and became clinically eligible. She does not seek Medicaid to pay the financial institution because she is presently financially needy[6]; rather, she wants to be considered eligible for Medicaid so that the transfer penalty, which she acknowledges must be imposed, can start to run, and thereby ensure her that she will be entitled to a Medicaid bed in the same facility in two years or whenever the penalty has run, whichever last occurs. Presumably, the petitioner either has access to the transferred resources, or a third party will be using them, to satisfy her two-year contractual obligation to the facility, particularly as no other guarantor is noted in the contract as having accepted the obligation to pay the facility. Regardless of this creative approach, the petitioner urges that her entitlement to Medicaid is not controverted, and that all she is seeking is an eligibility determination with ancillary services, but with no actual Medicaid payment to the facility.

While the petitioner has taken a rather unique approach to eligibility to ensure a Medicaid bed in two years, the petitioner has failed to consider the definition set forth in N.J.A.C. 10:71-2.1. The “application process” means all activity performed by the Income Maintenance Section relating to a request for **medical assistance payments**. N.J.A.C. 10:71-2.1 (emphasis supplied). The implication is that a party files an application when he or she is seeking payment for medical expenses, not just an eligibility determination. Here, the petitioner applied for an eligibility determination while not seeking present medical-assistance payments. It is an application for a determination of “present future eligibility,” which does not appear to be contemplated in the current regulations.

The petitioner asserts that if she were in the community in the same situation,

the penalty period would start to run because she was financially and clinically eligible, and that she would not be penalized if she then entered a facility. While that may well be true, the distinction here is that by executing a contract with a personal guaranteed payment for two years, the petitioner has essentially stated that although she may not have assets in her name, she, or persons acting on her behalf, have access to such assets. Her financial eligibility is a sham designed to have a Medicaid bed waiting for her when her transferred assets run out. Further, payment cannot be made to this facility by Medicaid because the facility will not accept Medicaid medical-assistance payments until the petitioner has been a resident for two years, as set forth in the contract. The result is that this application for Medicaid benefits is premature, and was properly denied.

ORDER

I **ORDER** that the decision of the respondent, Monmouth County Division of Social Services, denying the petitioner's eligibility for Medicaid Managed Long Term Care Special Services Program benefits is **AFFIRMED**, and that the petitioner's appeal is hereby **DISMISSED**.

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 days and unless such time limit is otherwise extended, this recommended decision shall become a final decision in accordance with N.J.S.A. 52:14B10.

Within seven 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, PO 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.

3 April 24, 2017

DATE **SUSAN M. SCAROLA**, ALJ

Date Received at Agency:

Date Mailed to Parties:

SMS

APPENDIX

WITNESSES

For petitioner:

Melissa Jacobs

For respondent:

Joanne Kumar, Human Services Specialist 2

Lauren Townsend, Human Services Specialist 3

EXHIBITS

For petitioner:

P-1 Contract and Addendums executed by the petitioner and the facility dated June 1, 2016

For respondent:

R-1 Summary, application and verification information

R-2 HUD-1 Statement

R-3 Bank account statements

R-4 Letter from Nursing Facility dated November 18, 2016

R-5 Denial Letter dated November 17, 2016

R-6 Emails

R-7 Bank Account Detail

R-8 Hearing Notice

R-9 Regulations

1 Three denials were issued: one on October 31, 2016; one on November 17, 2016; and one that was undated. Three requests for an appeal were also filed.

2 The petitioner executed the contract on her own behalf. On Schedule C, "Responsible Party Agreement and Guaranty," only the petitioner's name is listed. While E.D., the petitioner's daughter, is named in the preamble as a responsible party or guarantor, she did not execute the addendum.

3 The contract noted that Medicaid beds were limited and that the facility did not directly admit Medicaid residents.

4 The exact amount of the cash assets is in dispute, but the amount of the proceeds from the sale of the house is not in dispute (HUD-1). The Division indicated that information on two other possible bank accounts was required.

5 The penalty period for asset transfer 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 adjusted annually in accordance with the change in the Consumer Price Index-All Urban Consumers, rounded up to the nearest dollar. N.J.A.C. 10:71-4.10(m)(1).

6 Indeed, the facility would refuse to accept payment from Medicaid, as it takes no direct Medicaid admissions.

New Jersey is an Equal Opportunity Employer