STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

IN THE MATTER OF:

Reg. No.: 14-019552
Issue No.: 2001
Case No.:
Hearing Date: June 2, 2015
County: Genesee #06

ADMINISTRATIVE LAW JUDGE: Landis Y. Lain

HEARING DECISION

Following Claimant's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 45 CFR 99.1 to 99.33; and 45 CFR 205.10. After due notice, an in-person hearing was held on June 2, 2015, from Lansing, Michigan. Claimant was represented at the hearing by Authorized Hearings Representative (AHR) Attorney). Claimant is deceased as of October 7, 2014, and did not appear to testify at the hearing. Claimant's spouse, , appeared on Claimant's behalf.

The Department of Health and Human Services was represented by Assistant Attorney General). Participants/Witnesses on behalf of the Department of Health and Human Services (Department) included , Eligibility Specialist/Hearings Facilitator; , Department Specialist, Office of Legal Services; and , Director of Field Operations.

State's Exhibit A pages 1-190 and Brief Exhibits A-J were admitted as evidence without objection. Both parties filed briefs, which were considered in making this determination.

ISSUE

Did the Department properly deny Claimant's application for Medical Assistance – Long-Term Care (MA-LTC) based upon its determination that Claimant had excess assets?

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On January 8, 2014, Claimant (hereinafter referred to as Claimant) entered long-term care (LTC).

2. On August 1, 2014, the was established by Claimant's spouse for the sole benefit of Claimant's spouse. (State's Exhibit A pages 60-68)

3. On August 25, 2014, Claimant's Attorney filed an application for MA-LTC for Claimant. The months in dispute are August, September and October 2014.

4. An Initial Asset Assessment was conducted with the date Claimant entered LTC (January 8, 2014).

5. The Department determined in the initial asset assessment that on the date that Claimant entered LTC, Claimant and the spouse had combined resources in the amount of $ (State's Exhibit A page 118)

6. The Department determined that the spousal share amount was $ which was protected from being counted as Claimant's asset.

7. The Department determined that Claimant had total countable resources in the amount of $ (State's Exhibit A page 119)

8. The Claimant and spouse have several assets including a Solely for the Benefit Of (SBO) Trust.

9. The document was sent to the Office of Legal Services/Trusts and Annuities Unit for evaluation.

10. On August 25, 2014, the Department received a DHS-4574 Medicaid Application, DHS-4574 Asset Declaration, as well as verification of Identity, assets and income.

11. On August 29, 2014, the trust was evaluated as follows: is an Irrevocable Medicaid Trust; and there are circumstances under which payment of principal income can be made to or on behalf of (Claimant) from the trust. Therefore, the assets in this trust are countable. (State's Exhibit A pages 79-81)

12. On September 29, 2014, the Medicaid (MA) application was processed in Bridges resulting in an MA denial.

13. On September 29, 2014, the Department caseworker sent Claimant's AHR a Health Care Coverage Determination Notice of Case Action that the application for MA was denied due to excess assets.

14. On December 23, 2014, Claimant's AHR filed a request for a hearing to contest the Department's action stating that the Department incorrectly applied BEM Item 400, 401 and 402.

15. Claimant contests the denial of MA coverage for August 2014-October, 2014.

16. On June 2, 2014, the hearing was held.

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), Department of Health and Human Services Reference Tables Manual (RFT), and Department of Health and Human Services Emergency Relief Manual (ERM).

The regulations governing the hearing and appeal process for applicants and recipients of public assistance in Michigan are found in the Michigan Administrative Code, MAC R 400.901-400.951. An opportunity for a hearing shall be granted to an applicant who requests a hearing because his or her claim for assistance has been denied. MAC R 400.903(1). Claimants have the right to contest a Department decision affecting eligibility or benefit levels whenever it is believed that the decision is incorrect. The Department will provide an administrative hearing to review the decision and determine the appropriateness of that decision. BAM 600.

In this case, Claimant's representative contends:

> BEM 401 states: "A trust may allow use of one portion of the principal, but not another portion. Count only the usable portion. BEM 401 does address this language and implies that if trust principal may not be used then it is divested. The policy draws two conclusions: 1) the trust terms control, and 2) if the principal is not available it is divested. Sole benefit trusts are a safe harbor. BEM 405, page 11.
>
> The State Medical Program Section 3257 makes it clear that a transfer is considered to be for the sole benefit of a spouse if the transfer is arranged in such a way that no individual or entity except the spouse "can benefit from the assets transferred in any way, whether at the time of transfer or at any time in the future…
>
> There is no circumstance under which the principal or income of the [redacted] can be paid to Claimant, the assets held by the trustee of the trust must be considered to have been transferred for less than fair market value.
>
> BEM, 405 indicates that such a transfer is divestment; but no divestment penalty attaches to resources transferred from Claimant or spouse to an SBO Trust for the benefit of the spouse.
>
> That the [redacted] was initially considered an exempt asset by Michigan Department of Health and Human Services (DHHS) according to DHHS representative [redacted] prior to the change in interpretation of SBO Trust policy on August 20, 2014.
>
> That the Department did not afford proper notice of the change in interpretation of Trust policy and did not provide proper notice of which Bridges Eligibility Manual it was citing when making this determination.

The regulations governing the hearing and appeal process for applicants and recipients of public assistance in Michigan are found in the Michigan Administrative Code, MAC R 400.901 - .951. An opportunity for a hearing shall be granted to an applicant who requests a hearing because his or her claim for assistance is denied. MAC R 400.903(1). An opportunity for a hearing shall be granted to an applicant who requests a hearing because of a denial. MAC R 400.903(2)

Clients have the right to contest a Department decision affecting eligibility or benefit levels whenever it is believed that the decision is incorrect. BAM 600. The Department will provide an administrative hearing to review the decision and determine the appropriateness. BAM 600. The Michigan Administrative Hearing System (MAHS) may grant a hearing for any of the following:

- Denial of an application and/or supplemental payments
- Reduction in the amount of program benefits or service
- Suspension or termination of program benefits or service
- Restrictions under which benefits or services are provided
- Delay of any action beyond the standard of promptness
- For FAP only, the current level of benefits or denial of expedited service.

  Additionally, for MA purposes, MAHS may grant a hearing on other issues not applicable here, such as community spouse income, allowance, asset assessment, etc. BAM 600

Department policy also indicates that the application forms and each written notice of case action inform clients of their right to a hearing. These include an explanation of how and where to file a hearing request, and the right to be assisted by and represented by anyone the client chooses. The client must receive a written notice of all case actions affecting eligibility or amount of benefits. When a case action is completed it must specify:

- The action being taken by the department; **and**
- **The reason(s) for the action; and**
- **The specific manual item(s)** that cites the legal base for an action, or the regulation, or law itself. See BAM 220. BAM, Item 600, page 1.

In this case, the Department did provide the client with notice as is required by Department policy. BEM 402 does control trusts. The Department also used BEM 401,

Trust policy when making the determination. The Initial Asset Assessment Notice Cited BEM 402 as the Manual Policy Reference. (State's Exhibit A page 117) the Health Care Coverage Determination Notice cites: BEM 400; ERM 205.

This Administrative Law Judge finds that the Notice was sufficient. Though the notice does not state each and every policy item which was considered in making the determination, the department does cite the appropriate policy item in the Notice to give the Claimant notice that the Department determined that Claimant's application was denied because he possessed excess assets. BEM 400 is the policy item which governs Assets.

During the hearing, the Claimant's attorney argued that the term "the person" refers strictly to the Medicaid applicant. Therefore, the trust is a transfer for less than fair market value and would be subject to divestment, but for the fact that BEM 405, p. 9, provides that no divestment penalty attaches to resources transferred from the Claimant or his spouse to another solely for the benefit of the Claimant's spouse.

The Department argued that the term "the person" refers to the trust beneficiary and is, therefore, a countable asset for Claimant, because the assets of both spouses must be counted when determining eligibility, which puts the Claimant over the asset limit to be eligible for MA-LTC.

During the hearing, the Department conceded that it has changed its interpretation of policy in regards to SBO Trusts. That change would be that SBO Trust assets were not counted as Claimant's assets up until July or August of 2014. At that time, the Department changed its interpretation of the policy so that SBO Trust assets would be countable and in compliance with federal law. The policy itself never changed. Before the change in interpretation of the policy, if the distribution from the trust to the community spouse occurred in the future, the asset was not considered countable. The Department testified that, prior to the change in its interpretation of the policy in the summer of 2014; the trust assets in this case were not counted.

The Medical Assistance (MA) program is established by the Title XIX of the Social Security Act, 42 USC 1396-1396w-5, and is implemented by 42 CFR 400.200 to 1008.59. The Department of Human Services (formerly known as the Family Independence Agency) administers the MA program pursuant to MCL 400.10 and MCL 400.105. Department policies are found in the Program Administrative Manual (BAM), the Program Eligibility Manual (BEM) and the Program Reference Manual (PRM).

Title XIX of the Social Security Act, commonly referred to as "The Medicaid Act," provides for Medical Assistance services to individuals **<u>who lack the financial means to obtain needed health care</u>**. 42 U.S.C. §1396. (Emphasis added)

The Medicaid program is administered by the federal government through the Centers for Medicaid and Medicare Services (CMS) of the Department of Health and Human Services (HHS). The state and federal governments share financial responsibility for Medicaid services. Each state may choose whether or not to participate in the Medicaid

program. Once a state chooses to participate, it must operate its Medicaid program in accordance with mandatory federal requirements, imposed both by the Medicaid Act and by implementing federal regulations authorized under the Medicaid Act and promulgated by HHS.

Participating states must provide at least seven categories of medical services to persons determined to be eligible Medicaid recipients. 42 USC §1396a(a)(10)(A), 1396d(a)(1)-(5), (17), (21). One of the seven mandated services is *nursing facility services*. 42 USC §1396d(a)(4)(A).

For Medical Assistance eligibility, the Department has defined an asset as "any kind of property or property interest, whether real, personal, or mixed, whether liquid or illiquid, and whether or not presently vested with possessory rights." NDAC 75-02-02.1-01(3). Under both federal and state law, an asset must be "actually available" to an applicant to be considered a countable asset for determining Medical Assistance eligibility. *Hecker,* 527 N.W.2d at 237 (On Petition for Rehearing); *Hinschberger v. Griggs County Social Serv.,* 499 N.W.2d 876, 882 (N.D.1993); 42 U.S.C. § 1396a(a)(17)(B); 1 J. Krauskopf, R. Brown, K. Tokarz, and A. Bogutz, *Elderlaw: Advocacy for the Aging* § 11.25 (2d ed. 1993). Yet, "actually available" resources "are different from those *in hand.*" *Schweiker v. Gray Panthers,* 453 U.S. 34, 48, 101 S.Ct. 2633, 2642, 69 L.Ed.2d 460 (1981) (emphasis in original). NDAC 75-02-02.1-25(2) explains: Only such assets as are actually available will be considered. Assets are actually available when at the disposal of an applicant, recipient, or responsible relative; when the applicant, recipient, or responsible relative has a legal interest in a liquidated sum and has the legal ability to make the sum available for support, maintenance, or medical care; or when the applicant, recipient, or responsible relative has the lawful power to make the asset available, or to cause the asset to be made available. Assets will be reasonably evaluated···· *See also 45 C.F.R. § 233.20(a)(3)(ii)(D).*

As noted in *Hecker,* if an applicant has a legal ability to obtain an asset, it is considered an "actually available" resource. The actual-availability principle primarily serves "to prevent the States from conjuring fictional sources of income and resources by imputing financial support from persons who have no obligation to furnish it or by overvaluing assets in a manner that attributes non-existent resources to recipients." *Heckler v. Turner,* 470 U.S. 184, 200, 105 S.Ct. 1138, 1147, 84 L.Ed.2d 138 (1985).

The focus is on an applicant's actual and practical ability to make an asset available as a matter of fact, not legal fiction. *See Schrader v. Idaho Dept. of Health and Welfare,* 768 F.2d 1107, 1112 (9th Cir.1985). *See also Lewis v. Martin,* 397 U.S. 552, 90 S.Ct. 1282, 25 L.Ed.2d 561 (1970) (invalidating California state regulation that presumed contribution of non-AFDC resources by a non-legally responsible and non-adoptive stepfather or common law husband of an AFDC recipient's mother).

Determining whether an asset is "actually available" for purposes of Medical Assistance eligibility is largely a fact-specific inquiry depending on the circumstances of each case. *See, e.g., Intermountain Health Care v. Bd. of Cty. Com'rs,* 107 Idaho 248, 688 P.2d 260, 264 (Ct.App.1984); *Radano v. Blum,* 89 A.D.2d 858, 453 N.Y.S.2d 38, 39 (1982);

Haynes v. Dept. of Human Resources, 121 N.C.App. 513, 470 S.E.2d 56, 58 (1996). Interpretation of the “actually available” requirement must be “reasonable and humane in accordance with its manifest intent and purpose····” *Moffett v. Blum,* 74 A.D.2d 625, 424 N.Y.S.2d 923, 925 (1980).

That an applicant must sue to collect an asset the applicant has a legal entitlement to usually does not mean the asset is actually unavailable. *See, e.g., Wagner v. Sheridan County S.S. Bd.,* 518 N.W.2d 724, 728 (N.D.1994); *Frerks v. Shalala,* 52 F.3d 412, 414 (2d Cir.1995); *Probate of Marcus,* 199 Conn. 524, 509 A.2d 1, 5 (1986); *Herman v. Ramsey Cty. Community Human Serv.,* 373 N.W.2d 345, 348 (Minn.Ct.App.1985). *See also Ziegler v. Dept. of Health & Rehab. Serv.,* 601 So.2d 1280, 1284 (Fla.Ct.App.1992) At issue here is the methodology utilized in determining the availability of an individual's “resources” for purposes of evaluating his or her eligibility. SSI recipients, and thus SSI-related “medically needy” recipients, may not retain resources having a value in excess of $2,000. 42 U.S.C. § 1382(a)(1)(B).

The regulations governing the determination of eligibility provide that resources mean cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his support and maintenance. If the individual has the right, authority or power to liquidate the property, or his share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse).20 C.F.R. § 416.1201(a).

After the Medicaid program was enacted, a field of legal counseling arose involving asset protection for future disability. The practice of “Medicaid Estate Planning,” whereby “individuals shelter or divest their assets to qualify for Medicaid without first depleting their life savings,” is a legal practice that involves utilization of the complex rules of Medicaid eligibility, arguably comparable to the way one uses the Internal Revenue Code to his or her advantage in preparing taxes. See generally *Kristin A. Reich, Note, Long-Term Care Financing Crisis-Recent Federal and State Efforts to Deter Asset Transfers as a Means to Gain Medicaid Eligibility*, 74 N.D. L.Rev. 383 (1998). Serious concern then arose over the widespread divestiture of assets by mostly wealthy individuals so that those persons could become eligible for Medicaid benefits. Id.; see also *Rainey v. Guardianship of Mackey*, 773 So.2d 118 (Fla. 4th DCA 2000). As a result, Congress enacted several laws to discourage the transfer of assets for Medicaid qualification purposes. See generally *Laura Herpers Zeman, Estate Planning: Ethical Considerations of Using Medicaid to Plan for Long-Term Medical Care for the Elderly, 13 Quinnipiac Prob. L.J. 187 (1988)*. Recent attempts by Congress imposed periods of ineligibility for certain Medicaid benefits where the applicant divested himself or herself of assets for less than fair market value. *42 U.S.C. § 1396p(c)(1)(A); 42 U.S.C. § 1396p(c)(1)(B)(i); Fla. Admin. Code R. 65A-1.712(3).* More specifically, if a transfer of assets for less than fair market value is found within 36 months of an individual's application for Medicaid, the state must withhold payment for various long-term care services, i.e., payment for nursing home room and board, for a period of time referred to as the penalty period. *Fla. Admin. Code R. 65A-1.712(3)*. Medicaid does not, however, prohibit eligibility altogether. It merely penalizes the asset transfer for a certain period of time. See *generally Omar N. Ahmad, Medicaid Eligibility Rules for the Elderly Long-Term Care Applicant, 20 J.*

Legal Med. 251 (1999). [*Thompson v. Dep't of Children & Families*, *835 So.2d 357*, *359-360 (Fla App, 2003).]*

In *Gillmore* the Illinois Supreme Court recognized this same history, noting that over the years (and particularly in 1993), Congress enacted certain measures to prevent persons who were not actually "needy" from making themselves eligible for Medicaid:

In 1993, Congress sought to combat the rapidly increasing costs of Medicaid by enacting statutory provisions to ensure that persons who could pay for their own care did not receive assistance. Congress mandated that, in determining Medicaid eligibility, a state must "look-back" into a three- or five-year period, depending on the asset, before a person applied for assistance to determine if the person made any transfers solely to become eligible for Medicaid. *See 42 U.S.C. § 1396p(c)(1)(B) (2000)*. If the person disposed of assets for less than fair market value during the look-back period, the person is ineligible for medical assistance for a statutory penalty period based on the value of the assets transferred. *See 42 U.S.C.§ 1396p(c)(1)(A) (2000).* [*Gillmore,* 218 Ill 2d at 306 (emphasis added).]

See, also, *ES* v. *Div. of Med. Assistance and Health Servs.*, *412 NJ Super 340, 344; 990 A.2d 701 (2010)* (Noting that the purpose of this close scrutiny while "looking back" is "to determine if [the asset transfers] were made for the sole purpose of Medicaid qualification.").

This statutory "look-back" period, noted in *Gillmore* and *Thompson* and contained within 42 USC 1396p(c)(1), requires a state to "look-back" a number of years (in this case five) from the date of an asset transfer to determine if the applicant made the transfer solely to become eligible for Medicaid, which can be established if the transfer was made for less than fair market value. See 42 USC 1396p(c)(1); DHS Program Eligibility Manual (PEM) 405, pp 1, 4; see also *Gillmore*, 218 Ill 2d at 306.

"Less than fair market value means the compensation received in return for a resource was worth less than the fair market value of the resource." BEM 405, p 5.

A transfer for less than fair market value during the "look-back" period is referred to as a "divestment," and unless falling under one of several exclusions, subjects the applicant to a penalty period during which payment of long-term care benefits is suspended. See, generally BEM 405, pp 1, 5-9. "Congress's imposition of a penalty for the disposal of assets or income for less than fair market value during the look-back period is intended to maximize the resources for Medicaid for those truly in need." *ES*, 412 NJ Super at 344. See also *Mackey v Department of Human Services, Michigan Court of Appeals, Docket No. 288966, decided September 7, 2010*.

Under BEM, Item 400, an eligible Medical Assistance recipient may not possess in excess of $2,000 in assets.

Assets mean cash, any other personal property and real property. **Real property** is land and objects affixed to the land such as buildings, trees and fences. Condominiums are real property. **Personal property** is any item subject to ownership that is **not** real property (examples: currency, savings accounts and vehicles). BEM, Item 400, page 1. Countable assets **cannot** exceed the applicable asset limit. Not all assets are counted. An asset is countable if it meets the availability tests and is **not** excluded. Available

means that someone in the asset group has the right to use or dispose of the asset. BEM, Item 400, page 5. All types of assets are considered for SSI-related MA. BEM, Item 400, page 2. For Medicare Savings Programs (BEM 165) and QDWI (BEM 169) the asset limit is:

- $4,000 for an asset group of one.
- $6,000 for an asset group of two.

For all other SSI-related MA categories, the asset limit is:

- $2,000 for an asset group of one.
- $3,000 for an asset group of two. BEM, Item 400, page 5.

BEM, Item 401, controls Medical Assistance Trust. Policy defines trust as a right of property created by one person for the benefit of himself or another. It includes any legal instrument or device that exhibits the general characteristics of a trust but is not called a trust or does not qualify as a trust under state law. Examples of such devices might be annuities, escrow accounts, pension funds and investment accounts managed by someone with fiduciary obligations. A trustee is defined by policy as the person who has the legal title to the assets and income of a trust and the duty to manage the trust with the benefit of the beneficiary. BEM, Item 401, p. 1.

The Department caseworker is to refer a copy of the trust to the Medicaid Eligibility policy section for evaluation. An evaluation of the trust advises local offices on whether the trust is revocable or irrevocable and whether any trust income or principle is available. Advice is only available to local offices for purposes of determining eligibility or for an initial assessment when a trust actually exists. Advice is not available for purposes of estate planning including advice on proposed trust or proposed trust limits. BEM, Item 401, p. 2.

The Medicaid Trust Unit/Eligibility policy section must determine if a trust established on or after August 11, 1993, is a Medicaid Trust using Medicaid trust definitions and Medicaid trust criteria. The policy unit also has to determine if the trust is a Medicaid trust and whether there are countable assets for Medicaid trusts; whether there is countable income for Medicaid trusts; and whether there is transfers of assets for less than fair market value. BEM, Item 401, p. 3.

A Medicaid trust is a trust that meets conditions 1 through 5 below:

1. The person whose resources were transferred to the trust is someone whose assets or income must be counted to determine MA eligibility, an MA post-eligibility patient-pay amount, a divestment penalty or an initial assessment amount. A person's resources include his spouse's resources (see definition).

2. The trust was established by:

   - The person.
   - The person's spouse.
   - Someone else (including a court or administrative body) with legal authority to act in place of or on behalf of the person or the person's spouse, or an attorney, or adult child.
   - Someone else (including a court or administrative body) acting at the direction or upon the request of the person or the person's spouse or an attorney ordered by the court.

3. The trust was established on or after August 11, 1993.

4. The trust was not established by a will.

5. The trust is **not** described in Exception A, Special Needs Trust, or Exception B, Pooled Trust in this item. BEM, Item 401, pages 5-6.

In this case, the [redacted] meets all of the criteria of a Medicaid trust. The person whose resources were transferred to the trust is someone whose assets or income must be counted to determine MA eligibility, and MA post-eligibility patient pay amount, a divestment penalty or an initial asset amount. The trust was established by the Claimant's spouse. The trust was established/amended on or after August 11, 1993. The trust was not established by will. The trust does not meet the condition of an exception A, special needs trust; or exception B, pooled trust as described in BEM, Item 401.

An initial asset assessment is needed to determine how much of a couple's assets are protected for the community spouse.

An initial asset assessment means determining the couple's (his, hers, their) total countable assets as of the first day of the **first** continuous period of care that began on or after September 30, 1989.

> **Example:** A married man entered a nursing home on 12/6/89. He was released on 6/10/90 and returned home.
>
> On 3/16/91 he re-entered the nursing home and has been there continuously ever since.
>
> He applied for MA on 10/2/91. To determine his asset eligibility, do an initial asset assessment for 12/6/89 - the first day of the first continuous period of care that began on or after September 30, 1989. BEM Item 402, page 7

In conducting the initial asset assessment, the Department must count both Claimant's and his spouse's total combined assets which were in existence as of the date when Claimant entered long-term care. Claimant's spouse did not place assets into an irrevocable trust until [redacted]. The spouse's transfer of assets to an irrevocable trust does not undo the initial asset assessment amount. The initial amount of

combined assets was $[redacted] The protected spousal amount was $[redacted] leaving Claimant with total countable assets of $[redacted] as of the long-term care entry date. Thus, the entire amount contained in the SBO Trust must be counted for purposes of Medicaid eligibility determination.

BEM, Item 401, page 10 states that the following are countable assets:

> Assets that are countable using SSI – related MA policy in BEM 400. Do not consider an asset unavailable because it is owned by the trust rather than the person.

The Department is to count as the person's countable asset the value of the trust's countable income if there is any condition under which the income could be paid to or on behalf of the person. Individuals can keep income made off of property and the money goes to the individual not the trust. Property cannot be taken out of the trust. BEM Item 401, page 11.

Section 2.2 of the trust document states:

> **Distribution of Income and Principal**. During each fiscal year of the Trust, trustee shall from time to time during the fiscal year pay or distribute to me, or for my sole benefit, during my lifetime whatever part of the net income and principal (the Resources) of the trust that Trustee determines is necessary to distribute the resources on an actuarially sound basis. However, during the first fiscal year, the distribution shall be made to me after November 30, 2014. State’s Exhibit A page 61.

The Trustee was advised to distribute all the assets on an actuarially sound basis, which for Medicaid purposes means that it must be returned to Claimant’s spouse over her lifetime. BEM, Item 405 pages 11 – 12. The “available” standard used for assets does not apply to trusts. BEM, Item 400, page 12. Thus, even if the trust had limitations on the yearly amounts, all assets are expected to be paid to Claimant’s spouse so there are conditions under which the principal could be paid to or on behalf of the person and all assets are countable. BEM, Item 401, page 11.

A “Solely for the Benefit Of” Trust (SBO Trust) does not make assets disappear or become uncountable simply by the creation of such a trust. Medicaid policy dictates that spouses are responsible for one another. BEM 401, page 4 indicates that all income and assets of a person and the person’s spouse are a resource for both spouses. It includes income and assets that the person or spouse is entitled to but does not receive because of an action by the person or the spouse; by some else with legal authority to act in place of or on behalf of the person or spouse; or by someone else acting at the direction or upon the request of the person or spouse.

In an application for LTC for an individual, the assets of both spouses are calculated when determining if there are excess assets, BEM 402, page 4.; 42 USC 1396r-5(c). The couple is permitted to retain $2,000 in assets for the applicant spouse, BEM 400,

page 7, plus the amount calculated as the Spousal Protected Resource amount, BEM 402; 42 USC 1396r-5.

Medicaid is the joint state/federal program that provides payment for covered health care services for eligible ***indigent*** individuals. MCL 400.105, *et seq*; 42 USC 1396a, *et seq.* Medicaid is a means tested program. If Medicaid applicants have sufficient assets, income or insurance to pay for health care they do not qualify for the Medical Assistance program. Indigent for purposes of Medicaid eligibility in Michigan means that a two-person household between the ages of 19-64 must have household income of under $20,920.90. Claimant and spouse have more than $20,920.00 in income and would not be considered indigent under Department policy or Federal poverty guidelines.

Congress enacted the Medicare Catastrophic Coverage Act (MCCA) of 1988, 42 USC 1396r-5, and the Omnibus Budget Reconciliation Act (OBRA), 42 USC 1396p, to prevent the medical expenses of the spouse in a hospital or LTC facility (the institutionalized spouse) from causing the impoverishment of the spouse remaining in the community (the community spouse) and to prevent financially secure couples from sheltering assets for the purpose of qualifying for Medicaid. *Johnson v Guhl,* 166 F Supp 2d 42, 46-47 (D NJ 2001) *(Johnson II)*, aff'd 357 F3d 403 (CA 3, 2004) *(Johnson III)*; *Hughes v McCarthy*, 734 F3d 473, 475 (CA 6, 2013). When an institutionalized spouse who has transferred assets to a trust applies for Medicaid benefits, the applicant's eligibility is subject to trust and transfer rules set forth in §§ 1396p and 1396r-5 respectively. *Johnson v Guhl,* 91 F Supp 2d 754, 762 (D NJ, 2000) *(Johnson I).*

The Spousal Impoverishment provision of the Medicare Catastrophic Act of 1988 is a federal law that only applies to couples. The intent of the law recognizes that it makes little sense to impoverish both spouses, when only one spouse needs long-term care. Under the Medicaid spousal impoverishment provisions, a certain amount of the couple's combined resources is protected for the spouse living in the community. The community spouse is allowed to keep one half of all assets to a maximum of $117,240.00 plus a Minimum Monthly Maintenance Needs Allowance (MMMNA), regardless of monthly income, so that the community spouse does not have to dip into savings each month to make expenses while the other spouse remains in long-term care.

Federal law allows a community spouse to retain a certain amount of assets. Department policy must be interpreted in accordance with Federal and State Laws and regulations. Any assets retained by the applicant or community spouse which exceed those allowed by law are necessarily countable. Department policy dictates that transfers from the client's spouse to another SBO irrevocable trust are not divestment. BEM 405, p.9. The transfer of the assets to the community spouse does not mean that the assets are not counted for Medicaid eligibility for the LTC spouse. Department policy requires that the distributions in excess of the protected amount allotted to the community spouse be counted for the applicant's eligibility. The trust, in the instant case, requires that assets be distributed back to the beneficiary community spouse during his/her lifetime. Therefore, there is a condition under which the principal could be

paid to or on behalf of the person (the community spouse), which makes the assets countable for purposes of Claimant's Medicaid benefit eligibility determination.

POMS SI 01120.201 explains the policy:

a. General rule for irrevocable trusts

   In determining whether an irrevocable trust established with the assets of an individual is a resource, we must consider how payments from the trust can be made. *If payments from the trust could be made to or for the benefit of the individual or individual's spouse (SI 01120.201F in this section), the portion of the trust from which payment could be made that is attributable to the individual is a resource*.

b. Circumstance under which payment can or cannot be made

   In determining whether payments can or cannot be made from a trust to or for the benefit of an individual (SI 01120.201F.1.), take into consideration any restrictions on payments. Restrictions may include use restrictions, exculpatory clauses, or limits on the trustee's discretion included in the trust. *However, if a payment can be made for the benefit of the individual under any circumstance, no matter how unlikely or distant in the future, the general rule in SI 01120.201D.2.a., in this section applies (i.e., the portion of the trust that is attributable to the individual is a resource.*

The POMS contains the emphasis for "*any circumstance*", no matter how unlikely or distant in the future and gives the following example:

> If a trust contains $50,000 that the trustee can pay to the beneficiary only in the event that he or she needs a heart transplant on his or her 100th birthday, the entire $50,000 is considered to be a payment which could be made to the individual under some circumstance and is a resource. (POMS SI 01120.201(D)(2))

Claimant's AHR also argues that Claimant relied upon the prior interpretation of Department policy in creating the SBO Trust for the benefit of Claimant's spouse and was never notified of the change in interpretation of the policy and that the change in interpretation of the policy occurred after the date of application so the old interpretation should control.

The matter presented is limited to the legal issue of (i) whether Spouse's SBO Trust is a countable asset under existing law and policy and (ii) if so, the value of the SBO Trust for MA asset eligibility purposes. It is noted that the Department's current position that irrevocable "solely for the benefit of" trusts such as Spouse's SBO Trust are countable assets is a change in the Department's long-standing policy finding that such trusts were not countable assets. While the Department's change in its position may raise issues concerning whether proper notice was provided, where Department policy is not contrary to existing law, the authority of an Administrative Law Judge is limited to

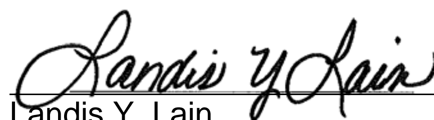
determining whether the Department's actions in denying Claimant's MA application were in accordance with Department policy. BAM 600 (July 2013), p. 35; Delegation of Hearing Authority executed by [redacted], Department Director, July 13, 2011, (expressly providing that ALJs "have no authority to make decisions on constitutional grounds, overrule statutes, overrule promulgated regulations, or overrule or make exceptions to Department policy.")

In this case, the community spouse's attempt to circumvent both federal law and Department policy by creating an SBO Trust to shelter excess personal assets is an attempt to retain assets which are in addition to/exceed the amounts allowed by policy and federal law. Such an attempt must fail. The Claimant's spouse cannot retain assets in excess of that allowed by law and policy. Claimant and spouse are not indigent. They, at all times relevant to this application, retained sufficient assets to pay claimant's LTC, and in fact, retained excess assets for purposes of MA benefit eligibility. The Department's determination must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, finds that the Department has established by the necessary competent, material and substantial evidence on the record that it acted in accordance with Department policy when it determined that the assets in the [redacted] were countable assets for purposes of MA benefit eligibility determination for Claimant; and that Claimant had in excess of $2,000 in countable available assets for purposes of MA and retroactive MA benefit eligibility on the date of application. The Department properly denied Claimant's application for MA under the circumstances and determined that he had in excess of $2,000 of countable available assets.

Accordingly, the Department's decision is **AFFIRMED**.



Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

Date Signed: **6/5/2015**

Date Mailed: **6/5/2015**

LYL/jaf

NOTICE OF APPEAL: The Claimant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely Request for

Rehearing or Reconsideration was made, within 30 days of the receipt date of the Decision and Order of Reconsideration or Rehearing Decision.

Michigan Administrative Hearing System (MAHS) **MAY** order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. MAHS will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request (60 days for FAP cases).

A Request for Rehearing or Reconsideration **MAY** be granted when one of the following exists:

- Newly discovered evidence that existed at the time of the original hearing that could affect the outcome of the original hearing decision;
- Misapplication of manual policy or law in the hearing decision which led to a wrong conclusion;
- Typographical, mathematical or other obvious error in the hearing decision that affects the rights of the Claimant;
- Failure of the ALJ to address in the hearing decision relevant issues raised in the hearing request.

The Department, AHR or the Claimant must specify all reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration. A request must be *received* in MAHS within 30 days of the date the hearing decision is mailed.

The written request must be faxed to (517) 335-6088 and be labeled as follows:

Attention: MAHS Rehearing/Reconsideration Request

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

cc: