STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

RICK SNYDER
GOVERNOR

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: May 31, 2018
MAHS Docket No.: 17-017134
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Landis Lain

AMENDED HEARING DECISION

Following Petitioner'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; 42 CFR 438.400 to 438.424; 45 CFR 99.1 to 99.33; and 45 CFR 205.10; and Mich Admin Code, R 792.11002. After due notice, a telephone hearing was held on May 15, 2018, from Lansing, Michigan. The Petitioner was represented by Attorney [redacted] ([redacted]). The Department of Health and Human Services (Department or Respondent) was represented by Assistant Attorney General [redacted] ([redacted]). [redacted], Long Term Care Specialist, appeared as a witness for the Department.

Petitioner's Exhibit 1-18 and Respondent's Exhibit A pages 1-56 were admitted as evidence.

ISSUE

Did the Department properly determine the months in which the divestment penalty must be entered?

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 [redacted], the Department received a Long-Term Care Medical Assistance (MA-LTC) application for Petitioner.

2. On [redacted], the Department sent Petitioner a Health Care Coverage Determination approving Petitioner's application for Medical Assistance benefits.

3. On [redacted], an e-mail was received by the Department caseworker in regard to $[redacted] that was gifted to Petitioner's daughter, copy of the check dated [redacted].

4. Proof of the gift was provided to the Department with the [redacted], along with other verification information.

5. On [redacted], the Department caseworker sent Petitioner a DHS-176 Benefit Notice indicating that Petitioner has a divestment penalty and explaining that the original notice was not automatically generated in December like it should have. Baseline date: [redacted] Penalty Begin Date: [redacted] Divestment End Date: [redacted] Manual Policy Reference BEM 400.

6. On [redacted], the Department received a request for hearing to contest the divestment penalty.

7. On [redacted], the Michigan Administrative Hearing System received the Hearing summary and attachments from Respondent Department.

8. Petitioner concedes on the record that the divestment penalty is proper and that the amount of the divestment penalty is proper.

9. Petitioner argues the divestment should begin [redacted], and that Medical Assistance should be paid for [redacted] forward.

CONCLUSIONS OF LAW

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). Clients 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.

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 Medical Assistance (MA) program is established by Title XIX of the Social Security Act, 42 USC 1396-1396w-5; 42 USC 1315; the Affordable Care Act of 2010, the collective term for the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and 42 CFR 430.10-.25. The Department (formerly known as the Department of Human Services) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

Title XIX of the Social Security Act, commonly referred to as "The Medicaid Act," provides for medical assistance services to individuals **who lack the financial means to obtain needed health care**. 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 also45 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*.
Pertinent Department policy states:

> Assets must be considered in determining eligibility or SSI related categories. Assets mean cash, any other personal property and real property. (BEM, Item 400 Page 1). Countable assets cannot exceed the applicable asset limit. Not all assets are counted. Some assets are counted for one program but not for another program. (BEM Item 400, Page 1).

The department is to consider both of the following to determine whether and how much of an asset is countable: An asset is countable if it meets the availability test and is not excluded. The department is to consider the assets of each person in the asset group. (BEM, Item 400, Page 1).

Asset eligibility exists when the asset groups countable assets are less than or equal to the applicable asset limit at least one day during the month being tested. (BEM, Item 400, Page 4). An application does not authorize MA for future months if the person has excess assets on the processing date.

The SSI related MA asset limit for SSI related MA categories that are not medicare savings program or QDWI is $2000.00 for an asset group for one person and $3000.00 for an asset group of 2 people. BEM, Item 400 Page 5.

An asset must be available to be counted. Available means that someone in the asset group has the legal right to use or dispose of the asset. BEM, Item 400, Page 6. The department is to assume an asset is available unless the evidence shows that it is not available.

BEM, Item 405, states:

Divestment results in a penalty period in MA, **not** ineligibility. Divestment is a type of transfer of a resource and not an amount of resources transferred.

Divestment means a transfer of a resource (see RESOURCE DEFINED below and in glossary) by a client or his spouse that are all of the following:

- Is within a specified time; see LOOK-BACK PERIOD in this item.
- Is a transfer for LESS THAN FAIR MARKET VALUE;
- Is not listed below under TRANSFERS THAT ARE NOT DIVESTMENT

See Annuity Not Actuarially Sound and Joint Owners and Transfers below and BEM 401 about special transactions considered transfers for less than fair market value.

During the penalty period, MA will **not** pay the client's cost for:

- LTC services.
- Home and community-based services.
- Home Help.
- Home Health. BEM, Item 405, page 1

Resource means all the client's and his spouse's assets and income. It includes all assets and all income, even countable and/or excluded assets, the individual or spouse receive. It also includes all assets and income that the individual

(or their spouse) were entitled to but did **not** receive because of action by one of the following:

- The client or spouse.
- A person (including a court or administrative body) with legal authority to act in place of or on behalf of the client or the client's spouse.
- Any person (including a court or administrative body) acting at the direction or upon the request of the client or his spouse. BEM, Item 405, page 2

Transferring a resource means giving up all or partial ownership in (or rights to) a resource. Not all transfers are divestment. Examples of transfers include:

- Selling an asset for fair market value (not divestment).
- Giving an asset away (divestment).
- Refusing an inheritance (divestment).
- Payments from a **MEDICAID TRUST** that are **not** to, or for the benefit of, the person or his spouse; see BEM 401 (divestment).
- Putting assets or income in a trust; see BEM 401.
- Giving up the **right** to receive income such as having pension payments made to someone else (divestment).
- Giving away a lump sum or accumulated benefit (divestment).
- Buying an annuity that is **not** actuarially sound (divestment).
- Giving away a vehicle (divestment).
- Putting assets or income into a Limited Liability Company (LLC)BEM, item 405, page 2

Department policy states that it is **not** divestment to transfer a homestead to the client's:

- Spouse; see Transfers Involving Spouse above.
- Blind or disabled child; see Transfers Involving Child above.
- Child under age 21.
- Child age 21 or over who:
  - Lived in the homestead for at least two years immediately before the client's admission to LTC or BEM 106 waiver approval, **and**

- Provided care that would otherwise have required LTC or BEM 106 waiver services, as documented by a physician's (M.D. or D.O.) statement. BEM Item 405, page 8.

Policy also states that the uncompensated value of a divested resource is:

- The resource's cash or equity value.
- Minus any compensation received.
- The uncompensated value of a promissory note, loan, or mortgage is the outstanding balance due on the "Baseline Date" BEM, Item 405, page 12.

When divestment occurs, the department must invoke a penalty period. The transferred amount is used to calculate the penalty period. The Department may only recalculate the penalty period under certain circumstances. Pertinent policy dictates that the first step in determining the period of time that transfers can be looked at for divestment is determining the baseline date. Once the baseline date is established, you determine the look-back period. The look back period is 60 months prior to the baseline date for all transfers made after February 8, 2006. BEM, Item 405, page 2-4.

The penalty period starts on the date which the individual is eligible for Medicaid and would otherwise be receiving institutional level care (LTC, MIChoice waiver, or home help or home health services), and is not already part of a penalty period. When a medical provider is paid by the individual, or by a third party on behalf of the individual, for medical services received, the individual is not eligible for Medicaid in that month and the month is not a penalty month. That month cannot be counted as part of the penalty period. This does not include payments made by commercial insurance or Medicare. (Emphasis Added)

Note: If a past unreported divestment is discovered ***or* an agency error is made which should result in a penalty**, **a penalty must be determined under the policy in place at the time of discovery**. If a penalty is determined for an unreported transfer in the past, apply the penalty from the first day after timely notice is given; see Recipient Exception in this item. (Emphasis Added)

Timely notice must be given to LTC recipients and (BEM 106) waiver recipients before actually applying the penalty. Adequate notice must be given to new applicants. Ridges Eligibility Manual (BEM) 405, pages 14-15 (Emphasis Added)

Bridges Policy Glossary (BPG), page 68 states that **TIMELY NOTICE** is,

> An adequate notice which is mailed at least 11 days prior to the effective date of an intended negative action."

ADEQUATE NOTICE is,

> A written notice sent at the time a case action is effected (not pended) which specifies all of the following:
>
> • The action being taken by the department.
> • The reason for the action.
> • The specific manual item which cites the legal basis for the action.
> • An explanation of the individual's right to request a hearing.
> • The circumstances under which benefits are continued if a hearing is requested. BPG page 1

In this case, the Department determined that Petitioner was eligible for MA-LTC On [redacted]. The Department did not provide notice of the divestment penalty, even though it had been provided with verification of the divestment. The Department concedes that this was agency error. The Department caseworker was notified of the error by Petitioner's Representative via e-mail on [redacted]. A copy of the check for $[redacted] was provided to the Department in [redacted] The Department caseworker then determined the divestment period and imposed the penalty from [redacted]- [redacted]

Petitioner's Representative argues that the penalty should have been imposed from [redacted] to [redacted], because she filed a timely retroactive Medical Assistance Application for MA-LTC on [redacted] and Petitioner was determined to be eligible for MA-LTC with a start date of [redacted]. If the Department had not made an error, Petitioner's divestment penalty would have occurred in [redacted] rather than [redacted].

This Administrative Law Judge finds that Department policy is explicit:

The penalty period starts on the date which the individual is eligible for Medicaid and would otherwise be receiving institutional level care (LTC, MIChoice waiver, or home help or home health services), and is not already part of a penalty period. BEM 405, page 14. However, Department policy is also explicit when it dictates that TIMELY NOTICE must be given to LTC recipients and waiver recipients <u>before actually applying the penalty.</u> BEM 405, page 15

On [redacted], the Department caseworker sent Petitioner's Representative an e-mail stating,

> "I entered the information & I am currently trying to get the system to show a divestment period & it is not. I am still working on it & consulting with a few others for help."

TIMELY NOTICE of divestment was not provided to Petitioner until [redacted]. If the Department is to follow the Notice policy, the penalty would not begin until [redacted], because TIMELY NOTICE requirements dictate that the penalty must not be imposed before the effective date of the intended negative action.

The Department has not established by the necessary competent, substantial and material evidence on the record that it was acting accordance with department policy when it instituted the divestment penalty from [redacted] to [redacted]. The Department's decision must be reversed.

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, if any, finds that the Department has established by a preponderance of the evidence contained on the record that the divestment penalty was not appropriately applied. The divestment period should run from the [redacted] date of approval.

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

The Department shall **initiate the process** to impose the divestment penalty in accordance with Department policy which states:

The penalty period starts on the date which the individual is eligible for Medicaid and would otherwise be receiving institutional level care (LTC, MIChoice waiver, or home help or home health services), and is not already part of a penalty period. BEM 405, page 14.

It is so **ORDERED.**

LL/hb

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

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 763-0155; 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

Counsel for Respondent

[redacted]

DHHS

[redacted]

Counsel for Petitioner

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