[redacted]
[redacted]
[redacted], MI [redacted]

Date Mailed: May 30, 2019
MOAHR Docket No.: 19-002701
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Landis Lain

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 7, 2019, from Lansing, Michigan. Petitioner was represented by Attorney David Carrier (P41531). [redacted] [redacted] MA paralegal appeared on behalf of Petitioner. The Department of Health and Human Services (Department or Respondent) was represented by Assistant Attorney General Geraldine Brown (P67601). Terri Reed, Eligibility Specialist, and Angela Jean Baptiste, Supervisor appeared as witnesses.

Respondent's Exhibit A pages 1-45 and B pages 1-18 were admitted as evidence.

ISSUE

Did the Department properly deny Petitioner's Long-Term Care Medical Assistance (MA) application?

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] [redacted] 2019, the Department received a long-term care application and assets declaration from Petitioner.

2. On [redacted] [redacted] 2019, the initial asset assessment was completed.

3. On February 12, 2019, the Department issued a verification checklist requesting additional information for the Medicaid application.

4. On March 4, 2019, the Medicaid application was denied. Petitioner is in a contract shall care arrangement. Per Department policy in the Bridges Eligibility Manual 270, an institutionalized individual with a contractual care arrangement is not eligible for Medicaid.

5. On March 4, 2019, the Department sent Petitioner a healthcare coverage determination notice indicating that Petitioner is not eligible for medical assistance benefits because Petitioner failed to verify or allow the Department to verify information necessary to determine eligibility for this program.

6. On March 8, 2019, Petitioner's Authorized Hearings Representative filed a request for hearing to contest the Department's negative action.

7. On April 11, 2019, after careful review of policy, the original long-term care application and assets declaration form were re-registered.

8. The initial asset assessment was completed, and an initial asset assessment notice was issued showing the $[redacted] as an available, countable asset which raise the protect espousal amount to $[redacted]

9. On April 12, 2019, the Medicaid application was again denied, and a healthcare coverage determination notice was issued with the revise determination notice of excess assets.

10. On April 16, 2019, Petitioner's Authorized Hearings Representative filed it a second request for hearing to contest the Department's negative action.

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.

Petitioner alleges that in April 2017, Petitioner and her husband entered into a residency agreement with [redacted] is a part of the [redacted] of [redacted] which provide seniors with various levels of living assistance from independent living to assisted living to skilled nursing. [redacted] and is an independent living facility. The [redacted] granted Petitioner and her husband the right to occupy an apartment as long as they are able and access to higher levels of care within the continuum as they are required at reduced assisted living rates. The Residency further provides for the payment of a membership fee and for a refund of the fee under certain circumstances. In November 2018, and after more than six months of residency at [redacted] Petitioner transitioned into long-term care at the [redacted] which is also part of Heritage Community. In [redacted] 2019, Petitioner applied for Medicaid long-term care benefits.

The Membership fee paid by Petitioner and her husband was $[redacted] The monthly service fee is $[redacted] for the first resident and $[redacted] for the second resident. The monthly fee includes the long-term care program coverage for the resident with a beginning date of 90 days after the date of move-in.

In [redacted] 2019, the Department denied Petitioner's application on the grounds of excess assets because the $[redacted] held by the [redacted] facility is an available asset and is there for countable for Petitioner's application.

The Michigan Department of Health and Human Services Medicaid Provider Manual at Section 5 - Contractual Care Arrangements for Long-Term Care indicates:

> A **Life Care Contract** is created when an individual enters into an agreement with the continuing care retirement community to provide for all the individual's needs, including Health Care, for the rest of his life. The individual pays a onetime entrance fee in monthly payments thereafter. The continuing care retirement community assumes full financial responsibility if the individual is unable to make his monthly payments at a later date. An individual with a Life Care contract is not eligible for Medicaid.
>
> A **Continuing Care Contract** is created when an individual enters into an agreement with the continuing care retirement community to provide or pay for all, or some of the individual's Medical Care for the rest of his life. The individual pays a one-time entrance fee in monthly payments thereafter. An individual with

a continuing care contract may be eligible for some Medicaid benefits. (Beneficiary Eligibility, page 30, April 1, 2019)

Contractual Care Arrangement

Medicaid Only

A contractual care arrangement means there is a contract between an individual and another party which:

- Obligates the other party to provide or pay for all of the individual's medical care; and
- The obligation is not dependent on the individual's current income, assets or payments to the other party; and
- The other party is currently meeting the obligation. **An institutionalized individual with a contractual care arrangement is not eligible for Medicaid**. BEM 270, page 6

In this case, the "Residential Agreement" indicates:

Section I.A.

"This agreement grants the Resident the right to occupy the unit as long as resident is able unless this agreement is terminated by resident or Owner pursuant to the terms and conditions herein and **access to higher levels of care** within the continuum as they are required at reduced assisted living rates. If, in the opinion of your attending Physician and the owner, your physical and mental health requires that person or skilled care be given, you agree to relocate to a health center of your choice where proper care under licensed personnel can be given. Wyndham does not participate in the decision or limit the choice of the resident's selection of the health facility."

Section II. **MEMBERSHIP FEES**

A. To assure Resident a **lifetime membership** in WYNDHAM and subject to all the terms of this agreement, Resident will pay a membership fee of $65,000.00 and for a second Resident a fee of $15,000.00, which will entitle the Resident the right to use unit 337 and to **access to other levels of care within the continuum s they become necessary at reduced assisted living rates**. (Emphasis Added)

Section III. **MONTHLY SERVICE FEES**

A. All qualifying Traditional and Refundable Program Residents of Wyndham will have nursing, assisted living and memory care available as participants in the Long-Term Care Program. All qualifying traditional in refundable program residents are required to purchase a paid in the Windham long-term care program which is self-funded. The start date of coverage begins 90 days following admission to Windham and coverage is subject to a 100-day waiting period.

B. When a resident is admitted to a qualified facility, the waiting period begins in a punt fulfillment, the applicable benefits are paid to the facility on behalf of the residents. The current benefits and a skilled nursing facility is $60.00 per day. The current benefit at an assisted living or memory care facility is $25.00 per day. The benefit is paid for a total of two years (730 days).

This Administrative Law Judge finds that Petitioner has a contractual care arrangement which fits the definition of a continuing care contract. Petitioner is entitled to receive long term care or nursing care for two years (730 days) as a part of the contract.

The Medicaid program is governed by a complex web of interlocking statutes, as well as regulations and interpretive documents published by state and federal agencies. The program was created by Title XIX of the Social Security Act of 1965, PL 89-97; 79 Stat 343, codified at 42 USC 1396 *et seq*. Medicaid is generally a need-based assistance program for medical care that is funded and administered jointly by the federal government and individual states. *Ketchum Estate v Dep't of Health & Human Servs*, 314 Mich App 485, 488; 887 NW2d 226 (2016).

"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 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).

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).

In the instant case, Petitioner falls within the medically needy category for those over the age of 65. Therefore, to be eligible for Medicaid benefits, she and her spouse were required to reduce their countable incomes and assets to or below $2,000. See *Mackey v Dep't of Human Servs*, 289 Mich App 688, 698; 808 NW2d 484 (2010); *BEM 400* (July 1, 2014), p 7; *BEM 402* (April 1, 2014), p 4.

For married applicants such as the Petitioner, the eligibility rules for nursing-home services begin with the "spousal impoverishment" provisions of the Medicaid Act. See 42 USC 1396r-5. Enacted by Congress in 1988, these provisions "permit a spouse living at home (called the 'community spouse') to reserve certain income and assets to meet the minimum monthly maintenance needs he or she will have when the other spouse (the 'institutionalized spouse'[3]) is institutionalized, usually in a nursing home, and becomes eligible for Medicaid." *Wis Dep't of Health & Family Servs v Blumer*, 534 US 473, 478; 122 S Ct 962; 151 L Ed 2d 935 (2002).

When determining an institutionalized spouse's eligibility for Medicaid benefits, a computation of the couple's total joint resources is taken "as of the beginning of the first continuous period of institutionalization," which may or may not be the same month in which one applies for benefits. 42 USC 1396r-5(c)(1)(A). The stated purpose of this first computation is to determine the amount of the "spousal share" allocated to the community spouse. 42 USC 1396r-5(c)(1)(A)(ii). The couple's resources are divided into those that are countable and those that are exempt. One-half of the total value of their countable resources "to the extent either the institutionalized spouse or the community spouse has an ownership interest" is considered a spousal share. *Id.* This calculation is based on the resources available to the institutionalized spouse on the day that the institutionalized spouse submits his or her application for Medicaid benefits. "In determining the resources of an institutionalized spouse at the time of application for benefits . . . , *all the resources held by* either the institutionalized spouse, community spouse, or both, shall be considered to be *available to* the institutionalized spouse" to the extent that they exceed the CSRA. 42 USC 1396r-5(c)(2)(A) and (B) (emphasis added). "[A]fter the month in which an institutionalized spouse is determined to be eligible for benefits . . . , no resources of the community spouse shall be deemed available to the institutionalized spouse." 42 USC 1396r-5(c)(4).

For purposes of this case pertinent Department policy dictates:

> Assets must be considered in determining eligibility for FIP, SDA, RCA, G2U, G2C, RMA, SSI-related MA categories, CDC and FAP. FIP, SDA, RCA, G2U, G2C, CDC and RMA consider only the following types of assets:
>
> - Cash (which includes savings and checking accounts).
> - Investments (which includes 401(k), Roth IRA etc.).
> - Retirement Plans.
> - Trusts.

Assets mean:

- Cash (see Cash in this item).
- Personal property. Personal property is any item subject to ownership that is not real property (examples: currency, savings accounts and vehicles).
- Real property. Real property is land and objects affixed to the land such as buildings, trees and fences. Condominiums are real property. BEM 400, page 1

All types of assets are considered for SSI-related MA categories. BEM 400, page 2 Asset eligibility is required for G2U, G2C, RMA, and SSI-related MA categories. Asset eligibility exists when the asset group's countable assets are less than, or equal to, the applicable asset limit at least one day during the month being tested. At application, do not authorize MA for future months if the person has excess assets on the processing date.

If an ongoing MA recipient or active deductible client has excess assets, initiate closure. However, delete the pending negative action if it is verified that the excess assets were disposed of. Payment of medical expenses, living costs and other debts are examples of ways to dispose of excess assets without divestment. LTC and waiver patients will be penalized for divestment; see BEM 405, MA DIVESTMENT. BEM 400, page 6

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 400, page 8

Petitioner's allegation that the membership fee should not be available or countable as an asset because it would be difficult for Petitioner's spouse to vacate the apartment and Petitioner would have to leave the continuum of care is an equitable argument to be excused from the Department's program policy requirements.

Equity powers are not within the scope of authority delegated to this Administrative Law Judge pursuant to a written directive signed by the Department of Health and Human Services Director, which states:

> Administrative Law Judges have no authority to make decisions on constitutional grounds, overrule statutes, overrule promulgated regulations or overrule or make exceptions to the Department policy set out in the program manuals.

Furthermore, administrative adjudication is an exercise of executive power rather than judicial power and restricts the granting of equitable remedies. *Michigan Mutual Liability Co. v Baker*, 295 Mich 237; 294 NW 168 (1940).

This Administrative Law Judge has determined that the Department has established by the necessary, competent and material evidence on the record that it was acting in compliance with department policy when it determined that the $[redacted] they paid for the residency agreement which was used to defray the residency in occupancy costs at the senior living facility, was considered a contractual care arrangement and under policy in BEM 270, an institutionalized individual with a contractual care agreement is not eligible for Medicaid. [redacted] [redacted] [redacted] have a contract with the state of Michigan that allows them to have contractual care arrangements. The contract did agree to pay for benefits. The contract is not irrevocable and there are circumstances under which Petitioner, or her spouse, can access the [redacted] [redacted] Based on the terms of the [redacted] residency agreement, the $[redacted] that Petitioner paid was excess will buy either Petitioner or Petitioner's spouse and was therefore available in countable asset. The contract has expressed and clear provisions, and even provided forms to allow for the refund of the membership fee. Because the $[redacted] was an additional asset that was available at the time Petitioner became first institutionalized, it had to be calculated into the initial asset allocation in the Protected Spousal Amount. Even when those amounts are considered, Petitioner and her husband have too many assets to permit Petitioner to qualify for Medicaid long-term care benefits.

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's determination that Petitioner has more than $2,000.00 in countable, available assets for the month of application was correct under the circumstances.

Accordingly, the actions of the Department must stand and are **AFFIRMED.**

LL/hb

Landis Lain
Administrative Law Judge
for Robert Gordon, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

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

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