STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: October 20, 2011
CASE #: M00X01182
AGENCY: Suffolk
FH #: 5934164M

In the Matter of the Appeal of

[redacted]

from a determination by the Suffolk County Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on January 17, 2012, in Suffolk County, before Antonia Ezechi, Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

Howard Atlas, Appellant's Attorney
Lynn Mandaro, Legal Assistant
[redacted], Appellant's Daughter
[redacted], Appellant's Son-in-Law

For the Social Services Agency

Elinor Fibel, Fair Hearing Representative

ISSUE

Was the Agency's determination that the Appellant was not eligible under Medical Assistance ("Medicaid") for nursing facility services, including home waivered services under the Long Term Home Care Program for a period of 6.11 months or until September 1, 2011, because the Appellant transferred assets for less than fair market value correct?

Was the Agency's determination that the Appellant was eligible for nursing facility services with a partial penalty for the month of September, 2011, because the Appellant transferred assets for less than fair market value correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. On April 4, 2011, an application for Medicaid was made on behalf of the Appellant. The Appellant is 90 years old, and has been receiving nursing facility services at a local nursing home since December 16, 2010. The nursing facility requested a pick-up date of March 26, 2011.

2. By notice dated, August 25, 2011, the Agency determined that the Appellant was not eligible under Medicaid for nursing facility services, including home waivered services under the Long Term Home Care Program for a period of 6.11 months or from March, 2011, until September 1, 2011, and further determined to impose a partial penalty for September, 2011, because the Appellant transferred assets valued at $70,036.14 for less than fair market value. Chronic care coverage was granted effective October, 2011, with a Net Available Monthly Income, which was not an issue for this hearing.

3. The Agency was informed that the Appellant recently transferred certain property for less than its fair market value, and has evaluated that property as follows:

Date of Transfer	Description of Property	Value
December 9, 2006	**Transfer to son-in-law**	**$9,500.00**
December 9, 2006	**Transfer to daughter**	**$9,500.00**
January 18, 2007	**Transfer to daughter for rent**	**$8,500.00**
January 18, 2007	**Transfer to daughter for rent**	**$8,500.00**
January 16, 2010	**Transfer to daughter for rent**	**$7,000.00**
February 6, 2010	**Transfer to**	**$8,000.00**
March 26, 2010	**Transfer to TD Bank for back rent**	**$11,650.09**
September 24, 2010	**Transfer to daughter for rent**	**$12,020.46**
TOTAL		**$74,670.55**

4. The Agency calculated the Appellant's nonexempt resources based on a snapshot of the information it received as follows:

Non-Exempt Resources	Equity

	Value
Total Transferred Assets	$74,670.55
First Account Number	$309.99
Second Account Number	$1,883.11
Life Insurance Policy	$6,972.49
Total	$9,165.59
Less the following deductions:	
Medical Assistance Resource Level for one Person	-$13,800.00
Resource Deficit	$4,634.41
Remainder-Uncompensated Transfers	$70,036.14

5. The Agency determined to impose a penalty period of 6.11 months, during which the Appellant may not receive Medicaid coverage for the cost of nursing facility services either in a nursing facility or as home-based waivered services, and a partial penalty of $1,366.14 for one month, by dividing $70,036.14, the remainder uncompensated value of transferred assets, by $11,445.00, the applicable regional rate, resulting in the following calculation:
$70,036.14 divided by $11,445.00 (2011 regional rate) = 6.11 months penalty
$11,445.00 X 6 (full penalty months) = $68,670.00
$70,036.14 - $68,670.00 = $1,366.14

6. On February 6, 1987, the Appellant and her husband (now deceased) moved into the home of their daughter and son-in-law and on November 14, 1994, the Appellant entered into an Occupancy Agreement with them with the understanding that in lieu of paying rent, she would contribute toward the college tuition of their children, her grandchildren when they commence their college education.

7. On September 15, 1992, the Appellant executed her Last Will and Testament. That Will, in relevant part provided for the future college education of the same grandchildren in the event that the Appellant predeceased that occurrence.

8. The Appellant started this pattern of transfer of funds which were, in turn, specifically sent to the colleges attended by her grandchildren and clearly utilized for their college education before the look back period.

9. The Appellant remained solvent. Her bills were paid, her living expenses were met and she was not in debt.

10. On December 2, 2010, by all account, the Appellant suddenly suffered a stroke although she had been of good health and had an active lifestyle hitherto.

11. On October 20, 2011, the Appellant requested this fair hearing.

APPLICABLE LAW

Sections 360-4.1 and 360-4.8(b) of 18 NYCRR (herein referred to as "the Regulations") provide that all income and resources actually or potentially available to a Medicaid applicant or recipient must be evaluated, but only such income and/or resources as are found to be available may be considered in determining eligibility for Medicaid. A Medicaid applicant or recipient whose available non-exempt resources exceed the resource standards will be ineligible for Medicaid coverage until he or she incurs medical expenses equal to or greater than the excess resources.

Under Section 360-4.4 of the Regulations, "Resources" are defined to include any liquid or easily liquidated resources in the control of an applicant or recipient, or anyone acting on his or behalf, such as a conservator, representative, or committee. Certain resources of a Medicaid-qualifying trust, as described in Section 360-4.5 of the Regulations, may also be counted in evaluating Medicaid eligibility.

Section 366.5(d) of the Social Services Law and Section 360-4.4(c)(2) of the Regulations govern Transfers of Assets made by an applicant or recipient or his or her spouse) on or after August 11, 1993. Section 366.5(e) governs transfers made on or after February 8, 2006.

Generally, in determining the Medicaid eligibility of a person receiving nursing facility services, either as an in-patient in a nursing facility (including an intermediate care facility for the mentally retarded), as an in-patient in a medical facility at a level of care such as is provided in a nursing facility, or as a recipient of care, services, or supplies at home pursuant to a waiver under section 1915(c) of the federal Social Security Act ("waivered services"), any transfer of assets for less than fair market value made by the person or his or her spouse within or after the "look-back period" will render the person ineligible for nursing facility services.

Pursuant to GIS 07 MA/018 if an individual applies for Medicaid coverage of home and community based waiver services, the applicant is only required to provide documentation of his/her current resources. The individual is not subject to a transfer of assets look-back period nor is the individual subject to a transfer penalty period.

Prior to August 1, 2006, the "look-back period" was the 36-month period immediately preceding the date that a person receiving nursing facility services is both institutionalized and has applied for Medicaid. However, In the case of payments to or from a trust which may be deemed assets transferred by an applicant or recipient, the "look-back period" shall be a 60-month period instead of the thirty-six month period. A person is institutionalized if a patient is in a nursing facility, or in a medical facility receiving the level of care provided in a nursing facility, or if the person is receiving waivered services. The uncompensated value of an asset is the fair market value of such asset at the time of transfer minus the amount of the compensation received in exchange for the asset. Social Services Law 366.5(d).

For applications filed on or after August 1, 2006, for Medical Assistance coverage of nursing facility services, the "look-back period" is the period immediately preceding the date that

an institutionalized individual is both institutionalized and has applied for Medical Assistance. Beginning February 1, 2009 the look back period will increase from 36 months to 37 months and each month thereafter it will increase by one month until February 1, 2011 when a 60 month look-back period will be in place for all types of transfers of assets. 06 OMM/ADM-5. The uncompensated value of an asset is the fair market value of such asset at the time of transfer less any outstanding loans, mortgages, or other encumbrances on the asset, minus the amount of the compensation received in exchange for the asset. Social Services Law 366.5(e).

Effective August 1, 2006 if an applicant or recipient seeking coverage for nursing facility services purchased an annuity on or after February 8, 2006 the State must be named as the beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant, or the State must be named in the second position after a community spouse or minor or disabled child and must be named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value. If the applicant/recipient or applicant or recipient's spouse fails or refuses to so name the State as the remainder beneficiary the purchase will be considered a transfer of assets for less than fair market value. In addition, if an annuity is purchased by or on behalf of an applicant or recipient,, the purchase will be treated as a transfer of assets for less than fair market value unless the annuity is:

1. an annuity described in subsection (b) or (q) of Section 408 of the Internal Revenue Code of 1986, or

2. purchased with the proceeds from an account described in subsection (a), (c), (p) of Section 408 of such Code; a simplified employee pension within the meaning of Section 408(k) of such Code; or a Roth IRA described in section 408A of such Code; or

the annuity is:

3. irrevocable and non-assignable;

4. is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

5. provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

The annuity provisions apply to transactions, including purchases, which occur on or after February 8, 2006. Transactions subject to these provisions include any action by the individual that changes the course of payment from the annuity or that changes the treatment of the income or principal of the annuity. These transactions include additions of principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract and similar actions. Social Services Law 366.5(e), 06 OMM/ADM-5

Pursuant to GIS 07 MA/020, any annuity that a New York State Partnership for Long Term Care policy/certificate holder with Total Asset protection, or their spouse has purchased is exempt from the annuity requirements listed in 06 OMM/ADM-5.

GIS 07 MA/020 addresses annuities held by a Dollar for Dollar Partnership policy/certificate holder. If an annuity is a countable resource at the time of application the Dollar for Dollar Partnership policy/certificate holder or their spouse would not be required to name the State as a remainder beneficiary. In cases where an annuity is not a countable resource and the Dollar for Dollar Partnership policy/certificate holder is applying for Medicaid coverage of nursing facility services, the Partnership policy/certificate holder and their spouse will be required to name that State as a remainder beneficiary or else the purchase of the annuity may be treated as an uncompensated transfer.

The purchase of a life estate interest on or after February 8, 2006 in another person's home shall be treated as the disposal of an asset for less than fair market value unless the purchaser resided in such home for a period of at least one year after the date of purchase. In addition, the purchase of a promissory note, loan, or mortgage on or after February 8, 2006 shall be treated as the disposal of an asset for less than fair market value unless such note, loan, or mortgage meets the following criteria:

- has a repayment term that is actuarially sound;
- provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
- prohibits the cancellation of the balance upon the death of the applicant/recipient.

Social Services Law 366.5(e), 06 OMM/ADM-5

Section 366.5(e) of the Social Services Law provided that in the case of a trust established by the individual, any payment, other than a payment to or for the benefit of the individual, from a revocable trust is considered to be a transfer of assets by the individual and any payment, other than to or for the benefit of the individual, from the portion of an irrevocable trust which, under any circumstance, could be made available to the individual is considered to be a transfer of assets by the individual and, further, the value of any portion of an irrevocable trust from which no payment could be made to the individual under any circumstances is considered to be a transfer of assets by the individual for purposes of this section as of the date of establishment of the trust, or, if later, the date on which the payment to the individual is foreclosed.

Sections 366.5(d) and (e) of the Social Services Law provide that an individual will not be ineligible for Medicaid as a result of a transfer of assets if:

(a) the asset transferred was other than a homestead and was a disregarded or exempt asset under Section 360-4.4(d), 360-4.6, and/or 360-4.7 of the Regulations; or

(b) the asset transferred was a home, and title to the home was transferred to:

(1) the individual's spouse; or

(2) the individual's child, who is blind, disabled, or under the age of 21; or

(3) the individual's sibling, who has an equity interest in the home and was residing in the home for a period of at least one year immediately before the date the person became an institutionalized individual, or

(4) the individual's child, who was residing in the home for a period of at least two years immediately before the date the person became an institutionalized individual, and who provided care to the person which permitted her or him to continue residing at home rather than enter into an institution or facility; or

(c) the asset was transferred:

(i) to the individual's spouse or to another for the sole benefit of the spouse; or

(ii) from the individual's spouse to another for the sole benefit of the spouse; or

(iii) to the individual's child who is blind or disabled, or to a trust established solely for the benefit of such child; or

(iv) to a trust established solely for the benefit of a disabled person under 65 years of age.

(d) a satisfactory showing is made that:

(i) the individual or his or her spouse intended to dispose of the asset either at fair market value, or for other valuable consideration; or

(ii) the asset was transferred exclusively for a purpose other than to qualify for Medicaid; or

(iii) all assets transferred for less than fair market value have been returned to the individual.

In addition, Sections 366.5(d) and (e) of the Social Services Law provide that an individual will not be ineligible for Medicaid as a result of a transfer of assets if denial of

eligibility will result in an undue hardship. Section 360-4.4 of the Regulations provides that denial of eligibility will result in an undue hardship if:

(i) the individual is otherwise eligible for Medicaid;

(ii) said person is unable to obtain appropriate medical care without the provision of Medicaid; and

(iii) despite his or her best efforts, said person or his or her spouse is unable to have the transferred asset returned or to receive fair market value for the asset. Best efforts include cooperating, as deemed appropriate by the commissioner of the social services district, in efforts to seek the return of the asset.

For transfers made on or after February 8, 2006, section 366.5(e)(4)(iv) of the Social Services Law provides that an individual shall not be ineligible for services solely by reason of any such transfer to the extent that denial of eligibility would cause an undue hardship such that application of the transfer of assets provision would deprive the individual of medical care such that the individual's health or life would be endangered, or would deprive the individual of food, clothing, shelter or other necessities of life. The Department of Health in 06 OMM/ADM-5 has incorporated in addition to the deprivation of food, clothing, shelter or other necessities of life as set forth in the statute, the regulatory grounds set forth in Section 360-4.4 of the Regulations as stated above.

A transfer for less than fair market value, unless it meets one of the above exceptions, will cause an applicant or recipient to be ineligible for nursing facility services for a period of months equal to the total cumulative uncompensated value of all assets transferred during or after the look-back period, divided by the average cost of care to a private patient for nursing facility services in the region in which such person seeks or receives nursing facility services, on the date the person first applies or recertifies for Medicaid as an institutionalized person. For purposes of this calculation, the cost of care to a private patient in the region in which the person is seeking or receiving such long-term care will be presumed to be 120 percent of the average Medicaid rate for nursing facility care for the facilities within the region. The average regional rate is updated each January first.

For uncompensated transfers prior to February 8, 2006, the period of ineligibility begins with the first day of the first month during or after which assets have been transferred for less than fair market value, and which does not occur in any other period of ineligibility for any other prohibited transfer. Social Services Law 366.5(d)

For uncompensated transfers made on or after February 8, 2006, the penalty period starts the first day of the month during or after which assets have been transferred for less than fair market value, or the first day of the month the otherwise eligible individual is receiving services for which Medical Assistance would be available but for the transfer penalty, whichever is later, and which does not occur during any other period of ineligibility. Social Services Law 366.5(e).

With respect to bank accounts, 96 ADM-8 provides that as long as an SSI-related applicant or recipient is designated as the sole owner by the account title, and can withdraw funds and use them for his or her support and maintenance, the applicant or recipient is presumed to own all of the funds in the account, regardless of their source. This presumption cannot be rebutted. In the absence of evidence to the contrary, if an SSI-related applicant or recipient is a joint account holder, it is presumed that all of the funds in the account belong to the applicant or recipient. If there is more than one SSI-related applicant or recipient who is a holder of the joint account, it is presumed that the funds in the account belong to them in equal shares. This presumption may be rebutted.

With respect to personal services contracts, GIS 07 MA/019 provides guidelines to evaluate these contracts for Medicaid eligibility. Generally, the applicant's resources are transferred in a lump sum to a family member in exchange for services to be provided by the family member for the lifetime of the applicant. For Medicaid eligibility a determination must be made concerning whether the applicant received or will receive fair market value for the resources transferred to the caregiver. If a determination cannot be made that the applicant will receive fair market value for the resources transferred, the resources are subject to a transfer penalty. A personal services contract that does not provide for the return of any prepaid funds if the caregiver becomes unable to fulfill their duties under the contract, or if the applicant/recipient dies before their calculated life expectancy, must be treated as a transfer of assets for less than fair market value. If a personal services contract provides that services will be delivered on an "as needed" basis, then a determination cannot be made that fair market value will be received in the form of services provided through the contract. A transfer of assets penalty must be calculated for an otherwise eligible individual.

GIS 07 MA/019 provides that in calculating a transfer of assets penalty for a personal services contract, the district must give the applicant credit, by reducing the transfer amount, for the value of any services actually received from the time the personal service contract was signed and funded through the date of the Medicaid eligibility determination. No credit is allowed for services that are provided as part of the Medicaid nursing home rate. To assess the value of the furnished services, the district must be provided with credible documentation of services already provided. Any amount credited for caregiver services actually provided must be commensurate with a reasonable wage scale, based on fair market value for the actual job performed and the qualification of the caregiver. If credible documentation is not provided, then no credit is deducted when calculating the uncompensated transfer amount.

DISCUSSION

The Appellant could not participate in this proceedings. The salient issue is a matter of law.

A review of the record indicated that none of the factual issues in this case was in dispute. The dispute stemmed from the interpretation of the transfer of funds from the Appellant to her daughter and son-in-law.

The Appellant made some transfers totaling $70,036.14 to her family strictly and specifically for her grandchildren's college education in exchange for lodgings pursuant to an agreement executed as far back as 1994.

The evidence also showed that for each transfer, a corresponding payment was promptly sent to the children's college.

The Appellant's contention, through her attorney, and her relatives' testimony, was that the transfer was not uncompensated but was a pattern of gifts for value and that it was not done to qualify the Appellant for Medicaid benefits, as such; should come under the exceptions to the transfer rule.

In support of this contention, the Appellant established, through her attorney's rebuttal and the introduction of documents that the gifts were made at a time when there was absolutely no indication that the Appellant would need nursing home level of care. The Appellant was in excellent health despite her age, and her admission into the nursing facility was a result of a sudden stroke she had several years after the first set of gifts within the look back period were made. Some of the transfers were done prior to the look back period. She remained solvent thereafter and had expected to live out the rest of her days at her daughter's home.

To buttress his argument, the attorney cited Decision After Fair Hearing (DAFH) #5515265P (Herkimer County, 2010) in which DAFH #4898026L (Albany County, 2007) and DAFH #5307252M (Suffolk County, 2009) were cited, based on the legal authority that the presumption of making transfers within the look back period in order to qualify for benefits is rebuttable once such transfers meet certain criteria clarified in the prevailing Regulations.

The attorney argued persuasively that the circumstances of all the cases were similar to the one at bar to wit; although gifts are by definition uncompensated with no value exchanged, fair or otherwise, the record failed to establish that the Appellant made any of the gifts in order to qualify for Medical Assistance and there was nothing to suggest that the need for Medical Assistance loomed in the horizon at the time the gifts were made, despite the Appellant's advanced age. The evidence indicated that the gifts were clearly made in a pattern that the Appellant had over the years, even before the look back period, because she could and pursuant to an agreement with her relatives. The Appellant remained solvent for years thereafter. The Appellant paid her own bills, met all her living expenses, had no creditors and did not incur any debts in a manner that could suggest fraudulent conveyance. Furthermore, she could not recover the bonafide transfer that she made through any viable legal means especially since there was value attached.

In conclusion, the Appellant's representative averred that the transfer in this case was for legitimate reasons and was not done in order to qualify for Medicaid.

The Agency argued that pursuant to the guidelines in 96 ADM-08, services (in this case, the housing of the Appellant) provided free of charge by family members based on familial love or affection cannot be reimbursed in the manner in which it was done in the instant case.

However, the merit of that argument was mitigated in this case by the agreement between the parties entered into about eighteen years ago.

The Agency pointed out that although it received the financial statement histories indicating the grandchildren's colleges as the ultimate destination of the Appellant's transfers and a letter of explanation by the Appellant's daughter, it never received the occupation agreement, which might have led the Agency in a different direction and perhaps to a different conclusion in this case.

Pursuant to prevailing laws, the funds transferred to the Appellant's family on behalf of her grandchildren in this case failed to meet the criteria of uncompensated transfer for the purpose of qualifying for benefits. The Appellant's attorney satisfactorily rebutted the presumption that assets transferred for less than fair market value within the penalty period were done for the purpose of qualifying for Medical Assistance benefits.

Accordingly, the Agency's determination in this case, made with the information available to it at the time, can no longer be implemented.

DECISION AND ORDER

The Agency's determination that the Appellant was not eligible under Medical Assistance ("Medicaid") for nursing facility services, including home waivered services under the Long Term Home Care Program for a period of 6.11 months or until September 1, 2011, because the Appellant transferred assets for less than fair market value was correct when made.

The Agency's determination that the Appellant was eligible for nursing facility services with a partial penalty for the month of September, 2011, because the Appellant transferred assets for less than fair market value was correct when made.

1. The Agency is directed to redetermine the Appellant's eligibility for coverage pursuant to the Appellant's April 4, 2011, application, and if otherwise eligible, to provide the benefits sought in accordance with verified degree of need.

2. In making the new eligibility determination, the Agency is directed to take into account that the subject total of $70,036.14 from the Appellant to her relatives was not an uncompensated transfer made for the purpose of qualifying for Medicaid.

3. The Agency is directed to provide a reasonable opportunity for the Appellant to submit any documentation not already in its possession needed to re-evaluate the Appellant's financial eligibility.

4. The Agency is directed to change the effective date of chronic care budgeting status accordingly.

5. The Agency is directed to eliminate the penalty period based on the circumstances of this case as it related to the uncompensated transfer.

6. Upon completing its re-evaluation, the Agency is further directed to provide the Appellant with written notice of its new determination.

Should the Agency need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Agency promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
01/24/2012

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Thelma Lee

Commissioner's Designee