State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
PO BOX 712
TRENTON, NJ 08625-0712

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

CAROLE JOHNSON
Commissioner

CAROL GRANT
Acting Director

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
AND HEALTH SERVICES

C.M.,	:	
PETITIONER,	:	**ADMINISTRATIVE ACTION**
v.	:	**FINAL AGENCY DECISION**
	:	**OAL DKT. NO. HMA 09650-19**
MIDDLESEX COUNTY BOARD OF SOCIAL SERVICES,	:	
RESPONDENTS.	:	

As Assistant Commissioner for the Division of Medical Assistance and Health Services, I have reviewed the record in this case, including the Initial Decision, the OAL case file and the documents filed below. Petitioner filed Exceptions. Procedurally the time period for the Agency Head to file a Final Decision is May 13, 2020 in accordance with an Order of Extension. The Initial Decision was received on February 13, 2020.

The matter arises regarding the denial of Petitioner's March 2019 Medicaid application. On or about, March 21, 2019, Petitioner filed a Medicaid application with the Middlesex County Board of Social Services (MCBSS) seeking to incur a transfer penalty to commence with the Medicaid application. However, MCBSS denied Petitioner's application because her income exceeded the semi-private pay rate for the Assisted Living Facility

(ALF) where she resided. Her income included $1,629.50 in monthly social security benefits, $55.24 in monthly pension benefits and $3,650.11 per month in a limited payment annuity for a total monthly income of $5,334.85.

In her brief, Petitioner claims that she is not seeking payment from the State of New Jersey for Medicaid benefits due to the anticipated penalty, but that she is seeking a penalty determination based on the gifting of assets. In determining Medicaid eligibility for someone seeking institutionalized benefits, the counties must review five years of financial history. During that time period, a resource cannot be transferred or disposed of for less than fair market value. 42 U.S.C.A. § 1396p(c)(1); see also N.J.A.C. 10:71-4.10(a). If such a transfer occurs, the applicant will be subject to a period of Medicaid ineligibility to be imposed once the person is otherwise eligible for Medicaid benefits. Ibid. N.J.S.A. 30:4D-3(i)(15)(b). Based on my review of the record below, including income information, Petitioner has not established that she is eligible for Medicaid benefits. Consequently, there is no requirement to assess a transfer penalty for an applicant who has not otherwise established eligibility.

Medicaid is a federally-created, state-implemented program designed, in broad terms, to ensure that qualified people who cannot afford necessary medical care are able to obtain it. See 42 U.S.C.A. § 1396, et seq., Title XIX of the Social Security Act ("Medicaid Statute"). The overarching purpose of the Medicaid program is to provide benefits to qualified persons "whose income and resources are insufficient to meet the cost of necessary medical services." 42 U.S.C.A. § 1396-1. Atkins v. Rivera, 477 U.S.154, 156 (1986). In setting up the Qualified Income Trust (QIT) the federal courts described situations where individuals in nursing homes had incomes that were "too low to enable them to pay their own nursing home costs, but too high to qualify for Medicaid benefits." Miller v. Ibarra, 746 F.Supp. 19 (1990).

The type of financial planning used by Petitioner is called "half-a-loaf" where a Medicaid applicant gifts half of their assets while using the remaining half to pay for care during the transfer penalty. The Deficit Reduction Act of 2005 specifically sought to put an end to this planning by delaying the transfer penalty until the applicant was otherwise eligible for Medicaid. See N.M. v. Div. of Med. Assist. & Health Servs., 405 N.J. Super. 353. 362-63 (App. Div.), certif. denied, 199 N.J. 517 (2009) (explaining the Congressional intent behind the enactment of the DRA). However, Medicaid annuities are now used to convert resources to an income stream to pay for nursing home care while subject to penalty.

Petitioner argues that because she has insufficient income to pay for her ALF, she is eligible for Medicaid benefits. ALFs are considered community placements and are available to Medicaid eligible individuals under a federal waiver that permits the expansion of services. Unlike nursing homes, individuals in an assisted living facility are responsible to pay their room and board costs. See New Jersey FamilyCare Comprehensive Waiver. https://www.state.nj.us/humanservices/dmahs/home/NJFC_1115_Amendment_Approval_Package.pdf and www.nj.gov › humanservices › doas › forms › PR-2 inst. Because room and board costs in an ALF are not considered a medical expense, it must be teased out of the daily rate so as to determine Petitioner's actual medical expenses. See G.T. v. DMAHS and Gloucester Board of Social Services, OAL Dkt. No. HMA 7855-12 (Final Decision December 12, 2012, where the monthly room and board cost of a $6,250 facility was determined to be $1,491 a month). ALFs also include services such as housekeeping, laundry, day programs, transportation, and assistance with dressing, bathing or medications. These are not shelter costs and these too must be teased out of the monthly rate. Petitioner, however, has not established her medical costs.

I agree with the ALJ that Petitioner's paperwork is deficient. In exceptions, Petitioner argues that she has shown her expenses exceed her income regardless of which

room rate is applied. In support of her brief, Petitioner included a resident ledger showing room and board billed at rate of $4,172 to $4,619 per month; something called "Assisted Living Select" billed at a monthly rate of $830 to $940; "AL Medication Level 3" billed at a rate of $980 to $1,085, as well as other miscellaneous expenses such as cable T.V. and hair care. These may very well be Petitioner's expenses, but Petitioner provides no documentation or testimony to clarify these terms or identify the types of services included in these categories. Without further explanation, the unexplained categories in the resident ledger appear to be more of a catchall rather than an itemized list of expenses. Consequently, there is no way to determine that these categories include the types of medical expenses used to offset Petitioner's income.

I agree with the ALJ that Petitioner has failed to meet her burden of proof demonstrating she was eligible for Medicaid effective March 1, 2019. I note that while Petitioner took exception with the finding that her documentation was deficient, Petitioner did not request an opportunity to present additional evidence on remand. In fact, Petitioner asserted that the record established her financial need "under every metric proposed and applied thus far." Although I agree that clinical eligibility was not at issue in this matter, and the absence of Petitioner's application or LTC-13 is not necessarily determinative of financial eligibility, the resident ledger relied upon by Petitioner is insufficient evidence of medical expenses, and fails to demonstrate how said expenses exceeded her income.

THEREFORE, it is on this 7th day of MAY 2020,

ORDERED:

That the Initial Decision is hereby ADOPTED.

Jennifer Langer Jacobs, Assistant Commissioner
Division of Medical Assistance
and Health Services