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

SARAH ADELMAN
Acting Commissioner

JENNIFER LANGER JACOBS
Assistant Commissioner

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

S.O.	:	
PETITIONER,	:	**ADMINISTRATIVE ACTION**
v.	:	**ORDER OF REMAND**
DIVISION OF MEDICAL ASSISTANCE	:	**OAL DKT. NO. HMA 7270-2020**
AND HEALTH SERVICES AND	:	
BURLINGTON COUNTY BOARD OF	:	
SOCIAL SERVICES,	:	
RESPONDENTS.	:	

As Assistant Commissioner of 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. Neither party filed exceptions in this matter. Procedurally, the time period for the Agency Head to file a Final Decision is March 25, 2021 in accordance with an Order of Extension.

The matter arises regarding the denial of Medicaid benefits due to Petitioner's residence in a non-Medicaid assisted living facility. Petitioner filed an application for benefits in June 2020. She listed she had made transfers beginning in 2018 that, at

minimum, totaled $218,693. She reported income from Social Security and an annuity totaling $5,406. R-C.

The disclosures on the application raise questions about whether Petitioner is seeking to have Medicaid pay for benefits under Long Term Services and Supports (LTSS).[1] The Initial Decision finds Petitioner that LTSS "can be provided in an assisted living facility setting and therefore contradict the basis of the denial." ID at 5. However, Petitioner's counsel states that Petitioner "is not asking New Jersey Medicaid to pay for or supplement any assisted living costs." Petitioner's Brief dated November 10, 2020. So what exactly is Petitioner asking New Jersey Medicaid to provide by filing an application for benefits?

The answer seems to be Petitioner is seeking to have a penalty period begin during which she plans to pay privately at a facility that does not accept Medicaid. See e.g. B.K. v. MCBSS OAL Dkt. No. HMA 18569-2016 (FAD June 5, 2017). The application discloses that Petitioner has transferred assets which comes with the presumption that she did so to qualify for Medicaid benefits.[2] Based on the penalty amount contained in

---

[1] With monthly income of $5,406, Petitioner's only path to eligibility for Medicaid benefits is under the Long-Term Care Services and Supports (LTSS) program that permits the use of a higher income level - 300 percent of the SSI benefit amount and, when above that limit, a Qualified Income Trust. In order for eligibility to be granted using this higher income level, Petitioner must be in need of nursing level of care. See 42 CFR § 435.236 and 42 CFR § 435.1005. That level of care requires that a pre-admission screening (PAS) be completed by "professional staff designated by the Department, based on a comprehensive needs assessment which demonstrates that the recipient requires, at a minimum, the basic NF services described in N.J.A.C. 8:85-2.2." N.J.A.C. 8:85-2.1(a). See also, N.J.S.A. 30:4D-17.10, et seq. While not part of the record, it can be assumed that a PAS found that Petitioner requires the basic nursing facility services.

[2] A resource cannot be transferred or disposed of for less than fair market value during or after the start of the sixty month period (the "look-back period") before the individual becomes institutionalized or applies for Medicaid as an institutionalized individual. 42 U.S.C.A. § 1396p(c)(1); see also N.J.A.C. 10:71-4.10(a). Such transfers are viewed as being made for the sole purpose of establishing eligibility for Medicaid. Ibid. To discourage applicants from disposing of assets for the purpose of becoming eligible for Medicaid nursing home facility services, 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). "A transfer penalty is the delay in Medicaid eligibility triggered by the disposal of

the application, Petitioner is subject to a penalty of at least 611 days ($218,693/$357.67). See Medicaid Communication No. 20-05. She has also acquired an annuity that raises her income to over $5,000. Thus, I hereby REVERSE the Initial Decision and REMAND the matter to OAL for further findings and testimony with regard to the issues set forth below.

The denial letter states that Petitioner is residing in an assisted living facility that does not participate in the Medicaid program. R-A. Petitioner is seeking eligibility as of June 1, 2020 at which time she was residing in the non-Medicaid facility. Petitioner does not appear to dispute this and the record does not substantiate that Petitioner is otherwise eligible to receive institutional level of care services at a facility that does not participate in the Medicaid program that, but for the imposition of a penalty period, would be covered by Medicaid .[3]

The specter of the transfer penalty looms over this case and needs to be further addressed on remand. Briefly, the transfer penalty is meant to penalize individuals by denying them Medicaid benefits during that period when they should have been using the transferred resources for their medical care. See W.T. v. Div. of Med. Assistance & Health Servs., 391 N.J. Super. 25, 37 (App. Div. 2007). CMS has issued guidance that transfer penalty beings on"[t]he date on which the individual is eligible for medical assistance

---

financial resources at less than fair market value during the look-back period." E.S. v. Div. of Med. Assist. & Health Servs., 412 N.J. Super. 340, 344 (App. Div. 2010). "[T]ransfers of assets or income are closely scrutinized to determine if they were made for the sole purpose of Medicaid qualification." Ibid. Congress's imposition of a penalty for the disposal of assets for less than fair market value during or after the look-back period is "intended to maximize the resources for Medicaid for those truly in need." Ibid.

[3] In M.W. v. SCBSS, OAL DKT. No. HMA 2077-2013 (FAD August 13, 2013), the applicant was residing in a Veterans' Administration nursing facility which is not a Medicaid Title XIX facility. Although she could not be found eligible as of the date of the application, her residence at a Medicaid nursing home in the three months prior to the application could be reviewed for Medicaid eligibility including imposing any transfer penalty.

under the State plan and is receiving institutional level of care services (based on an approved application for such services) that, were it not for the imposition of the penalty period, would be covered by Medicaid." (emphasis added) https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/TOAEnclosure.pdf. See also 42 U.S.C. § 1396p(c)(1)(D)(ii). Therefore, the transfer penalty can only begin when the individual is otherwise eligible to be covered under Medicaid benefits.

Medicaid may not pay for certain services received by the individual when there is a transfer penalty. These services include nursing home and home and community based services. State Medicaid Manual § 3258.8. ("Penalties for Transfers of Assets for Less Than Fair Market Value.--When you find that assets have been transferred for less than fair market value, OBRA 1993 provides for specific penalties. These penalties involve the denial of reimbursement for certain services received by the individual.") (emphasis added). Those services include nursing home and MLTSS such as assisted living. Petitioner has disavowed that she is seeking Medicaid to pay for her assisted living care and is not seeking to move into a nursing facility.

Thus, I FIND that the record does not demonstrate that Petitioner is seeking to receive services where she currently resides that would be covered by Medicaid but for the penalty. On remand, the issue of the transfer penalty should be reviewed and, if she is seeking to have the penalty begin, Petitioner should present further proofs so as to demonstrate that she would be able to receive institutional level of care services covered by Medicaid while residing at a facility that does not participate in the Medicaid program. Such proofs may include her admission agreement and other authority to demonstrate that the facility permits Medicaid-covered services to be provided to her at that facility.

THEREFORE, it is on this 23rd day of MARCH 2021,

ORDERED:

That the Initial Decision is hereby REVERSED; and

That the matter is REMANDED for additional testimony, document production and findings as set forth above.

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