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

A.T.,	:	
PETITIONER,	:	**ADMINISTRATIVE ACTION**
v.	:	**FINAL AGENCY DECISION**
DIVISION OF MEDICAL ASSISTANCE	:	**OAL DKT. NO. HMA 11890-16**
AND HEALTH SERVICES AND	:	
MERCER COUNTY BOARD OF	:	
SOCIAL SERVICES,	:	
RESPONDENTS.	:	

As Director 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. Procedurally, the time period for the Agency Head to file a Final Agency Decision in this matter is May 24, 2018 in accordance with an Order of Extension.

The matter arises as the result of the Mercer County Board of Social Services' ("the Board") imposition of a penalty based Petitioner's transfer of $45,000 for less than fair market value between October 1, 2014 and March 31, 2016. Based on information obtained during the application process, the Board found Petitioner to be eligible for Medicaid Only program benefits as of April 1, 2016. However, the Board determined that Petitioner transferred $63,000 to her daughter during the look back period. Of the total

transferred the Board determined that $45,000 was transferred for less than fair market value resulting in a penalty period of 136 days running from April 1, 2016 through August 14, 2016.

Petitioner transferred her money pursuant to a caregiver agreement. In determining Medicaid eligibility for someone seeking institutionalized benefits, the counties must review five years of financial history. Under the regulations, "[i]f an individual . . . (including any person acting with power of attorney or as a guardian for such individual) has sold, given away, or otherwise transferred any assets (including any interest in an asset or future rights to an asset) within the look-back period" a transfer penalty of ineligibility is assessed.[1] N.J.A.C. 10:71-4.10 (c). It is Petitioner's burden to overcome the presumption that the transfer was done – even in part – to establish Medicaid eligibility. The presumption that the transfer of assets was done to qualify for Medicaid benefits may be rebutted "by presenting convincing evidence that the assets were transferred exclusively (that is, solely) for some other purpose." N.J.A.C. 10:71-4.10(j). Here, Petitioner is seeking to show that she received fair market value based on the caregiver agreement she entered into with her daughter.

The best evidence to rebut the presumption that caregiving services provided by relatives was done to establish Medicaid eligibility would be a written agreement between the parties pre-existing the delivery of the care or services. However, even where a pre-existing care agreement exists, "the mere existence of a pre-existing care agreement for services does not automatically establish that the services were rendered for fair market value." See E.S. v. Div. of Med. Assistance & Health Servs., 412 N.J. Super. 340, 352-53 (App. Div. 2010)." E.A. v. DMAHS and Hunterdon County Board of Social Services, supra.

[1] Congress understands that applicants and their families contemplate positioning assets to achieve Medicaid benefits long before ever applying. To that end, Congress extended the look back period from three years to five years. Deficit Reduction Act of 2005, P.L. 109-171, § 6011 (Feb. 8, 2006).

The court went on to find that "[n]otwithstanding a care agreement, the applicant still bears the burden to establish the types of care or services provided, the type and terms of compensation, the fair market value of the compensation, and that the amount of compensation or the fair market value of the transferred asset is not greater than the prevailing rates for similar care or services in the community. N.J.A.C. 10:71-4.10(b)(6)(ii) and (j)." Id.

The Initial Decision found nothing in the record, including documentation, testimony, and the caregiver agreement itself to indicate Petitioner's level of disability at the time the agreement was created. Nor was there any evidence or testimony that the payments for the care Petitioner received from her daughter are commensurate with fair market value for the same level of care. As a result, the Initial Decision concluded that Petitioner failed overcome the rebuttable presumption that she transferred the money in order to establish Medicaid eligibility and held that the Board correctly calculated the transfer period.

As the ALJ noted, although Petitioner's daughter testified that she was trained to care for Petitioner, there was no evidence regarding who trained her or the extent of the training she received. Petitioner's daughter did not dispute that she is not certified or licensed to provide services. In this case, there is no clear delineation of time afforded to Petitioner's care. The agreement itself does not provide a breakdown of the hourly rates Petitioner pays her daughter for the various services outlined in it. Nor, as indicated in the Initial Decision, is it clear whether the varied rates provided in Petitioner's closing brief correspond to a particular degree of license training or certification.[2]

The Initial Decision concluded that Petitioner failed to demonstrate that she received fair market value for the transferred assets. Based on my review of the record, I concur with the findings and conclusion set forth. I hereby ADOPT the Initial Decision in its

[2] The hourly rate information is wholly without citation and there is no reference to the various hourly rates used. There is also no evidence this was used to set the caregiver agreement amount.

entirety.

THEREFORE, it is on this 11th day of APRIL 2018,

ORDERED:

That the Initial Decision is hereby ADOPTED.

Meghan Davey, Director
Division of Medical Assistance
and Health Services