STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
25 SIGOURNEY STREET
HARTFORD, CT 06106

[redacted] 2014
Signature Confirmation

Client ID: [redacted]
Request: 549042

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2013, the Department of Social Services (the "Department") sent [redacted] (the "Appellant") representative, [redacted] ("Representative") a notice that she had transferred $28,131.04 to become eligible for Medicaid, and the Department was imposing a penalty period of ineligibility for Medicaid payment of long term care services effective [redacted] 2012 through [redacted] 2012.

On [redacted], 2013, the Representative requested an administrative hearing on behalf of the Appellant to contest the Department's penalty determination.

On [redacted] 2013 the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") scheduled an administrative hearing for [redacted] 2013.

On [redacted] 2013, in accordance with sections 17b-60, 17b-61, and 4-176e to 4-189, inclusive, of the Connecticut General Statutes, the OLCRAH held an administrative hearing. The following individuals were present at the hearing:

[redacted], Appellant's representative
[redacted], Paralegal for [redacted]
[redacted], Appellant's daughter
[redacted], Appellant's son – in - law
Liza Perez, Department's representative
Scott Zuckerman, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department correctly determined: 1) the Appellant transferred $28131.04 to become eligible for Medicaid; and 2) the $28131.04 transfer subjected the Appellant to a penalty period of ineligibility for Medicaid payment of long term care services.

FINDINGS OF FACT

1. On [redacted] 2010, the Appellant entered into a Care-Giver Employment Contract (the "contract") with her daughter which refers to the Appellant as the ("employer") and her daughter as the ("care-giver"). (Ex. G: Care-Giver Employment Contract, [redacted]10)

2. On [redacted] 2010, the Appellant entered into a Care-Giver Employment Contract (the "contract") with her son-in-law which refers to the Appellant as the ("employer") and her son-in-law as the ("care-giver"). (Ex. H: Care-Giver Employment Contract, [redacted]/10)

3. The contracts state in part that the care-givers agree to provide the following types of services: housekeeping, laundry/change linens, garbage removal, dishwashing, errand running, grocery shopping, transportation, meal preparation, bathing/grooming, dressing, getting out of bed, getting around, feeding, nutrition/diet, exercise and medication reminders. The contract provides that it surpasses all prior communications, either written or oral, concerning the subject matter of the agreement. The contract provides for the employer to pay the care-giver $18.00 per hour. (Ex. G & H: Care Giver Contracts, [redacted]/10)

4. On [redacted] 2011, the Appellant's daughter and son-in-law, (the "care-givers") received $12,500 from the Appellant and Appellant's spouse. (Testimony, Ex. E: Copy of check # [redacted], [redacted]/11, Ex. I: Caregiver Tracking of Expenses [redacted]2010 through [redacted] 2011)

5. On [redacted] 2011, the care-givers received $4,014.08 from the Appellant. (Ex. E: Copy of check# [redacted], [redacted]/11)

6. On [redacted] 2011, the care-givers received $10,788.00 from the Appellant. (Ex. E: Copy of check # [redacted], [redacted]/11)

7. On [redacted] 2011, the care-givers received $4,120.00 from the Appellant. (Ex. E: Copy of check # [redacted] [redacted]/11)

8. On [redacted] 2011, the care-givers received $18,000 from the Appellant. (Ex. E: Copy of check # [redacted] [redacted]/11)

9. On [redacted] 2012, Touchpoints of Farmington ("the facility") admitted the Appellant. (Ex. T: Case narrative, [redacted]/13)

10. On [redacted] 2012, the Department received an application for Medicaid to cover the cost of long term care for the Appellant. There was no supporting documentation included with the application. (Summary)

11. On [redacted] 2012, the Department sent the Appellant's representative a W-1348LTC, We Need Verification from You form, requesting information needed to establish eligibility. Among the items requested was verification of all assets since [redacted] 2007. The form stated that Medicaid cannot be granted for any month in which assets exceed $1600.00. (Ex. C: W-1348LTC, [redacted]/12)

12. On [redacted], 2012, the Department reviewed information submitted and sent the Appellant's representative a W-1348LTC, requesting information needed to establish eligibility. Among the items requested was documentation explaining the following withdrawals from UBI Credit Union: $19,340 check [redacted], [redacted]11; $4014.08 # [redacted]11; $10,788.00 # [redacted], [redacted]/11; $4120.00 # [redacted]11 and the following withdrawal from Regions Bank account # [redacted] $18,000 # [redacted] [redacted]/11. The form stated that in order to avoid a penalty verification must be provided showing withdrawals were for the Appellant's needs. (Ex. D: W-1348LTC, [redacted]/12)

13. On [redacted] 2013, the Department sent the Appellant's representative a W-1348LTC, requesting information needed to establish eligibility. Among the items requested was a copy of the care-giver agreements along with detailed records of services provided. In addition, the form requested documentation explaining the following withdrawals from UBI Credit Union: $19,340 check [redacted], [redacted]/11; $4014.08 # [redacted], [redacted]/11; $10,788.00 # [redacted] [redacted]/11; $4120.00 # [redacted], [redacted]/11 and the following withdrawal from Regions Bank account #[redacted]: $18,000 # [redacted]11. (Ex. E: W-1348LTC, [redacted]/12)

14. On [redacted] 2012, the Department sent the Appellant's representative a W-1348LTC, requesting information needed to establish eligibility. Among the items requested was documentation of services performed by the care-givers and time spent each week performing the services. In addition, the form requested documentation explaining the following withdrawals from UBI Credit Union: $19,340 check #[redacted] [redacted]/11; $4014.08 # [redacted],[redacted]11; $10,788.00 # [redacted] [redacted]/11; $4120.00 # [redacted],[redacted]11 and the following withdrawal from Regions Bank account # [redacted]: $18,000 #[redacted], [redacted]/11. (Ex. F: W-1348LTC, [redacted]/12)

15. On [redacted] 2012, the Department received a document labeled "Caregiver Tracking of Expenses" for the Appellant. (Ex. I: Caregiver tracking of expenses, [redacted]2010 – [redacted] 2011)

16. On [redacted] 2012, the Department sent the Appellant's representative a W-1348LTC, requesting information needed to establish eligibility. Among the items requested was documentation explaining the following withdrawals from UBI Credit Union: $19,340 check [redacted] /11; $4014.08 # [redacted], /11; $10,788.00 # [redacted], /11; $4120.00 # [redacted] /11 and the following withdrawal from Regions Bank account # [redacted]: $18,000 # [redacted] /11. (Ex. K: W-1348LTC, /12)

17. On [redacted] 2013, the Department reviewed the Contract and the Caregiver Tracking of Expenses and determined 1.) There was no provision in the contract for the Appellant's use of car, restaurant meals, and reimbursement for heating or expenses while the Appellant was sharing a home with the care-givers. 2.) There is no basis for remote care giving administration while the Appellant was residing in Florida. 3.) The caregiver agreement does not provide for dividing of household expenses per couple while the Appellant and her spouse were living with the caregivers. (Ex. L: Emailed from Noeline K. Randall, -13)

18. On [redacted] 2013, the Department sent the Appellant's representative a W-1348LTC, requesting information needed to establish eligibility. Among the items requested was documentation of the actual hours spent performing the services agreed upon in the contract, and copies of receipts for reimbursements where the client was the recipient of the service. In addition, the form requested documentation explaining the following withdrawals from UBI Credit Union: $19,340 check #[redacted] /11; $4014.08 # [redacted] /11; $10,788.00 # [redacted], /11; $4120.00 # [redacted], [redacted] /11 and the following withdrawal from Regions Bank account # [redacted]: $18,000 # [redacted] /11. (Ex. M: W-1348LTC, /13)

19. On [redacted] 2013, the Department sent the Appellant's Representative a W-495A, Transfer of Assets, Preliminary Decision Notice stating that the Appellant had transferred $56,262.08 in order to be eligible for Medicaid. The notice was addressed to the Appellant and her spouse. The Appellant and her spouse are applying for Long Term Care Medicaid simultaneously. (Ex. 0: W-495A, Transfer of Assets, Preliminary Decision Notice, 13)

20. On [redacted] 2013, the Appellant's representative responded to the Department's W-495 with a copy of a Long Term care calculator comparing costs of home health aide, homemaker and day care costs in St. Petersburg Florida to CT. In addition they responded with a copy of an article regarding solutions when caregiving elderly parents remotely. (Ex. P: Appellant's rebuttal, /13)

21. The Appellant did not provide information regarding the specific hours of care provided. The number of hours in listed varies from 5-14 hours per day home care, The Appellant did not provide information regarding values assigned to each task listed each month for care-giver services. The tracking of expenses solely states "caregiving activities". There were no receipts provided for the

miscellaneous expenses. There is no other evidence in the record to support the claim of services provided. (Exhibit I- Contract and Tracking of Expenses; Record)

22. The fair market value of the services cannot be determined without detailed records of specific services provided as outlined in the contract. (Fact #21)

23. On [redacted] 2013, the Department sent the Appellant's representative a W-495C, Transfer of Assets, Final Decision Notice stating that the Appellant transferred $28,131.04 in order to be eligible for Medicaid. (Ex. S: W-495C, Transfer of Assets, Final Decision Notice)

24. On [redacted] 2013, the Department granted the Appellant's Long Term Care Medicaid benefits effective [redacted] 2012, with a penalty period from [redacted] 2012 through [redacted] 2012. (Ex. T: Case narrative, [redacted]/13)

CONCLUSIONS OF LAW

1. The Department is the state agency that administers the Medicaid program pursuant to Title XIX of the Social Security Act. The Department may make such regulations as are necessary to administer the medical assistance program. Conn. Gen. Stat. § 17b-2; Conn. Gen. Stat. § 17b-262

2. The Department is the sole agency to determine eligibility for assistance and services under the programs it operates and administers. Conn. Gen. Stat. § 17b-261b(a)

3. The Department shall grant aid only if the applicant is eligible for that aid. Conn. Gen. Stat. § 17b-80(a)

4. Any disposition of property made on behalf of an applicant or recipient or the spouse of an applicant or recipient by a guardian, conservator, person authorized to make such disposition pursuant to a power of attorney, or other person so authorized by law shall be attributed to such applicant, recipient, or spouse. Conn. Gen. Stat. §17b-261(a); Uniform Policy Manual ("UPM") § 3029.05(D)

5. The look-back date for transfers of assets is a date that is sixty months before the first date on which both the following conditions exist: 1) the individual is institutionalized; and 2) the individual is either applying for or receiving Medicaid. UPM § 3029.05(C)

6. Any transfer or assignment of assets resulting in the imposition of a penalty period shall be presumed to be made with the intent, on the part of the transferor or the transferee, to enable the transferor to obtain or maintain

eligibility for medical assistance. This presumption may be rebutted only by clear and convincing evidence that the transferor's eligibility or potential eligibility for medical assistance was not a basis for the transfer or assignment. Conn. Gen. Stat. § 17b-261a(a)

7. A legally-enforceable agreement is a binding and credible arrangement, either oral or written, wherein two or more parties agree to an arrangement in consideration of the receipt of money, property, or services and in which all parties can be reasonably expected to fulfill their parts of the agreement. UPM § 3000.01

8. The transaction between the Appellant and her parents meets the definition of a legally enforceable document.

9. The Department correctly determined that the contract was a legally enforceable agreement.

10. UPM § 3029.10(E) provides that an otherwise eligible institutionalized individual is not ineligible for Medicaid payment of LTC services if the individual, or his or her spouse, provides clear and convincing evidence that the transfer was made exclusively for a purpose other than qualifying for assistance.

11. UPM § 3029.10(F) provides that an institutionalized individual, or his or her spouse, may transfer an asset without penalty if the individual provides clear and convincing evidence that he or she intended to dispose of the asset at fair market value.

12. UPM § 3029.30 (A)(2) provides that compensation received prior to the time of the transfer is counted if it was received in accordance with a legally enforceable agreement.

13. UPM § 3029.30 (B) pertains to the value of compensation and provides in part: (1) In determining the dollar value of services rendered directly by the transferee, the Department uses the following amounts:

    a. for all services of the type normally rendered by a homemaker or home health aid, the current state minimum hourly wage for such services;
    b. for all other types of services, the actual cost

14. Based on Finding of Fact number 21 and 22, the Department correctly determined that for payments made from [redacted] 2011 through [redacted] 2011 to the caregivers, the Appellant did not receive fair market value for the services the Appellant's daughter and son-in-law provided as listed in the contract and that some of the services were not for compensation for care-giver services in accordance with the contract.

15. UPM § 3029.05 (H) provides for transfers affecting both spouses and states in part that:

    1. If a transfer made by an individual results in a penalty period for the individual, the penalty period is apportioned between the individual and spouse if:

        a. the spouse either is or becomes eligible for Medicaid; and

        b. the spouse is also institutionalized; and some portion of the penalty against the individual remains at the time conditions a and b are met.

    2. When a penalty period is apportioned between spouses as described in 1, the penalty period for each spouse is equal to one half the total penalty period remaining at the time.

16. The Department correctly determined that the payments from [redacted] 2011 through [redacted] 2011, totaling $28,131.04 ($56,262.08 split between Appellant and her institutionalized spouse), were transfers to the Appellant's daughter and son-in-law because the Appellant failed to provide clear and convincing evidence that the money was transferred exclusively for a purpose other than qualifying for assistance.

17. UPM § 3029.05 provides that there is a period established, subject to the conditions described in this chapter, during which institutionalized individuals are not eligible for certain Medicaid services when they or their spouses dispose of assets for less than fair market value on or after the look-back date specified in 3029.05 C. This period is called the penalty period, or period of ineligibility.

18. UPM § 3029.05 (E)(2) provides that the penalty period begins as of the later of the following dates: the date on which the individual is eligible for Medicaid under Connecticut's State Plan and would otherwise be eligible for Medicaid payment of the LTC services described in 3029.05 B based on an approved application for such care but for the application of the penalty period, and which is not part of any other period of ineligibility caused by a transfer of assets.

19. The Appellant is subject to a penalty period beginning [redacted], 2012, the date that the Appellant was otherwise eligible for Medicaid payment of long-term care services.

20. UPM § 3029.05 (F) provides in part that the length of the penalty period consists of the number of whole and/or partial months resulting from the computation described in 3029.05 F. 2. The length of the penalty period is determined by dividing the total uncompensated value of all assets transferred on or after the look-back date described in 3029.05 C by the average monthly cost to a private patient for LTCF services in Connecticut. For applicants, the average monthly cost for LTCF services is based on the figure as of the month of application.

21. The length of the penalty period is 2.65 months, which is determined by dividing the uncompensated value of the transferred asset by the average monthly cost of care to a private patient for long-term care services in Connecticut, or $28,131.04 ÷ 10,586.00 = 2.65 months. (Ex. S: W-495C, 6/28/13)

DISCUSSION

After reviewing the evidence and testimony presented, the Department's action to impose a Medicaid period of ineligibility for long term care coverage is upheld.

The Appellant's representatives testified that from [redacted] 2010 through [redacted] 2010 the Appellant and her spouse lived with the caregivers due to failing health. They testified they charged the Appellant a flat monthly fee of $2500.00 monthly which includes shelter, use of the caregivers vehicle for the Appellant and "caregiving activities". The caregivers did not provide any documentation of the actual activities as noted in the contract and the amount of hours spent performing specific tasks for the $18.00/ hr fee. In addition, the Appellant's daughter and son-in-law ("caregivers") paid themselves for reimbursements of restaurant meals, postal costs, retail, and medical expenses. The caregivers did not provide any receipts for these reimbursements.

The Appellant's representative testified she went to Florida [redacted], 2011 to [redacted] 2011 for caregiving activities and charged $6840 for caregiving and was paid $1824.00 for expenses. Again, there is no documentation of the specific daily tasks performed as outlined in the contract or receipts for the reimbursements sought by the caregiver.

The Appellant's caregivers paid themselves for remote caregiving when the Appellant returned to her home in Florida in 2010 and [redacted] through [redacted] of 2011. The Appellant's representative testified that check # [redacted] was for the remote caregiving during those times. The contract does not provide for caregiving while the Appellant was living in Florida. The Appellant's son-in-law testified that some of that money was payment for services also provided in 2009. The contract was signed [redacted]/10. The Appellant's daughter and son-in-law did not provide any documentation of specific services performed each day and the amount of time they were performed. During trips to Florida the Appellant's caregivers charged the Appellant for transportation, airfare and parking for trips to Florida. There were no receipts provided.

The Appellant's daughter testified that the [redacted]/11 check for $19,340 could be for caregiving provided earlier than 2010. The Appellant's daughter (caregiver) testified that it was hard to go back to dates. The son-in-law testified that he admits he should have kept receipts and records. The caregivers testified that actual receipts were not provided to the department, just the caregiver tracking of expenses, which does not give specifics. The Department testified that the tracking of expenses does not provide

actual receipts verifying reimbursements for purchased items on the Appellant's behalf. The Department indicated that the Appellant's caregivers did not provide verification actual services provided.

The Appellant's representative testified that part of check # [redacted] was for replacement of a Garage door that the Appellant's husband damaged while staying with the caregivers. There was no written documentation provided that the spouse agreed to reimbursement. The Appellant's caregivers also testified that the Appellant's spouse damaged a heating and air conditioning system which needed total replacement. There was no documentation provided that the spouse agreed to this reimbursement. The Appellant's daughter testified that some of the money from that check was given to the Appellant's granddaughter for her coordination of researching nursing homes. The Appellant's granddaughter is not a caregiver on the contract. Therefore, the services performed by the granddaughter are not considered caregiver services. The Appellant's testified that some of the payments may be for services prior to the contract due to oral agreements. The contract states that it supersedes any previous agreements, oral or written.

I find that the care-givers received funds for services not listed within the contract agreement that they had between the Appellant and the Appellant's spouse. The Appellant's representative was given the opportunity to submit supporting evidence to substantiate the argument that fair market value for the services was received and to provide detailed documentation and receipts regarding the reimbursements. The Appellant's representative provided no further documentation the record. The undersigned finds that the Department was correct to impose a penalty as fair market value could not be determined without detailed records of specific services provided as outlined in the contract.

I find the evidence clear and convincing that the transfers were made for the purpose of qualifying for Medicaid. The amount of the penalty, $28,131.04 is the Appellant's half of the total penalty of $56,262.08.

DECISION

The Appellant's appeal is **DENIED.**

Scott Zuckerman
Hearing Officer

Pc: Albert Williams, Operations Manager, Hartford Regional Office

RIGHT TO REQUEST RECONSIDERATION

The Appellant has the right to file a written reconsideration request within 15 days of the mailing date of the decision on the grounds there was an error of fact or law, new evidence has been discovered or other good cause exists. If the request for reconsideration is granted, the Appellant will be notified within 25 days of the request date. No response within 25 days means that the request for reconsideration has been denied. The right to request a reconsideration is based on §4-181a(a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, what new evidence, or what other good cause exists.

Reconsideration requests should be sent to: Department of Social Services, Director, Office of Legal Counsel, Regulations, and Administrative Hearings, 25 Sigourney Street, Hartford, CT 06106.

RIGHT TO APPEAL

The Appellant has the right to appeal this decision to Superior Court within 45 days of the mailing of this decision or 45 days after the Agency denies a petition for reconsideration of this decision, provided that the petition for reconsideration was filed timely with the Department. The right to appeal is based on §4-183 of the Connecticut General Statutes. To appeal, a petition must be filed at Superior Court. A copy of the petition must be served upon the Office of the Attorney General, 55 Elm Street, Hartford, CT 06106 or the Commissioner of the Department of Social Services, 25 Sigourney Street, Hartford, CT 06106. A copy of the petition must also be served on all parties to the hearing.

The 45 day appeal period may be extended in certain instances if there is good cause. The extension request must be filed with the Commissioner of the Department of Social Services in writing no later than 90 days from the mailing of the decision. Good cause circumstances are evaluated by the Commissioner or his designee in accordance with §17b-61 of the Connecticut General Statutes. The Agency's decision to grant an extension is final and is not subject to review or appeal.

The appeal should be filed with the clerk of the Superior Court in the Judicial District of New Britain or the Judicial District in which the Appellant resides.