STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06105-3725

[redacted] **2015**
Signature Confirmation

Client ID #[redacted]
Request # 534459

NOTICE OF DECISION

PARTY

[redacted]
Re: [redacted]
[redacted]
[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2013, the Department of Social Services (the "Department") sent [redacted] (the "Appellant") a Notice of Action ("NOA") denying her application for Long Term Care Medicaid benefits for the months of [redacted] 2011 through [redacted] 2012, inclusive, because her assets exceeded the limit in those months, and a notification that she was being assessed a penalty period due to transferring an asset.

On [redacted] 2013, the Appellant requested an administrative hearing to contest the Department's determination of the effective date of her eligibility for the program.

On [redacted] 2013, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice stating that it appears that since the time that the hearing was requested, the Department has taken an action which may have resolved the issue being appealed, and asking the Appellant to respond whether the Department's action has resolved her issue.

On [redacted] 2014, OLCRAH issued a notice scheduling the administrative hearing for [redacted] 2014, because the Appellant clarified that the matter being appealed still has not been resolved.

On [redacted] 2014, in accordance with sections 17b-60, 17-61 and 4-176e to 4-189 inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing.

The following individuals were present at the hearing:

[redacted] Appellant's Son and Power of Attorney
Joseph Jack, Department's Representative
Jyoti Ajodhi, representing Manchester Manor nursing facility
James Hinckley, Hearing Officer

The hearing record was held open until [redacted] 2014 for the Department to submit additional evidence, and for an additional seven days, until [redacted] 2014 to allow the Appellant time to respond. On [redacted] 2014, the hearing record closed.

STATEMENT OF THE ISSUE

1. The first issue to be decided is whether the Department correctly determined that the first month in which the Appellant had total assets less than the $1,600.00 Medicaid asset limit was [redacted] 2012.

2. The second issue to be decided is whether the Department correctly established the fair market value ("FMV") of the Appellant's 40% share of an office condominium whose transfer to her son resulted in a transfer of asset penalty.

FINDINGS OF FACT

1. As of [redacted] 2008, the Appellant owned a 40% share of a three-office office condominium located at [redacted] (the "Property"), which became her personal property after the corporation she was a 40% partner in since 1985 dissolved after the predetermined twenty year life of the corporation elapsed. (Appellant testimony)

2. On [redacted] 2008, the Appellant quit claimed her 40% ownership share of the Property to her son, [redacted] (Record)

3. On [redacted] 2010, the Appellant applied to the Department to receive Home Care Services from the State Funded portion of the Connecticut Home Care Program for Elders (the "M03" Program). (Ex. 2: Case Narrative)

4. After the Appellant applied for the M03 Program, the Department made a referral to its Resource Unit to determine the FMV of the Appellant's share of the Property as of the date it was transferred, because the transfer occurred within the Department's five year look back period; the Department assesses a penalty for transfers of assets that occur during the look back period, and the length of the penalty is dependent upon the value of the asset that was transferred. (Record)

5. On [redacted] 2011, the Department's Resource Unit made a determination that the FMV of the Appellant's interest in the Property as of [redacted] 2008 was $32,000.00. The Resource worker noted that there were no comparable

sales of office condominiums within the one and one half year period prior to the date of the transfer, and therefore determined the FMV based upon a 40% share of the $80,000.00 appraised value of the condominium ($80,000.00 times 40% equals $32,000.00). The Resource worker also noted that although there were no comparable sales, an office condominium unit in a different part of town sold on [redacted] 2007 for $80,000.00. (Ex. 7: Resource Unit response to referral)

6. On [redacted] 2011, the Department established that the Appellant should receive a penalty equaling 3.08 months of ineligibility for the M03 program based on having transferred assets valued at $32,000.00 during the look back period. (Ex. 2)

7. The Appellant did not contest the penalty that the Department established for the M03 Program. (Record)

8. On [redacted] 2011, the Appellant applied to the Department for Medicaid for long term care (the "L01" Program). (Record)

9. On [redacted] 2011, the Appellant was admitted to Vernon Manor, a long term care facility. (Record)

10. On [redacted] 2011, the Department discontinued the Appellant's eligibility for Home Care Services from the M03 program, because she was now residing in a long term care facility, and would now be seeking coverage from the L01 Program to pay for long term care. (Ex. 2)

11. As of [redacted] 2011, the Appellant's assets consisted of: 1) First Niagara Bank Account No. xxxxxx[redacted] 2) First Niagara Bank Account No. [redacted]; and 3) AARP Life Insurance Policy No. xxxxx[redacted]. (Record)

12. As of [redacted] 2012, AARP Life Insurance Policy No. xxxxx[redacted] had a Face Value of $10,000.00, and a Cash Surrender Value of $1,110.09. (Ex. 5: AARP Policy Information Letter dated [redacted] 2012)

13. On [redacted] 2013, the Department issued to the Appellant a W-495A Transfer of Assets Preliminary Decision Notice informing her that the Department made a decision that she transferred $32,000.00 on [redacted] 2008 for the purpose of qualifying for assistance, and offering her until [redacted] 2013 to offer rebuttal of the Department's findings. (Ex. 13: Form W-495A)

14. On [redacted] 2013, the Department received a rebuttal of its findings, but determined that the rebuttal did not offer clear and convincing evidence that its decision was incorrect. (Ex. 2)

15. On [redacted] 2013, the Department issued to the Appellant a W-495B Transfer of Assets Notice of Response to Rebuttal/Hardship Claim form informing her that

the Department does not agree with her rebuttal arguments, and that if she becomes eligible for Medicaid she will receive a penalty of being ineligible for payment of long term care medical services for a period of 3.08 months from the date she becomes eligible for Medicaid. (Ex. 14: Form W-495B)

16. On [redacted] 2013, the Department found that the Appellant's assets exceeded the Medicaid asset limit of $1,600.00 for the months of [redacted] 2011 through [redacted] 2012, inclusive; the Department's month by month determination of the Appellant's assets is summarized in the chart below (First Niagara is abbreviated "F.N."):

	F.N. [redacted]	F.N. [redacted]	AARP Life Ins	Total Assets
[redacted] 2011	$1,220.94	$501.53	$1,110.09	$2,331.03
[redacted] 2011	$1,712.90	$0	$1,110.09	$2,822.99
[redacted] 2011	$1,548.25	$0	$1,110.09	$2,658.34
[redacted] 2011	$1,548.25	$0	$1,110.09	$2,658.34
[redacted] 2011	$1,569.01	$0	$1,110.09	$2,679.91
[redacted] 2011	$1,135.78	$0	$1,110.09	$2,245.87
[redacted] 2012	$1,246.54	$0	$1,110.09	$2,356.63
[redacted] 2012	$1,037.57	$0	$1,110.09	$2,147.66
[redacted] 2012	$1,003.83	$0	$1,110.09	$2,133.92
[redacted] 2012	$948.35	$0	$1,110.09	$2,058.44
[redacted] 2012	$948.35	$0	$1.110.09	$2,058.44
[redacted] 2012	$903.61	$0	$1,110.09	$2,013.70
[redacted] 2012	$875.37	$0	$1,110.09	$1,985.46
[redacted] 2012	$677.09	$0	$1,110.09	$1,787.18
[redacted] 2012	$412.35	$0	$1,110.09	$1,522.44

(Ex. 3: Department's asset calculation summary, Ex. 4: First Niagara Account Statements and summary printout, Ex. 5: Proof of AARP Life Insurance policy face value and cash value dated [redacted] 2012, Ex. 6: Proof that AARP Life Insurance policy was surrendered on [redacted] 2013)

17. On [redacted] 2013, the Department issued to the Appellant a W-495C Transfer of Assets Final Decision Notice informing her that it decided that she transferred $32,000.00 on [redacted] 2008 in order to become eligible for Medicaid, and that she will be eligible for certain Medicaid benefits beginning [redacted] 2012, but that she will receive a penalty that Medicaid will not pay for any long term care services until the penalty ends on [redacted] 2012. (Ex. 15: Form W-495C)

18. On [redacted] 2013, the Department mailed a NOA to the Appellant notifying her that her application for the L01 program was denied for the months of [redacted] 2011 through [redacted] 2012, inclusive, because her assets were more than the limit for the program in each month. (Ex. 10: Notice of Action dated [redacted] 2013)

19. On [redacted] 2013, the Department mailed a NOA to the Appellant notifying her that she is eligible for the L01 Program beginning [redacted] 2013. (Ex. 9: Notice of Action dated [redacted] 2013)

CONCLUSIONS OF LAW

1. Section 17b-260 of the Connecticut General Statutes provides for the administration of the Medicaid program pursuant to Title XIX of the Social Security Act.

2. Uniform Policy Manual ("UPM") § 4005.05(B) provides that, for purposes of establishing eligibility for Medicaid, the Department counts the assistance unit's equity in an asset toward the asset limit if the asset is not excluded by state or federal law and is either available to the unit, or deemed available to the unit, and that the Department considers an asset available when it is actually available to the individual or when the individual has the legal right, authority or power to obtain the asset, or to have it applied for, his or her general or medical support.

   UPM § 4030.30 discusses the treatment of life insurance policies as assets.

   UPM § 4030.30(A) provides that for all programs: 1. The owner of a life insurance policy is the insured unless otherwise noted on the policy, or if the insurance company confirms that someone else, and not the insured, can cash in the policy; and 2. Policies such as term insurance policies having no cash surrender value are excluded assets.

   UPM § 4030.30(C) provides that for the AABD and MAABD programs: 1. If the total face value of all life insurance policies owned by the individual does not exceed $1500.00, the cash surrender value of such policies is excluded. In computing the face value of life insurance, the Department does not count insurance such as term insurance which has no cash surrender value; and 2. Except as provided above, the cash surrender value of life insurance policies owned by the individual is counted toward the asset limit.

   The Department correctly determined that the Appellant's AARP Life Insurance policy had a face value of $10,000.00, which exceeds $1500.00, and that the policy's cash surrender value of $1,110.09 was therefore countable toward the Medicaid asset limit. The Department correctly determined that the cash surrender value of the Life Insurance policy was

available to the Appellant, and therefore countable as an asset, for each month that the Appellant owned the policy, until it was redeemed on [redacted] 2013.

UPM § 4030.05(B) provides that: That portion of a checking account to be considered as a counted asset during a given month is calculated by subtracting the actual amount of income the assistance unit deposits into the account that month from the highest balance in the account for that month.

The Department correctly calculated the value of the Appellant's bank balances for each month by applying the methodology specified in its policy, using amounts that are documented by actual bank statements from First Niagara Bank.

3. UPM § 4005.10(A)(2)(a) provides that the asset limit for Medicaid for a needs group of one is $1600.00.

The Department correctly determined that the Appellant was ineligible for Medicaid during the period from [redacted] through [redacted] 2012, inclusive, because her countable assets exceeded the asset limit of $1600.00 in each month.

The Department correctly determined that the Appellant became eligible for Medicaid effective [redacted] 2012.

4. UPM § 3029.03 provides that the Department uses the policy contained in UPM § 3029 to evaluate asset transfers that occurred on or after [redacted] 2006.

UPM § 3029.05(A) 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.

UPM § 3029.05(B)(1) provides that the policy in this chapter pertains to institutionalized individuals and to their spouses.

UPM § 3029.05(C) provides that the look-back date for transfers is a date that is 60 months before the first date on which both of the following conditions exist:

1. The individual is institutionalized; and
2. The individual is either applying for or receiving Medicaid.

The Appellant applied for Medicaid on [redacted] 2011 and was institutionalized on [redacted] 2011. The Appellant's look back period is established based on the date, [redacted] 2011. The Department was correct to determine that the Appellant's quit claim of her 40% share of the Property on

[redacted] 2008 was a transfer of assets that occurred within the 60 month look back period.

Connecticut General Statutes § 17b-261a(a) provides that 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.

The Appellant has not provided clear and convincing evidence rebutting the presumption that the asset transfer that occurred on [redacted] 2008 was made with the intent to enable the Appellant to obtain medical assistance. The Department was correct to assess a penalty based on the asset transfer.

UPM § 3029.05(F) provides that the length of the penalty period is computed 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 long term care facility ("LTCF") services in Connecticut as of the month of application for the program, and that the resulting number of whole and/or partial months equals the penalty period.

The Appellant applied for the L01 Program on [redacted] 2011. The average cost of care for a private patient in a LTCF in Connecticut as of [redacted] 2011 was $10,366.00. Dividing the uncompensated transfer amount of $32,000.00 by $10,366.00, equals 3.08. The Department correctly determined that the length of the Appellant's penalty period should be 3.08 months.

UPM § 3029.05(G) provides that:

1. During the penalty period, the following Medicaid services are not covered:
    a. LTCF services; and
    b. Services provided by a medical institution which are equivalent to those provided in a long-term care facility; and
    c. Home and community-based services under a Medicaid waiver.

2. Payment is made for all other Medicaid services during a penalty period if the individual is otherwise eligible for Medicaid.

The Department correctly determined that during the first 3.08 months of her Medicaid eligibility, the Appellant is not eligible to have her cost of LTCF services paid, because she must be assessed a penalty period for having made an uncompensated transfer of assets during the look back period. The Department correctly determined that the Appellant is eligible to have all other Medicaid services, except for LTCF services, paid effective [redacted] 2012, the date her eligibility for Medicaid began.

DISCUSSION

The Appellant's son was dissatisfied with the effective date that the Appellant became eligible to have her costs of long term care paid, and he contested both the Department's determination that the Appellant's assets exceeded the limit for several months, and the Department's valuation of the asset whose transfer resulted in a penalty.

Regarding the Department's determination of the Appellant's assets, the Appellant's son presented his own personal check register of the Appellant's balances and argued that one check that he wrote on [redacted] 2011 that was never cashed should not have been counted by the Department toward the limit. Further, he argued that the value of the Appellant's AARP Life Insurance policy should not be counted because for a long period of time he was unaware that it had any cash value, and that the Department should have seen proof of the premium payments on her bank statements and brought to his attention that the policy might have a cash value that could adversely affect the Appellant's eligibility. He testified that it never occurred to him that the policy might have a cash value, and that he assumed that he would be guided through the application process by the Department.

The Department's determination of the Appellant's assets was correct. The Department relied on balances from actual bank records to determine the monthly values, rather than on a personal register that contains only self-kept records that do not necessarily reflect the actual balances. Regarding the life insurance policy, the cash value of the policy is not excluded as an asset simply because the Appellant's son was unaware that the policy had any cash value. It was not the Department's responsibility to bring to the Appellant's son's attention the possibility that the policy might have a cash value. While the Department disseminates basic eligibility information through several sources, it cannot guarantee that all of the complex Medicaid rules, or that all possible scenarios are explained personally to each individual applicant. It is ultimately the responsibility of each applicant to perform a though inventory and accounting of their own assets, and to report their assets to the Department, not for the Department to investigate each asset which the applicant may potentially own.

Regarding the Property that was transferred, incurring a penalty, the Appellant's son maintained that the Department's valuation was inaccurate and unfairly high. He argued that at the time the property was transferred in 2008, the real estate market was

in the midst of a crash, and that the Department based its valuation on the sale of an unrelated unit in a different building, in a different part of town. He claimed that the unit may be unsaleable, and that it may have no value at all. He provided a letter from the previous co-owner indicating that a real estate broker informed him that two units in the same building were put up for sale at some point for approximately $76,000.00 each and taken off the market after six months when they didn't sell. The letter drew the conclusion that "there doesn't appear to be any market for these units" and that there is no way to determine their worth "if any". The Appellant's son also provided proof that a unit in the same building sold in 2014 for only $43,000.00, which was less than its appraised value of $68,200.00. Finally, he questioned how the Department could impose a penalty for the L01 Program when it already assessed a penalty earlier against the M03 Program, the State funded program that assisted the Appellant with the cost of home based services when she was still residing in the community.

Estimating the value of property is, by its nature, inexact. The Department's Resource Unit did not capriciously use less reliable information to arrive at its valuation, while ignoring more reliable information. It noted that because there were no recent comparable sales, it would rely instead on the city's tax appraisal value, which must be assumed to have validity. It did not, as the Appellant's son suggested, rely on the sale of an unrelated unit in another part of town to establish the value of the Appellant's unit. It merely noted that another sale occurred, but it established the value of the Appellant's unit by using the appraised value of the unit itself.

I am not persuaded that the failure of two units in the same building to sell at their $76,000.00 asking price is an indication that all of the units in the building are therefore valueless. It is not inconceivable that the city's appraisal value from 2008 somewhat overvalued the Property, but there is no way to know for certain, and the appraisal represented the best and most reliable information available at the time for the Department to use. The Appellant did not appeal the city's tax valuation of her unit in 2008, and she did not appeal the Department's establishment of a transfer of asset penalty when she applied for the M03 program in 2010. While the Appellant's son provided proof of the sale of a similar unit in the same building that occurred six years later, I must still consider the appraisal value of the actual unit that the Department used to be the best information available on which to base the Property's valuation at the time the transfer occurred.

Finally, it is understandable for the Appellant's son to question why the Department is imposing a penalty against the Appellant's eligibility for the L01 Program beginning in [redacted]2012, when it already imposed a penalty, based on the same transferred asset, against her eligibility for the M03 Program in 2011. The L01 Program is part of federally funded Medicaid, and its rules are established in federal Medicaid law. The M03 Program is a discretionary program established by the state, that solely uses State of Connecticut funds to assist individuals with the cost of home care. Medicaid rules require that the Appellant receive a penalty for making an uncompensated asset transfer during the look back period, and the fact that the State imposed a penalty against its own program for the same transfer does not relieve the Department from

being required to impose a penalty when the Appellant became eligible for Medicaid, based on Medicaid rules.

DECISION

The Appellant's appeal is DENIED.

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James Hinckley
Hearing Officer

CC: John Hesterberg, SSOM Manchester

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, 55 Farmington Avenue, Hartford, CT 06105.

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, 55 Farmington Avenue, Hartford, CT 06105. 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.