National Update

PRESENTED BY:
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Federal and State Legislative Developments Impacting Elder and Special Needs Law

Presented by

Michael J. Amoruso, President Elect of NAELA

January 23, 2018

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Health Reform 2017

- AHCA/BCRA/Graham-Cassidy:
  - Major Medicaid reform
  - Repeal and Replace of ACA
  - Ultimately failed in the Senate

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NAELA Advocacy on Health Reform

I. Limitations to Annuities
II. Limits to Home Equity
III. Repeal of Retroactive Coverage

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H.R. 181, CALM Act

- Half of income from a community spouse's annuity available to the institutionalized spouse
  - Except for IRA annuities.

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HR 181, CALM Act

- Concerns raised
  - Includes non-IRA retirement accounts;
  - Incentivizes divorce;
  - Hurts elderly women in the most; and
  - Current draft hurts working class not just errant high dollar value annuities.

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American Health Care Act

- Annuities bill dropped, but included:
  - repeal of three-month retroactive coverage
  - limitations to home equity.
- Medicaid Per-Capita Caps!
- Repeal of Community First Choice.

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H.R. 1082, Medicaid Home Improvement Act.

- Ends option for state to expand home equity limit for "single individuals" above 560k up to 840k (inflation adj.)

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Home Equity Limits

- Concerns Raised:
  - No guarantee of reverse mtg/line of credit;
  - If institutionalized: in some states becomes an available resource or in others family must maintain and deal with potential estate recovery; and
  - Counteracts HCBS

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H.R. 180, End of 3 month retroactive coverage

- Moved three month retroactive eligibility only to month of application.

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End of Three Month Retroactive Coverage

- Lose-Lose for Providers and Families:
  - Providers don't get paid.
  - Families could get sued or not admit family member at appropriate time without Medicaid guarantee.

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Results in Senate

- Home equity limits out!
- Three month retroactive coverage modified to not apply to 65+ and persons with disabilities.

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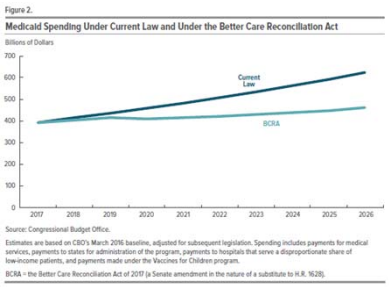
Medicaid Spending under BCRA



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Per-Capita Cap Basics

- **Federal Spending Limited Per Beneficiary**
  - By State
  - By Category
  - Grows by an inflator
  - Top/Bottom 25% adjusted up/down by up to 2%
  - Cannot keep excess funds

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Per Capita Caps Concerns

- Services and payment cuts.
- Future eligibility limits
- HCBS cut first because its optional
- Baselines unfair
- Easily “dial-able”

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1115 Waivers: Mar. 14 Price-Verma Letter and November CMS Directives

- “Ushering in new era” where states have more freedom to design plans
- State plan amendments- more fast-tracking and approval of demos done in another state

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1115 Waivers Basics

- **"Experimental, pilot, or demonstration project,"**
- **Likely to assist in promoting the objectives of the Medicaid program.**
- **Can waive Medicaid requirements under 42 U.S.C 1396a**
- **Budget neutral (HHS Policy Not Law)**

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How does this impact Elder Law?

- (a)(1) Statewideness
- (a)(3) Fair hearings
- (a)(7) Confidentiality
- (a)(8) Reasonable promptness for decisions
- (a)(10) (a) Categories of eligible individuals
- (a)(10)(B) Equality of amount, duration and scope
- (a)(10)(C) Comparability with SSI
- (a)(14) Fees, copayments, deductions only per 1396o
- (a)(17)(D) Responsibility of relatives & spend down of incurred medical expenses
- **(a)(18) Liens, recoveries, transfers & trusts only per 1396p**
- (a)(23) Freedom of choice
- (a)(25) Claims against third party payers
- **(a)(34) Three month retroactivity**
- (a)(43) Early & periodic screening, diagnosis & treatment for those under 21
- (a)(45) Mandatory assignment of support rights per 1396k
- (a)(50) Personal needs allowances

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42 USC §1396p (SSA §1917)

- Excluding Residence as a Resource but State Liens on Property
- Estate Recovery for LTSS recipients 55 and older
- Transfer Penalty Rules
  - Annuities.
  - Promissory Notes.
  - Transfers to Spouses
- Supplemental Needs Trusts (d4A and d4C) and Miller Trusts (d4B).

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Maine Waiver

- For Medicaid LTSS:
  - Repeal of three month retroactive eligibility
    - Some success: updated doesn't apply to LTSS
  - Limit annuity length to 80 percent life expectancy

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Iowa waiver

- Includes repeal of three month retroactive eligibility for all beneficiaries
- NAELA led a group of aging and disability advocates in opposing
- CMS approved; Congressional Democrats Raise Alarm

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Waivers Going Forward

- Maine could be the crack in the door to modifications to 1396p happen.
- Much of focus of new limits has been on the "able-bodied" population.
- End of Three month retroactive being asked for by many states.
- Kaiser Family Foundation tracking 1115s
- https://www.kff.org/medicaid/issue-brief/which-states-have-approved-and-pending-section-1115-medicaid-waivers/

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Recent CMS Policy Pronouncements

- 1/11/2018 – How to use 1115 waiver to require Medicaid adult beneficiaries to work or engage in community activities
  - Exempt elderly, pregnant, acute medical conditions and disabled
  - Must comply with ADA, ACA, Rehab Act of 1973, Civil Rights Act and Age Discrimination Act

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Recent CMS Policy Pronouncements

- 7/7/2017 and 10/27/2017 – significantly eased monetary penalties on NHs who violated CMS's requirements for Participation in Medicare/Medicaid under Obama Administration.
  - Gives regional offices discretion to not impose penalty if a "one time offense"
- 11/24/2017 – adds an 18 month moratorium on penalties imposed by new CMS rules that phased in 11/2017

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Key Cases and Impact on Planning

- Daley and Nadeau cases (consolidated), 477 Mass. 188, 74 N.E.3d 1269 (SJC 5/30/2017)
  - Both cases involved irrevocable trusts done prior to needing Medicaid
  - In each case, Medicaid held the home was a countable asset due to certain trust provisions

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Nadeau Trust

- Income payable to the grantors as the trustee determines
- Principal held in trust until the death of the grantors
- Lifetime power to appoint all or any part of the trust property to charitable beneficiaries
- Nadeau reserved the right to "use and occupy" any residence held by the trust

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Daley Trust

- Funded their irrevocable trust with a remainder interest in their home
- Reserved Life Estate
- Income payable to the grantors as the trustee determines
- Principal held in trust until the death of the grantors
- Trustee could reimburse them for their income tax liability

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Mass Health Arguments

- HCFA 64 states that use and occupancy of a home is a payment from the trust
- This payment equals access to the corpus, thus the home is countable
- Challenged trust terms to find "any circumstances"

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Supreme Judicial Court's Decision

- MassHealth has misinterpreted the meaning of "payment from the trust" in HCFA 64 and 42 USC 1396p(d)(3)
- HCFA 64, P. 8 - Where there is the right to use and occupy, the grantors have the right to receive income that may be generated from the rental of the home, as well as the right to that rental income by residing in the home themselves.

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Supreme Judicial Court Decision

- HCFA 64 accurately recognizes that, where a trust grants the use or occupancy of a home to the grantors, it is effectively making a payment of rent to the grantors in the amount of the fair market value of that property
  - Only a payment from income of the trust, not the corpus. Can only affect how much an applicant pays toward her share of cost, not eligibility

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Supreme Judicial Court Decision

- Regarding the Special Power of Appointment to charitable beneficiaries:
  - Court hypothesized a situation where Mr. Daley could have received care at a nonprofit nursing home, and that nursing home could have received trust property
  - Will this fall under the "any circumstances" test?

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Doris A. Mass. Fair Hearing 1615178 (11/30/17)

- Joint Irrevocable Trust
  - No distribution of principal to grantor
  - Mandates income to grantor
  - Reserved "use and occupancy"
- Mass Health denied MA due to excess resources focusing on Daley/Nadeau payment of imputed income from "use and occupancy" – fair rental value taken from HUD Fair Market Rent Tables for 2016

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Doris A. Mass. Fair Hearing 1615178 (11/30/17)

- $1,565 (Fair Rental Value) x 12 months x 7.76 years = $145,919.04 excess resources

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Doris A. Fair Hearing 1615178 (11/30/17)

- Hearing Officer's Decision:
  - Mass Health misinterprets Daley/Nadeau as they do not stand for availability of assets! Instead, a "income of the corpus" means the amount MA is required to contribute to care on a monthly basis.
  - Trust must be read as a whole so accumulated income is NOT available.
    - Under Regs: Income in month received then principal
    - Trust prohibits distribution of principal

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Doris A. Fair Hearing 1615178 (11/30/17)

- Proper calculation of monthly contribution would be:
  - Fair Market Value of Rent divided by 50% - since this is a JOINT Trust
    - $1,567/50% = $783.50
  - However, MA must be given opportunity to deduct business expenses since trust only can distribute NET income (depreciation, taxes, expenses and other liabilities)

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Key Cases and Impact on Planning

- Fagan v. Bremby, Civ. No. 3:16cv73 (USDC District of CT 3/21/2017)
  - Extent of spousal exempt transfer rules
  - Fagan severely injured in a motorcycle accident and moved into SNF
  - Approved for institutional Medicaid
  - Received a $2Million dollar settlement
  - All medical bills, Medicare liens, and repayment to Medicaid fully satisfied
  - Coverage discontinued

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Key Cases and Impact on Planning

- Fagan v. Bremby, Civ. No. 3:16cv73 (USDC District of CT 3/21/2017)
  - Transferred $879,000 to his spouse
  - Spouse used part of the transfer to purchase a SPIA
  - Reapplied for Medicaid and denied based on transfer of assets penalty
  - Since a continuous period of institutionalization, the spousal exempt transfer rules only apply to original snap shot date!

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Key Cases and Impact on Planning

- Fagan v. Bremby, Civ. No. 3:16cv73 (USDC District of CT 3/21/2017)
  - Since a continuous period of institutionalization, the spousal exempt transfer rules only apply to original snap shot date!
  - What if spouse removed from facility for 30 days prior to re-application?

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House Sought to End the Medical Expense Deduction

"Suzanne Hollack moved her husband, who has frontotemporal dementia, to a memory care facility 18 months ago. His long term care and medical expenses cost the couple $90,000 last year

New York Times
Ending Medical Tax Break Could Be a 'Gut Punch' to the Middle Class
November 8, 2017

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Medical Expense Deduction

- **Old law:**
  - Can itemize for expenses above 10% of AGI.
  - "Chronically ill" individuals can deduct "qualified long-term care expenses."
- **Impact on LTSS:**
  - Some private-pay residents EVICTED- can't pay tax and facility!
  - Medicaid medically needy with a pension: uncollectible tax!
  - Seniors w- 401k: the higher your health costs, the higher your taxes!
  - Hurts family caregivers!

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Medical Expense Deduction

- **Advocacy Outcome: Final legislation keeps and Lowers threshold to 7.5% AGI 2018/2019!**

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Item	Old Law	New Law (expires 2025)
Brackets	10%, 15%, 25%, 28%, 33%, 35%, 39.6%	10%, 12%, 22%, 24%, 32%, 35%, 37% T&E:10%,24%,35%,37%
AMT	Yes	Retains with increased exemption/exception thresholds $70,300/$500k (single) $109,400/$1M (joint)
Personal Exemption	$4,150	None
Standard Deduction	$6,500 (single); $13,000 (joint)	$12,000 (single); $24,000 (joint)
Child Tax Credit	$1,000	$2,000
Family Credits	None	$500 other dependents
State and Local Tax Deduction	Yes	10k cap (not indexed for inflation; joint or single)
Mtg Int.	Up to $1.1 million	$750k cap acquisition debt only
Inflator	CPI- Urban	Chained CPI-U
Estate Tax	$5.6 million	Doubled

ABLE Act Additions

- **529 Account rollovers to ABLE**
- **ABLE to Work.** Extra ABLE contribution allowed up to federal poverty level ($11,400) if working above Substantial Gainful Activity or up to their income amounts whichever is less
- **Access to Savers Credit. B**eneficiary of may claim the saver's credit for contributions made to ABLE account. Up to $2,000 (single) or $4,000 (joint). https://www.irs.gov/retirement-plans/plan-participant-employee/retirement-savings-contributions-savers-credit

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THANK YOU!

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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SMD: 18-002

RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries

January 11, 2018

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) is announcing a new policy designed to assist states in their efforts to improve Medicaid enrollee health and well-being through incentivizing work and community engagement among non-elderly, non-pregnant adult Medicaid beneficiaries who are eligible for Medicaid on a basis other than disability.[1] Subject to the full federal review process, CMS will support state efforts to test incentives that make participation in work or other community engagement a requirement for continued Medicaid eligibility or coverage for certain adult Medicaid beneficiaries in demonstration projects authorized under section 1115 of the Social Security Act (the Act). Such programs should be designed to promote better mental, physical, and emotional health in furtherance of Medicaid program objectives. Such programs may also, separately, be designed to help individuals and families rise out of poverty and attain independence, also in furtherance of Medicaid program objectives. [2]

This guidance describes considerations for states that may be interested in pursuing demonstration projects under section 1115(a) of the Act that have the goal of creating incentives for Medicaid beneficiaries to participate in work and community engagement activities. It addresses the application of CMS' monitoring and evaluation protocols for this type of demonstration and identifies other programmatic and policy considerations for states, to help them design programs that meet the objectives of the Medicaid program, consistent with federal statutory requirements.

[1] States will have the flexibility to identify activities, other than employment, which promote health and wellness, and which will meet the states' requirements for continued Medicaid eligibility. These activities include, but are not limited to, community service, caregiving, education, job training, and substance use disorder treatment.
[2] Section 1901 of the Social Security Act authorizes appropriations to support State Medicaid programs: "For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care[.]"

Health Benefits of Community Engagement, including Work and Work Promotion

While high-quality health care is important for an individual's health and well-being, there are many other determinants of health. It is widely recognized that education, for example, can lead to improved health by increasing health knowledge and healthy behaviors.[3] CMS recognizes that a broad range of social, economic, and behavioral factors can have a major impact on an individual's health and wellness, and a growing body of evidence suggests that targeting certain health determinants, including productive work and community engagement, may improve health outcomes. For example, higher earnings are positively correlated with longer lifespan.[4] One comprehensive review of existing studies found strong evidence that unemployment is generally harmful to health, including higher mortality; poorer general health; poorer mental health; and higher medical consultation and hospital admission rates.[5] Another academic analysis found strong evidence for a protective effect of employment on depression and general mental health.[6] A 2013 Gallup poll found that unemployed Americans are more than twice as likely as those with full-time jobs to say they currently have or are being treated for depression.[7] Other community engagement activities such as volunteering are also associated with improved health outcomes[8,9], and it can lead to paid employment.

CMS, in accordance with principles supported by the Medicaid statute, has long assisted state efforts to promote work and community engagement and provide incentives to disabled beneficiaries to increase their sense of purpose, build a healthy lifestyle, and further the positive physical and mental health benefits associated with work. CMS supports state efforts to enable eligible individuals to gain and maintain employment. Optional Medicaid programs such as the Medicaid Buy-In, for example, allow workers with disabilities to have higher earnings and maintain their Medicaid coverage. For beneficiaries who are able to work but have been unable to find employment, some states encourage employment through concurrent enrollment in state-sponsored job training and work referral, either automatically or at the option of the Medicaid beneficiary. A number of states have also initiated programs to connect non-disabled Medicaid beneficiaries to existing state workforce programs.

States also provide a range of employment supports to individuals receiving home and community based services under section 1915(c) waivers or section 1915(i) state plan services. These include habilitation services designed to "assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in

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[3] Bartley, M and Plewis, I. (2002) Accumulated labor market disadvantage and limiting long term illness. International Journal of Epidemiology 31:336-41.

[4] Chetty R, Stepner M, Abraham S, et al. The association between income and life expectancy in the United States, 2001-2014. JAMA. 2016; 315(16):1750-1766.

[5] Waddell, G. and Burton, AK. Is Work Good For Your Health And Well-Being? (2006) EurErg Centre for Health and Social Care Research, University of Huddersfield, UK

[6] Van der Noordt, M, Jzelenberg, H, Droomers, M, and Proper,K. Health effects of employment: a systemic review of prospective studies. BMJournals. Occupational and Environmental Medicine. 2014: 71 (10).

[7] Crabtree, S. In U.S., Depression Rates Higher for Long-Term Unemployed. (2014). Gallup. http://news.gallup.com/poll/171044/depression-rates-higher-among-long-term-unemployed.aspx

[8] United Health Group. Doing good is good for you. 2013 Health and Volunteering Study.

[9] Jenkins, C. Dickens, A. Jones, K. Thompson-Coon, J. Taylor, R. and Rogers, M. Is volunteering a public health intervention? A systematic review and meta-analysis of the health and survival of volunteers BMC Public Health 2013. 13 (773)

home and community based settings."[10] These activities have been historically focused on services and programs for individuals with disabilities and receipt of these supports is not a condition of eligibility or coverage.
The successes of all these programs suggest that a spectrum of additional work incentives, including those discussed in this letter, could yield similar outcomes while promoting these same objectives.

New Opportunity for Promoting Work and Other Community Engagement for Non-Elderly, Non-Pregnant Adult Beneficiaries Who Are Eligible for Medicaid on a Basis Other than Disability

On March 14, 2017, the Department of Health and Human Services (HHS) and CMS issued a letter to the nation's governors affirming the continued commitment to partner with states in the administration of the Medicaid program. In the letter, we noted that CMS will empower states to develop innovative proposals to improve their Medicaid programs. Demonstration projects under section 1115 of the Act give states more freedom to test and evaluate approaches to improving quality, accessibility, and health outcomes in the most cost-effective manner. CMS is committed to allowing states to test their approaches, provided that the Secretary determines that the demonstrations are likely to assist in promoting the objectives of the Medicaid program.

Some states are interested in pursuing demonstration projects to test the hypothesis that requiring work or community engagement as a condition of eligibility, as a condition of coverage, as a condition of receiving additional or enhanced benefits, or as a condition of paying reduced premiums or cost sharing, will result in more beneficiaries being employed or engaging in other productive community engagement, thus producing improved health and well-being. To determine whether this approach works as expected, states will need to link these community engagement requirements to those outcomes and ultimately assess the effectiveness of the demonstration in furthering the health and wellness objectives of the Medicaid program.[11]

Today, CMS is committing to support state demonstrations that require eligible adult beneficiaries to engage in work or community engagement activities (e.g., skills training, education, job search, caregiving, volunteer service) in order to determine whether those requirements assist beneficiaries in obtaining sustainable employment or other productive community engagement and whether sustained employment or other productive community engagement leads to improved health outcomes. This is a shift from prior agency policy regarding work and other community engagement as a condition of Medicaid eligibility or coverage,[12] but it is anchored in historic CMS principles that emphasize work to promote health and well-being.

We look forward to working with states interested in testing innovative approaches to promote work and other community engagement, including approaches that make participation a condition of eligibility or coverage, among working-age, non-pregnant adult Medicaid beneficiaries who qualify for Medicaid on a basis other than a disability. Consistent with section

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[10] Social Security Act, section 1915(c)(5)(A)
[11] https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html
[12] https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=29927

1115(a) of the Act, demonstration applications will be reviewed on a case-by-case basis to determine whether the proposed approach is likely to promote the objectives of Medicaid. CMS is also committed to ensuring state accountability for the health outcomes produced by the program, and demonstration projects approved consistent with this guidance will be required to conduct outcomes-based evaluations, based on evaluation designs subject to CMS approval. We note that approved demonstration projects that promote positive health outcomes may also achieve the additional goal of the Medicaid program to promote independence.

State Flexibility in Program Design

In its work with states, CMS has identified a number of issues for states to consider as they develop programs to promote work and other forms of community engagement among Medicaid beneficiaries. Each state is different, and states are in the best position to determine which approaches are most likely to succeed, based on their specific populations and resources. In drafting demonstration project applications, states should articulate the reasoning behind their proposal. While CMS will evaluate each demonstration project application on its own merits, we believe the following considerations will facilitate states' work to develop proposals and allow them to focus their resources on permissible areas of innovation while allowing CMS to maintain its oversight and fiduciary responsibilities.

Alignment with Other Programs

Many states already have systems in place for implementing employment and community engagement programs. For instance, beginning in 1996, welfare reform provided states with more flexibility to manage their state welfare programs under the Temporary Assistance for Needy Families (TANF) program consistent with the four statutory purposes of TANF. Supplemental Nutrition Assistance Program (SNAP) rules require all recipients to meet work requirements unless they are exempt. Exemptions may include, but are not limited to age, disability, responsibility for a dependent, participation in a drug addiction or alcohol treatment and rehabilitation program, or another state-specified reason.

CMS supports states' efforts to align SNAP or TANF work or work-related requirements with the Medicaid program as part of a demonstration authorized under section 1115 of the Act, where such alignment is appropriate and consistent with the ultimate objective of improving health and well-being for Medicaid beneficiaries. Based on states' experiences with their TANF or SNAP employment programs, they may wish to consider aligning Medicaid requirements with certain aspects of the TANF or SNAP programs, such as:

- Excepted populations (e.g., pregnant women, primary caregivers of dependents, individuals with disabilities or health-related barriers to employment, individuals participating in tribal work programs, victims of domestic violence, other populations with extenuating circumstances, full time students);
- Protections and supports for individuals with disabilities and others who may be unable to meet the requirements;
- Allowable activities (e.g., subsidized and unsubsidized employment, educational and vocational programs, job search and job readiness, job training, community service, caregiving, and other allowable activities under TANF or SNAP) and required hours of participation (e.g., hours/week, including hours completed under TANF or SNAP);

- Changes to requirements or allowable activities due to economic or environmental factors (e.g., unemployment rate in affected areas);
- Enrollee reporting requirements (e.g., frequency and method for reporting work activities); or
- The availability of work support programs (e.g., transportation or child care) for individuals subject to work and community engagement requirements.

CMS will consider the extent to which proposed Medicaid community engagement or work requirements align with features of the TANF or SNAP programs and whether that alignment is consistent with Medicaid objectives. For example, aligning certain requirements across these programs would streamline eligibility and could reduce the burden on both states and beneficiaries and maximize opportunities for beneficiaries to meet the requirements. Many states have already developed or are developing integrated eligibility systems, and have taken advantage of the waiver of OMB Circular A-87 cost allocation rules (available through CY 2018) to support the integration of eligibility systems between health and human services programs. These integrated systems may be poised to allow for alignment of eligibility requirements for a segment of the Medicaid population, and to facilitate implementation of streamlined application and verification processes. Where additional information technology systems enhancements are required to support Medicaid demonstration activities, costs will be expected to be reasonable and comply with Medicaid statute and regulations. Federal Medicaid funding will be limited to allowable activities directly linked to Medicaid beneficiaries.

Individuals enrolled in and compliant with a TANF or SNAP work requirement, as well as individuals exempt from a TANF or SNAP work requirement, must automatically be considered to be complying with the Medicaid work requirements. To the degree that specific good cause exemptions exist in a state TANF or SNAP program, the state should make a reasonable effort to incorporate similar exemptions within a framework for a Medicaid community engagement and work requirement. States should also describe how they will communicate to beneficiaries any differences in program requirements that individuals will need to meet in the event they transition off of SNAP or TANF but remain subject to a Medicaid community engagement or work requirement.

Populations Subject to Work Promotion/Community Engagement Requirements
States should clearly identify the eligibility groups subject to the work and community engagement requirements and included in the demonstration. States may consider submitting for CMS consideration a proposal to tailor such requirements to adults within specific eligibility groups or sub-populations within the eligibility group. CMS recognizes that adults who are eligible for Medicaid on a basis other than disability (i.e. classified for Medicaid purposes as "non-disabled") will be subject to the work/community engagement requirements as described in this guidance. These individuals, however, may have an illness or disability as defined by other federal statutes that may interfere with their ability to meet the requirements. States must comply with federal civil rights laws, ensure that individuals with disabilities are not denied Medicaid for inability to meet these requirements, and have mechanisms in place to ensure that reasonable modifications are provided to people who need them. States must also create exemptions for individuals determined by the state to be medically frail and should also exempt

from the requirements any individuals with acute medical conditions validated by a medical professional that would prevent them from complying with the requirements.

States are required, in the design and administration of Medicaid demonstration projects, to comply with all applicable federal civil rights laws, including the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act, the Age Discrimination Act, and other applicable statutes. The federal disability rights laws are of particular importance, given the broad scope of protection under these laws and the fact that disabilities can affect an individual's ability to participate in work and community engagement activities. States may not impose such requirements on individuals classified as "disabled" for Medicaid eligibility purposes.

CMS recognizes that individuals who are eligible for Medicaid on a basis other than disability (and are therefore classified for Medicaid purposes as "non-disabled") may have a disability under the definitions of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, or section 1557 of the Affordable Care Act. States should include, in their proposals, information regarding their plans for compliance with these requirements, including provision of reasonable modifications in work or community engagement requirements. The reasonable modifications must include exemptions from participation where an individual is unable to participate for disability-related reasons, modification in the number of hours of participation required where an individual is unable to participate for the required number of hours, and provision of support services necessary to participate, where participation is possible with supports. States may not receive Federal Medicaid match for such supportive services for individuals enrolled in these Medicaid demonstrations. In addition, States should evaluate individuals' ability to participate and the types of reasonable modifications and supports needed. CMS, in consultation and coordination with the HHS Office for Civil Rights, is available to assist states in designing projects that comply with the civil rights laws.

CMS also recognizes that many states currently face an epidemic of opioid addiction, which has been declared a national public health emergency by the Secretary. States will therefore be required to take certain steps to ensure that eligible individuals with opioid addiction and other substance use disorders (who may not be defined as disabled for Medicaid purposes but may be protected by disability laws) have access to appropriate Medicaid coverage and treatment services. States must make reasonable modifications for these individuals, consistent with states' obligations under civil rights laws described above, and specifically identify such modifications in their demonstration applications. Such modifications may include counting time spent in medical treatment towards an individual's work/community engagement requirements, or exempting individuals participating in intensive medical treatment (e.g. inpatient treatment or intensive outpatient treatment) for substance use disorder from the work/community engagements requirements. CMS will also consider other reasonable modifications that states may design and propose in furtherance of their obligations under disability laws. Finally, states should identify, in their demonstrations, other strategies to support such individuals in meeting the requirements, and in obtaining access to treatment when they are ready.

Range of community engagement activities
We encourage states to consider a range of activities that could satisfy work and community-engagement requirements. Career planning, job training, referral, and job support services offered should reflect each person's employability and potential contributions to the labor market. As many Medicaid beneficiaries live in areas of high unemployment, or are engaged as caregivers for young children or elderly family members, states should consider a variety of activities to meet the requirements for work and community engagement, including volunteer and tribal employment programs, in addition to the activities identified to meet the requirements under SNAP or TANF.

Beneficiary supports
States will be required to describe strategies to assist beneficiaries in meeting work and community engagement requirements and to link individuals to additional resources for job training or other employment services, child care assistance, transportation, or other work supports to help beneficiaries prepare for work or increase their earnings. However, this demonstration opportunity will not provide states with the authority to use Medicaid funding to finance these services for individuals. Nothing in this letter changes the types of services eligible for Federal match; states may only receive Federal Medicaid match for allowable services in accordance with statute.

CMS expects that states will design their programs consistent with statutory and regulatory procedural requirements, including through provisions to ensure Medicaid beneficiaries' due process rights are protected. States are encouraged to include procedures that allow for an assessment of individuals' disabilities, medical diagnosis, and other barriers to employment and self-sufficiency in order to identify appropriate work and community engagement activities and services, supports, and any reasonable modifications necessary for those individuals to participate in work and community engagement activities and attain long-term employment and self-sufficiency.

Attention to market forces and structural barriers
CMS recognizes that States will need flexibility to respond to the local employment market by phasing in and/or suspending program features, as necessary. A state may need time to establish supports for beneficiaries in regions with limited employment opportunities, for example, or localities facing particular economic stress or lack of viable transportation. The state should describe its plan for assessing and addressing these and related issues in its demonstration application. In addition, the state should consider whether other circumstances may arise that could prevent individuals from complying with a community engagement and work requirement. States should detail how they would support individuals in meeting program requirements during those periods, which may include incorporation of good cause exemptions similar to those used in SNAP and TANF.

Transparency
CMS remains committed to supporting reasonable public input processes that provide states an opportunity to consider the views of Medicaid beneficiaries, applicants, and other stakeholders and gather input that may support continuous improvement of the program. Demonstration projects under section 1115 of the Act intended to promote work and other community

engagement are subject to all relevant public notice and transparency requirements, including those described in 42 C.F.R. Part 431, subpart G. Where applicable, states will also be required to comply with tribal consultation requirements and describe how they are responding to comments received through the tribal consultation process.

Budget Neutrality

To promote long-term sustainability of the Medicaid program for states and the federal government, we will continue to require states to demonstrate that projects authorized under section 1115 of the Act are budget neutral. CMS will work with states to identify those components of the demonstration that will be included in budget neutrality calculations and provide technical assistance as needed in determining budget neutrality. States will not be permitted to accrue savings from a reduction in enrollment that may occur as a result of using this section 1115 authority. States will be required to document the financial performance of the demonstration and track expenditures to ensure the demonstration does not exceed established budget neutrality limits. States will provide updated budget neutrality workbooks with every required monitoring report, and the specific reporting requirements for monitoring budget neutrality will be set forth in the demonstration special terms and conditions (STCs).

Monitoring and Evaluation

CMS remains committed to ensuring state accountability for the health and well-being of Medicaid enrollees. Monitoring and evaluation are important for understanding these outcomes and the impacts of the state innovations being demonstrated. We are undertaking efforts to help states monitor the elements of their programs, while giving them the flexibility to adapt to changing conditions in their states. States will be required to develop monitoring plans and submit regular monitoring reports describing progress made in implementing their requirements for work and other community engagement activities. We will also undertake our own monitoring and technical assistance efforts through regular communications with states and will review written reports from states on a quarterly basis.

Monitoring

States approved to implement work and other community engagement requirements for Medicaid beneficiaries will submit to CMS a draft of proposed metrics for quarterly and annual monitoring reports, and CMS will work with the state to jointly identify metrics for these reports. Metrics will reflect the major elements of the demonstration, including but not limited to data that applies to the work and other community engagement initiatives. CMS will combine these programmatic metrics with general metrics aimed at monitoring beneficiary enrollment and termination for failure to meet program requirements, access to services for both beneficiaries and individuals terminated for failure to meet the requirements, and the overall functioning of the demonstration.

States will be subject to other monitoring and reporting requirements, consistent with regulations in 42 C.F.R. § 431.420 and § 431.428. State reports will be required to provide sufficient information to document key challenges, underlying causes of those challenges, and strategies for addressing those challenges, as well as key achievements and the conditions and efforts that lead to those successes. Specific details related to monitoring and reporting for each state's demonstration will be discussed with states and described in the demonstration STCs.

Evaluation

States will also be required to evaluate health and other outcomes of individuals that have been enrolled in and subject to the provisions of the demonstration, and will be required to conduct robust, independent program evaluations. Evaluations must be designed to determine whether the demonstration is meeting its objectives, as well as the impact of the demonstration on Medicaid beneficiaries and on individuals who experience a lapse in eligibility or coverage for failure to meet the program requirements or because they have gained employer-sponsored insurance. A draft evaluation design should be submitted with the application, and the final evaluation design will be submitted for CMS approval no more than 180 days after demonstration approval.

Evaluation designs will be expected to include a discussion of the evaluation questions and hypotheses that the state intends to test, including the hypothesis that requiring certain Medicaid beneficiaries to work or participate in other community engagement activities increases the likelihood that those Medicaid beneficiaries will achieve improved health, well-being, and (if the State designs its program to pursue this additional goal) independence as contemplated in the objectives of Medicaid. Evaluation designs will be expected to include analysis of how this requirement affects beneficiaries' ability to obtain sustainable employment, the extent to which individuals who transition from Medicaid obtain employer sponsored or other health insurance coverage, and how such transitions affect health and well-being.

The hypothesis testing should include, where possible, assessment of both process and outcome measures, and proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. The evaluation design should use both quantitative and qualitative methods, and will need to identify comparison groups and appropriate statistical analyses to evaluate the impact of the demonstration. Evaluation designs should also include descriptions of multiple data sources to be used, including but not limited to multiple stakeholder perspectives, surveys of beneficiaries (both enrolled and those no longer enrolled as a result of the implementation of program requirements), claims data, and survey data (such as Consumer Assessment of Healthcare Providers and Systems (CAHPS)).

To the extent permitted by federal and state privacy laws, states should be prepared to track and evaluate health and community engagement outcomes both for those who remain enrolled in Medicaid, and those who are subject to the requirements but lose or experience a lapse in eligibility or coverage during the course of the demonstration, and provide details on how they will track these outcomes in their demonstration evaluation designs. Ongoing monitoring and evaluation efforts will help CMS learn more about the challenges and successes states experience while implementing innovative policies to increase productive community engagement, which we will then be able to share with other states looking to achieve similar goals related to their residents' well-being.

We hope this information is helpful, and we look forward to continuing to work with states to implement innovative solutions to improve their Medicaid programs. Questions and comments regarding this policy may be directed to Judith Cash, Acting Director, State Demonstrations Group, CMCS, at 410-786-9686.

Sincerely,

/s/

Brian Neale
Director

Cc:
National Association of Medicaid Directors
National Academy for State Health Policy
National Governors Association
American Public Human Services Association
Association of State and Territorial Health Officials
Council of State Governments
National Conference of State Legislatures
Academy Health
National Association of State Alcohol and Drug Abuse Directors

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C 18-04-NH

DATE: **November 24, 2017**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Temporary Enforcement Delays for Certain Phase 2 F-Tags and Changes to *Nursing Home Compare*

Memorandum Summary

- **Temporary moratorium on imposing certain enforcement remedies for specific Phase 2 requirements:** CMS will provide an 18 month moratorium on the imposition of certain enforcement remedies for specific Phase 2 requirements. This 18 month period will be used to educate facilities about specific new Phase 2 standards.
- **Freeze Health Inspection Star Ratings:** Following the implementation of the new LTC survey process on November 28, 2017, CMS will hold constant the current health inspection star ratings on the *Nursing Home Compare* (NHC) website for any surveys occurring between November 28, 2017 and November 27, 2018.
- **Availability of Survey Findings:** The survey findings of facilities surveyed under the new LTC survey process will be published on NHC, but will not be incorporated into calculations for the *Five-Star Quality Rating System* for 12 months. CMS will add indicators to NHC that summarize survey findings.
- **Methodological Changes and Changes in Nursing Home Compare:** In early 2018, NHC health inspection star ratings will be based on the two most recent cycles of findings for standard health inspection surveys and the two most recent years of complaint inspections.

Background

On September 28, 2016, CMS revised the SNF and NF Requirements for Participation, which became effective on November 28, 2016, and have a three-part phase-in of implementation dates over three years. Phase 1 became effective on November 28, 2016. Implementation of the new regulations for nursing homes under Phase 2 will become effective on November 28, 2017 (see S&C memo: 17-36-NH, dated June 30, 2017).

We also published revised interpretive guidance for Appendix PP of the SOM with the June 30, 2017 memo reflecting the new regulatory changes, which includes renumbering the nursing home F-Tags to correspond with the new regulatory sections. Implementation of Phase 2 reforms is scheduled to occur simultaneously with a new, computer-based LTC survey process in which we are incorporating the new regulatory requirements as well as combining the Traditional and Quality Indicator Survey processes.

To address concerns about the implementation of the new requirements and new LTC survey process, CMS will be making specific policy and process adjustments to the enforcement system and results posted on Nursing Home Compare. These changes are described in more detail below.

Temporary Moratorium on Imposition of Certain Enforcement Remedies

To address concerns regarding the scope and timing of the revised requirements (42 CFR part 483, subpart B), there will be a 18-month moratorium on the imposition of civil money penalties (CMPs), discretionary denials of payment for new admissions (DPNAs) and discretionary termination where the remedy is based on a deficiency finding of one of the specified Phase 2 F-tags noted below. CMS is not extending the moratorium to F608 which addresses reporting reasonable suspicion of a crime due to the concerns about significant resident abuse going unreported. CMS will use this 18-month moratorium period to educate surveyors and the providers to ensure they understand the health and safety expectations that will be evaluated through the survey process since these Phase 2 requirements are associated with unique and separate tags where specialized efforts and technical assistance may be needed. Previous communication indicated that the moratorium would be in effect for 12 months; that has been extended to 18 months to ensure provider understanding and readiness. Deficiency findings for all other F-tags will follow the standard enforcement process which includes all available enforcement remedies. Please note, facilities cited for any noncompliance with Phase 1 or Phase 2 requirements (beginning November 28, 2017), or both, will continue to be subject to statutorily-required provisions (mandatory DPNA and termination for failure to achieve substantial compliance within the required timeframes). Further note that this 18 month moratorium on the imposition of remedies does not change the implementation date for the Phase 2 provisions and state survey agencies should cite these tags as appropriate and continue to forward their findings to the RO as normal.

The following F-Tags included in this moratorium are:

- F655 (Baseline Care Plan); ***§483.21(a)(1)-(a)(3)***
- F740 (Behavioral Health Services); ***§483.40***
- F741 (Sufficient/Competent Direct Care/Access Staff-Behavioral Health); ***§483.40(a)(1)-(a)(2)***
- F758 (Psychotropic Medications) related to PRN Limitations ***§483.45(e)(3)-(e)(5)***
- F838 (Facility Assessment); ***§483.70(e)***
- F881 (Antibiotic Stewardship Program); ***§483.80(a)(3)***
- F865 (QAPI Program and Plan) related to the development of the QAPI Plan; ***§483.75(a)(2)*** and,
- F926 (Smoking Policies). ***§483.90(i)(5)***

For surveys identifying noncompliance of both Phase 1 and the Phase 2 tags specified above, the CMS Regional Office (RO) will follow standard enforcement procedures related to the Phase 1 tag if the Phase 1 tag(s) necessitates the imposition of remedies. For example, if a survey conducted during the moratorium period cites deficiencies both for infection control practices at tag F880 and antibiotic stewardship at tag F881 and the RO determines enforcement remedies are warranted, the RO may impose appropriate remedies as it relates to F880; however, only a Directed Plan of Correction (DPOC) and/or Directed In-Service training (DIST) remedy could be imposed for the findings related to tag F881. Once the temporary moratorium period is over, enforcement for all cited tags will return to the normal enforcement policies. The following chart explains how the enforcement remedies will be applied during the 18month moratorium time period.

Application of Discretionary Enforcement Remedies During 18 Month Moratorium

Discretionary Enforcement Remedies	Phase 1 Tags Only	Both Phase 1 and Phase 2 Tags	Phase 2 Tags Only
Normal Enforcement Policies Apply Or 18 Month Moratorium Enforcement Policies Apply (DPOC/DIST)	Normal Enforcement Policies Apply	Normal Enforcement Policies Apply for the Phase 1 tag(s); and DPOC/DIST only may be imposed for Phase 2 tag(s)	18 Month Moratorium Enforcement Policies Apply (DPOC/DIST)

Directed Plan of Correction

A Directed Plan of Correction (as defined in 42 CFR §488.424) is an enforcement remedy developed by CMS, the State Survey Agency (or a temporary manager if applicable) requiring a facility to take action within specified timeframes to correct cited non-compliance. For these Phase 2 F-Tags identified above, we expect that the Directed Plan of Correction would address the structures, policies and processes needed by the facility to demonstrate and maintain substantial compliance.

A Directed Plan of Correction is completed when the facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that can be verified by CMS without an on-site visit. Surveyors are expected to go back on-site to review compliance when there is a credible allegation of compliance by the facility if any of the F-tags cited are Substandard Quality of Care (SQC), or when tags are at the actual harm or immediate jeopardy levels. See § 7317.2 of the CMS State Operations Manual (SOM) for information concerning on-site revisits and § 7500 for information concerning Directed Plans of Correction.

Directed In-Service Training

Directed In-Service Training is an enforcement remedy that may be used when CMS or the State, (or the temporary manager if applicable) believes that education is likely to correct the deficiencies and help the facility achieve and sustain substantial compliance. For this remedy to be used effectively and appropriately, the deficiency finding should demonstrate that a knowledge deficit significantly contributed to the deficiency. This remedy requires the relevant staff of the facility to attend an in-service training program that will address a demonstrated knowledge deficit. The purpose of directed in-service training is to provide the information necessary for the facility to achieve and maintain substantial compliance. Facilities should use programs developed by well-established centers of geriatric health services education such as schools of medicine or nursing, centers for
the aging, and area health education centers which have established programs in geriatrics and geriatric psychiatry. If it is willing and able, a State may provide special consultative services for obtaining this type of training. The State or CMS RO may also compile a list of resources that can provide directed in-service training and could make this list available to facilities and interested organizations. Facilities may also utilize their state's ombudsman program to provide training about residents' rights and quality of life issues.

After the directed in-service training has been completed, CMS RO or the State will assess whether substantial compliance has been achieved either through an on-site visit or by examining credible written evidence that it can be verified without an on-site visit. See § 7317.2 of the SOM for information concerning on-site revisits and § 7502 for information concerning Directed In-Service Training.

Statutorily Mandated Remedies not affected by Temporary Moratorium

The temporary moratorium described above does not include remedies that are required by federal law such as the Denial of Payment for New Admissions (DPNA) if the facility has not achieved compliance within 3 months of the finding under sections 1819(h)(2)(D) and 1919(h)(3)(C) of the Social Security Act (Act) and Termination after 23 days for immediate jeopardy under sections 1819(h)(4) and 1919(h)(5) of the Act or termination after 6 months for non-immediate jeopardy noncompliance under sections 1819(h)(2)(C) and 1919(h)(2)(D) of the Act.

CMS expects that the non-compliance for covered Phase 2 requirements would be corrected in advance of the statutorily-mandated timeframes as occurs with most cited deficiencies.

Temporary Freeze of Health Inspection Five-Star Ratings

Most facilities will be surveyed for compliance with Phase 2 requirements using the LTC revised survey process within one year after the November 28, 2017 Phase 2 implementation date. Due to the differing standards and process between those facilities surveyed under the new survey process compared to prior surveys, CMS will be holding constant, or "freezing," the health inspection star rating for health inspection surveys and complaint investigations conducted on or after November 28, 2017. We expect this freeze to begin in early 2018, and last approximately one year. Note that recent health surveys and complaint investigations conducted before November 28, 2017, will continue to be calculated in a facility's star rating, including any revisit

or changes based on informal dispute resolutions (IDR) or independent IDR. *Examples of when ratings can change include*:

1) A standard health inspection survey and revisit is conducted within the month of October 2017, and is closed after November 28, 2017. The survey results will be used in the nursing home's star rating as a survey conducted before the ratings freeze. Similar actions will take place for complaint investigations conducted prior to the ratings freeze.

2) A request for an IDR is received prior to the freeze and completed after November 28, 2017 with a change in scope/severity for at least one citation. The change will be reflected in the nursing home's star rating as a change prior to the ratings freeze.

Additionally, the health inspection star rating will no longer use information of the third (oldest) cycle of health inspection survey and complaint investigation data that is part of a nursing home's health inspection score. The weighted health inspection score and star rating for all nursing homes will then be based on the two most recent cycles of survey data. This change is to account for the fact that the data would have been dropped from the health inspection score because of its age, as part of the normal update process. This change will also occur in early 2018 for all facilities. At that time, the most recent cycle of data will be weighted at 60 percent and the prior cycle of data will receive a 40 percent weighting. We will be updating the *Five Star Quality Rating System* Technical User's Guide to reflect these changes.

CMS will continually monitor survey activity during the one year period to determine if any changes to the freezing methodology need to be made.

Other Changes to Nursing Home Compare

In addition to the items listed above, CMS is implementing other adjustments to ensure transparency. In addition to freezing the health inspection star rating on *Nursing Home Compare*, CMS plans to provide summaries of a facility's most recent survey findings, such as the total number of deficiencies cited, and the highest scope and severity level cited. This also includes identifying nursing homes with deficiency-free surveys. We also will post the full report of each survey (Form CMS-2567), which provides more details about the survey findings. We expect to implement these changes in early 2018, concurrent with the changes to the *Five Star Quality Rating System.*

CMS is aware that multiple programs (e.g., accountable care organizations (ACOs), bundled payment models, Medicare Advantage plans) use the *Five-Star Quality Rating System* as a component of their program. We have communicated information about changes to the rating system noted in this memorandum to these programs so they can evaluate any potential impact, and make any changes they feel warranted. The *Nursing Home Compare* website will also display information about the changes to the ratings system. For questions about how the *Five-Star Quality Rating System* is used or may impact one of these or other programs, we encourage individuals to communicate directly with the program's specific organizational or primary contact.

The changes explained in the memorandum serve a temporary need to accommodate the implementation of the first major regulatory change to the LTC requirements in over 25 years.

These types of changes are rare, and the *Five Star Quality Rating System* and *Nursing Home Compare* website remain an excellent source for information about nursing homes. In addition to survey findings, consumers can find information about quality measures and staffing to help support their decision making. We're also looking forward to future improvements, such as the inclusion of new staffing data from the Payroll-Based Journal program. That said, we believe the website and ratings system is one source of information about nursing homes, but consumers should seek other sources as well. For example, we encourage families to visit the facility and speak to the administrator, other staff, current residents, or the family or resident council. Also, speak with their physician or friends who have had similar situations.

Contact: For questions or concerns, please contact NHSurveyDevelopment@cms.hhs.gov

Effective Date: November 28, 2017. This policy should be immediately communicated to all survey and certification staff, their managers and the State/Regional Office training coordinators.

/s/
David R. Wright

cc: Survey and Certification Regional Office Management

DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 18-01-NH

DATE: **October 27, 2017**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Revised Policies regarding the Immediate Imposition of Federal Remedies- FOR ACTION

Memorandum Summary

- **This policy memo replaces S&C: 16-31-NH released July 22, 2016 and the revision on July 29, 2016.**
- **Revisions to Chapter 7 of the State Operations Manual (SOM) (Attachment):** The Centers for Medicare & Medicaid Services (CMS) has revised guidance relating to the Immediate Imposition of Federal Remedies. Other sections of Chapter 7 have been revised to ensure consistency with these revisions. Major revisions include:
  - We specify that when the current survey identifies Immediate Jeopardy (IJ) that does not result in serious injury, harm, impairment or death, the CMS Regions may determine the most appropriate remedy;
  - We clarified that Past Noncompliance deficiencies as described in §7510.1 of this chapter, are **not** included in the criteria for Immediate Imposition of Remedies;
  - For Special Focus Facilities (SFFs), we now exclude any S/S level "F" citations under tags F812, F813 or F814 from the tags that require immediate imposition of remedies.
- **This memo is being released in draft. We seek comment on this policy by December 1, 2017.**

Background

Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs) and dually participating facilities (SNF/NFs) are required to be in substantial compliance with Medicare and Medicaid requirements at all times and are always responsible for the health and safety of its residents.

The purpose of federal remedies is to promote the initiative and responsibility of facilities to continuously monitor their performance and promptly achieve, sustain and maintain compliance with all federal requirements. To support this purpose, we are directing the immediate imposition of federal remedies in certain situations.

In addition to the required enforcement action(s), remedies should be selected that will bring about compliance quickly and to maintain continued compliance. Noncompliance may occur for a variety of reasons and can result in various levels of harm or likely harm to residents. The CMS Regional Offices (ROs) should consider the extent to which the noncompliance is a one-time mistake or accident, the result of larger systemic concerns, or a more intentional action or disregard for resident health and safety.

CMS is in the process of updating the SOM to reflect this revised guidance. The final version of this document when published in the on-line SOM may differ slightly from this interim advanced copy which is attached.

Contact: Please contact the CMS Regional Office or the dnh_triageteam@cms.hhs.gov to provide feedback on this draft by December 1, 2017.

Effective Date: CMS is seeking input on this draft and requests comments. CMS will review these comments before issuing a final version.

/s/
David R. Wright

Attachment: Advanced Guidance Revisions to SOM Chapter 7

cc: Survey and Certification Regional Office Management
State Medicaid Agencies

CMS Manual System

Pub. 100-07 State Operations Provider Certification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal- ADVANCE COPY **Date: XXXX**

SUBJECT: Revisions to the State Operations manual (SOM 100-07) Chapter 7

I. SUMMARY OF CHANGES: Revisions to the State Operations manual (SOM 100-07) Chapter 7 – To provide revisions in sections 7304 through 7304.3, 7306, 7308.3, 7313.2, 7400.5, and 7400.5.1 regarding policies related to Immediate Imposition of Federal Remedies (previously referred to as Opportunity or No Opportunity to Correct). Sections 7304.2.1 and 7304.2.2 have been deleted and incorporated into other sections noted above.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: Upon Issuance
IMPLEMENTATION DATE: Upon Issuance

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Chapter 7/7304/ Mandatory Immediate Imposition of Federal Remedies
R	Chapter 7/7304.1/ Criteria for Mandatory Immediate Imposition of Federal Remedies
R	Chapter 7/7304.2/ Effective Dates for Immediate Imposition of Federal Remedies
D	Chapter 7/7304.2.1/ Mandatory Criteria for Having No Opportunity to Correct
D	Chapter 7/7304.2.2/ Additional State Discretion
R	Chapter 7/7304.3/ Responsibilities of the State Survey Agency and the CMS Regional Office when there is an Immediate Imposition of Federal Remedies
R	Chapter 7/7306/ Timing of Civil Money Penalties *(CMPs) for Immediate Imposition*
D	Chapter 7/7306.1/ I Imposition of a Civil Money Penalty when a Facility is not allowed an Opportunity to
D	Chapter 7/7306.3 When State Recommends a Civil Money Penalty for Past Noncompliance
D	Chapter 7/7306.4/ Amount
R	Chapter 7/7308/ Enforcement Actions When Immediate Jeopardy *(IJ)*

	Exists
D	**Chapter 7/7308.1/ Action That Must Be Taken**
D	**Chapter 7/7308.2/ Enforcement Action That Must Be Taken**
D	**Chapter 7/7308.3/ Action That Must Be Taken**
R	**Chapter 7/7309/ Key Dates When Immediate Jeopardy *(IJ)* Exists**
R	**Chapter 7/7309.1/ 2nd *Business* Day**
R	**Chapter 7/7309.2/ 5th *Business* Day**
R	**Chapter 7/7309.3/ 5th - 21st Calendar Day**
R	**Chapter 7/7309.4/ No Later Than 10th *Calendar* Day**
R	**Chapter 7/7309.5/ By 23rd Calendar Day**
R	**Chapter 7/7313/ Procedures for Recommending Enforcement Remedies When Immediate Jeopardy Does Not Exist**
R	**Chapter 7/7313.1/ *Facilities Given an Opportunity to Correct Deficiencies prior to the Immediate Imposition of Federal Remedies***
D	**Chapter 7/7313.2/ Facilities Given an Opportunity to Correct Deficiencies prior to the Immediate Imposition of Federal Remedies**
R	**Chapter 7/7400/ *Enforcement Remedies for Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs) and Dually Participating Facilities (SNFs/NFs)***
R	**Chapter 7/7400.1/ *Available Federal Enforcement Remedies***
R	**Chapter 7/7400.2/ *Enforcement Remedies for the State Medicaid Agency***
R	**Chapter 7/7400.3/ *Selection of Remedies***
R	**Chapter 7/7400.3.1/ Availability of State Medicaid Agency Remedies to the Regional Office in Dually Participating Facilities**
R	**Chapter 7/7400.5/ *Factors That Must Be Considered When Selecting Remedies***
D	**Chapter 7/7400.5.1/ *Matrix for Scope & Severity***

III. FUNDING: No additional funding will be provided by CMS.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

7304 - Mandatory Immediate Imposition of Federal Remedies
(Rev.)

Noncompliance may occur for a variety of reasons and can result in harm to residents or put residents at risk for harm. When facilities do not maintain substantial compliance, CMS may use various enforcement remedies to encourage prompt compliance. The purpose of federal remedies is to promote the initiative and responsibility of facilities to continuously monitor their performance and promptly achieve, sustain and maintain compliance with all federal requirements. To support this purpose, we are directing the immediate imposition of federal remedies in certain situations outlined in §7304.1 below, and we recommend using the type of remedy that best achieves the purpose based on the circumstances of each case.

This guidance does not apply to ***past noncompliance*** *deficiencies as described in §7510.1 of this chapter. The determination to impose federal remedies for past noncompliance is at the discretion of the CMS Regional Office (RO).*

7304.1 - Criteria for Mandatory Immediate Imposition of Federal Remedies Prior to the Facility's Correction of Deficiencies
(Rev.)

A facility *shall not be offered* an opportunity to correct deficiencies before federal remedies are imposed if the situation meets *any one or more of* the *following* criteria:

- Immediate Jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; **OR**
- *Any d*eficiency *from the current survey at levels "G, H or I", that falls into any of the* Substandard Quality of Care (SQC) *regulatory sections* that are not IJ *but did result in injury, harm, or impairment*; **OR**
- *Any d*eficiency *at "*G*"* or above on the current survey ***AND*** *if there were any* deficiencies *at "G" or above* on the previous standard health or LSC survey **or** *if there was any* deficiency *at "G"* or above on any type of survey between the current survey and the last standard *health or LSC* survey. *These surveys (standard health or LSC, complaint, revisit) must be separated by a certification of compliance, i.e., be from different noncompliance cycles. In other words, level G or above deficiencies from multiple surveys within the same noncompliance cycle must not be combined to make this "double G or higher" determination*; **OR**
- A facility classified as a Special Focus Facility (SFF) **AND** has a deficiency citation at level "F," *(excluding any level "F" citations under tags F812, F813 or F814)* or higher for the current health survey or "G" or higher for the current Life Safety Code (LSC) survey.

*The remedies to be imposed by statute do not change, (e.g., 3-month automatic Denial of Payment for new admissions (DPNA), 23-day termination when IJ is present and 6-month termination). In addition to these statutory remedies, t*he CMS RO **must *also*** *immediately* impose *one or more additional* remedies *for any situation that* meets the criteria identified above. The State Survey and/or Medicaid Agencies **shall not** permit changes to this policy.

NOTE: "Current" survey is whatever Health and/or LSC survey is currently being performed, e.g., standard, revisit, or complaint. *"Standard" survey (which does not include complaint or revisit surveys) is a periodic, resident-centered inspection that gathers information about the quality of service furnished in a facility to determine compliance with the requirements of participation.*

While States are not required to recommend the types of remedies to be imposed, they are encouraged to do so, since States may be more familiar with a facility's history and the specific circumstances in the case at hand. The CMS RO may or may not accept these recommendations.

Regardless of a State's recommendation, the CMS RO must take the necessary actions to impose a remedy or multiple remedies, based on the seriousness of the deficiencies following the criteria set forth in *42 C.F.R.* §488.404. *Also refer to §§7400.5.1 and 7400.5.2 of this chapter. In addition to any statutorily imposed remedy, additional remedies should be selected that will bring about compliance quickly and achieve and maintain compliance. When making remedy choices, the CMS RO considers the extent to which the noncompliance is the result of a one-time mistake, larger systemic concerns, or an intentional action of disregard for resident health and safety.*

The State Survey Agency is authorized to both recommend and impose one or more Category 1 remedies, in accordance with §7314 of this Chapter. **CATEGORY 1** remedies include:

- Directed plan of correction,
- State monitoring, and
- Directed in-service training.

Use of Federal Remedies in Immediate Jeopardy (IJ) Citations *- When IJ is identified on the current survey that resulted in serious injury, harm, impairment or death a CMP* ***must*** *be imposed.*

For IJ citations where there is ***no resultant*** *serious injury, harm, impairment or death but the likelihood is present, the CMS RO must impose a remedy or remedies that will best achieve the purpose of attaining and sustaining compliance. CMPs may be imposed, but they are not required.*

Types of Remedies *- The choice of remedy is made that best achieves the purpose of attaining and sustaining compliance based on the circumstances of each case and recommendations from the State. Federal remedies are summarized below. Refer to §§7500 - 7556 of this chapter for more detail on these remedies.*

Civil Money Penalties (CMPs) *- Federal CMPs are only imposed by the CMS RO. If a CMP is imposed, it must be done in accordance with instructions in the CMP Analytic Tool and §§7510 through 7536 of this chapter.*

If a per instance CMP is imposed, the facility shall not be given an opportunity to correct any deficiency for which this CMP is imposed prior to the imposition of this remedy.

Directed In-Service Training *– Refer to §7502 of this chapter. Consider this remedy in cases where the facility has deficiencies where there are knowledge gaps in standards of practice, staff competencies or the minimum requirements of participation and where education is likely to correct the noncompliance. Depending on the topic(s) that need to be addressed and the level of training needed, facilities should consider using programs developed by well-established centers of geriatric health services such as schools of medicine or nursing, centers for the aging, and area health education centers which have established programs in geriatrics and geriatric psychiatry. If it is willing and able, a State may provide special consultative services for obtaining this type of training. The State or regional office may also compile a list of resources that can provide directed in-service training and could make this list available to facilities and interested organizations. Facilities may also utilize the ombudsman program to provide training about residents' rights and quality of life issues.*

Directed Plan of Correction *Refer to §7500 of this chapter. This remedy provides for directed action(s) from either the State or CMS RO that the facility must take to address the noncompliance or a directed process for the facility to more fully address the root cause(s) of the noncompliance. Achieving compliance is ultimately the facility's responsibility, whether or not a directed plan of correction is followed.*

Temporary Management *- Refer to §7550 of this chapter. This is the temporary appointment by CMS or the State of a substitute facility manager or administrator with authority to hire, terminate or reassign staff, obligate facility funds, alter facility procedures, and manage the facility to correct deficiencies identified in the facility's operation. A temporary manager may be imposed anytime a facility is not in substantial compliance, but must be imposed when a facility's deficiencies constitute IJ or widespread actual harm and a decision is made to impose an alternative remedy to termination. It is the temporary manager's responsibility to oversee correction of the deficiencies and assure the health and safety of the facility's residents while the corrections are being made. A temporary manager remedy may also be imposed to oversee orderly closure of a facility. The State will select the temporary manager when the State Medicaid Agency is imposing the remedy and will recommend a temporary manager to the regional office when CMS is imposing the remedy. Each State should compile a list of individuals who are eligible to serve as temporary managers. These individuals do not have to be located in the State where the facility is located.*

Denial of Payment for all <u>New</u> Medicare and Medicaid Admissions (DPNA) *– See §7506 of this chapter. This remedy may be imposed alone or in combination with other remedies to encourage quick compliance. Regardless of any other remedies that may be imposed, a mandatory denial of payment for new admissions* ***must*** *be imposed when the facility is not in substantial compliance three months after the last day of the survey identifying deficiencies, or when a facility has been found to have furnished substandard quality of care on the last three consecutive standard surveys (see 42 CFR 488.414).*

Denial of all Payment for all Medicare and Medicaid Residents (DPAA) (Discretionary). *See §7508 of this chapter. Only CMS has the authority to deny all payment for Medicare and/or Medicaid residents. This is in addition to the authority to deny payment for all new admissions*

(discretionary) noted above. This is a severe remedy. Factors to be considered in selecting this remedy include but are not limited to:

1. *Seriousness of current survey findings;*
2. *Noncompliance history of the facility; and*
3. *Use of other remedies that have failed to achieve or sustain compliance.*

***State Monitoring** - Refer to §7504 of this chapter. A State monitor oversees the correction of cited deficiencies in the facility as a safeguard against further harm to residents when harm or a situation with a potential for harm has occurred. Consider imposing this remedy when, for example, there are concerns that the situation in the facility has the potential to worsen or the facility seems unable or unwilling to take corrective action. A State monitor **must** be used when a facility has been cited with substandard quality of care (SQC) deficiencies on the last three consecutive **standard health** surveys.*

***Termination of Provider Agreement** - See §7556 of this chapter. While this remedy may be imposed at any time the circumstances warrant regardless of whether IJ is present; regardless of any other remedies that may be imposed, termination of a facility's provider agreement **must** be imposed when the facility is not in substantial compliance six months after the last day of the survey identifying deficiencies or within no more than 23 days if IJ is identified and not removed.*

7304.2 - Effective Dates for Immediate Imposition of Federal Remedies *(Rev.)*

The State Survey Agency must immediately inform its CMS RO when immediate imposition of remedies must be made so that the notice letter, from the State Survey Agency or the CMS RO, to the facility can promptly be sent out and meet the timelines for notice as outlined in §7305 of this chapter. *This will ensure that remedies are imposed as soon as possible.* Once a remedy is imposed, it *becomes* effect*ive* as of the date in the notice letter. All remedies remain in effect and continue until the facility *is determined to be* in substantial compliance *(which may occur before the revisit date)*. Substantial compliance must be verified in accordance with §7317 of this chapter.

For Immediate Jeopardy *(IJ)* Situations: *A facility's* removal of the conditions that *caused the* IJ may, at CMS's discretion, result in the rescission of the 23-day termination. *A per day CMP must be lowered when the survey agency has verified that the IJ has been removed but deficiencies at a lower level continue. Refer to the CMP Analytic Tool instructions for determining the dates of a per day CMP. H*owever, CMS **shall not** rescind any *other* remedies imposed *until the facility achieves substantial compliance or is terminated.* Remedies imposed must remain in effect, irrespective of when the IJ is removed, unless otherwise rescinded *or revised* as a result of legal proceedings. Remedies will be immediately imposed and effectuated whether or not the *IJ* was:

- removed during the survey, or,
- removed in a subsequent IJ removal revisit before the 23rd day.

7304.3 - Responsibilities of the State Survey Agency and the CMS Regional Office *(RO)* when there is an Immediate Imposition of Federal Remedies

(Rev.)

When federal remedies *are to be immediately imposed* as outlined in §7304.1, *within five (5) business days from when the initial notice was sent to the facility by the survey agency,* the State Survey Agency **MUST:**

- *C*opy the CMS RO on its initial notice to the facility. The State Survey Agency does not need prior approval from the CMS RO before sending this notice to the facility*; and*
- *A*ssure *all of* these cases are referred to the CMS RO for *their review and* action.

The survey agency (State or Federal) must enter all of these cases as a NO opportunity to correct into the *Automated System Processing Environment (ASPEN)/ASPEN Enforcement Manager (AEM)* system within five (5) business days of sending the initial notice to the facility. The State Survey Agency and the CMS RO must have systems in place to routinely check and monitor the ASPEN-AEM database to identify cases that may require enforcement action or additional follow-up, as needed.

7306 - Timing of Civil Money Penalties *(CMPs)*

(Rev.)

7306.1 - *Immediate* Imposition of a Civil Money Penalty *(CMP)*

(Rev)

If a per instance CMP is imposed, the facility shall not be given an opportunity to correct any deficiency for which this CMP is imposed prior to the imposition of this remedy.

*While t*he State *Survey Agency is not required to* recommend that a *CMP (or the amount of a CMP)* be imposed as a result of the noncompliance referenced in §7304*.1, they may do so. This recommendation must be sent to* the *CMS* regional office *(RO)* and *the* State Medicaid Agency.

The *CMS RO* and *the* State Medicaid Agency *must respond* to the State survey agency's recommendation and, if accepted, *the CMS RO* sends out the formal notice *of the immediate imposition of a CMP to the facility* in accordance with the requirements in §§7305, *7309* and 7520.

7308 - Enforcement Actions When Immediate Jeopardy *(IJ)* Exists

(Rev.)

When the State *Survey Agency* identifies *IJ, no later than two business days following the survey date which identified the IJ, it* must notify;

- The *CMS* Regional Office *(RO) and* the State Medicaid Agency *of its survey findings by telephone, e-mail, or other means acceptable to the CMS RO and the State Medicaid agency: and,*
- *The facility of the IJ findings in writing. A written notice or letter to the facility in lieu of a Form CMS 2567 would be acceptable.*

Waiting for the complete statement of deficiencies (Form CMS-2567) and the facility's plan

of correction for the *non-IJ* deficiencies can result in undue delay in determining removal of *IJ*. Therefore, *a Statement of Deficiencies (Form CMS-2567) and a facility's* plan of correction *for the non-IJ deficiencies may* be deferred until the *survey agency verifies the IJ* is removed.

In addition to the imposition of enforcement remedies, the *CMS RO* terminates the *Medicare* provider agreement within 23 calendar days of the last date of the survey, and/or appoints a temporary manager who must remove the *IJ* within *no more than* 23 calendar days of the last date of the survey. When the *CMS RO* imposes termination of a Medicare provider agreement, it *must* notify the State Medicaid Agency.

In order *to prevent* termination *from occurring within 23 days*, the *IJ* **must be removed, even if the underlying deficiencies have not been fully corrected.** When *IJ* is identified, the facility must submit an allegation that the *IJ* has been removed, *including* a *specific* plan detail*ing* how and when the *IJ* was removed.

Documentation must be completed indicating whether the *IJ* was removed and deficiencies corrected (Form CMS-2567B), or that the *IJ* was removed but compliance had not been achieved (Form CMS-2567).

If the facility alleges that the *IJ* is removed and *the survey agency* verifies *this* but the facility is still not in substantial compliance, *then complete a full Statement of Deficiencies (CMS Form 2567)*, which requires a plan of correction for all *remaining deficiencies*.

In addition, whenever a facility has deficiencies that constitute both IJ **and** substandard quality of care (SQC) *(as defined in 42 CFR §488.301),* the survey agency must notify the attending physician of each resident found to have received SQC as well as the State board responsible for licensing the facility's administrator. Notify physicians and the administrator licensing board in accordance with §7320.

7309 - Key Dates When Immediate Jeopardy *(IJ)* Exists
(Rev.)

NOTE: These timelines apply whether the survey was conducted by a State Survey Agency, CMS Regional Office (RO) or a CMS contractor.

7309.1 - 2nd *Business* Day
(Rev.)

When the State *Survey Agency* identifies *IJ, no later than two business days following the survey date which identified the IJ, it* must notify;

- The *CMS* Regional Office *(RO) and* the State Medicaid Agency *of its survey findings by telephone, e-mail, or other means acceptable to the CMS RO and the State Medicaid agency: and,*
- *The facility of the IJ findings in writing that the State is recommending to the CMS RO (for skilled nursing facilities and dually participating facilities) or to the State*

Medicaid Agency (for nursing facilities) that the provider agreement be terminated and that a Civil Money Penalty (CMP) or other remedies may be imposed, refer to §§7304 and 7304.1. A temporary manager may be imposed in lieu of or in addition to termination. Procedures pertaining to the imposition of CMPs and temporary management can be found in §§7510-7536 and §7550, respectively.

This letter *may also* serve as *the* formal notice *from the State Survey Agency* for imposition of any category 1 remedy or denial of payment for new admissions remedy when authorized by *the* CMS *RO* and/or the State Medicaid Agency. *This notice must also* include the facility's right to informal dispute resolution *(IDR) or an independent informal dispute resolution (IIDR)* and to a formal appeal of the noncompliance.

7309.2 - 5th *Business* Day
(Rev.)

Within five business days from when the initial notice was sent to the facility by the State *Survey Agency, they* must *assure these IJ cases are forwarded and referred to the CMS RO for their review and action,* including all documentation (e.g., notice letter, contact reports, Forms CMS-1539 *and CMS-2567*, if completed). *This information may be transmitted and referred to the CMS RO via the Automated System Processing Environment (ASPEN)/ASPEN Enforcement Manager (AEM) system.*

7309.3 - 5th - 21st Calendar Day
(Rev.)

Except when formal notice of remedies is provided by the State *Survey Agency*, as authorized by CMS and/or the State Medicaid Agency, the *CMS RO* and/or the State Medicaid Agency issues a formal notification of remedies to the facility (see §7305). In addition, the notice should include the facility's right to a formal appeal of the noncompliance which led to the temporary management remedy, termination, or any other enforcement actions (except State monitoring). For the temporary management remedy, the notice will advise the facility of the conditions of temporary management as specified in §7550, and that failure to relinquish control to the temporary manager will result in termination. The general public is also given notice of the impending termination.

7309.4 - No Later Than 10th *Calendar* Day
(Rev.)

If the survey entity verifies that the IJ has been removed, then the survey agency must *send the Statement of Deficiencies (Form CMS-2567)* to the facility, the *CMS RO*, and, if the facility participates in Medicaid, the State Medicaid Agency.

NOTE: The facility is not required to submit a *PoC* in order to verify the removal of the *IJ. T*he facility *should* submit *a written* allegation of removal of the *IJ* with sufficient *detailed* information to *demonstrate* how *and when* the *IJ w*as removed. If a *PoC* is to be submitted, it

must be received no later than 10 calendar days after the facility receives their *Statement of Deficiencies (Form CMS*-CMS-2567) *from the survey agency.*

The CMS RO must impose a Civil Money Penalty (CMP) if the IJ resulted in serious injury, harm, impairment or death on the current survey.

For IJ citations where there is no resultant serious injury, harm, impairment or death but the likelihood is present, a remedy must be imposed; however, the CMS RO may select whichever type of remedy best achieves the purpose of achieving and sustaining compliance and address various levels of noncompliance.

7309.5 - By 23rd Calendar Day
(Rev.)

Termination takes effect unless the *IJ* has been removed. If the *IJ* has been removed *and verified by the survey agency however additional deficiencies remain and* substantial compliance has not been achieved, the facility may be given up to 6 months from the last day of survey during which to achieve substantial compliance. (See §7316 for key dates when immediate jeopardy does not exist.)

7313 - Procedures for Recommending Enforcement Remedies When Immediate Jeopardy Does Not Exist
(Rev.)

Once noncompliance is identified, the surveying entity *must first* determine whether to *immediately* impose remedies *in accordance with the criteria in §7304.1* or give the facility an opportunity to correct its deficiencies before *remedies* are imposed.

7313.1 - Facilities Given an Opportunity to Correct Deficiencies prior to the Immediate Imposition of Federal Remedies
(Rev.)

A facility may be permitted to correct its deficiencies and *delay* the imposition of remedies only when the criteria outlined in §7304.1 of this chapter are not met. *Facilities must submit an acceptable plan of correction for its deficiencies.*

The State Survey Agency, or the CMS regional office (RO) for federal surveys, provides the initial notice to the facility that failure to correct cited deficiencies may result in the recommendation or imposition of remedies. The State Survey Agency may provide formal notice in its initial notice to the facility or in its notice letter related to the first revisit survey of the imposition of Category 1 remedies and the denial of payment for new admissions if authorized by its CMS RO.

If at the time of the first revisit the facility has not achieved substantial compliance, remedies may be imposed and will be effective once formal notice has been provided to the facility. In these circumstances, the State *Survey Agency* recommends *to the CMS RO and the State*

Medicaid Agency that remedies be imposed and/or *become* effective. The *CMS RO* and *the* State Medicaid Agency should establish procedures with the State *Survey Agency* as to when and how the documentation of noncompliance is to be communicated *and how and when responses regarding these recommendations will be made.*

7400 - Enforcement Remedies for Skilled Nursing Facilities *(SNFs)*, Nursing Facilities *(NFs)* and Dually Participating Facilities *(SNFs/NFs)*
(Rev.)

Sections 1819(h) and 1919(h) of the Act, as well as 42 CFR §§488.404, 488.406, and 488.408, provide that CMS or the State may impose one or more remedies in addition to, or instead of, termination of the provider agreement when the State or CMS finds that a facility is out of compliance with *federal* requirements. *E*nforcement protocols/procedures are based on the premise that all requirements must be met and take on greater or lesser significance depending on the specific circumstances and resident outcomes in each facility.

7400.1 - Available Federal Enforcement Remedies
(Rev.)

In accordance with 42 CFR §488.406, the following remedies are available:

- Termination of the provider agreement;
- Temporary management;
- Denial of payment for all Medicare and/or Medicaid residents by CMS;
- Denial of payment for all new Medicare and/or Medicaid admissions;
- Civil money penalties;
- State monitoring;
- Transfer of residents;
- Transfer of residents with closure of facility;
- Directed plan of correction;
- Directed in-service training; and
- Alternative or additional State remedies approved by CMS.

7400.2 - Enforcement Remedies for the State Medicaid Agency
(Rev.)

Regardless of what other remedies the State Medicaid Agency may want to establish in addition to the remedy of termination of the provider agreement, it must establish, at a minimum, the following statutorily-specified remedies or an approved alternative to these specified remedies:

- Temporary management;
- Denial of payment for all new admissions;
- Civil money penalties;
- Transfer of residents;
- Transfer of residents with closure of facility; and
- State monitoring.

The State Medicaid Agency may establish additional or alternative remedies as long as the State has been authorized by CMS to do so under its State plan. Guidance on the review and approval (or disapproval) of State Plan amendment requests for alternative or additional remedies can be found in §7805.

Whenever a State Medicaid Agency's remedy is unique to its State plan and has been approved by CMS, then that remedy may also be imposed by the regional office against the Medicare provider agreement of a dually participating facility in that State. For example, where CMS has approved a State's ban on admissions remedy as an alternative remedy under the State plan, CMS may impose this remedy but only against Medicare and Medicaid residents; only the State can ban the admission of private pay residents.

7400.3 - Selection of Remedies
(Rev.)

In order to select the appropriate remedy(ies) for a facility's noncompliance, the seriousness, *scope and severity* of the deficiencies must first be assessed. *The purpose of federal remedies is to encourage the provider to achieve and sustain substantial compliance. In addition to the required enforcement action(s), remedies should be selected that will bring about compliance quickly. While a facility is always responsible for all violations of the Medicare and Medicaid requirements, when making remedy choices, the CMS RO should consider the extent to which the noncompliance is the result of a one-time mistake, larger systemic concerns, or an intentional action of disregard for resident health and safety.*

7400.3.1 – Matrix for Scope & Severity
(Rev.)

Immediate jeopardy to resident health or safety	**J**	**K**	**L**
Actual harm that is not immediate	**G**	**H**	**I**
No actual harm with potential for more than minimal harm that is not immediate jeopardy	**D**	**E**	**F**
No actual harm with potential for minimal harm	**A** No PoC	**B**	**C**
	Isolated	**Pattern**	**Widespread**

Substandard Quality of Care (SQC) is defined in 42 C.F.R. §488.301 as one or more deficiencies which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm, related to certain participation requirements.

Substantial compliance means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm. Substantial compliance constitutes compliance with participation requirements (42 C.F.R. §488.301).

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 17-37-NH

DATE: **July 07, 2017**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Revision of Civil Money Penalty (CMP) Policies and CMP Analytic Tool

Memorandum Summary

- **Revisions to CMP Tool:** When noncompliance exists, enforcement remedies, such as civil money penalties (CMPs), are intended to promote a swift return to substantial compliance for a sustained period of time, preventing future noncompliance. To increase national consistency in imposing CMPs, the Centers for Medicare & Medicaid Services (CMS) is revising the CMP analytic tool in the following areas which are further explained within this policy memorandum:
  - Past Noncompliance;
  - Per Instance CMP is the Default for Noncompliance Existed Before the Survey;
  - Per Day CMP is the Default for Noncompliance Existing During the Survey and Beyond;
  - Revisit Timing; and
  - Review of High CMPs.

- **This policy memo replaces S&C Memo 15-16-NH:** The prior versions of the CMP Tool are obsolete, as of the effective date of this memo, July 17, 2017.

The Omnibus Budget Reconciliation Act of 1987 (OBRA '87) modernized the survey process for long term care facilities and provided a range of remedies that CMS could impose to encourage a swift return to substantial compliance and sustained compliance going forward, thus preventing harm to residents. Among the remedies authorized by OBRA '87 are civil money penalties (CMPs). CMS imposes two types of CMPs: Per Day and Per Instance. Per Day CMPs are divided into lower and upper level ranges. The upper level range CMPs must be used when facility noncompliance puts resident health and safety in immediate jeopardy. Lower level CMPs must be used for facility noncompliance that results in actual harm to residents or poses the potential for more than minimal harm to residents.

More information on CMP amounts and ranges can be found in 42 CFR 488.408, and on the CMS website at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Civil-Monetary-Penalties-Annual-Adjustments.html.

When selecting an enforcement remedy, CMS Regional Offices (ROs) review the survey findings to determine which remedy is most appropriate to address the noncompliance. The statute and regulations (488.406) outline a variety of federal remedies (CMP, directed plan of correction, directed in-service training, etc). We encourage use of the remedy that will best achieve swift and sustained compliance with federal health and safety requirements. If the RO determines that imposition of a CMP will best achieve the goal, the ROs use an analytic tool to calculate the amount imposed based on the type of noncompliance. Notwithstanding the type of noncompliance, CMP amounts can vary based on factors such as the date of the noncompliance and the timing of the revisit survey to certify compliance. To reduce this variation, CMS is making several changes to the CMP analytic tool.

Revised CMP Policies and Analytic Tool

The revised CMP Analytic Tool instructs ROs how to use Per Day and Per Instance CMPs depending on the timing of the noncompliance in relation to the survey, whether residents were harmed or abused, whether the facility has a good compliance history, and whether the noncompliance was an isolated event or persistent deficient practices were identified.

When noncompliance exists, enforcement remedies, such as civil money penalties (CMPs), are intended to promote a swift return to substantial compliance for a sustained period of time, preventing future noncompliance. To increase national consistency in imposing CMPs, CMS is revising the CMP analytic tool in the following manner:

- **Past Noncompliance:** ROs will impose a per-instance CMP for past noncompliance – something occurred before the current survey, but has been fully addressed and the facility is back in compliance with that area.

- **Per Instance CMP is the Default for Noncompliance that Existed before the Survey:** CMS ROs will generally impose a Per Instance CMP retroactively for non-compliance that still exists at the time of the survey, but began earlier. However, a Per Day will be used to address noncompliance that occurred where: (1) a resident suffers actual serious harm at the immediate jeopardy level; (2) a resident was abused; (3) or the facility had persistent deficient practices violating federal regulations.

- **Per Day CMP is the Default for Noncompliance Existing during the Survey and Beyond:** In contrast, Per Day CMPs will be the default CMPs for noncompliance identified during the survey and beyond, because there is an urgent need to promote a swift return to substantial compliance for a sustained period of time, preventing future noncompliance. Exceptions allowing Per Instance CMPs will be made for facilities with good compliance histories, and where a single isolated incident causes harm to a resident, unless abuse has been cited.

- **Revisit Timing:** CMS ROs should consider the timing of the revisit survey to certify compliance when imposing the final CMP amount. CMS has added language specifying this consideration.

- **Review of High CMPs:** CMS Central Office will Review CMPs of $250,000 or greater.

Contact: For questions or concerns, please contact DNH_TriageTeam@cms.hhs.gov.

Effective Date: July 17, 2017 for all enforcement cases where the CMS RO determines that a CMP is an appropriate enforcement remedy. This guidance should be communicated to all RO and State Survey Agency survey, certification and enforcement staff, their managers and the State/RO training coordinators.

/s/
David R. Wright

Attachment- CMP Analytic Tool User's Guide Version 1.3

cc: Survey and Certification Regional Office Management
State Medicaid Agency

Centers for Medicare & Medicaid Services
Center for Clinical Standards & Quality
Survey & Certification Group
Division of Nursing Homes

CMP Analytic Tool

User's Guide

Version 1.3

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2 CMP Analytic Tool

2.1 Introduction Section

2.1.1 General Instructions

CMS Regional Offices have a variety of enforcement remedies to choose from in addressing non-compliance by a facility. These remedies include civil money penalties, denial of payment for all individuals, discretionary denial of payment for new admissions, mandatory denial of payment (new admissions 3-months), directed in-service training, directed plan of correction, discretionary termination, mandatory termination, state monitoring, temporary management, transfer of residents, and transfer of residents/closure of facility. Not all situations require the same remedies. The RO should use the enforcement remedy most appropriate in considering the level/severity of harm to the resident, the context behind the facility non-compliance, and the type of enforcement that has the best chance of the facility achieving future compliance.

All CMS Regional Offices (ROs) are required to use the following CMP Analytic Tool and Instructions: (1) to choose the appropriate type of CMP to be imposed; and (2) to calculate the CMP amount, when the RO determines that a CMP is an appropriate remedy to impose. The RO must complete all sections of the tool that apply to the type of CMP selected. Please refer to the CMP Analytic Tool User's Guide for information about using this tool. Though remedies are usually imposed on Level 3 and Level 4 deficiencies, depending upon the circumstances, Regional Offices may impose CMPs for level 2 deficiencies based on the factors listed in 42 CFR 488.404 and 488.438(f).

Note: Use a separate calculation for each Life Safety Code (LSC) CMP, Health Survey CMP, or any new or changed CMP within a noncompliance cycle. For factors that may result in an increase in the CMP (e.g., culpability, facility history of noncompliance, etc.), only calculate those factors one time for each survey. Apply the added dollar amounts to each CMP you impose per survey, unless otherwise instructed. Always use the tool and User's Guide at this link (save in your bookmarks/favorites) for the most current version. Required fields are marked with an asterisk.*

2.2 "Select the Calculation Type" Section

2.2.1 Input

Field	Input	Detailed Instructions
Calculation Type (Required)	• Preliminary • Final	Select "Final" if in compliance or terminated.

2.3 "Enter the Case Information" Section

2.3.1 Input

Field	Input	Detailed Instructions
CCN (Required)	Text	N/A
Confirm CCN (Required)	Text	N/A
Provider Name (Required)	Text	N/A
Analyst Name (Required)	Text	Enter full name (first and last name).
Cycle Start Date (Required)	Text	Enter the date in mm/dd/yyyy format.

2.4 "Select the CMP Type (Per Day or Per Instance)" Section

2.4.1 General Instructions

Section 1819(h)(2)(B)(ii) of the Social Security Act.

The factors to consider in this tool for each type of CMP are intended to determine amounts for each CMP to be imposed. Also, if a Life Safety Code (LSC) deficiency is the basis for the CMP, the whole Tool algorithm applies to the LSC deficiencies, not the health deficiencies.

Note: This tool is to be used to calculate an amount for each new or changed CMP imposed against a facility within a noncompliance cycle.

Note: This tool does not address noncompliance at level 2, S/S of "D" or "E." Depending on the circumstances, Regional Offices may impose CMPs for level 2 deficiencies based on the factors listed in 42 CFR 488.404 and 488.438(f).

2.4.2 Input

2.4.2.1 Past Noncompliance

Field	Input	Detailed Instructions
CMP Type (Required)	Per Instance CMP (PI) for Past Noncompliance	Select "Per Instance CMP (PI) for Past Noncompliance" for all past noncompliance in which a CMP would be recommended. Past noncompliance occurs when a facility was out of substantial compliance before the current survey began, but took specific action to fully address the issue and come back into compliance with a specific regulatory tag. See Chapter 7, Section 7510.1 for additional information.

2.4.2.2 Continuing Noncompliance Identified Before the Start Date of the Current Survey (Not Past Noncompliance)

Field	Input	Detailed Instructions
CMP Type (Required)	Per Instance CMP (PI) Before the Start of the Survey	Select "Per Instance CMP (PI) Before the Start of the Survey" if noncompliance that was not past noncompliance existed before the start date of the survey and none of the factors requiring a per day CMP are present. Do NOT select this CMP Type if you select a "Per Day CMP (PD) Before the Start of the Survey." Note: Multiple PIs may be imposed for different types or dates of noncompliance.
CMP Type (Required)	Per Day CMP (PD) Before the Start of the Survey	Select "Per Day CMP (PD) Before the Start of the Survey" if any of the noncompliance factors identified below existed prior to the start date of the survey (check the factors that apply) .
CMP Factors for **Per Day CMP (PD) Before the Start of the Survey**	• IJ (S/S of "J", "K", or "L") was cited with actual harm to a resident • Abuse was cited at a level 3 (S/S of "G", "H", "I"), or IJ (S/S of "J", "K", or "L") with actual harm to a resident • The same *tag* at a S/S of "G" or above was cited within the last year on any survey and the tag is cited at a S/S of "J", "K", or "L" on the current survey • Deficiencies at a S/S of "H" or "I"	N/A

2.4.2.3 Noncompliance Existing at the Time of the Survey

Field	Input	Detailed Instructions
CMP Type (Required)	Per Instance CMP (PI) During the Survey	Select "Per Instance CMP (PI) During the Survey" if any of the noncompliance factors identified below existed at the time of the survey (check the factors that apply). Do NOT select this CMP Type if a Per Day CMP is in effect at the time of the survey. Note: Multiple PIs may be imposed for different types or dates of noncompliance.
CMP Factors for **Per Instance CMP (PI) During the Survey**	• Findings of noncompliance that is a singular event of actual harm at a S/S of "G" or "J" • Findings of current/ongoing noncompliance at a S/S of "G" or above or SQC findings at a S/S of "F" but where a facility has a good compliance history	N/A
CMP Type (Required)	Per Day CMP (PD) During the Survey	Select "Per Day CMP (PD) During the Survey" for noncompliance existing at the time of the survey if none of the "Per Instance CMP (PI) During the Survey" factors is present.

2.5 "Select the CMP Start and End Dates (Only for Per Day CMPs)" Section

2.5.1 General Instructions

PD CMP Start Date - A PD CMP should begin on the first day noncompliance at the cited S/S level is documented, even if that date precedes the first day of the current survey unless the facility can demonstrate that it corrected the noncompliance prior to the current survey (past noncompliance). If the team cannot document the first day of noncompliance, then the CMP should start on the date the noncompliance was observed and documented at the time of the current survey.

PD CMP End Date - Except in cases when IJ is removed on the same date that it was identified, do not include the day on which IJ is removed, the day the S/S is lowered, thereby lowering the CMP amount to another level or substantial compliance is achieved when calculating the final PD CMP.

2.5.2 Input

Field	Input	Detailed Instructions
CMP Start Date	Text	Enter the date in mm/dd/yyyy format.
CMP End Date	Text	Enter the date in mm/dd/yyyy format.

2.6 "Select the CMP Base Amount" Section

2.6.1 General Instructions

Select the highest S/S level for the base Calculated CMP Amount.

2.6.2 Input

Field	Input	Detailed Instructions
CMP Base Amount (Required)	• Per Day - Regional Office Discretion - $105 • Per Day - Potential for More than Minimal - S/S Level F - $405 • Per Day - Actual Harm - S/S Level G - $505 • Per Day - Actual Harm - S/S Level H - $1255 • Per Day - Actual Harm - S/S Level I - $2055 • Per Day - Immediate Jeopardy - S/S Level J - $6394 • Per Day - Immediate Jeopardy - S/S Level K - $8444 • Per Day - Immediate Jeopardy - S/S Level L - $10494 • Per Instance - Potential for More than Minimal - S/S Level F - $5000 • Per Instance - Actual Harm - S/S Level G - $10000 • Per Instance - Actual Harm - S/S Level H - $12500 • Per Instance - Actual Harm - S/S Level I - $15000 • Per Instance - Immediate Jeopardy - S/S Level J - No Harm - $10000 • Per Instance - Immediate Jeopardy – S/S Level J - Harm - $17000 • Per Instance - Immediate Jeopardy - S/S Level K - No Harm - $12500 • Per Instance - Immediate Jeopardy - S/S Level K - Harm - $18000 • Per Instance - Immediate Jeopardy - S/S Level L - No Harm - $15000 • Per Instance - Immediate Jeopardy - S/S Level L - Harm - $20000	Select the highest S/S level for the base Calculated CMP Amount.
Abated IJ	Yes	N/A

2.7 "Is There a History of Facility Noncompliance?" Section

2.7.1 General Instructions

42 CFR §488.438(f)(1).

If a facility has a history and/or a pattern of noncompliance at a S/S of "G" or above for surveys (standard, complaint, or revisit) conducted in the past 3 calendar years, add an amount indicated below based on the S/S pattern/trend of a facility's noncompliance history.

2.7.2 Input

Field	Input	Detailed Instructions
Facility Noncompliance Amount Added	• Per Day - Add $205 • Per Day - Add $405 • Per Day - Add $605 • Per Day - Add $805 • Per Day - Add $1005 • Per Instance - Add $1000 • Per Instance - Add $2500 • Per Instance - Add $5000	Select the amount to add to the Calculated CMP Amount.

2.8 "Are There Repeated Deficiencies?" Section

2.8.1 General Instructions

42 CFR §488.438(d)(2)(3).

"Repeated Deficiencies" are deficiencies within the same regulatory grouping of requirements under which deficiencies were cited at the last survey, subsequently corrected, and cited again at the next survey.

2.8.2 Input

Field	Input	Detailed Instructions
Repeated Deficiencies Amount Added	• Per Day - S/S Level F - Add $105 • Per Day - S/S Level G, H, I - Add $205 • Per Day - S/S Level J, K, L - Add $305 • Per Instance - S/S Level F - Add $1000 • Per Instance - S/S Level G, H, I - Add $2500 • Per Instance - S/S Level J, K, L - Add $5000	Select the amount to add to the Calculated CMP Amount based on the highest S/S level of the repeat deficiencies.

2.9 "Are There Multiple Deficiencies?" Section

2.9.1 General Instructions

42 CFR §488.404(c)(1).

Survey findings that include multiple deficiencies can indicate a systemic problem relating to the noncompliance, as opposed to a survey that identifies a singular or a few incident(s) of noncompliance. For surveys with greater than ***five*** deficiencies, add an amount between the ranges indicated below. The scope and severity of the deficiencies should also be considered. As the number of increases, and/or the level of S/S increases, the amount added should increase.

2.9.2 Input

Field	Input	Detailed Instructions
Multiple Deficiencies Amount Added	• Per Day - Add $100 • Per Day - Add $300 • Per Day - Add $500 • Per Day - Add $700 • Per Day - Add $900 • Per Day - Add $1100 • Per Day - Add $1300 • Per Day - Add $1500 • Per Instance - Add $2500 • Per Instance - Add $3000 • Per Instance - Add $3500 • Per Instance - Add $4000 • Per Instance - Add $4500 • Per Instance - Add $5000 • Per Instance - Add $5500 • Per Instance - Add $6000 • Per Instance - Add $6500 • Per Instance - Add $7000 • Per Instance - Add $7500 • Per Instance - Add $8000 • Per Instance - Add $8500 • Per Instance - Add $9000 • Per Instance - Add $9500 • Per Instance - Add $10000	Select the amount to add to the Calculated CMP Amount based on the guidance above.

2.10 "Is Facility Culpability a Factor?" Section

2.10.1 General Instructions

42 CFR §488.438(f)(4).

Add an amount indicated below if culpability is a factor above the base level of non-compliance. Culpability as defined in the regulation refers to situations which include, but are not limited to, neglect, indifference, or disregard for resident care, comfort or safety.

2.10.2 Input

Field	Input	Detailed Instructions
Base Culpability Amount Added	• S/S Level F at SQC - Add $205 • S/S Level F at SQC - Add $405 • S/S Level G, H, or I - Add $605 • S/S Level G, H, or I - Add $805 • S/S Level G, H, or I - Add $1005 • S/S Level G, H, or I - Add $1205 • S/S Level G, H, or I - Add $1405 • S/S Level G, H, or I - Add $1605 • S/S Level G, H, or I - Add $1805 • S/S Level G, H, or I - Add $2005 • S/S Level J, K, or L - Add $2505 • S/S Level J, K, or L - Add $2705 • S/S Level J, K, or L - Add $2905 • S/S Level J, K, or L - Add $3105 • S/S Level J, K, or L - Add $3305 • S/S Level J, K, or L - Add $3505 • S/S Level J, K, or L - Add $3705 • S/S Level J, K, or L - Add $3905 • S/S Level J, K, or L - Add $4105 • S/S Level J, K, or L - Add $4305 • S/S Level J, K, or L - Add $4505	Select the amount to add to the Calculated CMP Amount based on the highest S/S level cited.

2.11 "Does the Calculated CMP Amount Exceed the Maximum Regulatory Amount?" Section

2.11.1 Input

Field	Input	Detailed Instructions
Reduced Calculated CMP Amount	• Per Day - Calculated CMP Amount for IJ Case > $20965 - Reduce Calculated CMP Amount to $20965 • Per Day - Calculated CMP Amount for Non-IJ Case > $6289 - Reduce Calculated CMP Amount to $6289 • Per Day - Calculated CMP Amount for Non-IJ Case > $6289 and a repeat deficiency - No change • Per Instance - Calculated CMP Amount Exceeds $20965 - Reduce Calculated CMP Amount to $20965	Select the highest permissible CMP amount.

2.12 "Determine the Final Calculated CMP Amount" Section

2.12.1 General Instructions

The Final Calculated CMP is determined according to CMP Type:

- The lowest Calculated CMP Amount is determined: lowest of Calculated CMP Amount and Reduced Calculated CMP Amount (adjusted for exceeding the maximum regulatory amount).
- Final Calculated CMP Amount, Per Day: The lowest Calculated CMP Amount multiplied by the Total CMP days, less any Discount.
- Final Calculated CMP Amount, Per Instance: The lowest Calculated CMP Amount, less any Discount.

2.12.2 Input

Field	Input	Detailed Instructions
Discounts Applied to Final Calculated CMP Amount	• No Discount • Discount for Waiving Appeal (35%) • Discount for Self-reporting and Waiving Appeal (50%)	N/A

2.12.3 Output

Field	Description
Final Calculated CMP Amount	N/A

2.13 "Is An Additional Adjustment to the Final Calculated CMP Amount Necessary?" Section

2.13.1 General Instructions

The Final Calculated CMP Amount may be adjusted by no more than 35%. If an Adjusted Final Calculated CMP Amount is entered, provide a rationale below. If the RO believes that the Final Calculated CMP Amount should be adjusted by more than 35%, they must consult with and obtain prior approval from the CO before making any further adjustment using this tool.

Note: Any CMP that is projected to exceed $250,000 must be sent to CO for review prior to sending the imposition letter.

2.13.2 Input

Field	Input	Detailed Instructions
Adjusted Final Calculated CMP Amount	Number	Enter a dollar amount (no cents). Adjust the Final Calculated CMP Amount (which is the total amount for Per Instance or Per Day) and enter above. Note: The amount entered should reflect the total amount (not a Per Day amount).
Adjusted Final Calculated CMP Amount Rationale	• The amount of time between the noncompliance and the survey (do not select this if the delay was caused by the facility's failure to timely report to the SA) • The amount of time for the revisit survey if it exceeded the amount of time required by the SOM • Other	N/A

2.14 "Is the Facility Financial Condition a Factor?" Section

2.14.1 General Instructions

42 CFR §488.438(f)(2).

A facility is responsible for notifying CMS of hardship and providing financial documentation.

2.14.2 Input

Field	Input	Detailed Instructions
Lower Final Calculated CMP Amount	Number	Enter a dollar amount (no cents) in multiples of $50. Note: The amount entered should reflect the total amount (not a Per Day amount).
Lower Final Calculated CMP Amount Rationale	CMS reviewed the financial information and determined that facility documentation proves (select one): • A reduction is necessary. • A reduction is not necessary.	Select an option.

2.15 "Enter Any Additional Case-Related Information (Optional)" Section

2.15.1 Input

Field	Input	Detailed Instructions
Additional Information	Text	N/A

2.16 "View Totals" Section

2.16.1 Output

Field	Description
Calculated CMP Amount	The **Calculated CMP Amount** is the sum of **CMP Base Amount** and **Facility Noncompliance Amount, Repeated Deficiencies Amount , Multiple Deficiencies Amount**, and **Base Culpability Amount,** if any.
Reduced Calculated CMP Amount	The **Reduced Calculated CMP Amount** is the amount after the adjustment for exceeding the maximum regulatory amount, if any.
Total CMP Days	The **Total CMP Days** for Per Day is the total number of days from the **CMP Start Date** to the **CMP End Date.**
Discounts Applied to Final Calculated CMP Amount	The **Discounts Applied to Final Calculated CMP Amount** include one of the following options: No discount, 35% discount if waiving appeal, or 50% discount for self-reporting and waiving appeal.
Final Calculated CMP Amount	The **Final Calculated CMP Amount** for Per Day is the lowest **Calculated CMP Amount** multiplied by the **Total CMP Days**, less any **Discount**. Note: This is a total amount, not a Per Day amount. The **Final Calculated CMP Amount** for Per Instance is the lowest **Calculated CMP Amount**, less any Discount.
Adjusted Final Calculated CMP Amount	The **Adjusted Final Calculated CMP Amount** is the amount after the adjustment to the **Final Calculated CMP Amount**. Note: This is a total amount, not a Per Day amount.
Lower Final Calculated CMP Amount	The **Lower Final Calculated CMP Amount** is the amount after the adjustment for facility financial condition, if any. Note: This is a total amount, not a Per Day amount.
Total Final CMP Amount	The **Total Final CMP Amount** is the **Adjusted Final Calculated CMP Amount or Lower Final Calculated CMP Amount** if an adjustment was made, otherwise the **Final Calculated CMP Amount.**

2.17 "View Summary" Section

2.17.1 Input

Field	Detailed Instructions
Display Summary	Note: If changes are made to any of the fields above, display Summary again.
Begin a New Case	N/A

2.17.2 Output

Field	Output
Calculation Type	final *or* preliminary
CCN	*Provider Number*
Provider Name	*Provider Name*
Analyst Name	*Analyst Name*
Cycle Start Date	mm/dd/yyyy
Current Date	mm/dd/yyyy
CMP Type	Per Day *or* Per Instance
CMP Type Description	*As Selected (include the exact wording of the selection)*
CMP Per Instance Factors	*As Selected (include the exact wording of the selection)*
CMP Start Date	mm/dd/yyyy
CMP End Date	mm/dd/yyyy
Abated IJ	yes *if checked*
CMP Base Amount	*As Selected (include the exact wording of the selection)*
Facility Noncompliance Amount Added	*As Selected (include the exact wording of the selection)*
Repeated Deficiencies Amount Added	*As Selected (include the exact wording of the selection)*
Multiple Deficiencies Amount Added	*As Selected (include the exact wording of the selection)*
Base Culpability Amount Added	*As Selected (include the exact wording of the selection)*
Calculated CMP Amount	*Dollar Amount*
Reduced Calculated CMP Amount - Maximum Exceeded	*As Selected (include the exact wording of the selection)*
Discounts Applied to Final Calculated CMP Amount	*As Selected (include the exact wording of the selection)*
Total CMP Days	*Number of Days*
Final Calculated CMP Amount	*Dollar Amount*
Adjusted Final Calculated CMP Amount	*Dollar Amount*
Adjusted Final Calculated CMP Rationale	*As Selected (include the exact wording of the selection)*
Lower Final Calculated CMP Amount - Financial Condition	*Dollar Amount*
Lower Final Calculated CMP Amount Rationale	*As Selected (include the exact wording of the selection)*
Total Final CMP Amount	*Dollar Amount*

Field	Output
Additional Information	*As Completed*

3 Instructions

3.1 Instructions for Use and Completion of the Civil Money Penalty (CMP) Analytic Tool

All CMS Regional Offices (ROs) are required to use the following instructions and CMP Analytic Tool: (1) to choose the appropriate type or types of CMPs to be imposed; and (2) to calculate the CMP amount, when the RO determines that a CMP is an appropriate remedy to impose. The RO must complete all sections of the tool that apply to the type of CMP selected.

Consistent with CMS policy on immediate imposition of remedies, ROs must evaluate each case and consider whether or not to impose a CMP in addition to or instead of other remedies for deficiencies with a Scope and Severity (S/S) of "G" or above, and for deficiencies with a S/S of "F" when Substandard Quality of Care (SQC) is cited. For deficiencies cited at other S/S levels, the RO should consider imposing alternative remedies other than a CMP as appropriate.

For cases in which the State Survey Agency fails to recommend a CMP, the RO must evaluate whether or not a CMP remedy is warranted. In such cases, the RO must review the survey findings and impose the appropriate remedy(ies) regardless of a State's recommendation or lack thereof.

ROs must use this tool in the calculation of each new or changed[1] CMP imposed on a facility within a noncompliance cycle[2]. Each time a survey is conducted within an already running noncompliance cycle and a CMP is imposed, the facility is given appeal rights and may exercise its waiver of right to a hearing (refer to section 7526 of the State Operations Manual (SOM), Chapter 7).

This tool is not dispositive, and does not replace professional judgment or the application of other pertinent information in arriving at a final CMP amount. However, it does provide logic, structure, and defined factors for mandatory consideration in the determination of CMPs. The tool should be used with this protocol, which more fully explains factors that lead to final CMP amounts.

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[1] A CMP is changed when the circumstances initiating the original CMP imposed have changed and an increase or decrease to the original CMP may be warranted. For example, a facility has corrected some but not all of the original deficiencies and is still within its noncompliance cycle and the remaining deficiencies warrant an increase or decrease in the original CMP imposed. See section 7516.3 of the SOM.

[2] A noncompliance cycle begins with a recertification, complaint or temporary waiver revisit survey that finds noncompliance and ends when substantial compliance is achieved or the facility is terminated (or voluntarily terminates) from the Medicare and Medicaid programs. The noncompliance cycle cannot exceed 6 months. Once a remedy is imposed, it continues until the facility is in substantial compliance (and in some cases, until it can demonstrate that it can remain in substantial compliance), or is terminated from the programs.

Instructions

3.2 Choosing the Type of CMP to be Imposed

After making a determination that a CMP will be imposed, ROs must use the Tool and the guidance provided in the tool to decide whether to impose a Per Instance (PI) CMP versus a Per Day (PD) CMP, or both, regardless of the State Survey Agency's recommendation. Note: Multiple PIs may be imposed for different types or dates of noncompliance.

Factors to consider when determining "a good compliance history" include but are not limited to:

- The facility is not a Special Focus Facility;
- The facility has not had findings at a S/S of "G" or above within the past three (3) calendar years, unless they were cited as past noncompliance;
- The facility has a history/pattern of achieving compliance prior to or at the time of the first revisit; and/or
- The facility has a history/pattern of sustaining compliance with previously cited deficiencies (i.e., no repeat deficiencies).

3.3 Choosing the PD CMP Start Date

A PD CMP should begin either on the first day noncompliance at the cited S/S level is documented, or on the first day of the survey that noncompliance was identified. Per day CMPs should not begin before the start date of the survey unless:

- IJ (S/S of "J", "K", or "L") was cited with actual harm to a resident; or
- Abuse was cited at a level 3 (S/S of "G", H", "I"), or IJ (S/S of "J", "K", or "L") with actual harm to a resident
- The same tag at a S/S of "G" or above was cited within the last year on any survey and the tag is cited at a S/S of "J", "K", or "L" on the current survey; or
- Deficiencies at a S/S of "H" or "I" were cited.

If the facility can demonstrate that it corrected the noncompliance prior to the current survey, that is past noncompliance, and a per instance CMP should be used. If the team cannot document the first day of noncompliance, then the CMP should start on the date the noncompliance was observed and documented at the time of the current survey.

For example, a survey begins on May 1 and on that date the survey team finds evidence of immediate jeopardy, that resulted in a resident suffering a fractured hip. If the survey team is able to document that the immediate jeopardy began on April 1, the PD CMP start date is April 1. However, if the survey team is unable to document the first day of noncompliance at the immediate jeopardy level, the CMP would start on May 1.

3.4 Guidance on Determining the Dates of a PD CMP

PD CMP Start Date[3] - In all cases where this tool requires a PD CMP be imposed before the start date of the survey, the RO analyst shall calculate the start date for the proposed CMP with the first supportable date of noncompliance, as determined by the evidence documented by surveyors in the Statement of Deficiencies (CMS form 2567).

Therefore, in performing the survey and when making a recommendation for a PD CMP to CMS, the State Survey Agency must determine the earliest date for which supportable evidence shows that the noncompliant practice began.

If this start date is not clearly identified and supportable, then the RO should contact the State Survey Agency to see if such a date can be determined and should document this discussion and conclusion. If the start date cannot be determined, the PD CMP would begin on the first day during the survey on which the survey team identified the noncompliant practice.

PD CMP End Date - Except in cases when IJ is removed on the same date that it was identified, do not include the day on which IJ is removed, the day the S/S is lowered, thereby lowering the CMP amount to another level or substantial compliance is achieved when calculating the final PD CMP. See 42 C.F.R. §488.440(h), penalties accrue until the date of correction. The RO analyst will input the resulting number of days into the CMP Analytic Tool.

3.5 CMPs for Past Noncompliance

Past noncompliance identified during the current survey means a deficiency citation at a specific survey data tag (F-tag or K-tag) (with a S/S at "G" or above, or SQC findings at a S/S at "F") that meets **all** of the following three criteria:

1. The facility was not in compliance with the specific regulatory requirement(s) (as referenced by the specific F-tag or K-tag) at the time the situation occurred;
2. The noncompliance occurred after the exit date of the last standard (recertification) survey and before the survey (standard, complaint, or revisit) currently being conducted; and
3. There is sufficient evidence to determine that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement(s), as referenced by the specific F-tag or K-tag.

See the State Operations Manual, Chapter 7, Section 7510.1 for additional information.

[3] A CMP may not include days prior to the date of the last standard survey.

3.6 Required Central Office Prior Approval for Any Adjustment to Final Calculated CMP Amount of More than Thirty-five Percent (35%)

If the RO believes that the circumstances involved in the specific case require an adjustment to the CMP amount which was calculated using this Tool, the RO may increase or reduce the CMP by NO MORE THAN 35 percent**. If the RO makes such an adjustment, in each instance, it must provide a rationale for that adjustment when completing the tool.** An adjustment to the CMP is not the same thing as imposing a different CMP based on different or new deficiencies. Whenever such an adjustment is made, the analyst will annotate the tool when calculating the original CMP to explain why an adjustment was made. For a newly imposed or revised CMP within the same noncompliance cycle, a separate tool is to be completed.

NOTE: If the RO believes that a calculated CMP should be adjusted by **more** than 35 percent, it must consult with and obtain prior approval from CMS Central Office before making the adjustment. Requests for prior approval should be sent to the CMS Central Office. Any CMP of $250K must be sent to CMS Central Office for review prior to sending the imposition letter.

A 35 percent adjustment that the RO may make is not the same as, and does not affect, the 35 or 50 percent reductions made to the total CMP amount based on §§488.436 and 488.438. The facility will receive a 35 percent reduction if it timely waives its right to an Administrative Hearing. The facility should be notified that it will receive a 50 percent reduction if **all** of the following conditions are met:

- The facility must have self-reported the noncompliance to CMS or the State before it was identified by CMS or the State and before it was reported to CMS or the State by means of a complaint lodged by a person other than an official representative of the nursing home;
- Correction of the noncompliance must have occurred on the earlier of either 15 calendar days from the date of the self-reported circumstance or incident that later resulted in a finding of noncompliance or 10 calendar days from the date (of CMS' notice to the facility) that a CMP was imposed;
- The facility waives its right to a hearing;
- The noncompliance that was self-reported and corrected did not constitute a pattern of harm, widespread harm, immediate jeopardy, or result in the death of a resident;
- The CMP was not imposed for a repeated deficiency that was the basis of a CMP that previously received a reduction; and
- The facility has met mandatory reporting requirements for the incident or circumstance upon which the CMP is based as required by Federal and State law.

If you have any questions regarding the memorandum, Tool or guidance, please contact the CMS Central Office.

Effective Date: Immediately for all enforcement cases when the CMS RO determines that a CMP is an appropriate enforcement remedy. This guidance should be communicated to all RO and State Survey Agency survey, certification and enforcement staff, their managers and the State/RO training coordinators within 30 days of this memorandum.

3.7 For Training and General Examples ONLY[4]

The following information provides some examples of situations in which the Departmental Appeals Board (DAB)[5] and/or the DAB Administrative Law Judges (ALJs) determined that there was **facility culpability**. The DAB and ALJ decisions cited below were issued before the 2016 update to the federal regulations, so the regulatory references listed below are those that existed at the time those decisions were issued.

Physical Environment: 42 C.F.R. §483.70

1. Life Safety Code (LSC) and/or maintenance issues considered detrimental to the health, safety and welfare of the residents. DAB CR3000

Quality of Care: 42 C.F.R. §483.25

1. Repeated failure to timely follow or clarify doctor's treatment orders (including for pressure sores). DAB 2390 and 2299
2. Repeated failure to notify doctor of significant changes. DAB 2479 and 2304
3. Repeated failure to notify physician of change which exposed resident to high likelihood of suffering grave harm. DAB 2304 and 2300
4. Repeated failure to properly assess pressure sores. DAB 2426
5. Multiple residents with severe weight loss (> 5% in a month) not detected or addressed despite care plan. DAB 2511
6. Repeated failure to timely provide testing, care, treatment & services for residents receiving anticoagulant therapy. DAB 2411
7. Repeated failure to closely monitor resident with compromised respiratory status, or failure to have necessary oxygen equipment. DAB, 2511, 2344, 2327, and 2299
8. Failure to administer CPR to "full code" resident. DAB 2396 and 2336
9. Repeated failure to implement interventions and supervise to prevent falls for resident with history of falls. DAB 2470, 2380, and 2357
10. Repeated failure to adequately supervise resident with known choking problems to provide prompt intervention. DAB 2520 and 2192
11. Repeated failure to provide blood sugar monitoring and care as ordered as ordered by physician. DAB 2375
12. Repeated failure to supervise residents with known history of elopement. DAB 2450, 2446, 2434, and 2288
13. Repeated transfer of residents by one aide despite care plan requiring two aides for transfer. DAB CR1863

[4] Note this information is provided only by way of providing some examples in which the DAB found culpability in the past.
[5] DAB website

Instructions

Resident Behavior and Facility Practices: 42 C.F.R. §483.13

1. Staff failure to promptly report physical, verbal or sexual abuse. DAB 2256

Quality of Life: 42 C.F.R. §483.15

1. Egregious dignity issues. DAB 2513

Analysis
As of: Jun 29, 2017

MARY E. DALEY, personal representative,[1] *vs.* SECRETARY OF THE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES & another.[2] LIONEL C. NADEAU *vs.* DIRECTOR OF THE OFFICE OF MEDICAID.

1 Of the estate of James Daley.
2 Director of the Office of Medicaid.

SJC-12200, SJC-12205.

SUPREME JUDICIAL COURT OF MASSACHUSETTS

477 Mass. 188*; *74 N.E.3d 1269*; *2017 Mass. LEXIS 365

January 5, 2017, Argued
May 30, 2017, Decided

NOTICE:

Corrected June 8, 2017.

PRIOR-HISTORY: Worcester. CIVIL ACTION commenced in the Superior Court Department on February 11, 2015.

The case was heard by *Dennis J. Curran*, J., on a motion for judgment on the pleadings.

The Supreme Judicial Court granted an application for direct appellate review.

Civil action commenced in the Superior Court Department on December 23, 2014.

The case was heard by *Shannon Frison*, J., on a motion for judgment on the pleadings.

The Supreme Judicial Court on its own initiative transferred the case from the Appeals Court.
Daley v. Sudders, 2015 Mass. Super. LEXIS 125 (Mass. Super. Ct., Dec. 23, 2015)

HEADNOTES-1 *Medicaid. Trust*, Irrevocable trust. *Real Property*, Life estate, Ownership.

This court concluded that neither the grant in an irrevocable trust of a right of use and occupancy in a primary residence deeded to that trust, nor the retention of a life estate in a primary residence after deeding it to such a trust, makes the equity in the home owned by the trust a countable asset for the purpose of determining an applicant's eligibility for long-term care benefits under the Federal Medicaid Act; therefore, this court vacated the judgments in two cases that relied on a finding that the home was a countable asset but remanded each matter for further findings regarding other possible sources of countable assets contained in the trust at issue in each matter.

COUNSEL: *Lisa Neeley* (*Patrick Tinsley* also present) for Lionel C. Nadeau.

Brian E. Barreira (*Nicholas G. Kaltsas* also present) for Mary E. Daley.

Ronald M. Landsman, of Maryland, for National Academy of Elder Law Attorneys, Inc.

Elizabeth Kaplan & Julie E. Green, Assistant Attorneys General, for Director of the Office of Medicaid & another.

Patricia Keane Martin, for National Academy of Elder Law Attorneys (Massachusetts Chapter), was present but did not argue.

Leo J. Cushing & Thomas J. McIntyre, for Real Estate Bar Association for Massachusetts, Inc., amicus curiae, submitted a brief.

JUDGES: Present: GANTS, C.J., LENK, HINES, GAZIANO, LOWY, & BUDD, JJ.

OPINION BY: GANTS

OPINION

GANTS, C.J. These two cases require this court to navigate the labyrinth of controlling statutes and regulations to determine whether applicants are eligible for long-term care benefits under the Federal Medicaid Act (act) where they created an irrevocable trust and deeded their primary asset -- their home -- to that trust but retained the right to reside in and enjoy the use of the home for the rest of their life. The Director of the Massachusetts Office of Medicaid (MassHealth) determined that the applicants in these two cases were not eligible for long-term care benefits because their retention of a right to continue to live in their homes made the equity in their homes a "countable" asset whose value exceeded the asset eligibility limitation under the act. The applicants unsuccessfully challenged MassHealth's determinations in the Superior Court pursuant to *G. L. c. 30A, § 14*. We granted Mary E. Daley's application for direct appellate review and transferred Lionel C. Nadeau's appeal to this court on our own motion. We conclude that neither the grant in an irrevocable trust of a right of use and occupancy in a primary residence to an applicant nor the retention by an applicant of a life estate in his or her primary residence makes the equity in the home owned by the trust a countable asset for the purpose of determining Medicaid eligibility for long-term care benefits. We therefore vacate the judgments that rely on such a finding and remand the matters to MassHealth for findings regarding two other possible sources of countable assets contained in the trusts.[3]

3 We acknowledge the amicus brief submitted by the National Academy of Elder Law Attorneys, Inc., in both cases; the amicus brief submitted by the Real Estate Bar Association for Massachusetts, Inc., in Mary E. Daley's case; and the amicus brief submitted by the National Academy of Elder Law Attorneys (Massachusetts Chapter) in Lionel C. Nadeau's case.

Background. The act, enacted in 1965 as Title XIX of the Social Security Act, *42 U.S.C. §§ 1396 et seq.*, created a cooperative State and Federal program to provide medical assistance to individuals who cannot afford to pay for their own medical costs. See *Arkansas Dep't of Health & Human Servs. v. Ahlborn, 547 U.S. 268, 275, 126 S. Ct. 1752, 164 L. Ed. 2d 459 (2006)*. The general administration of Medic- aid is entrusted to the United States Secretary of Health and Human Services, who in turn exercises authority through the Centers for Medicare and Medicaid Services (CMS). *Id.*[4] Although the Medicaid program is voluntary for States, participating States must comply with certain requirements imposed by the act and regulations promulgated by the Secretary through CMS. See *Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498, 502, 110 S. Ct. 2510, 110 L. Ed. 2d 455 (1990)*. Massachusetts has opted to participate in Medicaid via the establishment of a State Medicaid program known as MassHealth. See *G. L. c. 118E, § 9* (establishing program of medical assistance "pursuant to and in conformity with the provisions of Title XIX").

4 Until 2001, the Centers for Medicare and Medicaid Services were known as the Health Care Financing Administration. See *Centers for Medicare & Medicaid Services Statement of Organization, Functions and Delegations of Authority, and Reorganization Order, 66 Fed. Reg. 35,437-03 (2001)*.

Participating States are required to cover the costs of care for the "categorically needy," which the act defines as those individuals who are unable to cover the costs of

their basic needs and who already receive or are eligible for certain forms of public assistance. See *Roach v. Morse, 440 F.3d 53, 59 (2d Cir. 2006)*. States have the option to cover the costs of care for the "medically needy," *Haley v. Commissioner of Pub. Welfare, 394 Mass. 466, 467-468, 476 N.E.2d 572 (1985)*, which the act defines as people who have income and resources to cover the costs of their basic needs but not their necessary medical care. See *42 U.S.C. § 1396a(a)(10)(C)*.

Medicaid has become one of the largest programs in the Federal budget as well as a major expenditure for State governments, which must finance a significant portion of Medicaid benefits on their own. See R. Rudowitz, Kaiser Commission on Medicaid and the Uninsured, Medicaid Financing: The Basics (Dec. 2016) (Medicaid is third largest domestic program in Federal budget, exceeded only by Medicare and Social Security); Massachusetts Medicaid Policy Institute & Massachusetts Budget and Policy Center, Understanding the Actual Cost of MassHealth to the State (Nov. 2014) (reporting net cost of MassHealth and health reform programs as twenty-three per cent of State budget). As of 2015, the Medicaid program provided health and long-term care coverage to nearly 70 million low-income Americans, including, among many others, poor senior citizens who are also covered by Medicare. See Kaiser Family Foundation, Medicaid at 50 (2015), http://kff.org/medicaid/report/medicaid- at-50 [https://perma.cc/TK7Q-72KR].

The demand for Medicaid long-term care benefits, which cover nursing home care as well as other forms of personal long-term care services, has grown steadily as a result of our country's aging population and the expense of paying privately for nursing homes or other long-term care. See *Cohen v. Commissioner of the Div. of Med. Assistance, 423 Mass. 399, 402, 668 N.E.2d 769 (1996)*, cert. denied sub nom. *Kokoska v. Bullen, 519 U.S. 1057, 117 S. Ct. 687, 136 L. Ed. 2d 611 (1997)*. See also Bernstein, With Medicaid, Long-Term Care of Elderly Looms as a Rising Cost, N.Y. Times, Sep. 6, 2012, http://www.nytimes.com/2012/09/07/health /policy/long-term-care-looms-as-rising-m edicaid-cost.html [https://perma.cc/2JB6-L6NM] (describing Medicaid as "the only safety net for millions of middle-class people whose needs for long-term care, at home or in a nursing home, outlast their resources"). A recent survey estimated that the median annual cost of nursing home care for a senior in a semiprivate room in Massachusetts was more than $128,000. See Genworth 2015 Cost of Care Survey, Massachusetts, https://www.genworth.com/dam/Americas/US /PDFs/Consumer/corporate/cost-of-care/11 8928MA_040115_gnw.pdf [https://perma.cc/2RNC-6P5G]. Private long-term care insurance can cost more than $3,000 annually. See AARP, Understanding Long-Term Care Insurance (May 2016), http://www.aarp.org/health/health-insura nce/info-06-2012/understanding-long-term -care-insurance.html [https://perma.cc/56MK-DYZ2]. Because many individuals cannot afford these expenses, Medicaid pays for the care of two-thirds of people in nursing homes in the United States. See Zernike, Goodnough, & Belluck, In Health Bill's Defeat, Medicaid Comes of Age, N.Y. Times, Mar. 27, 2017. See also E.L. Reaves & M. Musumeci, Kaiser Commission on Medicaid and the Uninsured, Medicaid and Long-Term Services and Supports: A Primer (Dec. 2015), http://kff.org/medicaid/report/medicaid- and-long-term-services-and-supports-a-pr imer [https://perma.cc/KJZ5-5WJR]. The cost of Medicaid's long-term care benefit is expected to rise by fifty per cent over the next decade, and State and Federal officials are reportedly "scrambling to control spending." Gorman & Feder Ostrov, Long-Term Care Is an Immediate Problem -- For the Government, Kaiser Health News, Aug. 1, 2016, http://khn.org/news/long-term-care-is-an -immediate-problem-for-the-government [https://perma.cc/N9V9-5QKE].

In order to qualify for Medicaid in Massachusetts, MassHealth requires that "[t]he total value of countable assets owned by or available to" an individual applicant not exceed $2,000. *130 Code Mass. Regs. § 520.003(A)(1)* (2014).[5] For a couple living together, the limit is $3,000. *130 Code Mass. Regs. § 520.003(A)(2)* (2014). This asset limit often requires applicants to "spend down" or otherwise deplete their resources to qualify for Medicaid long-term care benefits when they enter a nursing home. See *Lebow v. Commissioner of the Div. of Med. Assistance, 433 Mass. 171, 172, 740 N.E.2d 978 (2001)*.[6]

5 This asset limit is not codified in Title XIX of the Social Security Act, *42 U.S.C. §§ 1396 et seq.* Instead, Federal law and guidance from Federal regulators generally instruct the State Medicaid programs that their treatment of applicants' resources in determining eligibility may not be

more restrictive than the methodology that would be employed under the Federal supplemental security income (SSI) program. See *42 U.S.C. § 1396a(a)(10)(C)(i)*; State Medicaid Manual, Health Care Financing Administration Pub. No. 45-3, Transmittal 64 § 3257.B.4 (Nov. 1994). But see *Mistrick v. Division of Med. Assistance & Health Servs., 154 N.J. 158, 174-175, 712 A.2d 188 (1998)* (specific Congressional legislation regarding Medicaid eligibility supersedes general rule that State Medicaid eligibility rules may be "no more restrictive" than SSI). The asset limit for SSI beneficiaries is $2,000. See *42 U.S.C. § 1382(a)*.

6 As we discuss later in this opinion, an applicant's principal residence is generally not considered to be a countable asset in the eligibility determination and thus an applicant does not have to sell his or her home in order to qualify for Medicaid long-term care benefits. See *20 C.F.R. § 416.1212(b)*; *130 Code Mass. Regs. §§ 520.007(G)(3), 520.008(A)* (2014).

Through "Medicaid planning," individuals attempt to transfer or otherwise dispose of their assets long before they need long-term care so that, when the need arises, they may satisfy the asset limit and qualify for Medicaid benefits. In essence, the purpose of Medicaid planning is to enable persons whose assets would otherwise render them ineligible for long-term care benefits to become eligible for Medicaid benefits by transferring to their children or other loved ones the assets they would otherwise use to pay for long-term care, shifting to the taxpayers the burden of paying for that care. See generally *Cohen, 423 Mass. at 402-403*. As a report of the House of Representatives's committee on energy and commerce declared in 1985, "When affluent individuals use Medicaid qualifying trusts and similar 'techniques' to qualify for the program, they are diverting scarce Federal and State resources from low-income elderly and disabled individuals, and poor women and children." H.R. Rep. No. 265, 99th Cong., 1st Sess., pt. 1, at 72 (1985), quoted in *Cohen, supra at 404*.

Congress has imposed two substantial constraints on such Medicaid planning. The first is the so-called "look-back" rule, which imposes a penalty for any asset transfer for less than fair market value made by an individual within five years of the individual's application for Medicaid benefits. See *42 U.S.C. § 1396p(c)(1)(B)(i)*. See generally D. Westfall, G.P. Mair, J.R. Buckles, N.M. Oliveira, & W. Murieko, Estate Planning Law & Taxation § 13.05 (2017) (Westfall). In its present form, the "look-back" rule provides that, if such a transfer occurs, the applicant is ineligible for Medicaid benefits for a period of time determined by dividing the value of the transfer by the average monthly cost of the nursing home facility. See *42 U.S.C. § 1396p(c)(1)(E)*. Thus, if an applicant transfers $100,000 in assets during the look-back period, in a State where the average monthly cost of a nursing home is $10,000, the applicant will be ineligible for Medicaid benefits for ten months. See Westfall, *supra*.

Second, where an applicant has created an irrevocable trust and transferred assets to that trust, "if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income (I) to or for the benefit of the individual, shall be considered income of the individual, and (II) for any other purpose, shall be considered a transfer of assets by the individual." *42 U.S.C. § 1396p(d)(3)(B)(i)*. This is commonly referred to as the "any circumstances" test. See *Heyn v. Director of the Office of Medicaid, 89 Mass. App. Ct. 312, 315, 48 N.E.3d 480 & n.7 (2016)*.[7] The effect of the test is that if the trustee is afforded even a "peppercorn of discretion" to make payment of principal to the applicant, or if the trust allows such payment based on certain conditions, then the entire amount that the applicant could receive under "any state of affairs" is the amount counted for Medicaid eligibility. See *Cohen, 423 Mass. at 413*.[8]

7 The cognate Massachusetts regulation states: "Any portion of the principal or income from the principal (such as interest) of an irrevocable trust that could be paid under any circumstances to or for the benefit of the individual is a countable asset." *130 Code Mass. Regs. § 520.023(C)(1)(a)* (2014).

8 To illustrate the operation of this rule, Federal regulators provide the example of a trust containing $50,000 in principal under which payment of principal may be made to the Medicaid applicant only in the event that the applicant requires a heart transplant. Because it is

possible the applicant could require a heart transplant, "this full amount is considered as payment that could be made under *some* circumstances, even though the likelihood of payment is remote." See State Medicaid Manual, Health Care Financing Administration Pub. No. 45-3, Transmittal 64 § 3259.6(E) (Nov. 1994).

Under the "any circumstances" test, where the grantor of the irrevocable trust gives the trustee any "leeway to respond to emergency and unexpected circumstances," the total amount available to be paid to address such circumstances is counted as fully available to the grantor, even if the trust provisions otherwise limit the trustee's discretion to pay for long-term care. See *id. at 418-420*. Consequently, where the terms of an irrevocable trust give the trustee discretion to pay both income and principal to the grantor for various purposes, but limit that discretion in an attempt to assure the grantor's eligibility for public assistance despite the considerable resources otherwise available to the grantor, the full amount of the trust, both principal and income, is the amount deemed available for purposes of determining Medicaid eligibility. *Id. at 421-422*.

The "any circumstances" test is qualified by an important caveat: if the amounts that may be paid to the Medicaid applicant come only from the income of the trust, those income payments do not render the principal of the trust available as an asset; rather, they are treated as income that may affect the *amount* of Medicaid benefits to be received but not the applicant's *eligibility* for such benefits. See *Guerriero v. Commissioner of the Div. of Med. Assistance, 433 Mass. 628, 632 n.6, 745 N.E.2d 324 (2001)*; *130 Code Mass. Regs. § 520.026* (2013). See also J.A. Bloom & S.M. Cohen, Nursing Home MassHealth Eligibility, in Estate Planning for the Aging or Incapacitated Client in Massachusetts § 26.3.2 (Mass. Cont. Legal Educ. 4th ed. 2012 & Supp. 2015) (explaining general rule that anyone whose income is less than monthly cost of his or her nursing home may be eligible for MassHealth).

The application of this labyrinth of statutes and regulations is best understood by examples. If a married couple without any savings forgoes Medicaid planning and continues jointly to own in fee simple a single family home, then when one spouse needs long-term care and applies for MassHealth benefits, the applicant's primary residence is *not* a countable asset for MassHealth eligibility purposes, so long as its value does not exceed an annually adjusted limit (currently $828,000). See *130 Code Mass. Regs. § 520.008(A)* (2013); *130 Code Mass. Regs. § 520.007(G)(3)* (2014). See also *20 C.F.R. § 416.1212(b)* (SSI regulation).[9] Thus, the spouse may be admitted to a nursing home and be covered by MassHealth without having to sell the home. However, Federal law requires that MassHealth must attempt to reclaim the costs of long-term care benefits provided to such an applicant from the applicant's estate after his or her death. *42 U.S.C. § 1396p(a), (b)*. See *130 Code Mass. Regs. § 515.011(A)* (2014). As a result, where the house is the only asset in the applicant's estate and is sold by the estate after both spouses have died, the children will be able to inherit only the proceeds of the sale that exceed the amount of the MassHealth recovery claim.

9 If the applicant's spouse, child under the age of twenty-one, disabled child, or caretaker child, among others, remains living in the home, the value of the home will not be counted even if it exceeds the limit. *130 Code Mass. Regs. § 520.007(G)(8)(b)* (2013).

If a married couple who owns no primary residence but has substantial liquid assets engages in Medicaid planning, they could create an irrevocable trust and transfer all of their assets to that trust. If, under the terms of the trust, the trustee were authorized to pay them only income from the trust and could not under any circumstance pay them a penny of principal, and if the transfer to the trust complied with the "look-back" rule because it occurred more than five years before either spouse applied to MassHealth for long-term care benefits, the applicant would be eligible for such benefits because the assets of the trust would not be countable as his or her assets. See *Cohen, 423 Mass. at 419-420* (where trust is written to deprive trustee of any discretion to pay principal and allows payment only of income, principal will not be counted as assets for Medicaid purposes); *Heyn, 89 Mass. App. Ct. at 314* (where properly structured, irrevocable trust may be used to place assets beyond grantor's reach and permit grantor to be eligible for Medicaid benefits).

In essence, a wealthy person may decide five years in advance of applying for Medicaid to either give away all of his or her assets to the children or transfer them to an irrevocable trust with the children as beneficiaries, reserving only the receipt of income, and therefore

become someone with less than $2,000 in assets who is eligible for Medicaid benefits. The inclusion of the primary residence among the assets transferred to the irrevocable trust allows the grantor to avoid the estate recovery claim against his or her primary residence that would occur had the grantor obtained Medicaid long-term care benefits and continued to own the home until it was transferred to his or her heirs as part of the probate estate.

Although the transfer of assets to an irrevocable trust through Medicaid planning offers substantial benefits to the grantor, it also poses considerable risks. Having been stripped of all assets, the grantor may be unable to pay unforeseen nonmedical expenses, and may need to look to children or other relatives for payment. If the grantor were to require nursing home care sooner than expected, he or she would face a significant penalty under the look-back rule. See A.K. Dayton, J.A. Garber, R.A. Mead, & M.M. Wood, Advising the Elderly Client § 29.82 (2016) ("planning only for Medicaid eligibility severely restricts planning options for other goals, and often the adverse impact of Medicaid planning outweighs the benefit if the client is advised thoroughly ... [and] consideration should be given to ... possible loss of autonomy, pride, and dignity" involved in process). If the grantor of the irrevocable trust leaves open even a "peppercorn" of discretion for the trustee to pay the grantor from the principal of the trust under any circumstance, the entire principal of the trust will be deemed available to the applicant and therefore will be treated as a "countable asset," making the applicant ineligible for Medicaid benefits. Where the grantor transfers his or her primary residence to the irrevocable trust, the value of the home, which would not be a countable asset if he or she were to continue to own it (provided its value does not exceed $828,000), would become a countable asset if it were found to be among the "resources available to the individual" under *42 U.S.C. § 1396p(d)(3)*. And if the terms of the trust were to bar the trustee from paying the grantor's nursing home expenses, the grantor might have no ability to pay for long-term care.

The risks of Medicaid planning are highlighted by these two cases, where the plaintiffs challenge the determinations by MassHealth that their primary residence was a countable asset that rendered them ineligible to receive Medicaid long-term care benefits because they had transferred ownership of the home to an irrevocable trust but retained the ability to reside in their home for the balance of their life. A key difference between these two cases is the property interest that was transferred to the irrevocable trust: in one, the home was transferred in fee simple but the terms of the trust granted the settlors the right of use and occupancy for their lifetimes; in the other, the settlors retained a life estate in the home and transferred only the remainder interest to the irrevocable trust. We look now to the terms of the irrevocable trust at issue in each case and to the MassHealth determinations.

Nadeau Trust. On March 27, 2001, plaintiff Lionel C. Nadeau and his wife (collectively, Nadeaus) deeded their primary resi- dence in Webster to an irrevocable trust (Nadeau Trust) in return for nominal consideration, naming their daughter as sole trustee. Under the terms of the trust, the trustee may pay to the Nadeaus, or on their behalf, whatever income she determines in her sole discretion to be necessary for their "care and well-being." The trustee, apart from two exceptions, must hold the principal until the termination of the trust, which shall occur upon the death of the Nadeaus or when the trustee, in her sole discretion, determines that the trust should be terminated. The first exception is that the Nadeaus may appoint "all or any part of the trust property then on hand to any one or more charitable or non-profit organizations over which [they] have no controlling interest." The second is that the trustee may distribute principal to the Nadeaus "to the extent that the income of the trust generates a tax liability" so that they may pay that tax liability. As earlier mentioned, the terms of the trust grant the Nadeaus "the right to use and occupy any residence that may from time to time be held" by the trust. Upon termination of the trust, the "trustee shall ... [p]ay the remaining principal and undistributed income in equal shares to [the Nadeaus'] children."

Thirteen years later, and after the passing of his wife, Nadeau was admitted to a skilled nursing facility and applied for MassHealth long-term care benefits. At the time, the assessed value of the residence held by the Nadeau Trust was $173,700, and Nadeau, then eighty-nine years old, had only $168.15 in cash assets. MassHealth denied Nadeau's application based on its finding that the home remained a "countable asset," placing Nadeau above the $2,000 asset limit for long-term care eligibility. MassHealth determined that he needed to spend down $171,868.15 of his assets in order to qualify for the requested benefits.

Daley Trust. On December 19, 2007, Mary E. Daley and her husband (collectively, Daleys) deeded their primary residence in Worcester to their children as trustees of an irrevocable trust (Daley Trust) in return for consideration of less than one hundred dollars, but retained a life estate in the property. Under the terms of the trust, the trustees are to pay to Daley or her husband "so much of the net income of the Trust as either Donor shall request in writing," but "[t]he Trustee[s] shall have no authority or discretion to distribute principal of the Trust to or for the benefit of either Donor." However, as with the Nadeau Trust, the trustee may pay principal as needed to satisfy any tax obligation arising from the payment of income to the Daleys.

Six years later, Daley's husband was admitted to a skilled nursing home; he applied for MassHealth long-term care benefits on February 21, 2014. At the time, he was eighty-seven years old, he had $18,176 in a bank account, and the principal of the Daley Trust had a value of $150,943. Daley was still living in the home. MassHealth denied her husband's application because it found that the trust principal was countable. While Daley was permitted a spousal resource allowance of $117,240, the value of the residence still placed her husband about $50,000 over the $2,000 eligibility limit.

In both cases, the MassHealth determination was appealed to a MassHealth hearing officer, who upheld the determination by finding that, because the applicant retained the ability to reside in the home, the home is "available" to the applicant and must be deemed a countable asset under *130 Code Mass. Regs. § 520.023(C)(1)(d)*, which provides:

> "The home or former home of a nursing-facility resident or spouse held in an irrevocable trust that is available according to the terms of the trust is a countable asset. Where the home or former home is an asset of the trust, it is not subject to the exemptions of *130 [Code Mass. Regs. §] 520.007(G)(2)* or *(G)(8)*."[10]

The hearing officers also found that the provision in the trusts that permit the trustee to pay the grantors' tax obligations arising from the payment of trust income does not render the *entirety* of the trust principal available under the "any circumstances" test. They specifically did not reach the issue of *how much* of the principal could be paid in that circumstance and therefore become countable, declaring that, if eligibility were to rest on that determina- tion, the matter would have to be remanded to MassHealth to make such findings.

> 10 The exemptions in these two provisions apply only to "real estate owned by the individual and the spouse." *130 Code Mass. Regs. § 520.007(G)(1)*. Under *130 Code Mass. Regs. § 520.007(G)(2)*, the value of real estate is exempt as a countable asset for nine months after the date of notice by MassHealth provided that the applicant executes an agreement within thirty days of the date of notice to sell the property at fair market value. Under *130 Code Mass. Regs. § 520.007(G)(8)*, where an applicant moves out of his or her home with no intent to return in order to enter a medical institution where placement is expected to continue for at least thirty days, the home becomes a countable asset unless a spouse, a child who is less than twenty-one years of age, a child who is blind or permanently and totally disabled, or other designated relatives reside in the home.

Discussion. The Medicaid program in Massachusetts was established "pursuant to and in conformity with the provisions of" the act. *G. L. c. 118E, § 9.* If a person meets the Federal financial eligibility requirements for Medicaid, MassHealth may not deny the person long-term care benefits. *Id.* ("[P]rovided that such persons meet the financial eligibility requirements of [the act], ... long-term care services shall be available to otherwise eligible persons whose income and resources are insufficient to meet the costs of their medical care as determined by the financial eligibility requirements of the program"). See *Cruz v. Commissioner of Pub. Welfare, 395 Mass. 107, 113, 478 N.E.2d 1262 (1985)* ("The language of this section clearly indicates that the Legislature intended the [Medicaid] benefits program to comply with the Federal statutory and regulatory scheme" [citation omitted]). "When there is a conflict between State and Federal regulations, the Legislature intended that [MassHealth] comply with the Federal rule." *Cruz, supra.*

Under Federal law, "[f]or purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under [the act] ... , the rules specified in

paragraph (3) shall apply to a trust established by such an individual." *42 U.S.C. § 1396p(d)(1)*. "[T]he rules specified in paragraph (3)" provide that "if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual." *42 U.S.C. § 1396p(d)(3)*. Therefore, the issue we must decide is whether *130 Code Mass. Regs. § 520.023(C)(1)(d)*, which MassHealth interprets to mean that the equity in a home that is part of the corpus of an irrevocable trust is a countable asset where the grantor of the trust retains the authority to reside in or otherwise enjoy the use of the home, is consistent with *42 U.S.C. § 1396p(d)(3)*.

The plaintiffs contend that *§ 1396p(d)(3)* makes an asset in the corpus of an irrevocable trust countable only where there are circumstances in which principal from the trust might be paid to them or for their benefit. They contend that, because they can only reside in the home but not reach any of the equity in the home under the trust, the equity should not be countable as an asset because it may not be paid to them. MassHealth argues that interpretive guidance from the Health Care Financing Adminis- tration (HCFA)[11] in its State Medicaid Manual (Manual), which provides instruction to State officials in applying the provisions of Federal Medicaid law, indicates that a right to use and occupancy can be a form of "payment" to a Medicaid applicant. Transmittal 64, issued in November, 1994, includes a section entitled "Treatment of Trusts," which states:

> "For purposes of this section a payment from a trust is a disbursal from the corpus of the trust or from income generated by the trust which benefits the party receiving it. A payment may include actual cash, as well as noncash or property disbursements, such as the right to use and occupy real property."

State Medicaid Manual, HCFA Pub. No. 45-3, Transmittal 64 § 3259.1.A.8 (Nov. 1994).

11 See note 4, *supra*.

The Manual is comprised of the various transmittals issued by HCFA and, later, by CMS. The transmittals contained in the Manual do not carry the force of regulations and are not entitled to the deference that we give to regulations that reflect an agency's interpretation of a statute it is obliged to enforce. See *Chevron, U.S.A., Inc. v. Natural Resources Defense Counsel, Inc., 467 U.S. 837, 845 (1984)*; *Springfield v. Department of Telecomm. & Cable, 457 Mass. 562, 567-568, 931 N.E.2d 942 (2010)*. However, we consider such guidance carefully for its persuasive power. See *Wos v. E.M.A. ex rel. Johnson, 568 U.S. 627, 133 S. Ct. 1391, 1402, 185 L. Ed. 2d 471 (2013)* (interpretations contained in policy statements, agency manuals, and enforcement guidelines lack force of regulations and "do not warrant *Chevron*-style deference," but are "'entitled to respect' in proportion to their 'power to persuade'" [citations omitted]); *Atlanticare Med. Ctr. v. Commissioner of the Div. of Med. Assistance, 439 Mass. 1, 9, 785 N.E.2d 346 & n.12 (2003)*.

We conclude that HCFA Transmittal 64 accurately interprets the meaning of "payment from the trust" in *42 U.S.C. § 1396p(d)(3)*. We also conclude that MassHealth has misinterpreted the meaning of these words in both the statute and the transmittal. *Section 1396p(d)(3)* recognizes that a "payment from the trust" may be made from the "corpus" of the trust or from "income on the corpus." Where a home is transferred to a trust, the home becomes another asset of the trust. Like any other asset, a home adds to the corpus of the trust, in that it may be sold for its fair market value; a home also increases the trust's capacity to generate income, in that rent may be collected for its use and occupancy. Where the trustee retains the discretion to pay income produced from the corpus to the grantors, as in the Nadeau and Daley Trusts, the trustee may pay any rental income earned from any real estate in the corpus of the trust to the grantors. Where the terms of the trust, as in the Nadeau Trust, grant a right of use and occupancy to the grantors for their lifetime, the grantors receive from the trust the right to receive any income that may be generated from the rental of the home, as well as the right to forgo that rental income by residing in the home themselves. See *Hinckley v. Clarkson, 331 Mass. 453, 454-455, 120 N.E.2d 285 (1954)* (right of use and occupancy grants "right to the income of the property [for] life," but not right to "alienate or consume" property). See also *Langlois v. Langlois, 326 Mass. 85, 87-88, 93 N.E.2d 264 (1950)*. HCFA Transmittal 64 accurately recognizes that, where a trust grants the use or occupancy of a home to the grantors, it is effectively making a payment to the

grantors in the amount of the fair rental value of that property.

To illustrate with an example, if a grantor transfers to an irrevocable trust ownership of a condominium unit and the trustee decides to rent the unit to a third person and pay the rental income to the grantor, there is a payment of rental income from the trust to the grantor. If the grantor instead exercises his or her right of use and occupancy under the terms of the trust, and decides to reside in the unit or permit a family member to reside there without the payment of rent, the fair market value of the rent that otherwise would have been earned and treated as actual trust income is deemed paid to the grantor under Transmittal 64.

This payment, however, is not a payment from the corpus of the trust; the grantors do not have the power through their right of use and occupancy to sell the property under any circumstances. It is instead a payment from the "income on the corpus." Such payments, whether actually received as rental income or imputed as the fair market rental value of the grantors' occupancy of the home, may be countable as income of the grantors, but the value of the home is not thereby countable as their asset.[12] Such payments, therefore, do not affect an applicant's eligibility for Medicaid long-term care benefits, but they may affect how much the applicant is required to contribute to the payment for that care. Just as the payment of income from the liquid assets of an irrevocable trust does not make those assets "available to the individual" under *§ 1396p(d)(3)* and therefore countable assets for purposes of Medicaid eligibility, the payment of what is essentially rental income from real estate owned by the trust does not make the equity in that real estate a countable asset.

> 12 Under the Massachusetts regulations implementing the Federal Medicaid act, countable income includes income to which an applicant, a person already receiving Medicaid benefits, or a spouse "would be entitled whether or not actually received when failure to receive such income results from [their] action or inaction." See *130 Code Mass. Regs. § 520.009(A)(4)* (2014). "In determining whether or not failure to receive such income is reasonably considered to result from such action or inaction, the MassHealth agency will consider the specific circumstances involved." *Id.*

The MassHealth regulation, *130 Code Mass. Regs. § 520.023(C)(1)(d)*, accurately interprets *§ 1396p(d)(3)* in providing, "The home or former home of a nursing-facility resident or spouse held in an irrevocable trust that is available according to the terms of the trust is a countable asset." There is no doubt that, where the terms of the trust grant the trustee the discretion in any circumstance to sell the grantors' home and distribute to them the proceeds, the home is a countable asset for Medicaid eligibility. Where MassHealth errs is in interpreting its regulation to mean that a home "is available according to the terms of the trust" simply because the terms of the trust give the grantors the right of use and occupancy of the home. Such a right is not a circumstance that would give the trustee the discretion to sell the home and distribute the proceeds to the applicant, and therefore is not a circumstance that may render the home a countable asset.

As the United States Supreme Court has declared, "the principle of actual availability ... has served primarily to prevent the States from conjuring fictional sources of income and resources by imputing financial support from persons who have no obligation to furnish it or by overvaluing assets in a manner that attributes nonexistent resources to recipients." *Heckler v. Turner, 470 U.S. 184, 200, 105 S. Ct. 1138, 84 L. Ed. 2d 138 (1985)*. The "any circumstances" test for trusts requires an additional layer of analysis, but it does not depart from this fundamental purpose. See *Guerriero, 433 Mass. at 634* (trust assets not available to applicant where trustee did not have "any legal discretion" to pay any part of trust principal to her). By declaring the equity in a home owned by an irrevocable trust to be actually available to an applicant where the trustee has no power to sell the home and distribute the proceeds to the applicant under any circumstance, Massachusetts is effectively "conjuring [a] fictional" resource (the applicant's home) by "imputing financial support" from a person who has no authority to furnish it (the trustee).

Because the MassHealth determination that Nadeau was ineligible to receive Medicaid long-term care benefits rests solely on the availability of his home as a resource, we vacate the judgment affirming this finding and remand the matter to MassHealth to evaluate two other possible sources of countable assets. As earlier discussed, the terms of the Nadeau Trust permit the equity in the Nadeau home to be paid at the Nadeaus' direction or for their benefit during their lifetimes in two

circumstances.

First, the Nadeaus may "appoint ... all or any part of the trust property ... to any one or more charitable or non-profit organizations" over which they have no controlling interest. Had Nadeau received care at a nursing home operated by a nonprofit organization, he could have used the assets of the trust, including his home, to pay the nonprofit organization for his care. Because approximately one-fourth of the nursing homes in Massachusetts are operated by nonprofit organizations,[13] albeit not the nursing home where he received care, it is appropriate for MassHealth to consider whether this possibility fits within the "any circumstances" test.

13 See MatchNursingHomes.org, Massachusetts Nursing Homes and Resources, http://matchnursinghomes.org/state/ma-nu rsing-homes [https://perma.cc/G7CS-2G3B] (citing 2011 data).

Second, because the trust is intended to be construed as a "grantors trust" under the Internal Revenue Code, *26 U.S.C. § 677(a)*, with all income distributed to the grantors taxable to them, the trustee may pay any tax liability arising from such distributions from the corpus of the trust. MassHealth may determine that this portion of the corpus is a countable asset under the "any circumstances" test and may ascertain, under *§ 1396p(d)(3)*, the size of the "portion of the corpus from which ... payment to the individual could be made" in this circumstance.

Our analysis is different for the Daley Trust because, in contrast with the Nadeau Trust, the Daley Trust did not own the home in fee simple; the Daleys retained a life estate and deeded only the remainder interest in their home to the trust. Their continued residence in the home, therefore, cannot be deemed putative income received from the trust through a right of use and occupancy, because the trust has no property interest in the home during the Daleys' lifetime. Instead, the life estate is an asset of the Daleys that can be sold, mortgaged, or leased. See *Hershman- Tcherepnin v. Tcherepnin, 452 Mass. 77, 88 n.20, 891 N.E.2d 194 (2008)*, quoting H.J. Alperin & L.D. Shubow, Summary of Basic Law § 17.5, at 586 (3d ed. 1996) ("[a] life estate is alienable by the life tenant, and he can accordingly convey his estate to a third person, or mortgage it, or lease it for a term of years"). Moreover, when the underlying property itself is sold, the life tenant has a right to a portion of the sale proceeds, pursuant to an actuarial evaluation of the life estate. See J.A. Bloom & H.S. Margolis, Elder Law § 12:3 (2016). Although we do not decide the question, it appears that MassHealth does not consider a life estate in an applicant's primary residence to be a countable asset for Medicaid eligibility purposes.[14,15] Where the irrevocable trust does not own the life estate in the applicant's primary residence, the continued use of the home by the applicant pursuant to his or her life estate interest does not make the remainder interest in the property owned by the trust available to the applicant. Therefore, we vacate the judgment affirming the finding that the equity in the Daleys' home is available to them and is accordingly a countable asset for purposes of Medicaid eligibility. Because the Daley Trust, like the Nadeau Trust, is intended to be construed as a "grantors trust" and the trustee may pay any tax liability arising from income distributions to the grantors from the corpus of the trust, we remand the matter to MassHealth to determine whether this portion of the corpus is a countable asset under the "any circumstances" test and to ascertain under *§ 1396p(d)(3)(B)(i)* the size of the "portion of the corpus from which ... payment to the individual could be made" in this circumstance.

14 In *Heyn v. Director of the Office of Medicaid, 89 Mass. App. Ct. 312, 313 n.3, 48 N.E.3d 480 (2016)*, MassHealth declared in its brief that it is "a correct statement of law" that retention of a life estate in a primary residence does not make an individual ineligible for Medicaid benefits.

15 We note that *42 U.S.C. § 1396p(b)(4)(B)* gives States the *option* to expand their estate-recovery procedures for Medicaid expenses to include assets beyond those within the individual's probate estate, including "any other real and personal property and other assets in which the individual had any legal title or interest at the time of death ... , including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement." Massachusetts has not chosen to expand its estate recovery provisions in this fashion. See *G. L. c. 118E, § 31 (c)*. In States that have exercised this option under *§ 1396p(b)(4)(B)* and increased the scope of estate recovery, the remainder interest in life estates retained by Medicaid beneficiaries are ultimately

subject to recovery after the beneficiary's death. See, e.g., *Matter of the Estate of Peterson v. Peterson, 340 P.3d 1143, 157 Idaho 827, 836 (2014)* ("When assets of a Medicaid recipient are conveyed to a survivor, heir or assign by the termination of a 'life estate,' the assets remain part of the recipient's 'estate' pursuant to *42 U.S.C. § 1396*p[b][4][B] and *Idaho Code section 56-218[4][b]*").

Conclusion. We reverse the judgments in both cases, and remand to MassHealth for further proceedings consistent with this opinion.

So ordered.

COMMONWEALTH OF MASSACHUSETTS

WORCESTER, ss.

SUPERIOR COURT
NO. 14-CV-02278C

LIONEL NADEAU,
Plaintiff,

vs.

KRISTIN THORN, Director of the Office of Medicaid, Executive Office of Health and Human Services, Defendant.

MEMORANDUM OF DECISION AND ORDER ON PLAINTIFF'S MOTION FOR JUDGMENT ON THE PLEADINGS

This case arises out of the Office of Medicaid's denial of Lionel Nadeau's application for long-term Medicaid benefits. The Office of Medicaid, also known as MassHealth for the Massachusetts Medicaid program it administers, see G. L. c. 118E, § 9A, falls under the authority of the Secretary of the Executive Office of Health and Human Services. See G. L. c. 6A, §§ 16, 16B. Mr. Nadeau brings this action for judicial review of MassHealth's decision under G. L. c. 30A, § 14. Mr. Nadeau now moves for judgment on the pleadings to vacate MassHealth's decision. A hearing has been held on that motion.

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For the following reasons, Mr. Nadeau's Motion for Judgment on the Pleadings is DENIED.

BACKGROUND

Judicial review of an agency decision is confined to the administrative record. G. L. c. 30A, § 14(4),(5). The record before MassHealth contained the following facts. On

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March 27, 2001, Mr. and Mrs. Nadeau created the "Lionel C. Nadeau and Jacqueline T. Nadeau Irrevocable Trust" (the "Trust"). Relevant provisions of the Trust are discussed below. That same day, the Nadeaus deeded to the Trust their interest in the real estate located at 1075 School Street in Webster. The assessed value of the property is $173,700. The Nadeaus continued to live at the property until, on April 1, 2014, health reasons required that Mr. Nadeau be admitted to the Webster Manor Healthcare Center.

On February 24, 2014, Mr. Nadeau applied for long-term care Medicaid benefits effective March 13, 2014. On June 27, 2014, MassHealth denied Mr. Nadeau's application after concluding that his assets exceeded Medicaid's $2,000 eligibility limit. MassHealth determined that he was financially ineligible for benefits because his assets included the Trust's principal, valued at $173,700. Mr. Nadeau appealed the decision to the Office of Medicaid Board of Hearings (the "Board").

Following a hearing, in a decision dated November 28, 2014, the Board affirmed MassHealth's decision and denied Mr. Nadeau's appeal. The Board counted the Trust's principal as an asset because:

> By its plain and clear language subsection (d) of [130 Code Mass. Regs. 520.023(C)(1)] treats an applicant's former home deeded into an irrevocable trust differently from all other asset[s] that could fund a trust. Subsection (d) does not require, as subsections (a), (b), and (c) require, a finding that the Trustee has discretion under any set of circumstances under the trust to pay or distribute the principal to the donor/applicant. As MassHealth correctly asserts, the regulation makes no distinction between the "availability" of either income or principal stating only that the home or former home has to be "available" pursuant to the terms of the trust. Here, the applicant may use the property during his lifetime either to occupy as his residence or to rent and derive income payable to [him] as an income beneficiary of the Trust; therefore, his former home, sitting in an irrevocable Trust, is available to him and countable for MassHealth Long-Term Care eligibility purposes.

Mr. Nadeau sought judicial review of the Board's decision under G. L. c. 30A, § 14. On July 31, 2015, Mr. Nadeau filed his instant motion for judgment on the pleadings arguing that his use and occupancy of his home does not make the Trust principal "available" to him.

DISCUSSION

I. Standard of Review

A motion for judgment on the pleadings is governed by G. L. c. 30A §14 and Superior Court Standing Order 1-96. This Court may affirm, remand, set aside, or modify the agency decision if it determines that the rights of any party may have been prejudiced because the agency decision is unconstitutional, in excess of the agency's authority, based upon an error of law or unlawful procedure, unsupported by substantial evidence, or arbitrary or capricious, an abuse of discretion, or otherwise not in accordance with law. G. L. c. 30A, §14 (7). This court must also "give due weight to the experience, technical competence, and specialized knowledge of the agency, as well as to the discretionary authority conferred upon it." G. L. c. 30A, §14(7). The party appealing an administrative decision bears the burden of demonstrating the decision's invalidity. *Merisme* v. *Bd. of Appeals of Motor Vehicle Liab. Policies & Bonds*, 27 Mass.App.Ct. 470, 474 (1989).

This court "must apply all rational presumptions in favor of the validity of the administrative action and not declare it void unless its provisions cannot by any reasonable construction be interpreted in harmony with the legislative mandate." *Thomas* v. *Commissioner of the Div. of Med. Assistance*, 425 Mass. 738, 746 (1997), citation omitted. Moreover, this "court will not substitute its own judgment concerning the

penalty the [agency] imposes." *Kobrin* v. *Bd. of Registration in Med.*, 444 Mass. 837, 842 (2005), citation omitted. Consequently, as the party appealing MassHealth's decision, Mr. Nadeau bears the heavy burden of demonstrating the decision's invalidity. *See Ten Local Citizen Group* v. *New Eng. Wind, LLC*, 457 Mass. 222, 228 (2010), internal quotation and citation omitted.

This Court gives substantial deference to an agency's interpretation of those statutes with which it is charged with enforcing. "Especially is this so when the case involves interpretation of a complex statutory and regulatory framework such as Medicaid." *Shelales* v. *Dir. of the Office of Medicaid*, 75 Mass. App. Ct. 636, 640 (2009), citation omitted. Deference is particularly appropriate when the statute in question explicitly grants broad-rule making authority to the agency, contains an ambiguity or gap, or broadly sets out a legislative policy that must be interpreted by the agency." *Souza* v. *Registrar of Motor Vehicles*, 462 Mass. 227, 229 (2012) (citations omitted).

II. Analysis

The Massachusetts Medicaid program, MassHealth, "is a joint State and Federal program designed to pay the cost of medical care for those who are otherwise unable to afford it." *Normand* v. *Dir. of the Office of Medicaid*, 77 Mass. App. Ct. 634, 636 (2010), citations omitted. See also 130 Code Mass. Regs. 515.002(A).[1] "Because MassHealth is a joint Federal and State program, the Massachusetts statutes and regulations governing the program must be consistent with the requirements of Federal [Medicaid] law." *Normand*, 77 Mass. App. Ct. at 637 n.8. Consequently, as required by Federal law, MassHealth applicants must meet certain financial eligibility requirements

[1] "The MassHealth agency is responsible for the administration and delivery of health-care services to low- and moderate-income individuals and couples." 130 Code Mass. Regs. 515.002(A).

to qualify for benefits. *Tarin* v. *Commissioner of Div. of Med. Assistance*, 424 Mass. 743, 747 (1997).

MassHealth provides nursing home benefits in the form of long-term care coverage for individuals who have $2,000 or less in "countable assets." 130 Code Mass. Regs. § 519.006(A)(2); 130 Code Mass. Regs. §520.003(A)(1).[2] "Countable assets are all assets that must be included in a determination of [Medicaid] eligibility." 130 Code Mass. Regs. §520.007. Here, if the Trust is considered a countable asset, then Mr. Nadeau would be financially ineligible for MassHealth benefits because the assessed value of his home exceeds $2,000. This Court concludes that the Office of Medicaid Board of Hearings correctly determined that Mr. Nadeau's Trust was a countable asset because Mr. Nadeau's home remained available for his use after he deeded it to the Trust.

A. Availability of Property

Property held in an irrevocable trust is a countable asset where it is "available according to the terms of the trust[.]" 130 Code Mass. Regs. 520.023 (C)(1)(d).[3] If a Medicaid applicant can use and occupy her home as a life tenant, then her home is "available." See *Doherty* v. *Dir. of the Office of Medicaid*, 74 Mass. App. Ct. 439, 441 (2009) (home was available because applicant retained the right to reside there during her lifetime).

Deferring to MassHealth's reasonable construction of its regulations, the Court concludes that Mr. Nadeau's home is "[t]he home or former home of a nursing-facility

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[2] State regulations require that "the total value of countable assets owned by or available to individuals applying for or receiving MassHealth [benefits] . . . may not exceed . . . $2,000." 130 Code Mass. Regs. 519.006(A)(2).

[3] The circular definition for the word "available" contained in the introductory statement to 130 Code Mass. Regs. §520.023 provides as follows: "Generally, resources held in a trust are considered available if under any circumstances described in the terms of the trust, any of the resources can be made available to the individual." 130 Code Mass. Regs. §520.023.

resident . . . held in an irrevocable trust that is available according to the terms of the trust," and is therefore a "countable asset" under 130 Code Mass. Regs. 520.023 (C)(1)(d). Mr. Nadeau's home is "available" because the Trust's express terms preserve his right to live there: Subsection 2.3 of Article 2 of the Trust, Entitled "Payment of Income and Principal," provides that" the Nadeaus "shall also have the right to use and occupy any residence that may from time to time be held in trust hereunder."

B. Any Circumstances Test

Mr. Nadeau argues that his home cannot be considered "available" or countable unless there are some circumstances under the Trust that give him the ability to receive some form of payment, such as the proceeds of the sale of the property. Mr. Nadeau observes that the entire subsection in the regulation at 130 Code Mass. Regs. 520.023 (C)(1) is entitled "Portion Payable." His argument proceeds under the "any circumstances" test described in 42 U.S.C. §1396p(d)(3)(B)(i);[4] 130 Code Mass. Regs. 520.023(C)(1)(a).[5] The Supreme Judicial Court has described the test as follows:

> [I]f there is *any* state of affairs, at *any* time during the operation of the trust, that would permit the trustee to distribute trust assets to the grantor, those assets will count in calculating the grantor's Medicaid eligibility.

Lebow v. *Commissioner of the Div. of Med. Assistance*, 433 Mass. 171, 177-178 (2001), emphasis in original. Even assuming, arguendo, that Mr. Nadeau's property must be both

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[4] If there are any circumstances under which payment from an irrevocable trust "could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual[.]" 42 U.S.C. §1396p(d)(3)(B)(i).

[5] Under 130 Code Mass. Regs. 520.023(C)(1)(a), "[a]ny portion of the principal or income from the principal (such as interest) of an irrevocable trust that could be paid under any circumstances to or for the benefit of the individual is a countable asset." See *Lebow* v. *Commissioner of the Div. of Med. Assistance*, 433 Mass. 171, 177-178 (2001) (discussing regulation).

available to him and payable to him for it to be countable, the Court, deferring to federal Medicaid policy guidelines, concludes the trust principal is payable to Mr. Nadeau.[6]

The Health Care Financing Administration (HCFA) is the agency charged with the interpretation and enforcement of the Medicare and Medicaid statutes. The HCFA issues policy guidelines called transmittals to states participating in the Medicaid program. See generally *Massachusetts Hosp. Ass'n* v. *Department of Pub. Welfare*, 419 Mass. 644, 646 (1995) (describing interplay between MassHealth and HCFA). Transmittal 64 defines "payment" broadly as: "any disbursal from the corpus of the trust or from income generated by the trust which benefits the party receiving it. A payment may include actual cash, as well as noncash or property disbursements, such as the right to use and occupy real property." Medicaid Manual HCFA Transmittal 64, Section 3259.1(A)(8). Massachusetts courts have applied Transmittal 64 when interpreting Medicaid statutes and regulations. See, e.g., *Atlanticare Med. Ctr.* v. *Comm'r of the Div. of Med. Assistance*, 439 Mass. 1, 9 (2003); *Andrews* v. *Div. of Med. Assistance*, 68 Mass. App. Ct. 228, 231 (2007). Transmittal 64 "is entitled to deference by the courts as long as it is consistent with the plain language and purposes of the statute and if [it is]

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[6] This court notes the Board correctly concluded additional income was countable under Article 6.1 of the Trust, entitled "Payments for our estate." Article 6.1 provides that "Our trustee may in its sole discretion pay to our estate or to the tax authorities any taxes payable by reason of my death chargeable against the residue of my estate and any other debts of our estate or expenses of its administration and legacies under by will that, if paid by our executor would reduce the residue of my estate. This paragraph shall not be construed to require any such payments by our trustee." Where, as here, the trustee has "a peppercorn of discretion, then whatever is the most the beneficiary might under any state of affairs receive in the full exercise of that discretion is the amount that is counted as available for Medicaid eligibility." See *Cohen* v. *Commissioner of the Div. of Med. Assistance*, 423 Mass. 399, 413 (1996).

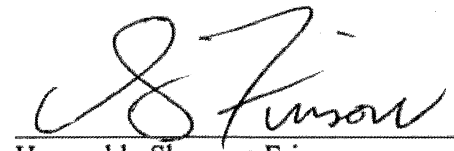
This court concludes that, because there are circumstances under which the trustee may exercise his discretion to pay these taxes, they are countable for purposes of Medicaid eligibility. See *Lebow*, 433 Mass. at 177-178; 130 Code Mass. Regs. 520.023(C)(1)(a). However, MassHealth has failed to demonstrate that the potential income accessible under this provision exceeds the $2,000 Medicaid eligibility threshold. As noted by the Board, MassHealth did not introduce evidence "articula[ing] just how much of the principal could be paid to the donor[.]"

consistent with prior administrative views." *Gillmore* v. *Ill. Dep't of Human Servs.*, 354 Ill. App. 3d 497, 501 (2004), citation and quotation omitted.

In this case, Subsection 2.3 of Article 2 of the Trust preserved Mr. Nadeau's right to use and occupy his home, which is a form of payment under Transmittal 64's broad definition. Consequently, Mr. Nadeau's property is a countable asset even if the applicable regulations require it to be both available and payable to him.

ORDER

For the foregoing reasons, the plaintiff's Motion for Judgment on the Pleadings is DENIED.



Honorable Shannon Frison
Justice of the Superior Court

December 29, 2015

Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

Robert [redacted]
c/o Doris A. [redacted]
[redacted] Street, Unit 208
Saugus, MA 01906

Appeal Decision:	Approved	**Appeal Number:**	1615178
Decision Date:	Nov 3 0 2017	**Hearing Date:**	01/20/2017
Hearing Officer:	Samantha Kurkjy	**Record Open:**	08/09/2017

Appellant Representative:
Robert Ford, Esq.

MassHealth Representative:
Andrea Pelczar

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Board of Hearings
100 Hancock Street, Quincy, Massachusetts 02171

APPEAL DECISION

Appeal Decision:	Approved	Issue:	Long-term care eligibility
Decision Date:	NOV 3 0 **2017**	**Hearing Date:**	01/20/2017
MassHealth Rep.:	Andrea Pelczar	**Appellant Rep.:**	Robert Ford, Esq.
Hearing Location:	Tewksbury MassHealth Enrollment Center	**Aid Pending:**	No

Authority

This hearing was conducted pursuant to Massachusetts General Laws Chapter 118E, Chapter 30A, and the rules and regulations promulgated thereunder.

Jurisdiction

Through a notice dated November 28, 2016, MassHealth denied the appellant's application for MassHealth long-term care benefits because MassHealth determined that the appellant's countable assets exceed the limit of the MassHealth program. (Exhibit 1.) The appellant filed this appeal with the Board of Hearings on December 5, 2016. (130 CMR 610.015(B); Exhibit 2.) The record was held open until February 21, 2017 for the appellant to submit a response to MassHealth's memorandum of law. (Exhibit 6.) MassHealth was given until March 14, 2017 to file a response memo. (Exhibit 6.) The appellant was given until April 4, 2017 to file a final response. (Exhibit 6.) On April 4, 2017, the appellant was granted an extension of the record open period until April 5, 2017. (Exhibit 9.) On June 28, 2017, the record was re-opened to allow both parties to comment upon recent Supreme Judicial Court decisions. (Exhibit 9.) MassHealth was given until July 19, . 2017 to submit a memo and the appellant was given until August 9, 2017 to submit a response. (Exhibit 9.) Denial of assistance is a valid ground for appeal. (130 CMR 610.032.)

Action Taken by MassHealth

MassHealth denied the appellant's application for MassHealth long-term care benefits because it determined that he has more countable assets than are allowable under MassHealth regulations.

Issue

Whether MassHealth was correct in determining that the appellant was over assets and therefore ineligible, pursuant to 130 CMR 520.003, for MassHealth long-term care benefits.

Summary of Evidence

The MassHealth representative appeared in person and testified that the appellant, who is over 65-years-old and has a community spouse, was admitted to a nursing facility on July 29, 2016. He submitted a long-term care application on September 36, 2016 and requested a benefit start date of October **1,** 2016. MassHealth denied the application on November 28, 2016 for excess countable assets. The appellant appealed the denial to the Board of Hearings on December 5, 2016.

The November 28, 2016 denial notice indicates that the appellant has countable assets totaling $380,141. The assets consist of bank account balances ($102,541) and a trust ($277,600) called The [redacted] Street Realty Trust (hereinafter "the Trust"), which MassHealth found to be countable. The Trust contains real property located in Saugus, MA. The appellant may keep $2,000 and his community spouse may keep $119,220 in assets. Therefore, the appellant has $258,921 in excess assets. At hearing, the trust instrument was submitted into evidence as part of Exhibit 5.

The Trust was established on January 14, 2010 and is irrevocable. The real property held in trust was located at 73-73A [redacted] Street, Everett, MA. On January 30, 2012, this property was sold and was replaced with property located at 48 [redacted] Street, Saugus, MA on February 6, 2012. The Settlors of the Trust are the appellant and his spouse. They are also the Trustees. The beneficiaries of the Trust are the Settlors' children. The relevant portions of the trust instrument are as follows:

> **ARTICLE II**
> **Irrevocability**
>
> The Seniors shall have NO right to alter, amend, revoke or terminate this Trust. **THIS TRUST IS IRREVOCABLE.**
> ••.
>
> **ARTICLE III**
> **Dispositive Provisions During Settlors' Lifetime**
>
> During the lifetime of the Settlors, the Trustees shall pay to the Settlors or apply for the Benefit of the Settlors all of the net income of the Trust not less often than quarterly. The Settlors shall also have the right to occupy, enjoy, and possess any real estate that may constitute part or all of the corpus of this Trust during their lifetime. The Settlors shall not have the right to any principal distributions under any circumstances.

ARTICLE VI
Provisions after Settlors' Death

I. A. Upon the death of the survivor of the two Settlors, the Trustee shall distribute the remaining Trust property as the surviving Settlor may appoint, by means of his or her Last Will and Testament, to any beneficiary, other than the powerholder, the powerholder's estate or creditors, or the creditors of the powerholder's estate, by reference to this special power of appointment....

ARTICLE XI
Trustee's Powers.

I. The Trustee shall have, in addition to those powers conferred by law or otherwise, the following discretionary powers, (excepts as otherwise provided in this instrument) *[sic]* whether or not personally interested in the exercise of any such powers.

A. To administer, retain, invest, and reinvest in any property[ ].. .

C. To manage real property in such manner as the Trustee shall deem best including authority to erect, alter or demolish buildings, to improve, repair, insure, subdivide, and vacate any of said property; to adjust boundaries, to dedicate streets or other ways for public use without compensation; to impose such easements, restrictions, conditions, stipulations and covenants as the Trustee may see fit; to lease (with or without option to purchase) for such times and on such terms as it deems advisable and whether or not the lease may extend beyond the terms of the trust.

D. To sell, lease, pledge, mortgage, transfer, exchange, convert, or otherwise dispose of, or grant options with respect to, any and all real or personal property at any time forming a part of the Trust estate, in any manner, at any time or times, for any purpose, for any price and upon any terms, credits and conditions as are deemed advisable.

E. To borrow money from itself individually or from others, upon such terms and conditions as it deems advisable and to mortgage or pledge trust property as security for the repayment thereof.

• • •

I. To retain such reserves out of income as the Trustee deems proper for expenses, taxes, depreciation and other liabilities of the trust.

L. The Principal and Income Act shall not apply to the provisions of this Trust.

M. To purchase assets from, or lend money to, the Settlors' estate at a fair value. Any such purchased assets shall be treated as part of this trust as if originally made a part hereof. The propriety of the purchase, the amount of the assets purchased, and the ascertainment of fair value shall be solely within the discretion of the Trustee, and the Trustee shall incur no liability as a result of any such purchase or the retention of such assets whether or not such assets constitute investments which may be legally made by Trustees.

0. To purchase and/or maintain any real estate as a residence for any one or more of the then current income beneficiaries and the spouse, issue, and/or guardian of any such beneficiary (or other person residing with, and caring for, the beneficiary) without charging rent to any one or more of such occupants.

. . .

Q. By unanimous agreement of all the members serving as Trustee, to add to, or subtract from, the number of members comprising the Trustee, provided that in the event the number of Trustees is increased, there shall be deemed to be a vacancy in the membership of the Trustee, and such vacancy shall be filled in accordance with the proper procedures otherwise applicable to this trust.

. . .

ARTICLE XIII
Resignation and Appointment of Trustee

I. Any Trustee may resign as Trustee from the trusts hereby created at any time by giving thirty (30) days written notice delivered personally or by certified or registered mail to the then legally competent current income beneficiaries and to the legal guardians of any current income beneficiaries who are not legally competent. In such event the resigning Trustee may appoint a Successor Trustee, and shall do so in the instrument of resignation, if able....

II....Nothing contained in this Article shall be construed to limit the power of the Senior to substitute a new Trustee.

• •

ARTICLE XVIII
Tax Liability

It is the intent of the Settlors that this Trust be construed as a

"Grantor Trust" under Internal Revenue Code Section 677(a). All income distributed, held, or accumulated by this Trust shall be taxable to the Settlors. The Trustee may, to the extent that the income of the Trust generates a tax liability for the Settlors, distribute, *[sic]* to the Settlors such amounts of income of the Trust as the Trustee deems necessary to satisfy such tax obligation.

ARTICLE XX
Right of Substitution

The Settlors retains *[sic]* the right to reacquire the principal of this Trust by substituting property of an equivalent value therefor.

ARTICLE XXI
Income

"Income" means net income and accumulated income not added to principal and does not include capital gain....

(Exhibit 5.) (Emphasis in original.)

The parties each submitted a legal memorandum of law. Their respective arguments are summarized below.[1]

MassHealth's Argument

MassHealth contends that the Trust is countable for Medicaid eligibility purposes in the amount of $145,919.04. As support for its argument, MassHealth cites to 130 CMR 520.023, as well as federal trust law:

> **(B)** In the case of an irrevocable trust—
>
> (i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources

[1] The parties were given an opportunity to submit written arguments through record open periods. On June 28, 2017, the record was re-opened to allow both parties to comment upon a recent Supreme Judicial Court decision, Daley v. EOHHS, SJC 12200, slip op., May 30, 2017. MassHealth was given until July 19, 2017 to submit a memo and the appellant was given until August 9, 2017 to submit a response. Both parties submitted a substitute memorandum of law. Their previous submissions are marked as exhibits but those arguments are not necessarily included above.

> available to the individual, and payments from that portion of the corpus or income—
>
> > (I) to or for the benefit of the individual, shall be considered income of the individual...

(42 USC 1396p(d)(3)(B).)

MassHealth states that the Trust provisions allow the appellant the right to occupy, possess, and enjoy the real estate held in Trust. He is also entitled to the Trust's net income in at least quarterly distributions. MassHealth argues that the right to use and occupancy entitles the appellant to the fair market value rental income from the Trust property. MassHealth cites to Daley in support of its contention:

> HCFA[2] Transmittal 64 accurately recognizes that, where a trust grants the use or occupancy of a home to the grantors, it is effectively making a payment to the grantors in the amount of the fair rental value of that property. To illustrate with an example, if a grantor transfers to an irrevocable trust ownership of a condominium unit and the trustee decides to rent the unit to a third person and pay the rental income to the grantor, there is a payment of rental income from the trust to the grantor. If the grantor instead exercises his or her right of use and occupancy under the terms of the trust, and decides to reside in the unit or permit a family member to reside there without the payment of rent, the fair market value of the rent that otherwise would have been earned and treated as actual trust income is deemed paid to the grantor under Transmittal 64.

(Exhibit 11) (quoting Daley v. EOHHS, SJC 12200, slip op., May 30, 2017 at 24).

Since the Massachusetts Supreme Judicial Court ("SJC") determined that this payment comes not from the trust corpus but from the "income on the corpus," MassHealth will calculate and then count rental income. (Exhibit 5) (quoting Daley v. EOHHS, SJC 12200, slip op., May 30, 2017 at 24). Further, federal Medicaid law dictates that a payment from "income on the corpus" is considered a "resource." While this requirement was not specifically mentioned in Daley, MassHealth must follow federal Medicaid law. MassHealth cites to Atkins v. Rivera, 106 S.Ct. 2456 (1986) for its holding that the plain language of the federal Medicaid statute controls over the Massachusetts Supreme Court.

MassHealth used the Housing and Urban Development ("HUD") Fair Market Rent tables for 2016 to determine the appropriate monthly rental value for the property in Trust. The appellant's Saugus, MA home is a condominium with two bedrooms and two bathrooms. Under the tables, the fair market monthly rental value is $1,567. Therefore, this amount is the monthly income incurred by

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[2] Health Care Financing Administration

the appellant. MassHealth then calculated the resource value by determining the appellant's life expectancy using the Social Security Administration Actuarial Life Table. According to the table, the life expectancy for a male aged 81 is 7.76 years. The appellant's countable resource amount is $1,567 x 12 months x 7.76 years, for a total of $145,919.04 in rental value of the Saugus, MA property over his lifetime.

MassHealth also states that the Trustee can pay accumulated income to the appellant, as "accumulated income" is included in the definition of "income" under Article XXI. Therefore, the Trustee may retain rental incomes before making any quarterly distributions to the appellant. Pursuant to 42 USC 1382b(e)(3)(6)(B), income that is added to a trust is corpus in the month after. receipt. Accumulated income, then, would be corpus in the month after it is received. The entire Saugus, MA property could be invested or rented and the income could then be accumulated and distributed to the appellant as accumulated income (corpus). When accumulated each quarter, the $1,567 monthly rent would exceed MassHealth's $2,000 asset limit. Since the Trustee can pay accumulated income to the appellant, there is a circumstance in which the Trust corpus could be distributed to the appellant in an amount over $2,000.

The Appellant's Argument

The appellant argues that the right to use and occupancy of a property in trust is not a countable asset, and cites to Daley in support of this contention:

> We conclude that neither the grant in an irrevocable trust of a right to use and occupancy in a primary residence to an applicant nor the retention by an applicant of a life estate in his or her primary residence makes the equity in the home owned by the trust a countable asset for the purpose of determining Medicaid eligibility for long-term care benefits.

(Exhibit 12) (quoting Daley v. EOHHS, SJC 12200, slip op., May 30, 2017 at

3). Instead, the right to use and occupancy is an income interest:

> Where the terms of the trust, as in the Nadeau Trust, grant a right of use and occupancy to the grantors for their lifetime, the grantors receive from the trust the right to receive any income that may be generated from the rental of the home, as well as the right to forgo that rental income by residing in the home themselves....HCFA Transmittal 64 accurately recognizes that, where a trust grants the use or occupancy of a home to the grantors, it is effectively making a payment to the grantors in the amount of the fair rental value of that property....This payment, however, is not a payment from the corpus of the trust; the grantors do not have the power through their right of use and occupancy to sell the property under any circumstances. It is

> instead a payment from the 'income on the corpus.' Such payments, whether actually received as rental income or imputed as the fair market rental value of the grantors' occupancy of the home, may be countable as income of the grantors, but the value of the home is not thereby countable as their asset... Such payments, therefore, do not affect an applicant's eligibility for Medicaid long-term care benefits, but they may affect how much the applicant is required to contribute to the payment for that care. Just as the payment of income from the liquid assets of an irrevocable trust does not make those assets `available to the individual' under [42 USC] § 1396p(d)(3) and therefore countable assets for purposes of Medicaid eligibility, the payment of what is essentially rental income from real estate owned by the trust does not make the equity in that real estate a countable asset.

Id. (quoting Daley v. EOHHS, SJC 12200, slip op., May 30, 2017 at 23-25) (internal citations • omitted).

Under the right to use and occupancy, payment from the Trust is not from the Trust corpus but from "income on the corpus," which is Trust income. Even if the income is held and accumulates over a period of time, the value is still characterized as income. The federal Medicaid definition of "corpus" found in 42 USC § 1382b(e)(6)(B) references "accumulated earnings," which is income.

- Federal Medicaid law acknowledges that income retains its characterization even when held after the month of receipt. If such income converted to principal on the day following the calendar month of receipt, there would not be a need to refer to "accumulated earnings." Further, any accumulated earnings converted to principal could not be distributed to the appellant as Article III of the Trust forecloses distributions of principal to the appellant.

Under 42 USC § 1396p(d)(3)(B),[3] only the portion of principal or income that can be paid to the appellant is a resource available to the appellant. If income is retained after the month the Trust

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[3] 42 USC § 1396p(d)(3)(B) reads as follows:

> (6) For purposes of this subsection—
> (A) the term "trust" includes any legal instrument or device that is similar to a trust;
> (B) the term "corpus" means, with respect to a trust, all property and other interests held by the trust, including accumulated earnings and any other addition to the trust after its establishment (except that such term does not include any such earnings or addition in the month in which the earnings or addition is credited or otherwise transferred to the trust); and
> (C) the term "asset" includes any income or resource of the individual (or of the individual's spouse), including—
> (i) any income excluded by section 1382a(b) of this title;

receives it and is available to be paid to the appellant, that income is a resource that must be spent down in an eligibility determination. However, the appellant is not entitled to that income, as he is only entitled to the net income from the Trust under Article III. Regulation 130 CMR 520.009 is in accord with this principle, as the countable-income amount is gross income minus income deductions and business expenses. If the appellant is given the fair rental value from the Trust property, business expenses must be deducted in order to arrive at countable income. Such expenses include condominium fees, real estate taxes, casualty and property insurance, and repair and maintenance costs. Repair and maintenance issues lack the predictability of the other expenses and vary in cost. Some repairs require budgeting due to their high costs. These expenses must be subtracted from gross income. Article XI of the Trust allows the trustee to retain reserves from income as he or she determines is proper for depreciation, taxes, expenses, and other liabilities. Net income is the amount left over after these reserves are deducted from gross income.. The Trust instrument recognizes that it can take time to assess and adjust the amounts to hold from income as a reserve. As a result, the Trust allows for the trustee to hold income for up to three months but such an action is not compulsory. The trustee may hold the income to determine expenses before the net income is distributed to the appellant. Only accumulated income or income that can be paid to the appellant is countable. Income cannot be paid out as soon as it is received. "If income is retained for a short while consistent with sound trust management and fiduciary duties, then, at best, that income is accumulated income, and not principal." (Exhibit 12.) The appellant further argues that use and occupancy is not an asset (Massachusetts) or resource (federal), but is income on the corpus, however long it is retained. Since "corpus" includes accumulated income, income remains income even though it is retained after the month of its receipt by the Trust. Only the net income can be paid to the appellant and it is that income that is considered available in an eligibility determination.

Resources are not countable to the appellant until and unless they can be paid to the appellant. MassHealth argues that since the trustee may accumulate income for up to three months, the accumulated income is a resource to be calculated using the appellant's life expectancy. MassHealth then considers the result the appellant's spenddown amount prior to any benefits being payable. Resources from a trust are countable only when the resources may be distributed out of the trust.

In its calculation of fair rental value, MassHealth uses the HUD statistical analysis instead of determining the actual fair market rental value. The HUD analysis is used for several purposes, but there is no indication that MassHealth or the Center for Medicare and Medicaid Services ("CMS") has used this analysis for an applicant who has a fixed spenddown figure. Using this calculation, the fair market rent in Lynn is equal to the fair market rent in Weston, when the two values in reality are not equal. MassHealth's procedure is speculative and should not be accepted. Medicaid requires values based on properties of similar type, quality, size, and neighborhood, otherwise an applicant can be charged with a spenddown amount that is greater than what he or she has available. MassHealth has not demonstrated rental value.

(ii) any resource otherwise excluded by this section[ ]...

Further, the actuarial tables MassHealth uses to multiply its monthly rental amount to determine the life expectancy of the appellant represent a life expectancy for the appellant that is conjecture, resulting in a conjectural calculation of income. The calculation attributes resources to the appellant that do not exist.[4] The income to be received over the appellant's actuarial life expectancy has neither been received by the appellant at this point nor does it exist, but MassHealth still requires him to spend down the actuarial lifetime value before he is deemed eligible for MassHealth benefits. If the monthly value of Trust income that is available to the appellant does not cover one month in a nursing facility, the appellant will still not be deemed eligible for MassHealth because he will be subject to the lifetime spenddown value. The net income[5] will be received by the appellant periodically for his actual lifetime. Therefore, the income should be applied to a patient-paid amount.

MassHealth takes its conjectural rental value, which is less than the asset limit of $2,000, and cites to the provision of the Trust which allows accumulated income in order to argue that the Trust can contain distributable income which exceeds the $2,000 limit, which MassHealth then claims is principal. MassHealth then argues that there are circumstances in which the appellant could receive over $2,000 in Trust principal. However, if the trustee distributes the income monthly, MassHealth's argument fails. The trustee has a fiduciary duty to act in the beneficiary's best interest, which means there is a duty to make distributions from the Trust that would allow the appellant to obtain MassHealth eligibility. "[T]herefore, the trustee would not have the authority, under any circumstances, to accumulate income." (Exhibit 12.) MassHealth's argument relies on the trustee's breach of fiduciary duty, and "Mlle Commonwealth is advocating violation of the law." (Exhibit 12.) In addition, as income accumulates the appellant is not receiving a distribution and would be eligible for benefits during that time. This scenario would lead to the appellant being eligible for benefits, then not eligible, and then eligible again. The law would favor a legal construction which would avoid such absurd results. Therefore, the appellant's interest is without value.

Because the appellant's spouse also has the right to use and occupy the property in Trust, the appellant's income is one-half of the net income, at best. The appellant cites to 20 CFR § 416.1201

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[4] The appellant cites to Heckler v. Turner, 470 US 184, 200 (1985) ("[T]he principle of actual availability...has served primarily to prevent the States from conjuring fictional sources of income and resources by imputing financial support from persons who have no obligation to furnish it or by overvaluing assets in a manner that attributes nonexistent resources to recipients.")

[5] The appellant argues that "resource" should not always be viewed in light of its statutory definition; it is sometimes subject to its dictionary definition:

> Income is a resource for payment of the care of an income beneficiary of the trust. However, that language does not render the income a part of the principal of the trust. It becomes part of the corpus, the body of property interests held in trust, but not the principal as that is distinguished from income for accounting, tax and Medicaid purposes.

(Exhibit 12.)

and states that under federal law, the appellant's use and occupancy interest cannot be liquidated within a period of 20 business days and has no value. MassHealth's use of the HUD survey assumes that the property is available for a set term and clear of all tenants, when in fact the interest is the value someone would pay "for the shared use and occupancy of the property with an elderly woman for the life of an elderly man[.]" (Exhibit 12.) The Hearing Officer must take judicial notice of the fact that no one would rent a shared interest in a property for an unknown term which is subject to ending at any moment. Since the appellant's right to use and• occupancy is not marketable, it has no value and is not an issue in his Medicaid eligibility determination.

Findings of Fact

Based on a preponderance of the evidence, I find the following:

1. The appellant, who is over 65-years-old and has a community spouse, was admitted to a nursing facility on July 29, 2016. (Exhibit 5; Testimony.)

2. He submitted a long-term care application to MassHealth on September 30, 2016 and requested a benefit start date of October 1, 2016. (Exhibit 5; Testimony.)

3. MassHealth denied the application on November 28, 2016 for excess countable assets. (Exhibit 1; Exhibit 5; Testimony.)

4. The appellant submitted a timely appeal to the Board of Hearings on December 5, 2016. (Exhibit 2.)

5. The appellant has countable assets totaling $380,141, consisting of bank account balances ($102,541) and a trust ($277,600), which MassHealth found to be countable. The Trust contains real property located in Saugus, MA. (Exhibit 1; Exhibit 5; Testimony.)

6. According to MassHealth, the appellant has $258,921 in excess countable assets. (Testimony.) •

7. The Trust was established on January 14, 2010 and is irrevocable. The real property held in trust was located at 73-73A [redacted] Street, Everett, MA. On January 30, 2012, this property was sold and was replaced with property located at 48 [redacted] Street, Saugus, MA on February 6, 2012. The Settlors of the Trust are the appellant and his spouse. They are also the Trustees. The beneficiaries of the Trust are the Settlors' children. (Exhibit 5; Exhibit 11; Exhibit 12; Testimony.)

8. The relevant portions of the trust instrument are as follows:

   ARTICLE II
   Irrevocability

The Settlors shall have NO right to alter, amend, revoke or terminate this Trust. **THIS TRUST IS IRREVOCABLE.**

...

ARTICLE III
Dispositive Provisions During Settlors' Lifetime

During the lifetime of the Settlors, the Trustees shall pay to the Settlors or apply for the Benefit of the Settlors all of the net income of the Trust not less often than quarterly. The Settlors shall also have the right to occupy, enjoy, and possess any real estate that may constitute part or all of the corpus of this Trust during their lifetime. The Settlors shall not have the right to any principal distributions under any circumstances.

. . .

ARTICLE VI
Provisions after Settlors' Death

I. A. Upon the death of the survivor of the two Settlors, the Trustee shall distribute the remaining Trust property as the surviving Settlor may appoint, by means of his or her Last Will and Testament, to any beneficiary, other than the powerholder, the powerholder's estate or creditors, or the creditors of the powerholder's estate, by reference to this special power of appointment....

ARTICLE XI
Trustee's Powers

I. The Trustee shall have, in addition to those powers conferred by law or otherwise, the following discretionary powers, (excepts as otherwise provided in this instrument) *[sic]* whether or not personally interested in the exercise of any such powers.

A. To administer, retain, invest, and reinvest in any property[ ]. • .

C. To manage real property in such manner as the Trustee shall deem best including authority to erect, alter or demolish buildings, to improve, repair, insure, subdivide, and vacate any of said property; to adjust boundaries, to dedicate streets or other ways for public use without compensation; to impose such easements, restrictions, conditions, stipulations and covenants as the Trustee may see fit; to lease (with or without option to purchase) for such times and on such terms as it deems advisable and whether or not the lease may extend

beyond the terms of the trust.

D. To sell, lease, pledge, mortgage, transfer, exchange, convert, or otherwise dispose of, or grant options with respect to, any and all real or personal property at any time forming a part of the Trust estate, in any manner, at any time or times, for any purpose, for any price and upon any terms, credits and conditions as are deemed advisable.

E. To borrow money from itself individually or from others, upon such terms and conditions as it deems advisable and to mortgage or pledge trust property as security for the repayment thereof.

.•

I. To retain such reserves out of income as the Trustee deems proper for expenses, taxes, depreciation and other liabilities of the trust.

L. The Principal and Income Act shall not apply to the provisions of this Trust.

M. To purchase assets from, or lend money to, the Settlors' estate at a fair value. Any such purchased assets shall be treated as part of this trust as if originally made a part hereof. The propriety of the purchase, the amount of the assets purchased, and the ascertainment of fair value shall be solely within the discretion of the Trustee, and the Trustee shall incur no liability as a result of any such purchase or the retention of such assets whether or not such assets constitute investments which may be legally made by Trustees.

...

0. To purchase and/or maintain any real estate as a residence for any one or more of the then current income beneficiaries and the spouse, issue, and/or guardian of any such beneficiary (or other person residing with, and caring for, the beneficiary) without charging rent to any one or more of such occupants.

...

Q. By unanimous agreement of all the members serving as Trustee, to add to, or subtract from, the number of members comprising the Trustee, provided that in the event the number of Trustees is increased, there shall be deemed to be a vacancy in the membership of the Trustee, and such vacancy shall be filled in accordance with the proper procedures otherwise applicable to this trust.

...

ARTICLE XIII
Resignation and Appointment of Trustee

I. Any Trustee may resign as Trustee from the trusts hereby created at any time by giving thirty (30) days written notice delivered

personally or by certified or registered mail to the then legally competent current income beneficiaries and to the legal guardians of any current income beneficiaries who are not legally competent. In such event the resigning Trustee may appoint a Successor Trustee, and shall do so in the instrument of resignation, if able....

II. ...Nothing contained in this Article shall be construed to limit the power of the Settlor to substitute a new Trustee.

ARTICLE XVIII
Tax Liability

It is the intent of the Settlors that this Trust be construed as a "Grantor Trust" under Internal Revenue Code Section 677(a). All income distributed, held, or accumulated by this Trust shall be taxable to .the Settlors. The Trustee may, to the extent that the income of the Trust generates a tax liability for the Settlors, distribute, *[sic]* to the Settlors such amounts of income of the Trust as the Trustee deems necessary to satisfy such tax obligation.

ARTICLE VC
Right of Substitution

The Settlors retains *[sic]* the right to reacquire the principal of this Trust by substituting property of an equivalent value therefor.

ARTICLE XXI
Income

"Income" means net income and accumulated income not added to principal and does not include capital gain....

(Exhibit 5.) (Emphasis in original.)

9. The Trust net income is countable to the appellant for Medicaid purposes.

10. Accumulated income becomes part of the Trust corpus in the month after it is received.

11. The appellant cannot access Trust principal.

Analysis and Conclusions of Law

The Trust provisions and arguments of the parties are documented above and are incorporated by

reference herein.

An irrevocable trust is defined as "a trust that cannot be in any way revoked by the grantor." (130 CMR 515.001.) The Trust provides, in Article II, that the Settlors cannot amend, revoke, alter, or terminate the Trust, and explicitly states that the Trust is irrevocable. As there is no provision that allows for the Trust to be revoked by the appellant as Settlor, the Trust is irrevocable.

Federal law at 42 U.S.C. 1396p(d)(3)(B)(i)(I) states, in pertinent part:

> (B) In the case of an irrevocable trust—
>
> (i) if there are **any circumstances** under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income—
>
> (I) to or for the benefit of the individual, shall be considered income of the individual...

(Emphasis added.)[6]

Regulation 130 CMR 520.023 addresses trusts that were created on or after August 11, 1993, and reads, in pertinent part, as follows:

> The trust and transfer rules at 42 U.S.C. 1396p apply to trusts or similar legal devices created on or after August 11, 1993, that are created or funded other than by a will. Generally, resources held in a trust are considered available if under any circumstances described in the terms of the trust, any of the resources can be made available to the individual.
>
> . . .
>
> (C) Irrevocable Trusts.
>
> (1) Portion Payable.
>
> (a) Any portion of the principal or income from the principal (such as interest) of an irrevocable trust that could be paid under any circumstances to or for the benefit of the individual is a countable asset.

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[6] See Cohen, 423 Mass. at 413 ("[I]f there is a peppercorn of discretion, then whatever is the most the beneficiary might under any state of affairs receive in the full exercise of that discretion is the amount that is counted as available for Medicaid eligibility.")

(b) Payments from the income or from the principal of an irrevocable trust made to or for the benefit of the individual are countable income.

(c) Payments from the income or from the principal of an irrevocable trust made to another and not to or for the benefit of the nursing-facility resident are considered transfers of resources for less than fair-market value and are treated in accordance with the transfer rules at 130 CMR 520.019(G).

(d) The home or fanner home of a nursing-facility resident or spouse held in an irrevocable trust that is available according to the terms of the trust is a countable asset. Where the home or former home is an asset of the trust, it is not subject to the exemptions of 130 CMR 520.007(G)(2) or 520.007(G)(8).

(2) Portion Not Payable. Any portion of the principal or income from the principal (such as interest) of an irrevocable trust that could not be paid under any circumstances to or for the benefit of the nursing-facility resident will be considered a transfer for less than fair-market value and treated in accordance with the transfer rules at 130 CMR 520.019(G).

In addition, 130 CMR 520.024(A) addresses irrevocable trusts:

(A) Irrevocable Trust.

(1) The assets and income held in an irrevocable trust established by the individual or spouse that the trustee is required to distribute to or for the benefit of the individual are countable.

(2) Payments from the income or principal of an irrevocable trust established by the individual or spouse to or for the benefit of the individual are countable.

(3) The assets and income held in an irrevocable trust established by other than the individual or spouse that the trustee is required to distribute to the individual are countable.

(4) Payments from the income or the principal of an irrevocable trust established by other than the individual or spouse to the individual are countable.[7]

[7] If any part of 130 CMR 520.021 through 130 CMR 520.024 conflicts with federal law, federal

Under Article III of the Trust, the appellant has the right to use and occupancy for any real estate held under the Trust. The appellant and community spouse must also receive all of the net income of the Trust at least quarterly. I agree with MassHealth that the SJC in Daley establishes that a use and occupancy in a Trust entitles the applicant to fair market value rental incomes from the property whether actual rental income is generated or received. Specifically, the SJC stated that "[s]uch payments, whether actually received as rental income or imputed as the fair market rental value of the grantors' occupancy of the home, may be countable as income of the grantors, but the value of the home is not thereby countable as their asset." Daley at 15. In imputing income to the Saugus property, which the appellant has the right to use and occupy under the terms of the Trust, MassHealth presents a reasonable valuation based on the HUD Fair Market Rent tables for 2016 to determine the estimated fair market monthly rental value of $1,567 per month. The appellant, while stating that MassHealth's calculation is speculative in that it does not take into consideration property type, quality, size, and neighborhood, offers no alternative calculation, but instead argues that the appellant's use and occupancy interest has no value. The appellant supports this argument by citing to 20 CFR § 416.1201 (which addresses resources and exclusions for supplemental security income) and stating that the use and occupancy value cannot be liquidated within a period of 20 business days.[8] He further states that the value of the property should be assessed as shared occupancy with the appellant's spouse for the period of the appellant's life, which he contends renders the right to use and occupancy not marketable and therefore without value. I simply do not agree that the appellant's right to use and occupancy has no value. The methodology MassHealth used to calculate the fair market rental value of the property takes into consideration that the property is located in Saugus, MA as well as how many bedrooms the property has. (See Exhibit 11.) This is a reasonable and acceptable manner by which to calculate fair rental value. Again, the appellant offers no alternative calculation other than an argument that the appellant's interest holds no value.

However, despite MassHealth's reasonable valuation of the Trust property's fair market value rental income, I find no direction from the SJC, and MassHealth has cited no authority, that directs MassHealth to convert to an asset the imputed value of rental income based upon the appellant's life expectancy. Rather, with regard to "income on the corpus" the SJC states that such payments "do not affect an applicant's eligibility for Medicaid long-term care benefits, but they may affect how much the applicant is required to contribute to the payment for that care." Daley at 15. The amount of income an individual is required to contribute to his or her care is appropriately characterized as patient-paid amount and not an asset. Accordingly, $1,567 is the monthly fair market rental value of the Trust corpus. The appellant has a 50% interest in the corpus, and thus has a 50% interest in the "income on the corpus" which totals $783.50 per month. Based on the clear direction from the SJC in determining that MassHealth may impute income on the corpus, I conclude that imputed income is countable to the appellant whether the Saugus property is actually rented.[9]

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supersedes. (130 CMR 520.021.)

[8] These resources are assessed according to equity value, which is defined as "[t]he price that item can reasonably be expected to sell for on the open market in the particular geographic area involved[...]" (20 CFR § 416.1201(c)(2)(i).)

. [9] According to the Center for Medicare and Medicaid Services, an applicant's "right to use and occupy"

The question then becomes whether the income that is accumulated may be distributed to the appellant. Based upon federal law, MassHealth regulations, and the terms of the Trust, **I** conclude that any accumulated income cannot in fact be distributed to the appellant. Federal law defines "corpus" as "all property and other interests held by the trust, including accumulated earnings and any other addition to the trust after its establishment (except that such term does not include any such earnings or addition in the month in which the earnings or addition is credited or otherwise transferred to the trust)[.]" (42 USC § 1382b(e)(6)(B).) MassHealth argues that accumulated income, which becomes principal in the month after receipt, can be distributed to the appellant under Article XXI. However, Article XXI defines "income" as both "net income and accumulated income **not added to principal...**" (Exhibit 5) (emphasis added). Since income becomes part of the Trust corpus in the month after it is received, the appellant cannot in fact receive accumulated income and is only entitled to distributions of net income in the month received, as all accumulated income becomes part of the Trust corpus. Further, a "clause may not be read in isolation; rather, it must be construed and qualified in light of the trust instrument as a whole." (Doherty v. Dir. of the Office of Medicaid, 74 Mass. App. Ct. 439, 441 (2009).) Reading the definition of income in Article XXI along with Article III ("The Settlors shall not have the right to any principal distributions under any circumstances[ ]"), distribution of principal to the appellant in the form of accumulated income is foreclosed; that is, since income becomes corpus in the month after it is received, accumulated income cannot be distributed under Articles III and XXI. (Exhibit 5.)

The appellant argues that 42 USC § 1396p(d)(3)(B) indicates that income (accumulated earnings) retains its characterization even when held after the month of receipt and does not convert to principal. This argument does not seem to be in accord with the federal statute, which specifically includes accumulated earnings in its definition of "corpus" and makes a distinction between accumulated earnings and earnings that become part of the trust in the month of receipt. While the term "accumulated income" is used, the statute makes clear that such value becomes part of the Trust corpus. The appellant's argument on this point seems to be one of semantics. Despite the appellant's assertion that accumulated income remains income and is not principal, the articles of the Trust do not actually allow for accumulated income to be disbursed, as federal law dictates that income that accumulates beyond the month of receipt becomes part of Trust corpus.

Therefore, for the reasons stated above, the appeal is approved.

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property that is held in trust is a payment:

> Payment—For purposes of this section a payment from a trust is any disbursal from the corpus of the trust or from income generated by the trust which benefits the party receiving it. A payment may include actual cash, as well as noncash or property disbursements, such as the right to use and occupy real property.

(HCFA Tr# 64, p. 3-3-109.25.8.)

Order for MassHealth

Rescind notice dated November 28, 2016 and remove the value of the principal of the Trust from the countable assets when redetermining. eligibility. The imputed rental income may be factored into a future patient-paid amount determination if and when the appellant is approved for MassHealth long-term care benefits.

Implementation of this Decision

If this decision is not implemented within 30 days after the date of this decision, you should contact your MassHealth Enrollment Center. If you experience problems with the implementation of this decision, you should report this in writing to the Director of the Board of Hearings at the address on the first page of this decision.

Samantha Kurkjy
Hearing Officer
Board of Hearings

cc:
MassHealth Representative: Sylvia Tiar
Robert Ford, Esq., 807 Turnpike Street, Suite 201, North Andover, MA 01845

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

MARTIN FAGAN by his agent Pamela Fagan and PAMELA FAGAN, *Plaintiffs,* *v.* RODERICK L. BREMBY, in his official capacity as Commissioner of the Connecticut Department of Social Services, *Defendant.*	Civil No. 3:16cv73 (JBA) March 21, 2017

RULING ON PARTIES' CROSS MOTIONS FOR SUMMARY JUDGMENT

Plaintiffs Martin Fagan ("Mr. Fagan") and Pamela Fagan ("Mrs. Fagan") filed this suit against Defendant Roderick L. Bremby, in his official capacity as Commissioner of the Connecticut Department of Social Services ("DSS"), on January 18, 2016, requesting injunctive relief from Defendant's decision to impose a transfer of assets penalty on Mr. Fagan that results in his being ineligible for Medicaid benefits until March 6, 2022. The parties now bring cross motions for summary judgment. For the following reasons, Plaintiffs' Motion [Doc. #31] for Summary Judgment is denied and Defendant's Motion [Doc. #28] for Summary Judgment is granted.

I. Background

A. Medicaid: The Statutory Landscape

The federal Medicaid program, enacted in 1965 as Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., provides funding to States that assist persons with paying for medical care who have insufficient income and resources. *See* Social Security Act, tit. XIX, as added, 79 Stat. 343, and as amended, 42 U.S.C. § 1396 et seq. "Each participating State develops a plan containing reasonable standards . . . for determining eligibility for and the extent of medical assistance within

boundaries set by the Medicaid statute and the Secretary of Health and Human Services." *Wisconsin Dep't of Health & Family Servs. v. Blumer*, 534 U.S. 473, 479 (2002) (internal quotation marks and citations omitted). In formulating those standards, States must "provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant." 42 U.S.C. § 1396a(a)(17)(B).

In 1988 Congress amended Title XIX of the Social Security Act by passing the Medicare Catastrophic Coverage Act ("MCCA"). The purpose of the MCCA was both "to protect community spouses from 'pauperization' while preventing financially secure couples from obtaining Medicaid assistance." *Blumer*, 534 U.S. at 480 (citing H.R.Rep. No. 100-105, pt. 2, pp. 66-67 (1987)).[1] In order to achieve this goal, the MCCA established "a set of intricate and interlocking requirements with which States must comply in allocating a couple's income and resources." *Id.*

When an institutionalized spouse first applies to Medicaid, the State Agency totals the assets of both the institutionalized and the community spouse "*as of the beginning of the first continuous period of institutionalization* . . . of the institutionalized spouse," and divides that sum in half resulting in what is called a "spousal share." 42 U.S.C. § 1396r-5(c)(1)(A) (emphasis added). This spousal share then becomes the basis for the calculation of the "community spouse resource

[1] The MCCA accordingly contains a set of instructions called the "spousal impoverishment" provisions, which "permit a spouse living at home (called the 'community spouse') to reserve certain income and assets to meet the minimum monthly maintenance needs he or she will have when the other spouse (the 'institutionalized spouse') is institutionalized, usually in a nursing home, and becomes eligible for Medicaid." *Blumer*, 534 U.S. at 478.

allowance" ("CSRA").[2] 42 U.S.C. § 1396r-5(f)(2). Thus, at the "initial determination of eligibility," the State Medicaid Agency treats "the resources held by either the institutionalized spouse, the community spouse, or both" to be available to the institutionalized spouse, 42 U.S.C. § 1396r-5(c)(2)(A), except that "the CSRA is considered unavailable to the institutionalized spouse . . . [so] all resources above the CSRA (excluding a . . . personal allowance reserved for the institutionalized spouse . . .) must be spent before eligibility can be achieved." *Blumer*, 534 U.S. at 482-83 (citing 42 U.S.C. § 1396r-5(c)(2)). In other words, aside from the calculated CSRA, all other community resources are considered in determining whether an institutionalized spouse is eligible for Medicaid, meaning that if the remaining resources exceed the Medicaid limit, the institutionalized spouse must "spend down" the remaining resources to qualify. (Ex. 2 (HHS Amicus Brief in *Hughes*) to Def.'s Mem. Supp. Mot. for Summary Judgment at 8.) This statutory scheme permits the institutionalized spouse to qualify for Medicaid while also allowing the community spouse to retain the CSRA to support him or herself.

When reviewing an application, the State Agency will also check that neither spouse disposed of any assets for less than fair market value "on or after the look-back date," which is defined as 60 months before "the first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State plan." 42 U.S.C. § 1396p(c)(1)(A)-(B).[3] Any such disposition of assets would result in a "penalty period" of

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[2] In Connecticut the CSRA is called the "community spouse protected amount" ("CSPA"), but the Court will refer to it as the CSRA throughout this opinion.

[3] This is referred to as the "look-back period" in this Ruling. *See* 42 U.S.C. § 1396p(c)(B)(i).

ineligibility.[4] However, there is an exemption (referred to as the "unlimited transfer exception") from this penalty period where the assets were transferred to the individual's spouse during the look-back period for the sole benefit of the spouse. § 1396p(c)(2)(B).

As explained by the Centers for Medicare & Medicaid Services ("CMS"),[5] "the unlimited transfer exception should have little effect on the eligibility determination, primarily because resources belonging to both spouses are combined in determining eligibility for the institutionalized spouse. Thus, resources transferred to a community spouse are still . . . considered available to the institutionalized spouse for eligibility purposes." (Def.'s Ex. 1 (State Medicaid Manual § 3258.11).)[6] However, once the institutionalized spouse has commenced a continuous period in which he is in an institution and "after the month in which [he] is determined to be eligible for benefits . . . no resources of the community spouse shall be deemed available to the institutionalized spouse." 42 U.S.C.A. § 1396r-5(c)(4). An institutionalized spouse does have an opportunity to transfer assets to the community spouse "as soon as practicable after the date of the initial determination of eligibility," but only "in an amount equal to the community spouse

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[4] If a penalty period is imposed, the institutionalized spouse will be ineligible "for the number[ ] . . . of months that the assets would have covered the average monthly cost of such services." *Hughes v. McCarthy*, 734 F.3d 473, 476 (6th Cir. 2013) (citing 42 U.S.C. § 1396p(c)(1)(A), (B)(i-ii), (C)(i)(I), D(ii), (E)(i)). This is also referred to as a "transfer of assets penalty."

[5] CMS is the division within the United States Department of Health and Human Services ("HHS") that sets Medicaid policy.

[6] This view is also articulated by HHS in its amicus brief. (*See* Ex. 2 to Def.'s Mem. Supp. Mot. for Summary Judgment at 7) ("prior to an eligibility determination, transfers between spouses or between either spouse and a third party for the sole benefit of either spouse as provided in Section 1396p(c)(2)(B)(i) have little, if any, effect on Medicaid eligibility because the assets of both spouses are pooled together and deemed to be available to the institutionalized spouse. Section 1396r-5(c)(1)(A)(i).").

resource allowance." 42 U.S.C. § 1396r-5(f)(1). It is the meaning of this phrase—"initial determination of eligibility"—in Section 1396r-5(f)(1) that controls disposition of this case.

B. Facts

After Mr. Fagan was severely injured in a motorcycle accident in June 2011, he was moved into Masonicare, a skilled nursing facility in Wallingford, Connecticut, where he has resided ever since. (Ex. 3 to Def.'s Mot. [Doc. # 28] for Summary Judgment ¶¶ 3, 5.) He applied to DSS for Medicaid long-term care benefits in February 2012 and was approved, effective March 1, 2012.[7] (*Id.* ¶¶ 6, 11.) Mr. Fagan continued to receive Medicaid coverage for long-term care services for the cost of his nursing home care until May 31, 2015, when his benefits were discontinued because in April he received a $2 million personal injury settlement,[8] which pushed Mr. Fagan over the Medicaid asset limit. (Pl.'s Local Rule 56(a) stmt. ("Pl.'s LR 56") ¶ 10.) After payment of attorney's fees, medical bills not covered by Medicaid, a Medicare lien, and repayment of $233,037.77 to the Connecticut Department of Administrative Services pursuant to the Medicaid Recovery Act, his

[7] DSS determined Plaintiffs' CSRA was $115,240.00, representing $1,600 for Mr. Fagan as the institutionalized spouse and $113,640 for Mrs. Fagan. (Ex. 3 to Def.'s Mot. for Summary Judgment ¶ 10.)

[8] DSS became aware of the lawsuit and subsequent settlement through Plaintiffs' attorney for the personal injury case in April 2012. (*See* Ex. 3, Attachment G (Letter from Attorney Donna R. Levine to DSS) to Def.'s Mem. Supp. Mot. for Summary Judgment.) On May 8, 2012 DSS sent Plaintiff notice his benefits would be discontinued effective May 31 due to his receipt of the settlement check, which placed him over the $1,600 asset limit for Medicaid eligibility. (Ex 3 to Def.'s Mot. for Summary Judgment ¶ 14.)

net proceeds were $966,102.69.[9] (Ex. 3 (Affidavit of Laura Catarino)[10] to Def.'s Mot. for Summary Judgment ¶ 12.)

On August 12 and September 23, 2015, several months after his coverage was discontinued, Mr. Fagan transferred $879,453.32 of his settlement proceeds to his wife in two transactions. (Pl.'s LR 56 ¶¶ 12, 13.) The amount of the first transfer, $581,453.32, is equivalent to the amount Mrs. Fagan paid for the purchase of her primary residence in Florida.[11] (*Id.* ¶ 12.) She subsequently purchased an actuarially sound single premium annuity with the money from the second transfer.[12] On September 30, 2015 Mr. Fagan reapplied for Medicaid long-term care, by which time his wife's assets countable by the Medicaid program were less than the CSRA she was allowed to retain without affecting her husband's Medicaid eligibility. (*Id.* ¶¶ 15, 17.)

Upon review of Mr. Fagan's reapplication for Medicaid long-term care benefits, DSS determined that the August 12 and September 23 transfers of funds from Mr. Fagan to Mrs. Fagan constituted improper transfers of assets for less than fair market value. (Ex. 3 to Def.'s Mot. for

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[9] Mrs. Fagan also received a personal injury settlement–with a net recovery of $948,964.10. (Ex. 3 to Def.'s Mot. for Summary Judgment ¶ 13.) Her recovery did not affect Mr. Fagan's ongoing Medicaid eligibility because of the "separate treatment of resources" requirement of 42 U.S.C. § 1396r-5(c)(4). (Def.'s Mem. [Doc. # 28-1] Supp. Mot. for Summary Judgment at 8 n. 7.)

[10] Ms. Catarino is a public assistance consultant for DSS who is familiar with Mr. Fagan's Medicaid case.

[11] 42 U.S.C. § 1396p(c)(2)(A)(i) provides that "[a]n individual shall not be ineligible for medical assistance . . . to the extent that the assets transferred were a home and title to the home was transferred to the spouse of such individual."

[12] "An annuity that satisfies various conditions does not qualify as a resource." *Morris v. Oklahoma Dep't of Human Servs.*, 685 F.3d 925, 932-33 (10th Cir. 2012) (citing § 1396p(c)(1)(G)). As the Medicaid regulations explain, "[i]f a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse)." 20 C.F.R. § 416.1201.

Summary Judgment ¶ 18.) On December 7, 2015 DSS sent Mr. Fagan a Preliminary Decision Notice (a W-495A form) informing him of its decision that the transfers totaling $952,006.52[13] to Mrs. Fagan were improperly transferred assets. (*Id.* ¶ 19.) Mr. Fagan disputed DSS's preliminary decision, arguing that because the transfers to his wife were pre-eligibility transfers they were exempt from § 1396r-5(f)(1)'s CSRA cap. (*Id.* ¶ 20.) However, DSS disagreed and issued its final decision notice on December 22, 2015 affirming its conclusion that Mr. Fagan improperly transferred assets to Mrs. Fagan, and consequently imposing a transfer of assets penalty precluding Mr. Fagan from receiving any Medicaid long-term benefits until March 7, 2022.[14] (*Id.* ¶ 22; Pl.'s LR 56 ¶ 22.) Mr. Fagan is now responsible for paying his monthly Masonicare bill of approximately $13,000. (Pl.'s LR 56 ¶ 25.)

II. Discussion[15]

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[13] There is a discrepancy between the amount Plaintiffs claim Mr. Fagan transferred to Mrs. Fagan and the amount computed by DSS. However, this is not a fact that is material under Rule 56 to the question of whether Mr. Fagan could transfer funds in excess of the CSRA to his wife because using either amount Mr. Fagan's transfer would have resulted in an asset penalty.

[14] The Final Decision Notice reads: "[a]though you are eligible for certain Medicaid benefits beginning 9/2015, we are setting up a penalty period starting 9/30/2015. This penalty ends 3/6/2022. During this time, Medicaid will not pay for any long-term care services." (Ex. E to Compl.) This penalty period was calculated based upon the number of months that the assets Mr. Fagan improperly transferred would have covered the monthly cost of the services. *See Hughes v. McCarthy*, 734 F.3d 473, 476 (6th Cir. 2013) (citing 42 U.S.C. § 1396p(c)(1)(A), (B)(i-ii), (C)(i)(I), D(ii), (E)(i)).

[15] Summary judgment is appropriate where, "resolv[ing] all ambiguities and draw[ing] all permissible factual inferences in favor of the party against whom summary judgment is sought," *Holcomb v. Iona Coll.*, 521 F.3d 130, 137 (2d Cir. 2008), "the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law," Fed. R. Civ. P. 56(a). "A dispute regarding a material fact is genuine if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Williams v. Utica Coll. of Syracuse Univ.*, 453 F.3d 112, 116 (2d Cir. 2006) (quotation marks omitted). "The substantive law governing the case

A. There is no Factual Dispute and Only The Single Legal Issue

Neither party claims any material factual dispute, and therefore this case is appropriate for disposition by summary judgment on the legal issue of whether the penalty DSS imposed on Mr. Fagan for his transfer of assets to his wife was lawful. Both parties agree that (1) Mr. Fagan was institutionalized in 2011, and has been continuously institutionalized since that time (Pl.'s LR 56 ¶ 2; Ex. 3 to Def.'s Mem. Supp. Mot. for Summary Judgment ¶ 3); (2) Mr. Fagan began receiving Medicaid benefits in early 2012, and continued to receive them until they were discontinued on May 31, 2015 because Mr. Fagan was over the asset limit (Pl.'s LR 56 ¶¶ 7, 10; Ex. 3 to Def.'s Mem. Supp. Mot. for Summary Judgment ¶¶ 11, 14); and (3) between May 31, 2015 and Mr. Fagan's subsequent reapplication in September 2015, Mr. Fagan transferred his personal injury settlement proceeds to Mrs. Fagan (Pl.'s LR 56 ¶¶ 12, 13; Ex. 3 to Def.'s Mem. Supp. Mot. for Summary Judgment ¶¶ 15, 16).

The Court must decide whether, once Mr. Fagan was originally determined eligible for Medicaid in 2012, the limits on spousal transfers found in 42 U.S.C. § 1396r-5(f)(1) continued to apply to Mr. Fagan's transfers of assets to Mrs. Fagan made after his benefits had been discontinued but before he reapplied for Medicaid; or whether this limitation provision does not apply and §

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will identify those facts that are material, and '[o]nly disputes over facts that might affect the outcome of the suit under the governing law will properly preclude the entry of summary judgment.'" *Bouboulis v. Transp. Workers Union of Am.*, 442 F.3d 55, 59 (2d Cir. 2006) (quoting *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986)). When considering a motion for summary judgment, the Court may consider depositions, documents, affidavits, interrogatory answers, and other exhibits in the record. Fed. R. Civ. P. 56(c). The same standard applies to cross-motions for summary judgment. *See Morales v. Quintel Entm't, Inc.*, 249 F.3d 115, 121 (2d Cir. 2001). The court must examine the merits of each motion independently and in each case must consider the facts in the light most favorable to the non-moving party. *Id.* at 121.

1396p(c)(2)(B)'s "unlimited transfer exception" should be the controlling statutory provision in these circumstances.

After the initial determination of eligibility, assets belonging to the institutionalized spouse and the community spouse are treated separately for purposes of determining the institutionalized spouse's ongoing Medicaid eligibility and "if [after initially being determined eligible] the institutionalized spouse attempts to transfer newly received resources . . . he will face a penalty." *Morris v. Oklahoma Dep't of Human Servs.*, 685 F.3d 925, 937 (10th Cir. 2012). The question is thus whether, with respect to a single continuous period of institutionalization, the "initial determination" in § 1396r-5(f)(1) refers only to the State Agency's first determination of an applicant's eligibility for Medicaid benefits, as Defendant contends, or as Plaintiffs argue, that "initial determination" also refers to a second application where an individual who, after having been deemed eligible and receiving benefits for a period of time, loses eligibility and then reapplies for benefits all while continuously institutionalized. Plaintiffs argue that Mr. Fagan's second application for benefits, although for future coverage on the same continuous period of institutionalization as his first application, constitutes a separate "initial determination of eligibility" resulting in a reversion back to the pre-eligibility transfer of assets rules. Defendant maintains that once Mr. Fagan became eligible for Medicaid and was institutionalized, thereby triggering the statute's separate treatment of resources provision, he and his wife's resources were to be treated separately and any subsequent transfer by Mr. Fagan to Mrs. Fagan while he remained

institutionalized would violate the statute unless it complied with the limited exception in § 1396r-5(f)(1).[16]

B. Neither the Courts nor HSS have Addressed Whether a Break in Eligibility After the Initial Determination Resets the Process

The applicability of Section 1396r-5(f)(1) to the Fagans' circumstances presents a case of first impression. Plaintiffs and Defendants rely almost exclusively on their different interpretations of *Morris*, 685 F.3d 925 (10th Cir. 2012) and *Hughes v. McCarthy*, 734 F.3d 473 (6th Cir. 2013), neither of which directly addresses the issue here, as well as an HHS amicus brief filed in *Hughes*, and two letters from CMS responding to questions from States regarding compliance of their policies with federal law.[17]

Plaintiffs claim that the circumstances in *Morris*, 685 F.3d 925 are identical to the Fagans' except for differences in time periods between the applications and that factually *Hughes*, 734 F.3d 473 is not materially different from their own case. However, there are important distinctions. Neither *Morris* nor *Hughes* involved an institutionalized spouse who reapplied for Medicaid benefits after having earlier received benefits with respect to a continuous period of institutionalization, as Mr. Fagan did. Nor did the institutionalized spouses in *Morris* or *Hughes*

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[16] Mr. Fagan does not contend that he is entitled to retroactive coverage for the months before he reapplied for Medicaid, but rather that his coverage should recommence from the date his second application was processed.

[17] "To the extent that HHS has issued guidance on the federal Medicaid statutes in the form of [the amicus brief and opinion letters] that lack the force of law, its statutory interpretations are not afforded deference under *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984), but are entitled to respect under . . . *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944), only to the extent that those interpretations have the power to persuade." *Hughes v. McCarthy*, 734 F.3d 473, 478 (6th Cir. 2013) (internal citations and quotation marks omitted).

transfer assets to their community spouse after their benefits were discontinued because they were over the asset limit and before submitting a second application for Medicaid benefits. Therefore, although both *Morris* and *Hughes* analyzed Section 1396r-5(f)(1), at issue here, which permits transfer as soon as practicable after the eligibility determination in an amount less than the CSRA, neither did so under the critical factual circumstances presented by the Fagans.

In *Morris* the institutionalized spouse applied for Medicaid but was denied because she and her community spouse had assets over the asset limit. 685 F.3d at 928. In an effort to spend down her assets so that she could qualify for Medicaid, the institutionalized spouse purchased a federally approved annuity paying benefits to her husband, the community spouse. *Id.* After her purchase of this annuity, the institutionalized spouse again applied for Medicaid. *Id.* The State Medicaid Agency imposed a transfer of assets penalty finding that the institutionalized spouse's purchase of the annuity for the community spouse was a transfer of assets for less than fair market value within the look-back period in violation of Sections 1396p(c)(1) and 1396r-5(f)(1) and thus concluded that the institutionalized spouse was ineligible for Medicaid. *Id.*

Morris focused on whether "initial determination of eligibility" refers only to a determination that the institutionalized spouse was in fact eligible for benefits, as those plaintiffs argued, or whether the denial of Medicaid benefits also constitutes an "initial determination" triggering Section 1396r-5(f)(1)'s spousal limit. The Tenth Circuit held that the limitations on spouse-to-spouse transfers only apply in cases where the applicant was determined to be eligible for Medicaid because "an agency's denial of Medicaid benefits is not a watershed moment; a determination that an individual is eligible, however, results in a dramatic change." *Id.* at 937. The court reasoned that § 1396r-5(f)(1) is not triggered upon the State Medicaid Agency's finding that an applicant is ineligible because from that finding the "couple merely learns that they must spend

down further in order to become eligible, and all resources – irrespective of which partner holds title – continue to affect the institutionalized spouse's eligibility for Medicaid." *Id.* The court found further support for its conclusion in 42 U.S.C. § 1396r-5(c)(4), under which the separate treatment of resources for a couple applies only after an institutionalized spouse is determined eligible for Medicaid. *Id.*[18]

Hughes similarly involved a pre-eligibility transfer of assets where the institutionalized spouse had never previously been determined to be eligible. There, the institutionalized spouse had paid her own costs at a nursing facility for about four years. Before she applied for Medicaid, the community spouse purchased an annuity for $175,000 that paid benefits only to him. 734 F.3d at 477. The institutionalized spouse then applied for Medicaid three months later and the State Medicaid Agency imposed a transfer of assets penalty on the institutionalized spouse because her community spouse "used a community resource in an amount that exceeded his CSRA." *Id.* The Sixth Circuit held that the transfer was allowed without penalty under § 1396p(c)(2)(B) because "§ 1396r-5(f)(1) 'has nothing to say about the inter-spousal transfers that are permissible before a determination of eligibility'" and that 42 U.S.C. § 1396r-5(f)(1) only applies to transfers "after the

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[18] Plaintiffs here contend that in *Morris* the Tenth Circuit rejected DSS's argument "that the cap on transfers to a spouse applies once there has been an initial eligibility determination, even though there has been a subsequent period of ineligibility, the applicant has made a second application, and there has been a second eligibility determination." (Pl.'s Mem. Supp. Mot. for Summary Judgment at 6.) However, in actuality, what the court rejected was the argument that a determination of *ineligibility* triggers the limitations on spouse-to-spouse transfers. *See Morris,* 685 F.3d at 937 ("[W]e see no reason why a determination of ineligibility would justify different transfer rules" than those in effect prior to that determination).

date of the initial determination of eligibility." *Id.* at 479-80 (emphasis in the original) (internal citations and quotation marks omitted).

Therefore, *Morris* and *Hughes* stand for the proposition that § 1396r-5(f)(1) applies only where the individual makes the transfer after he or she has been deemed eligible for Medicaid, rather than (1) where the transfer was made after the Agency initially determined that the institutionalized individual was not eligible, as in *Morris*; or (2) where the transfer was made after the institutionalization period had begun but before the institutionalized individual applied for benefits, as in *Hughes*. Thus, these cases do not inform the precise determination here: whether, when Mr. Fagan, while still institutionalized, reapplied for benefits in 2015 after they had been discontinued because he had surpassed the asset limit, Agency approval of his second application would still be considered "the initial determination of eligibility" relating to the same continuous period of institutionalization, or whether the whole process re-set with the second application and Agency's determination that Mr. Fagan was again eligible for benefits.

C. The Transfer of Asset Penalty Imposed by Defendant was Proper

i. Statutory Construction

The critical question in this case is which provision, 42 U.S.C. § 1396r-5(f)(1) or § 1396p(c)(2)(B), applies to Mr. Fagan's transfers of assets to Mrs. Fagan. Generally, where an individual "disposes of assets for less than fair market value on or after the look-back date" he will not be eligible for Medicaid. 42 U.S.C. 1396p(c)(1)(A). However, "a transfer of assets penalty will not be assessed for transfers that occur during the look-back period where assets were transferred 'to the individual's [institutionalized spouse's] spouse or to another for the sole benefit of the individual's spouse.'" (Def.'s Mem. Supp. Mot. for Summary Judgment at 5-6 (quoting 42 U.S.C. §

1396p(c)(2)(B)(i)).) If this look-back Section applies to Mr. Fagan's second Medicaid application, as Plaintiffs contend, Mr. Fagan's transfers would be a permissible exception to the limits on transfers. But, Section 1396r-5(f)(1) only permits a transfer of assets to be done "as soon as practicable after the date of the initial determination of eligibility."[19]

These two sections work in tandem, each applying to a different temporal period, to provide couples with the opportunity to reallocate their assets between them so that the institutionalized spouse's resources do not exceed the Medicaid limit.[20] Section 1396p(c)(2)(B) permits unlimited redistribution prior to the Agency's determination that the institutionalized spouse is eligible for benefits, and Section 1396r-5(f)(1) gives the couple the opportunity to correct

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[19] Mr. Fagan's transfers were indisputably in excess of "an amount equal to the community spouse resource allowance" for Mrs. Fagan and were made long after DSS's first determination of Plaintiff's eligibility. *See* 42 U.S.C. § 1396r-5(f)(1).

[20] Defendant argues that Section 1396(f)(1) controls by reason of Section 1396r-5(a)(1)'s supersedence provision because the two sections conflict with one another. *See* 42 U.S.C. § 1396r-5(a)(1) ("In determining the eligibility for medical assistance of an institutionalized spouse . . . the provisions of this section supersede any other provision of this subchapter . . . which is inconsistent with them.). However, HHS has taken the position that the two Sections pertain to different time periods and thus are not inconsistent with one another. *See Hughes v. McCarthy*, 734 F.3d 473, 480 (6th Cir. 2013) ("HHS has taken the same position in a series of opinion letters issued to state plan administrators and to the public, reasoning that § 1396r–5(f)(1) does not conflict with, and thus does not supersede, § 1396p(c)(2)(B), as the two provisions apply to different situations, before and after eligibility is established; and that permitting inter-spousal transfers under § 1396p(c)(2)(B) does not render § 1396r–5(f)(1) a nullity, as the latter provision still has meaning with respect to resource allocation after eligibility is established."); *see also Morris*, 685 F.3d 925; (Ex. 2 to Def.'s Mem. Supp. Mot. for Summary Judgment); (Ex. 1 (HHS Letters) to Pl.'s Statement [Doc. # 33] of Material Facts.) Although Defendant specifically disagrees with the language in *Hughes*, the Court need not decide if there is a conflict between the spousal transfer limit in Section 1396r-5(f)(1) and 1396p(c)(2)'s unlimited transfer exception because whether by supersedence or by virtue of the two provisions simply applying to different time periods, it is clear that Section 1396p(c)(2)(B) applies to pre-eligibility transfers of assets while Section 1396r-5(f)(1)'s limited transfer exception controls after the initial determination of eligibility.

any issues with regards to the titling of assets "as soon as practicable" after the applicant is first deemed eligible.[21] Defendant thus concludes that, by implication, aside from 1396r-5(f)(1)'s limited exception, any transfer to the community spouse made after the Agency first determines that the institutionalized spouse is Medicaid eligible for that period of institutionalization is prohibited by the statute. This Court agrees. If Section 1396p(c)(2) permitted an eligible institutionalized spouse who subsequently acquired disqualifying excess assets and who thus lost eligibility, to transfer those excess assets to the community spouse and seek resumption of Medicaid benefits without consequence, there would have been no need for Congress to create the specific limited exception of Section 1396r-5(f)(1). *See e.g., United States Olympic Comm. v. Intelicense Corp.*, 737 F.2d 263, 266 (2d Cir. 1984) ("[R]ules of statutory construction require a statute to be construed to give force and effect to each of its provisions rather than to render some of them meaningless.").

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[21] In its amicus brief in *Hughes,* HHS notes that

> Section 1396r-5(f)(1) was designed to serve a limited and somewhat different purpose than Section 1396p(c)(2)(B)(i). It is basically a "clean up" provision. If, after the date of eligibility, assets within the CSRA remain in the institutionalized spouse's name, the institutionalized spouse may transfer those assets to (or for the sole benefit of) the community spouse "as soon as practicable after the date of the initial determination of eligibility." 42 U.S.C. 1396r-5(f)(1). A failure to make such a transfer would lead to the denial of Medicaid eligibility when it came time for the institutionalized spouse's first eligibility redetermination – which must take place at least once every 12 months, *see* 42 C.F.R. 435.916(a).

(Ex. 2 to Def.'s Mem. Supp. Mot. for Summary Judgment at 8.)

The central dispute then, is what constitutes "the initial determination of eligibility," as the phrase is used in Section 1396r-5(f)(1).[22] The Court first examines whether the language of the statute itself "has a plain and unambiguous meaning with regard to the particular dispute in the case." *See Barnhart v. Sigmon Coal Co.*, 534 U.S. 438, 450 (2002). Here, the inquiry is whether use of the word "initial" means that the phrase "initial determination of eligibility" was intended to apply to each continuous period of institutionalization, or whether it corresponds to each new application for Medicaid benefits such that a break in eligibility resets the process.[23]

Defendant argues that "[b]y its plain language an 'initial determination' cannot mean a second determination of eligibility with respect to the same period of institutionalization." (Def.'s Mem. Supp. Opp'n to Summary Judgment at 10.) According to Webster's Dictionary, "initial" means "of or relating to the beginning," and thus, according to Defendant, this "would logically be the first finding that an applicant is eligible for Medicaid." (*See* Def.'s Mem. Supp. Mot. for Summary Judgment at 18.) In opposition, Plaintiffs claim that the only significance of the word "initial" is to distinguish between the first determination the Agency makes on an application for

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[22] This phrase is referenced in two other places in the statute. Section 1396r-5(c)(2), titled "Attribution of resources at time of initial eligibility determination," refers to the period during which the State Agency decides whether an applicant is eligible for Medicaid. Additionally, Section1396a(e)(13)(A)(iii) provides that "[t]he State may apply the provisions of this paragraph when conducting *initial determinations of eligibility*, redeterminations of eligibility, or both, as described in the State plan." 42 U.S.C.A. § 1396a(e)(13)(A)(iii) (emphasis added).

[23] Defendant indicates that the limit on spouse-to-spouse transfers after the initial determination of eligibility applies only when there has been a continuous period of institutionalization. Therefore, "if the institutionalized spouse's condition improves and he is discharged, the entire process may reset, allowing unlimited spouse-to-spouse transfers again." (Def.'s Reply to Pl.'s Opp'n at 3.)

Medicaid and its subsequent redeterminations of a beneficiary's eligibility.[24] (Pl.'s Mem. Supp. Opp'n to Summary Judgment at 2.)

The flaw in Plaintiff's argument regarding the significance of the word "initial" is that because they acknowledge that Mr. Fagan could not have made the transfers at issue prior to a redetermination without penalty, allowing Mr. Fagan to make these same prohibited transfers after his benefits were discontinued (upon redetermination) without penalty would essentially allow him to bypass the transfer limits essential to the statute's purpose. The Court sees no convincing reason why the language of the MCCA should be interpreted to give an institutionalized individual, found ineligible for benefits upon redetermination, a second opportunity to make transfers to his spouse prohibited at the time of his initial eligibility determination when the coverage relates to the same period of institutionalization. As Defendant reasons, the logical reading of the statute's plain language is that the *initial* determination of eligibility attaches not to each application for Medicaid, but rather to each continuous period of institutionalization regardless of the outcomes of renewal determinations during that period of care. Absent any language in the statute intimating that it was the intent of Congress to link the initial determination of eligibility to each new application for the same institutionalization, the Court interprets the word "initial" as encompassing only the very first determination declaring an individual eligible for Medicaid with respect to a single period of institutionalization.

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[24] "[T]he eligibility of Medicaid beneficiaries . . . must be renewed once every 12 months, and no more frequently than once every 12 months." 42 C.F.R. § 435.916(a)(1). However, "the agency must [also] promptly redetermine eligibility between regular renewals of eligibility . . . whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility." *Id.* § 435.916(d)(1). It appears this is the way in which Mr. Fagan's eligibility was revoked.

Because Section 1396r-5(f)(1) permits a limited transfer only "as soon as practicable" after the first determination of eligibility relating to one continuous period of institutionalization, and is silent about subsequent redeterminations resulting in discontinuation of benefits for that same period, a post-transfer application to resume benefits cannot constitute the "initial determination."

ii. The Dual Purposes of the Statute

In addition to the fact that the plain language of the statute is logically read as limiting the initial determination of eligibility to the first occasion where the Agency deems an individual eligible for Medicaid for a single period of institutionalization, this reading is also consistent with the dual purposes of the statute "to protect community spouses from 'pauperization' while preventing financially secure couples from obtaining Medicaid assistance." *See Blumer*, 534 U.S. at 480 (citing H.R.Rep. No. 100-105, pt. 2, pp. 66-67 (1987)). Medicaid is intended to assist "needy persons for the cost of medical care" and Mr. Fagan was such a person when he first applied in February 2012 because he and his wife's assets fell below the necessary threshold. *See id.* at 479. But, that status changed after he recovered nearly a million dollars in proceeds from a lawsuit, significantly ameliorating his financial position such that he no longer qualified for benefits.[25]

Plaintiffs contend that interpreting the statute as preventing Mr. Fagan from making transfers to his wife after his eligibility was revoked "would limit any inter-spousal transfers forever and ever, for years or decades, despite [the individual's] Medicaid eligibility having been terminated." (Pl.'s Mem. Supp. Opp'n to Summary Judgment at 2.) Plaintiffs' argument overlooks that Mr. Fagan's period of ineligibility is mathematically linked to the period of time his excess

[25] Nor was Mrs. Fagan, who recovered close to a million dollars herself, at risk of "pauperization." *See Blumer*, 534 U.S. at 480.

assets would cover the cost of his care, which is entirely consistent with the statute's purpose to prevent couples with the means of paying for their own care from receiving Medicaid benefits.[26]

It is difficult to imagine that Congress intended that an institutionalized spouse, upon inheriting or otherwise acquiring substantial assets after having initially been determined eligible for Medicaid, could wait for the Agency to determine he was no longer eligible for benefits and then transfer those assets to his spouse and successfully reapply for Medicaid.[27] This would create a loophole enabling couples with sufficient assets to pay for the institutionalized spouse's care to remain on Medicaid with little interruption of benefits, which flies in the face of Congress' clear expression that the MCCA was meant to "prevent[] financially secure couples from obtaining Medicaid assistance." *See Blumer*, 534 U.S. at 480 (citing H.R.Rep. No. 100-105, pt. 2, pp. 66-67 (1987)). This legislative goal is better served by construing the phrase "initial eligibility determination" as referring only to the very first determination by State Medicaid Agency declaring an applicant eligible with respect to one continuous period of institutionalization.[28]

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[26] Additionally, if Mr. Fagan's condition were to improve, resulting in his discharge from the institution, the entire process would reset, allowing him to transfer assets to his spouse without limit, thereby refuting Plaintiffs' argument that Defendant's interpretation would prohibit inter-spousal transfers indefinitely.

[27] Plaintiffs contend that because Medicaid is generally determined on a monthly basis, an individual could successfully reapply just one month after having his benefits discontinued without being penalized.

[28] Plaintiffs creatively argue that because Mr. Fagan repaid DSS for all of the Medicaid benefits he had received prior to the new application "[f]or all intents and purposes he had never been on Medicaid at all." (Pl.'s Mem. Supp. Opp'n to Summary Judgment at 2.) However, Plaintiffs were required by law to repay those expenses and they point to no authority that this is somehow significant when making a subsequent determination of an individual's eligibility for Medicaid. *See* 42 U.S.C. § 1396a(a)(25)(A)-(B), (H); Conn. Gen. Stat. §§ 17b-93, 17b-94.

iii. Morris' Watershed Moment

Finally, although *Morris* dealt with a different benefits posture, its analysis of the "initial determination of eligibility" as a "watershed moment" provides a useful construct. In *Morris* the court unequivocally held "that § 1396r-5(f)(1)'s limit on spousal transfers applies only after a State Agency has declared the institutionalized spouse *eligible* for Medicaid benefits," 658 F.3d at 928 (emphasis added), because this, unlike when an individual is *denied* benefits, "results in a dramatic change" *id.* at 937.[29]

Plaintiffs thus argue that because Mr. Fagan was deemed *ineligible* by DSS as of May 31, 2015, the spousal transfer limit is inapplicable. (Pl.'s Mem. Supp. Mot. for Summary Judgment at 5.) However, this argument fails to account for the fact that unlike in *Morris*, prior to that determination of ineligibility DSS had already determined that Mr. Fagan was eligible for Medicaid for that very same period of institutionalization. Therefore, Defendant asserts that once "Mr. Fagan's application was granted, Mr. Fagan's ongoing eligibility depended solely on his assets" and "[t]he only assets Mr. Fagan could transfer to Mrs. Fagan after his Medicaid application was approved were assets up to the CSRA, and he was required to do so 'as soon as practicable after the date of the initial determination of eligibility.' 42 U.S.C. § 1396r-5(f)(1)." (Def.'s Mem. Supp. Mot. for Summary Judgment at 16.) The Court agrees with this analysis.

Moreover, if an individual could simply transfer newly acquired assets after his benefits were discontinued and then reapply for Medicaid for that same period of institutionalization, the

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[29] *Hughes* likewise held that § 1396(f)(2) is irrelevant "before a determination of eligibility" but says nothing about what constitutes an initial determination of eligibility. *See* 734 F.3d at 480.

"watershed moment" of initially being granted Medicaid benefits would lose any significance. Instead, the moment of "initial determination" would be like a water faucet whose flow was controlled by the institutionalized spouse, with eligibility turned on and off, resulting in multiple cycles of applications, eligibility determinations, ineligibility determinations, and reapplications. This would allow any institutionalized spouse to transfer any newly obtained assets to his or her community spouse as soon as he or she went off Medicaid only to go back on the next month after the assets were transferred. Were the statute read to permit this, there would be no "dramatic change" as emphasized in *Morris*, given the fluidity between going on and off Medicaid that such a reading compels.

Given the clear asset consequences that relate to eligibility, the *initial* eligibility determination is a pivotal moment. Once the institutionalized spouse is first determined to be eligible for Medicaid, the Agency may look only at his individual resources (and not the community spouse's) in making determinations about his continued eligibility. *See* § 42 U.S.C. 1396r-5(c)(4). To this end, an institutionalized spouse cannot transfer disqualifying assets to the community spouse after he is determined to be eligible for benefits except for as provided by § 1396r-5(f)(1). Plaintiff's transfer did not fall into this limited exception–he transferred the money after he had initially been determined eligible for Medicaid, the transfer was well over the applicable CSRA, and the transfer occurred long after his initial determination of eligibility. Consequently, the penalty imposed by DSS was proper.

III. Conclusion

In sum, after DSS first found Mr. Fagan eligible for Medicaid, he was prohibited from transferring assets to his community spouse apart from the limited transfer provided for by Section 1396r-5(f)(1), as long as he remained continuously institutionalized, even if there was a break in

his eligibility and he reapplied and was again approved for benefits. This reading of the statute is required by the rules of statutory interpretation, consistent with the dual purposes of the statute, and follows from Morris's "watershed moment" analysis. Therefore, Defendant properly imposed a transfer of asset penalty on Mr. Fagan once he had been found eligible for Medicaid upon reapplication.

For the foregoing reasons, the Court finds that Defendant's imposition of a transfer of asset penalty was proper. Consequently Plaintiffs' Motion for Summary Judgment is DENIED and Defendant's Motion for Summary Judgment is GRANTED. The Clerk is requested to close this case.

IT IS SO ORDERED.

/s/
Janet Bond Arterton, U.S.D.J.

Dated at New Haven, Connecticut this 21st day of March 2017.