TRACK 7
Planning and Skills for Chronic Care Medicaid
Part 2

Presented By:
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MEDICAID ADMINISTRATIVE APPEALS

Appealing a Medicaid Denial

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I. BACKGROUND

A. REGULATIONS

The right to a fair hearing is based upon the federal Medicaid statute and regulations. New York State codified the federal regulations in the Social Services Law and the New York Code of Rules and Regulations. Under the federal law creating the Medicaid program, states must devise a plan to provide the opportunity for a fair hearing to anyone whose claim for benefits under the program is denied or not properly acted upon. The federal law is codified in the United States Code (USC) at 42 U.S.C. §1396a(a)(3) and the federal regulations are found in the Code of Federal Regulations (CFR) at 42 C.F.R. §431.200-.250.

The implementing state statute is codified in the New York Social Services Law (SSL) at SSL §22 and the State regulations are found in the New York Code of Rules and Regulations (NYCRR)

at 18 N.Y.C.R.R. Part 358. The fair hearing regulations cited in this outline can be found at 18 N.Y.C.R.R. §358.

B. THE RIGHT TO A FAIR HEARING (§358-3.1)

The moment applicants apply for Medicaid their due process rights are triggered. Due process rights exist from the filing of the application, to the eligibility determination, through the entire period that benefits are received until the termination of benefits. Applicants/recipients (A/R) have the right to written notice of any decision affecting their benefits and the right to be heard at a hearing.

The right to notice and the opportunity to have a fair hearing are activated in these types of situations:

- denial of an application;
- failure to process an application in a timely manner;
- reduction or termination of benefits; or
- inadequacy of benefits.

The parties to a fair hearing are the Medicaid applicant or recipient, known as the appellant, and the local Medicaid agency whose decision is the subject of the fair hearing.

C. PRE-HEARING CONFERENCE (§358-2.4; 3.8)

Prior to attending a fair hearing, an A/R may attend an agency conference, an informal meeting at the local Medicaid

office. At the conference, Medicaid is required to provide a meaningful opportunity to resolve the problem.

A hearing should be requested before proceeding to a conference to preserve the right to a fair hearing. A request for a conference is not considered a request for a hearing.

Conferences are useful to solve simple clerical errors or to have some simple issues clarified. The personnel handling conferences will not be able to make substantive judgments (errors of law) and can only correct straightforward errors that were made in reviewing the original information.

II. NOTICE REQUIREMENTS (§358-3.3)

A. NOTICE OF ACTION (§358-2.15)

Medicaid must provide written notice to A/R of any action to be taken by Medicaid affecting their benefits. The notice must be both timely and adequate. (§358-2.23, 2.2).

Receiving adequate notice starts the 60-day time limit for requesting a fair hearing (see below). The Notice of Action informing the A/R of the intended action must be mailed at least ten days prior to the date the proposed action is to go into effect (the effective date). (§358-2.23)

A notice of intent has two dates:

- Notice date: the notice date is the date the notice was issued; and

- Effective date: the effective date is the date the proposed action will go into effect.

The A/R must receive the notice of intent at least ten days before the effective date.

B. NOTICE CONTENT (§358-2.2)

An adequate notice must conform to certain requirements as to content. Failure to provide proper notice to the Medicaid A/R that is, any required information is not included, renders the proposed action void, and the notice must be withdrawn. The notice must conform to the requirements set forth in the regulations and must include:

- the date the notice of intent was issued;
- the effective date of the proposed action (except in the case of initial acceptance);
- an explanation of what action the agency is taking;
- the specific laws and/or regulations upon which the action is based;
- an explanation of the right to request a conference and a fair hearing;
- the procedure for requesting a conference and fair hearing (including time limits for making the request and the address and telephone number where a request may be made);
- an explanation of how to request the continuation of services pending the fair hearing date (aid continuing);
- an explanation that individuals may be held liable to repay Medicaid for continuing services if they lose the fair hearing;
- the right of individuals to review their case records and obtain copies of documents;
- the right to be represented by a lawyer, relative, friend or other person;

- the right to call and question witnesses; and the right to present written and oral evidence.

This list is not exhaustive, and the regulations should be checked for a comprehensive list. If the notice fails to list the above information, it is considered defective, and therefore inadequate.

C. IMPROPER OR NO NOTICE

Lack of a notice or a defective notice stops the 60-day limit for filing a fair hearing request (see discussion below). For example, if the notice fails to cite the regulation(s) upon which it is based, or cites the wrong regulation, the 60-day limit is stopped until a proper notice is issued. Therefore, if the 60-day deadline has passed, a fair hearing may still be requested. At the hearing, it must be proven that the notice was defective.

III. REQUESTING A FAIR HEARING SIXTY DAY DEADLINE (§358-3.5)

A. THE FAIR HEARING REQUEST

Once A/R receives the notice of intent, they have 60 days from the date of the notice to request a fair hearing challenging the action. If A/R fails to request hearings within the 60-day time limit, they must prove that the notice was improper or that they did not receive it in a timely manner,

that therefore the 60-day time limit for requesting a fair hearing did not expire. In addition, if a fair hearing is requested within 10 days of receipt of the notice of intent, or prior to the effective date on the notice, in some cases the Medicaid A/R is entitled to aid continuing (see discussion below). Note: for Food Stamp hearings, appellants have 90 days from the notice of intent to request a fair hearing.

Anyone acting on behalf of the appellant may make the request for a fair hearing. Merely requesting a fair hearing on behalf of an individual does not obligate the requester to represent the person at a fair hearing.

1) Requesting a fair hearing (§358-3.5)

Requests may be made in writing, by telephone, by fax or in-person.

Write to:	OAH-OTDA Fair Hearing Section P.O. Box 1930 Albany, NY 12201
Fax:	(518) 473-6735
On-Line:	www.otda.state.ny.us/oah/oahforms/erequestform.asp

B. WHAT SHOULD THE REQUEST CONTAIN? (§358-3.5)

All requests for a fair hearing must contain the following information:

- name, address and telephone number of the A/R;
- Medicaid case number and Social Security number;
- the notice date and effective date of the notice;
- the action or lack of action taken by Medicaid as explained in the notice received;
- whether the appellant is homebound if a telephone hearing is requested;
- name, address, and telephone number of the representative/requester;
- request for ongoing services to continue ("aid continuing"); and
- issues the administrative law judge will be asked to consider.

C. AID CONTINUING: KEEPING SERVICES IN PLACE (§358-3.6)

In certain situations, Medicaid recipients have the right to have their Medicaid benefits and services continued unchanged until a fair hearing decision is issued. This is known as the right to aid continuing. Medicaid recipients must make this request at the time they request a fair hearing and within 10 days of receiving adequate notice of the pending change.

If services have been terminated or reduced before the Medicaid recipient has made the request for aid continuing, Medicaid must restore the services as soon as possible, but no later than five business days after being informed that the recipient is entitled to aid continuing. To get services restored call OAH at 1-800-342-3334.

Aid continuing cannot be granted if the action taken was based upon a change in State or federal law.

1. Reimbursement

If appellants do not have aid continuing and win the fair hearing, they may seek reimbursement for medical and/or home care bills incurred during the time between the application and the fair hearing. For example, if a Medicaid recipient does not have aid continuing and wins the fair hearing, reimbursement may be requested from Medicaid for costs incurred in the time that the Medicaid case was closed to the time the case is reopened.

2. New applicants

Applicants appealing a denial of eligibility on an initial application are not entitled to aid continuing. If the applicants win the appeal of the denial of eligibility, they are entitled to retroactive coverage back to the date of application and three months prior to application if eligible and retroactive reimbursement of costs incurred.

3. Medicaid recovery for benefits received

If Medicaid continues benefits pending a fair hearing appeal and the appellant loses the appeal, the appellant will have to repay Medicaid for all benefits received during the period of aid continuing.

D. FAIR HEARING CONFIRMATION

A confirmation of the fair hearing request is usually mailed to the appellant two weeks after the fair hearing request is received by OAH. Included in the notice is the fair hearing number, the aid continuing status and the issue(s) to be decided.

IV. PREPARING FOR THE FAIR HEARING

A. THE EVIDENCE PACKET (§358-3.7)

Appellants have the right to be provided with copies, at no cost, of all documents relevant to their case prior to the fair hearing. At any reasonable time before the date of the fair hearing and also at the fair hearing, the appellant or the authorized representative has the right to examine the contents of the case record and all documents to be used by Medicaid at the hearing. This request may be made orally or in writing.

The evidence packet should include the application or re-certification with supporting documents, any documents generated by Medicaid and the adverse notice. Reviewing the documents provides some idea of why and how a particular decision was made and gives an idea of what evidence is needed to support the appellant's case.

1. Requesting the evidence packet

The fair hearing evidence packet may be obtained from the Medicaid Hearing Office. Requests should either be mailed return receipt requested or faxed, keeping the confirmation of transmission.

The evidence packet request should contain the following information:

- appellant's name and address;
- case number and Social Security number;
- fair hearing number;
- fair hearing date, if known; and
- if the appellant's representative is requesting the packet, enclose a release from the client authorizing the representative to receive the information.

2. Reasonable time

If the request was made more the five days before the fair hearing, Medicaid must send the packet within a reasonable time of receipt of the request. If the request was made less than five days before the hearing, Medicaid does not have to mail the documents, but rather may provide them at the hearing. Medicaid must also provide access to the documents at the fair hearing.

3. Failure to obtain/incomplete evidence packet

If Medicaid fails to send the evidence packet, Medicaid must withdraw its notice of intent. See Rivera v. Bane, 45305/92 (Sup. Ct. N.Y. Co. December 22, 1995). At the fair hearing, it is important to demonstrate that the request for the

evidence packet was made. For example, a fax confirmation or the "return receipt" card.

The fair hearing representative can submit into evidence at the fair hearing only documents provided in the evidence packet. If a document is not included in the evidence packet, Medicaid is precluded from submitting it into evidence at the hearing.

B. REPRESENTATION (§358-3.9)

The appellant has the right to be represented by an attorney or other authorized representative at any conference and/or fair hearing. An authorized representative, except an attorney, appearing without the appellant present must have written authorization from the appellant.

C. PREPARING FOR THE FAIR HEARING

1. Theory of the case

It is important to identify the issue or issues to be resolved at the fair hearing. Once a theory is identified, both the theory of the case and the plan to support that theory through evidence must be developed.

For example, if the notice is a denial of a Medicaid nursing home application due to the transfer of resources, the appellant would introduce evidence that the gifts/transfers made

were for purposes other than to qualify the appellant for Medicaid.

D. BURDEN OF PROOF (§358-5.9(a))

The burden of proof is the obligation of a party in a legal proceeding to substantiate an issue to prove the correctness of the claim to the ALJ.

The burden of proof at a fair hearing shifts depending on the issue of the case. Any action by Medicaid to discontinue, reduce or suspend Medicaid benefits must be justified by Medicaid, who must prove the correctness of its action taken regarding the appellant. In cases where the appellant's benefits have been denied or the appellant claims that the benefits are inadequate, the appellant has the burden of proof to demonstrate either that eligibility should be established or that the benefits are inadequate. The burden of proof must be documented and corroborated by evidence.

E. DEVELOPING EVIDENCE

The formal legal rules of evidence do not apply at fair hearings. Evidence presented must be relevant to the case being heard and hearsay evidence may be used. The ALJ determines what evidence is admissible at the hearing. Prior to the hearing, appellants and their representatives must obtain records or

information in addition to the appellant's Medicaid file that will support their position.

1. Types of Evidence

Obtain records or information from sources other than HRA, such as:

- letter or affidavit from treating physician, nurse, therapist indicating Applicants health status when gifts were made, along with corresponding medical records;
- detailed information (ledgers, cancelled checks, etc.) regarding gifts such as specific amounts, to whom, and reasons why gifts were made to them (i.e. holiday gifts, birthday gifts, tuition payments, compensation for care, etc.)
- if gifts or purchases were made with cash, provide a ledger with details as to whom received the cash, amount and reasons why;
- if cash was used to pay for home care aides, provide ledger with information such days/hours worked, by whom and services provided as well as any home care agreements entered into by the applicant or their legal representative;
- if transactions were made for the benefit of applicant such as for food, shelter, clothing, equipment, home repairs, etc., provide receipts reflecting same;
- if gifts are part of a larger gifting pattern, provide evidence of same such as copies of checks made payable to others, in similar amounts, prior to the lookback period, and specify reason for gift (i.e. family members tuition payments, annual federal exclusion amount, gifts to charities, etc.;
- provide evidence (statements with balance) that applicant did not impoverish themselves by gifting and that they remained financially solvent after gifts were made;
- promissory notes and proof that monies are being paid back;
- prior hearing decisions that support your argument;

- any other evidence you feel necessary to prove and support your position.

F. STARE DECISIS

ALJs must follow determinations established in past fair hearing decisions or explain in their decision why they have not done so. This principle of administrative stare decisis is essential to guaranteeing and ensuring equal justice to those affected by fair hearing decisions.

The failure of an administrative hearing decision to conform to agency precedent requires reversal as arbitrary even where there is substantial evidence to support the determination made.

The Greater Upstate Law Project (GULP) on-line Fair Hearing Bank (FHB) allows users to search summaries of fair hearing decisions and to download or print copies of actual hearing decisions that can be used as precedent in appropriate hearings. The FHB can be found on-line at www.gulpny.org or www.wnylc.net.

The Office of Temporary Disability and Assistance (OTDA) established a Fair Hearing archive for decisions rendered after November 1, 2010. The archive can be accessed at http://www.otda.state.ny.us/oah/FHArchive.asp.

V. THE FAIR HEARING

A. NOTICE OF FAIR HEARING (§358-5.1)

At least 10 days prior to the fair hearing, the appellant will receive notice of the fair hearing. The notice includes:

- date, time, place of the hearing;
- issue(s) to be resolved;
- aid continuing status;
- ALJ number;
- right to reimbursement for transportation expenses;
- right to be represented;
- right to review case file; and
- right to a translator.

B. THE ADMINISTRATIVE LAW JUDGE (ALJ) (§358-5.6)

The hearing officer is a State official who must act as an impartial trier of fact. The ALJ is obligated to ensure that a complete record of the hearing is made. The ALJ makes findings of fact and conclusions of law. The ALJ tape-records the fair hearing.

C. THE FAIR HEARING REPRESENTATIVE

The fair hearing representative presents Medicaid's case at the fair hearing, setting forth its facts and justifying the correctness of Medicaid's actions. The representative submits Medicaid's evidence to the ALJ. If the agency representative fails to produce the appellant's entire case record at the fair hearing, Medicaid must withdraw its Notice of Intent. See Annunziata v. Blum, 81 Civ. 302 (S.D.N.Y December 15, 1982.)

D. PARTICIPATING AT THE HEARING (§358-3.4(g))

The appellant has a right to appear and participate at the fair hearing in a meaningful manner. If an appellant is homebound (§358-3.4(j)) and unable to attend the hearing at the hearing location, two options exist:

(1) a telephone hearing where the ALJ calls the appellant; or

(2) the appellant's representative appears at the hearing office and participates at the hearing without the appellant.

If the ALJ cannot render a favorable decision for the appellant after the initial telephone hearing or hearing without the appellant, homebound appellants are given the opportunity to have a hearing in their home, thus giving them a meaningful opportunity to participate at the hearing. No decision is issued after the first hearing if the appellant "loses." The hearing will simply be rescheduled for a home hearing.

E. PRESENTING EVIDENCE (§358-5.9(c))

The appellant may present any evidence which is relevant to the issue before the hearing officer. The rules of evidence do not apply at administrative hearings.

1) Opening statement

The opening statement is an oral summary of the case presented at the commencement of the hearing. This should give the ALJ the information needed to know what the case is about and present the facts in a positive and meaningful way for the appellant.

2) Presenting Evidence

An appellant has the right to bring witnesses (§358-3.4(h)) and to present written or oral evidence at the hearing. Witnesses may have their evidence or statements placed into the hearing record through an affidavit instead of appearing at the hearing.

If witnesses refuse to appear voluntarily at a fair hearing, they may be subpoenaed. The ALJ presiding over the hearing must issue a subpoena (§358-5.6(b)(8)), (§358-5.9(e)) compelling the witness to appear.

3) Closing statement

The closing statement is a restatement of the opening statement. It also summarizes the essential points and evidence presented during the hearing.

4) Requesting relief

At the fair hearing, relief can be requested. The appellant can request that the ALJ reverse Medicaid's determination; or, in the alternative, that the ALJ remand the case back to Medicaid for a new evaluation.

If the appellant presents evidence that Medicaid should have known or, if known, would have dramatically changed the original action or decision made by Medicaid, the ALJ may order Medicaid to reopen the evaluation and make another decision.

VI. THE HEARING DECISION

A. THE HEARING RECORD (§358-5.11)

The fair hearing proceedings are taped, and the transcripts, documents and other evidence submitted become part of the official record and remain confidential. The hearing record can only be reviewed by the parties to the hearing or their authorized representatives.

B. THE FAIR HEARING DECISION (§358-6.1)

The fair hearing decision must be based exclusively on the hearing record. The decision must be in writing and set forth the hearing issues, relevant facts, the applicable laws and regulations upon which the decision is made. The decision is sent to all parties concerned.

The hearing decision will either affirm, reverse or make an adjustment the initial notice sent by Medicaid. In some instances, the ALJ will remand the case back to Medicaid for further processing. The decision is binding on Medicaid and must be complied with within a reasonable time.

C. REOPENING OF THE HEARING DECISION (§358-6.6)

A review of the issued fair hearing decision is permitted to correct an error of law or fact which is substantiated and supported by the fair hearing decision. The standard procedure to have a hearing decision reopened is to have the representative write a letter to the Commissioner of OAH. The correspondence should also state what the correct decision should have been.

D. COMPLIANCE (§358-4.4; 6.4)

OAH and the local Medicaid office must render a final decision within 90 days of the request for a fair hearing. Medicaid must comply with fair hearing decision promptly. If Medicaid fails to comply with the decision in a timely manner, call the OAH Compliance Unit at (518) 474-5603.

E. JUDICIAL REVIEW OF THE DECISION

If appellants receive unfavorable decisions, they may appeal and seek court review under the Civil Practice Laws and Rules by bringing a special proceeding in New York State Supreme Court (known as an Article 78 proceeding). An Article 78 proceeding must be commenced within four months of the date of the fair hearing decision. To have a Court reverse a fair hearing decision, the appellant must demonstrate that the ALJ's decision is arbitrary, capricious or an abuse of discretion.

Gifting[1]

Applicable Regulations

Section 366.5(e) of the Social Services Law governs transfers of assets made by an A/R or his/her spouse on or after February 8, 2006.

Generally, in determining the Medicaid eligibility of a person receiving nursing facility services, any transfer of assets for less than fair market value made by the person or his or her spouse within the "look-back period" (the 60-month period immediately preceding the date that an institutionalized individual is both institutionalized and has applied for Medical

[1] This Section has been updated and edited by Sara Meyers, Esq. and Kristine Garcia, a third-year law student at CUNY Law School and a summer intern with Enea, Scanlan & Sirignano, LLP.

Assistance (06 OMM/ADM-5)) will render the person ineligible for Medicaid to pay for the nursing facility services.

Sections 366.5(d) and (e) of the Social Services Law provides that [a penalty period will not be imposed upon]

> (d) a satisfactory showing is made that:
>
> (i) the individual or his or her spouse intended to dispose of the asset either at fair market value, or for other valuable consideration; or
>
> (ii) **the asset was transferred exclusively for a purpose other than to qualify for Medicaid**; or
>
> (iii) all assets transferred for less than fair market value have been returned to the individual.

It is presumed that any transfer of resources within five years prior to an application for medical assistance is done for the purpose of qualifying for Medical Assistance. Therefore, the burden of proof is on the Appellant to show that the transfer was made "exclusively for a purpose other than to qualify for Medical Assistance."

Cases and Examples

Gifts Made for Purposes OTHER than Qualifying for Medicaid

FH # 5571655Z (Agency: Erie; Request: July 14, 2010)

The agency determined Appellant was not eligible for Medicaid for nursing facility services because the Appellant transferred assets valued at $106,652.34 for less than fair market value, imposing a 14.37-month penalty period.

At the hearing, Appellant's son and Power of Attorney sufficiently rebutted the presumption that the various transfers were done for purposes other than qualifying for Medicaid. Appellant's son testified that his mother transferred the home to him to prevent his other sibling from getting the home after his mother and brother had a disagreement regarding the handling of his father's ashes. Appellant's son also sufficiently showed a pattern of gift giving going back multiple years, as well as the fact that his mother often took out large sums of cash for herself. Appellant's son further testified that while his mother had some medical issues, she was always independent and required little to no help. She drove herself to appointments, did her own food shopping, etc. She was once admitted to the hospital but was subsequently discharged and returned home. When she returned to the nursing home for a short rehab stay, son anticipated his mother returning home and when she decided she wanted to stay there because she was happy, he requested a psychological evaluation. The documentation and testimony was found to be credible. Accordingly, based on the record, the evidence established that the transfers were made exclusively for a purpose other than qualifying for Medicaid.

Decision: The Agency's determination that Appellant was not eligible for Medicaid for nursing facility services for a period of 14.37 months because the Appellant transferred assets valued

at $106,652.34 for less than fair market value was correct when made but cannot now be implemented.

FH # 6054793P (Agency: Albany; Requested: March 2, 2012)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $42,365.48 for less than fair market value, imposing a 5-month penalty period.

Decision After Fair Hearing was issued modifying the penalty period. Appellant's son and Power of Attorney asked for reconsideration due to factual errors in the Decision. Specifically, a check in the amount of $35,000 which was to cover tuition for grandchildren ($15,000) and the other $20,000 was to compensate her son for room and board for six years. Son provided sufficient documentation to establish a pattern of gift giving, as well as the fact that he constructed an extension to his home as a "parental apartment" for his mother to live in after his father passed away. The record also supports the fact that Appellant was in good health at the time the gifts were made.

Decision: The Agency's determination that Appellant not eligible for Medicaid for nursing facility services for a period of 5 months because the Appellant transferred assets valued at

$42,365.48 for less than fair market value was not correct and was reversed.

FH# 6766942N(Agency: Erie; Requested: June 30, 2014)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $44,549.79 for less than fair market value, imposing a 5.13-month penalty period.

Appellant's daughter testified that her parents were in good health and intended to die at home. Appellant's husband only went into a nursing home after an unexpected diagnosis. Letters from medical providers supported daughter's testimony. Daughter further testified that her sister lived in the upstairs flat of Appellants home and provided necessary assistance to her parents. Appellant's daughter established a pattern of gift giving and stated that monies giving to children and grandchildren was due to unemployment of one daughter and the tuition for grandchildren whose father had suddenly passed away. It was further established that after the gifts, Appellant and her husband retained another $150,000 in their bank account sufficient to cover the cost of aides in the home.

Decision: The Agency's determination that Appellant not eligible for Medicaid for nursing facility services for a period of 5.13 months because the Appellant transferred assets valued

at $44,549.79 for less than fair market value cannot be sustained and is reversed.

FH# 7378581Z(Agency: Madison; Requested: September 8, 2016)

The agency determined Appellant was not eligible for Medicaid for nursing facility, because the Appellant transferred assets valued at $35,653.23 for less than fair market value, imposing a 2.34-month penalty.

Appellant's spouse presented evidence showing that transfers were part of ongoing gifts to help grandchildren with college expenses. Although Appellant's spouse had been diagnosed with early Alzheimer's disease in 2011, she never intended to place him in nursing home care. Appellant was living a somewhat normal lifestyle. It wasn't until 2014 that Appellants spouse left her job to care for him and their daughter would also come by and help on a daily basis. Appellant's condition did not progress and become unmanageable until 2015. Even after gifts were made to grandchildren, Appellant and his spouse were still able to maintain financial solvency.

Decision: The Agency's determination that Appellant not eligible for Medicaid for nursing facility services for a period of 2.34 months because the Appellant transferred assets valued at $35,653.23 for less than fair market value was not correct and is reversed.

FH# 7515665K(Agency: Suffolk; Requested: April 17, 2017)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $51,000.00 for less than fair market value, imposing a 4.04-month penalty.

At the hearing Appellant's representative asserted that transfers were made for the purpose of helping Appellant's daughter when she fell into extreme financial trouble due to her spouse's mental health issues. Appellant's representative asserted that no other child had received gifts, and gifts made to the grandchildren had been returned. At the time the transfers were made, Appellant nor her spouse considered nursing home care, and they still had approximately $200,000 after the transfers were made. Appellant's daughter testified as to her and her spouse's situation and medical condition. Copies of checks showed that uncompensated transfer were issued directly to pay for daughter's mortgage, real estate taxes, state and federal income taxes, divorce mediation and other bills such as insurance. The evidence established that all of the transfers were made exclusively for a purpose other than qualifying for Medicaid.

Decision: The Agency's determination that Appellant not eligible for Medicaid for nursing facility services for a period

of 4.04 months because the Appellant transferred assets valued at $51,000.00 for less than fair market value was not correct and is reversed.

FH# 7726893Q(Agency: Schenectady; Requested: March 26, 2018)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $135,615.69 for less than fair market value, imposing a 12-month penalty.

At the hearing, Appellant's nephew and POA testified as to Appellant's life before facility placement. The Appellant never married, never had children, never lived alone and never drove. Appellant lived with her sister for over a decade before entering facility placement. Even when she lived with her sister, her sister was the one who cooked, did laundry, etc. and Appellant would contribute to the monthly living expenses. Appellant was also known for gifting during special occasions or holidays but never larger sums than $100. Appellant would often leave the house daily and not return until dinner-time, but no one knew where she was going or what she was doing. The family did know Appellant always carried cash and enjoyed going on bus trips to the casino. They did not become aware of Appellant's finances or the large withdrawals until after Appellant's entry into the nursing facility. Withdrawal slips from the bank did

not contain much helpful information. The lack of information in this case is not sufficient to overcome the presumption that transfer were made for the purpose of qualifying for Medicaid. However, the evidence established Appellant was at risk of losing appropriate medical care without the provision of Medicaid as she is unable to care for herself and her remaining family is not able to provide such care. Therefore, Appellant meets the criteria for undue hardship should she be denied such benefits.

Decision: The Agency's determination that Appellant not eligible for Medicaid for nursing facility services for a period of 12 months because the Appellant transferred assets valued at $135,615.69 for less than fair market was not correct when made but can no longer be sustained.

Gifts found to have been made to qualify for Medicaid

FH# 5594426J (Agency: Fulton; Requested: August 16, 2010)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $98,360.00 for less than fair market value, imposing a 13.54-month penalty.

At the hearing Appellant was represented by her niece and POA. Appellant's niece contended that transfers were not made

for the purposes of qualifying for Medicaid. Instead Appellant's niece claimed it was an early retirement gift so that niece could retire and care for her mother (Appellant's sister) and as a gift for all she had done for her. Appellant's niece further explained that Appellant had no children of her own and was always generous with her family. Even when Appellant was advised to secure her money in a trust before entering the nursing home, she preferred to pay her own way and she did from 2003 through present.

However, without anything in writing evidencing that Appellant intended to compensate her niece and considering that Appellant had been in nursing home care since 2003 and not returned home, the transfers made after Appellant entered a nursing home (2006-2008) should not have been made.

The Agency's determination that Appellant is not eligible for nursing facility services for 13.54 months is affirmed.

FH# 6599242Z(Agency: Suffolk; Requested: January 8, 2014)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $97,600.00 for less than fair market value, imposing an 8.11 month penalty.

Appellant's counsel did not dispute the transfers or respective amounts, but instead contends that the transfers are

part of a larger pattern of gift giving. In 2004 when Appellant sold his house, he began gifting funds to his adult children, which continued through 2013, with the exception of 2008. He further argued that Appellant maintained $160,000 in assets to cover any medical expenses if necessary. Additionally, that Appellant was in good health when the transfers were made.

Appellant's counsel did not provide an explanation for the gifts other than Appellant wanted to be generous with his kids. Based on Appellant's age, his physical and mental condition at the time the gifts were made, the fact that his wife was the one who signed all the checks and naming his daughter POA showed at least an expectation of a need for nursing home care. There was also no indication that Appellant lived independently and cared for himself. Without any documentation or medical testimony to the contrary, this argument was not persuasive.

The Agency's determination that Appellant is not eligible for nursing facility services for 8.11 months is affirmed.

FH# 6728007H (Agency: Erie; Requested: May 17, 2014)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $32,000.00 for less than fair market value, imposing a 3.69-month penalty.

At the hearing Appellant's son contended that transfers were part of a larger pattern of gift giving. Son testified that Appellant wanted to give all her grandchildren money when they got married. She had done this in 2006 when she gave one of them a $2,000 but because she felt she wouldn't be around to see all of them get married, she started giving them gifts beforehand. Specifically, in 2012 she gifted $2,000 to each of her three grandchildren and $13,000 (each) to both of her children. However, gifts to the children were given under the condition that if Appellant needed nursing care the money would be returned.

The evidence presented does not establish that gifts were made for reasons other than qualifying for Medicaid. Small $50-100 gifts, and one isolated $2,000 gift prior to 2012 does not establish a pattern of gift giving. Furthermore, the condition of the gifts to the children that the money be returned should Appellant need home care demonstrate that Appellant was already considering the need for skilled nursing care.

The Agency's determination that Appellant is not eligible for nursing facility services for 3.69 months is affirmed.

FH# 7399514Z(Agency: Suffolk; Requested: October 11, 2016)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $73,383.98 for less than fair market value, imposing a 5.81-month penalty.

At the hearing, the Appellant, through her daughter, argued that transfers totaling $73,383.98, from the Appellant to her family members during the period of December 2011 to May 2014 were gifts as holiday presents as well as renovations. Renovations to the storefront and home where Appellant was residing, which Appellant's daughter owned. Furthermore, Appellant's daughter further argued that Appellant had more than $350,000.00 in assets to pay the cost of the facility and that there was no indication of a need for nursing home care.

The bank logs showed checks disbursed as holiday gifts in 2010 and 2011 but not 2009, and do not support a pattern of gift giving. Additionally, no medical documentation was provided to establish Appellant's good health or sudden medical issues. The fact that the Appellant's daughter moved the Appellant into her home in 2011 indicates some need for a higher level of care and the contemplation of the need for nursing home care. Furthermore, the evidence regarding renovations to the storefront and Appellant's daughter's home were not supported by receipts or explanation as to the medical need for such renovations for the benefit of the Appellant.

The Agency's determination that Appellant is not eligible for nursing facility services for 5.81 months is affirmed.

FH# 7657450Q(Agency: Westchester; Requested: November 27, 2017)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $28,298.21 for less than fair market value, imposing a 2.3-month penalty.

At the hearing, Appellant's daughter testified as to the transfers in question. At issue here was a transfer to Appellant's daughter in the amount of $7,320.00, which she claimed she was holding for her mother and would withdraw the funds as necessary. She could not explain the reasons for the $3,500.00 to another daughter (her sister). As for the remaining $17.478.21, she testified that Appellant was swindled (by a friend) into gifting her that money. Appellant's daughter confirmed that the signature on the withdrawal slip was Appellant's, but the name, date and withdrawal amount was not written in Appellant's handwriting. No police reports were filed.

The court found the $3,500 is an unexplained and therefore uncompensated transfer. Although Appellants daughter wrote the agency a letter indicating that she is holding the funds for her mother and would withdraw them as needed, the $7,320.00 is

attributable to Appellants daughter as an uncompensated transfer. Lastly, lack of documentation indicating Appellant was swindled makes this claim unreliable and not sufficient to rebut the presumption that funds for transferred for purpose other than qualifying for Medicaid.

The Agency's determination that Appellant is not eligible for nursing facility services for 2.3 months is affirmed.

Decisions where DOH made adjustments to penalty period

FH# 7487016Q(Agency: Chautauqua; Requested: February 27, 2017)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $22,098.29 for less than fair market value, imposing a 2.3-month penalty.

At the hearing, Appellant was represented by her son and POA. Appellant's son argued that the uncompensated transfer should be reduced to $6,185.51 because the other $15,903.78 was paid to contractor for door and window repairs in Appellant's home prior to her needing nursing facility care. The agency argued that because Appellant retained a life estate in the property, all improvements made to said property constituted uncompensated transfers.

The court found that because Appellant was in relatively good health when the transfer was made and was living independently (for several months) in the home before her unexpected need for nursing home care. That such repairs were made for the benefit Appellant to enable her to remain in her home. The court also found that Appellant was financially solvent after the transfers and payment to the nursing facility as well as burial fund.

Therefore, the Agency determination that Appellant transferred assets valued at $22,098.29 for less than fair market value, imposing a 2.3-month penalty was not correct and was revered. The Agency was directed to reduce the uncompensated transfers by $15,903.78, and to only impose a partial penalty of $6,185.51.

FH# 7459103K(Agency: Albany; Requested: January 17, 2017)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $125,929.00 for less than fair market value, imposing an 8.92-month penalty with a remaining penalty amount of $9,079.00.

Appellant, by her attorney, did not dispute the $87,000 withdrawal (promissory note), for which Appellant had already received $37,970.00. They did dispute the four checks made to

Appellant's church totaling $23,505.00 and the $15,424.00 cash withdrawal for the purchase of a vehicle. They argued that the transfers to the church were made for charitable purposes. The record supports a pattern of gift giving going back several years in similar amounts while maintaining financial solvency. Appellant's health and expectation of nursing care was determined by her earliest payment for nursing home care in 2014. However, the Appellant had already established a pattern of gift giving to the church. Further, withdrawal slips and bank check submitted indicate the $15,424.00 cash withdrawal was used to purchase a vehicle.

Therefore, the Agency determination that Appellant transferred assets valued at $125,929.00 for less than fair market value, imposing an 8.92-month penalty with a remaining penalty amount of $9,079.00 was not correct and was revered. The Agency was directed to reduce the uncompensated transfers by the total transfer to the church ($23,505.00), the amount used to purchase the vehicle (15,424.00) and the amount received thus far as it relates to the promissory note ($37,970.00) leaving a penalty amount of $49,030.00.

Article 78 Appeals

Rivera v. Blass, 127 A.D.3d 759 (2015)

The agency determined applicant was not eligible for Medicaid for nursing facility, because the Appellant transferred assets valued at $152,567.42 for less than fair market value, imposing a 14.058-month penalty. Applicant appealed, and the Commissioner of New York State Department of Health affirmed. Applicant petitioned for judicial review.

A review of the record shows that on January 2008 when petitioner was 84 years old, her husband loaned their grandson and his wife $200,000 to make home repairs. A promissory note had been executed to reflect a 15-year repayment period with a 5.5% interest rate. The grandson and wife had been making payments accordingly. In March 2009 petitioner fell, broke her hip and entered nursing home care. In August 2009 petitioner applied for Medicaid and in May 2010, the original promissory note was amended to comply with certain Medicaid rules. DDS concluded that petitioner was not eligible for Medicaid, finding the loan to be an uncompensated transfer.

At the hearing husband testified that the loan provided him a stream of income and proved that grandson had been making payments as per the promissory note, with a greater rate of return than he would have received at any bank at the time the loan was made. The petitioner concedes that the loan was not made for fair market value considering their age and 15-year repayment period. However, the evidence presented rebutted the

presumption that the transfer was motivated by an anticipation of need to qualify for Medicaid, which was supported by letter from her physician stating petitioner was in good health when the loan was made. Furthermore, evidence shows prior family loans that had been fully repaid.

Based on the substantial evidence presented in this case, the petition was granted and DOH was directed to provide retroactive Medicaid benefits for a period of 14.058 months.

Matter of Collins v. Zucker, 144 A.D.3d 1441 (2016)

The agency determined applicant (now deceased) was not eligible for Medicaid for nursing facility, because the Appellant transferred assets valued at $26,000.00 for less than fair market value, imposing a 3.04-month penalty. Applicant appealed, and the Commissioner of New York State Department of Health affirmed. Applicant petitioned for judicial review.

The record shows that applicant was in her 90s and living independently. In 2009 and 2010 she transferred $26,000.00 to her daughter for use by her grandson (a military veteran with small children and a service related disability) to purchase a home and make repairs. After the transfer, applicant retained approximately $200,000.00 in assets. In 2011 applicant broke her right femur and moved to an assisted living facility. Later that year she fractured her pelvis and entered a nursing home for

what was expected to be a temporary stay. Due to complications, she remained there. Applicant paid for the cost of her care with her own assets until June 2012 when she applied for Medicaid.

The substantial evidence in this case supports the claim that transfers where gifts to applicant's grandson for the purchase of a house and repairs, which were substantially more than the amount contributed by the applicant. While applicant had some health conditions, it wasn't until her fall in 2011 that she needed nursing home care. Transfers were made several years prior to the need for nursing home care, she retained large sums of assets and was able to live independently until then. The substantial evidence in this case adequately rebuts the presumption that transfer were made for the purpose of qualifying for Medicaid.

Therefore, respondent was directed to provide retroactive Medicaid benefits for a period of 3.04 months.