

The Sole Benefit Trust - Whatever Happened to this Planning Tool?

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SOLE BENEFIT TRUSTS

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The Basics - Statute

The Statute - (42 USC § 1396p(c)(2)(B))

No penalty period will be imposed IF the assets -

- i. were transferred to the individual's spouse **or to another for the sole benefit of the individual's spouse,**
- ii. were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,
- iii. were transferred to, or to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of, the **individual's disabled child** described in subparagraph (A)(ii)(II), or
- iv. were transferred to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of an **individual under 65 years of age who is disabled** (as defined in section 1382c(a)(3) of this title).



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The Basics - Purpose

Dual Purpose

- Avoid penalty for SSI and Medicaid
 - ✓ Not true for non SBT 3rd Party SNTs
- Assets not countable resource for grantor **OR** disabled beneficiary

Particularly Useful When...

- No advance planning done by parent
- Therefore, great crisis planning tool

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The Basics – For Whom Created?

Must be for the “Sole Benefit Of” Certain Individuals

1. Spouse
 - ✓ Not a SNT
 - ✓ **Known as Community Spouse Annuity Trust**
2. Disabled Child or Blind Child (SNT)
 - ✓ No Age Limit – over or under 65 works
 - ✓ Must be certified blind or disabled
3. Disabled Individual (SNT)
 - ✓ Must be Under 65 and disabled

If not one of these individuals, then not SBT!

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The Basics – Disabled Beneficiary

FOR DISABLED BENEFICIARY (NOT CS)

Usually 3rd Party SNT

- **Disabled Beneficiary (except CS)**
- No payback provision required in statute
 - ✓ BUT - Some states require payback anyway

HCFA Transmittal No. 64

- § 3257.6 adds to statutory provisions

What it is Not

- A self-settled SNT
- Clearly – 3rd Party Funds are used

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HCFA Transmittal No. 64

Clarifies Definition of “Sole Benefit Of”

Only valid if the trust benefits no one but that individual (spouse, blind or disabled child, disabled individual)

- Whether **at the time the trust is established**
- OR

- **Any time in the future**

HCFA Transmittal No. 64 - § 3257.B.6.

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HCFA Transmittal No. 64

DISTRIBUTIONS - Trust **MUST** provide for distributions

- On actuarially sound basis,
- Using life expectancy of beneficiary

If NOT

Then no exemption from transfer penalty rules!

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HCFA Transmittal No. 64

DISTRIBUTIONS – You/Your Client does not wish to provide for actuarial sound distributions?

No Problem – HCFA 64 provides an alternative way to draft SBT while still meeting definition of Sole Benefit Of...

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HCFA Transmittal No. 64

IF a SBT provides –

- Payback Provision - Upon the death of individual any funds remaining in the trust must go to the State up to the amount of Medicaid benefits paid

THEN -

- Trust distributions need not be made on an actuarially sound basis

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HCFA Transmittal No. 64

State Interpretational Issues

Payback Trust Required - In some states, SBT **MUST** be a payback trust

- Despite HCFA 64 language to the contrary – can be actuarially sound

Naming of Other Beneficiaries - In some states, other beneficiaries can be named after full payback

- See Hamilton Letter dated January 19, 2001 from HHS to Raymon Harvey, Esq.

Name Disabled Beneficiary's Estate as Remainder - In some states, you can name disabled beneficiary's estate as remainder beneficiary

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HCFA Transmittal No. 64

Compensation of Trustee

- Is allowed by HCFA 64
- Reasonable compensation as defined by State law

Investment Costs

- Also allowed by HCFA 64
- Reasonable costs to invest or otherwise manage trust funds

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96 ADM-8

Clarifies Sole Benefit Requirements For CS

Written statement clearly limiting use and enjoyment of funds to spouse

OR

If no written statement - then the person who transferred funds may sign a statement attesting that the transfer was intended for the sole benefit of the spouse.

IN ADDITION – the social services district must conclude, based on the age of the spouse, amount of assets transferred, and the rate and amount of actual expenditures from the transferred assets for the benefit of the spouse, that the transferred assets are likely to be totally expended

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96 ADM-8

Sole Benefit Statement

I transferred the following assets to _____ on _____.

At the time of the transfer, it was my intent, and it was the agreement of myself and the transferee, that the transferred assets henceforth would be used for the sole benefit of _____.

Specifically, it was and is my intent that the assets be expended for the following purposes: _____.

I acknowledge that I have a responsibility to provide to the social services agency evidence of a continuous course of conduct by the transferee, consistent with this intent, since the time of the transfer.

I further acknowledge that, pursuant to regulations of the New York State Department of Social Services, any action by myself or the transferee which has the effect of reducing or eliminating the above-named beneficiary's use of the transferred property, or has the effect of reducing or eliminating the transferee's ownership or control of the transferred property, will be considered a transfer of assets (on the date such action is taken) which may affect my or my spouse's eligibility for Medical Assistance.

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Trusts for the Sole Benefit of the Community Spouse

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Availability of Assets in Sole Benefit Trusts – The Community Spouse

Streimer Letter - HCFA Letter Dated April 16, 1998, to Jean Galloway Ball, Esq.

1. Compares the ‘purchase of an annuity’ to ‘funds placed into community spouse SBT’
2. Considers whether actuarial soundness
 - Available Resource - Protects trust assets from being deemed an available resource

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Availability of Assets in Sole Benefit Trusts – The Community Spouse

Streimer Letter Conclusion

Commercial Annuity

- Give up control of assets in exchange for a commodity (i.e., the annuity product)

Sole Benefit Trust

- Actuarial soundness only applies to transfer of assets rules
 - ✓ But not to determine if trust assets are available
- Availability of Assets analyzed under § 1917(d) of the Social Security Act

“if there are any circumstances under which trustee can pay assets to CS...”

Implications

- Some states will only allow creation of SBTs for CS up to the CSRA

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Availability of Assets in Sole Benefit Trusts

Argument that Streimer Letter is Flawed

The control of assets is given up whether the funds are used to purchase an irrevocable annuity or placed into a trust for the sole benefit of the community spouse

The only condition in HCFA 64 is that the definition of “sole benefit of” must be satisfied

- Actuarially Sound Payout
- CS is only beneficiary of trust assets

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Availability of Assets in Sole Benefit Trusts

Two Cases Support Streimer Letter Interpretation

- *McNamara v. Ohio Dep't. of Human Services, Ohio App. Ct., 2d Dist., C.A. Case No. 18234 (August 4, 2000)*
- *Johnson v. Guhl, U.S. Dist. Ct., N.J., No. 99-CIV-5403 WGB, 2000 WL 359624 (April 7, 2000)*

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Availability of Assets in Sole Benefit Trusts

McNamara v. Ohio Dep't. of Human Services,
Ohio App. Ct., 2d Dist., C.A. Case No. 18234 (August 4, 2000)

Facts

- H created spousal annuity trust and funded with \$221k
 - ✓ Entire marital estate valued at \$256k
- Monthly income to H - Principal annually to H over 5 years
- W received no benefit from trust
 - ✓ So it was for sole benefit of H
- H was 76 at trust creation date, and life expectancy was 8.76 years
- H had no authority to withdraw assets from trust
- At death of H, remainder to 2 children
- Medicaid imposed 30 month penalty period

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Availability of Assets in Sole Benefit Trusts

McNamara v. Ohio Dep't. of Human Services (cont.)

Appellant's Arguments

No penalty period should be imposed on the transfer of assets into the SBT -

- Exempt spousal transfers can be made in unlimited amounts - 42 USC § 1396p(c)(2)(B)
- The CSRA does NOT operate as a restriction on the amount of exempt spousal transfers
- The trust was for the sole benefit of H notwithstanding remainder provisions to children, because only H could benefit during his lifetime

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Availability of Assets in Sole Benefit Trusts

McNamara v. Ohio Dep't. of Human Services (cont.)

Medicaid Argument

No one can benefit from the trust except CS, now or at any time in the future; therefore, naming children as residuary beneficiaries violates this rule

Holding

- Court concludes the CSRA limits amount of assets that can be transferred between spouses
- Upholds penalty for funding of SBT since the amount transferred into the trust exceeded the applicable CSRA (about \$80,000 in Ohio at that time).

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Availability of Assets in Sole Benefit Trusts

McNamara v. Ohio Dep't. of Human Services (cont.)

Appellant (H) cites HCFA Transmittal No. 64 in support of his position –

“The exceptions to the transfer of assets penalties regarding interspousal transfers and transfers to a third party for the sole benefit of a spouse apply even under the spousal impoverishment provisions [contained in 1396r-5]. Thus, the institutional spouse can transfer unlimited assets to the community spouse or to a third party for the sole benefit of the community spouse.”

Court dismisses this argument, stating that HCFA policy transmittals are entitled to some deference IF they are consistent with the plain language and purposes of the statute.

Court Reasoning - Since Congress enacted CSRA provisions, it must have intended to limit the amounts that can be transferred between spouses to this limit; otherwise, why have a CSRA?

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Availability of Assets in Sole Benefit Trusts

McNamara v. Ohio Dep't. of Human Services (cont.)

Appellant (H) cites HCFA Transmittal No. 64 in support of his position –

WAIT - if the *McNamara* court's reasoning was adopted, there would be an impermissible transfer between spouses any time assets above the CSRA were transferred!

The court never got to the question of availability of assets issue, considering this issue to be moot in light of the improper transfer of assets between spouses.

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Availability of Assets in Sole Benefit Trusts

Johnson v. Guhl, 91 F.Supp.2d 754 (D.N.J. 2000)

Facts

- Class action seeking injunctive relief against NJ Medicaid policy of treating assets in CS Annuity Trust available resources
- Plaintiffs are Community Spouses and Institutionalized Spouses
- Some applied for Medicaid and some did not yet apply

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Availability of Assets in Sole Benefit Trusts

Johnson v. Guhl (cont.)

“

“There can be no doubt but that the statutes and provisions in question, involving the financing of Medicare and Medicaid, are among the most completely impenetrable texts within human experience. Indeed, one approaches them at the level of specificity herein demanded with dread, for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase.”

”

Rehabilitation Ass'n of Virginia v. Kozlowski, 42 F.3d 1444 (4th Cir. 1994)

“With this in mind, we begin.”

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Availability of Assets in Sole Benefit Trusts

Johnson v. Guhl (cont.)

NJ Medicaid Policy

- Since late 1994 (when OBRA '93 compliance was implemented through HCFA 64), the use of CSATs was approved and excluded the resources contained in CSATs from countable resources of institutionalized spouse

BUT

- Streimer letter dated April 16, 1998 is cited by *Johnson* court and given deference - While not binding on the court, it is instructive...
- The corpus of the CSAT can “at some point in the future” be paid to the community spouse
- Therefore, under 1917(d) of the Social Security Act, it is an available resource to the community spouse

Same result as in *McNamara* case!

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Did Anything Positive Come from the Streimer Letter?

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Availability of Assets in CS Sole Benefit Trusts

Streimer Letter cited in Support of Annuity Planning by Community Spouse

Delaware Dep't. of Health and Social Services v. Ethelda Dean, Sup. Ct., C.A. No. 00A-05-006, May 15, 2001

- Annuity purchase by CS deemed available resource by Medicaid
- Medicaid denies application due to resources in excess of CSRA
- Lower court holds that while Transmittal 64 clearly dislikes annuities purchased to protect assets instead of retirement planning, if actuarially sound payout and fair market value received, then it is income and not a resource
- Pre-DRA Annuity Rules applied
- Streimer Letter cited in support of commercial annuity being a valid way in which to convert resources into income stream for CS

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Availability of Assets in CS Sole Benefit Trusts

Streimer Letter cited in Support of Annuity Planning by CS

James v. Richman, 465 F. Supp. 2d 395, (USDC, M.D. Pennsylvania – November 21, 2006)

- Post-DRA case citing Streimer Letter in support of community spouse annuity not being an available resource

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Availability of Assets in CS Sole Benefit Trusts

So we find the Streimer Letter being used to support a CS Annuity not being a countable resource.

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Availability of Assets in CS Sole Benefit Trusts

But we still do not know if we can establish a SBT fbo CS without it being considered a countable resource!

That is, until *Hegadorn*...

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Availability of Assets in Sole Benefit Trusts

Hegadorn v. Department of Human Services Director,
Michigan Supreme Court 2019 WL 2064530 (May 19, 2019)

MAJOR BREAKTHROUGH OPINION

Facts

- Medicaid counted assets in SBT fbo CS
- Any circumstances test under 1396p(d)(3)(B) applied by Michigan high court
- BUT – court determines that the test only applies to the Medicaid applicant, and not the CS!
- If an irrevocable trust can make payments only to the CS, the any circumstances test is only satisfied if there is evidence that those payments could benefit the IS

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Availability of Assets in Sole Benefit Trusts

Hegadorn v. Department of Human Services Director,
Michigan Supreme Court 2019 WL 2064530 (May 19, 2019)

- The trusts in *Hegadorn* all provided for actuarial sound payouts and solely to or for the benefit of the CS
- Neither the CS or IS were the trustees or successor trustees
- The fact that an irrevocable trust, which includes former assets of the IS, can make payments to a CS does not automatically render the assets held by the SBT countable for purposes of the IS' Medicaid eligibility!
- The SBTs at issue all contain language stating that distributions or payments from the trust may only be made to or for the benefit of the CS

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Availability of Assets in Sole Benefit Trusts

Hegadorn v. Department of Human Services Director,
Michigan Supreme Court 2019 WL 2064530 (May 19, 2019)

- Cases were remanded for a determination as to whether payments from the trusts could be made to or for the benefit of the IS with appropriate explanations for the rationale of this decision.

BUT CONCURRING OPINION IS OMINOUS

If an IS can achieve immediate eligibility for Medicaid assistance by simply placing assets over the eligibility limit in an irrevocable trust, and also avoid the divestment penalty that accompanies that kind of divestment so as any payments from the trust are made only to the CS during his/her lifetime, then...

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Availability of Assets in Sole Benefit Trusts

Hegadorn v. Department of Human Services Director,
Michigan Supreme Court 2019 WL 2064530 (May 19, 2019)

- The result would be a perfect loophole to Congress' carefully constructed eligibility rules.
- Put another way, is a transfer of assets to a third party trustee "for the sole benefit of" the CS if that transfer "benefits" the IS by allowing her to satisfy Medicaid's eligibility limits while avoiding the specific rules that apply to CS Medicaid?
- And, what if a SBT names as a remainder beneficiary a person or entity other than the state agency? If a third party can receive the remainder, is the transfer "for the sole benefit of" the CS?

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Availability of Assets in Sole Benefit Trusts

Colorado FH Decision

Arapahoe County, May 14, 2008

Facts –

- CSAT established September 2007
 - ✓ \$223,810
- CS assets otherwise < CSRA
- Medicaid applied for – October 2007
- CSAT assets considered available and application denied
- CS sole beneficiary – check
- Residuary payable to CS estate
- CSAT actuarially sound - check

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Availability of Assets in Sole Benefit Trusts

Colorado FH Decision

- Trust analysis under state regulations applied to determine assets available to CS (same as § 1396p(d)(3))
- “If there are any circumstances under which payments from the [irrevocable] trust could be made to or for the benefit of **the individual**, the following shall apply:
 - ✓ The portion of the corpus of the trust, or the income on the corpus, from which payment to the individual could be made, shall be considered as resources available to the individual.”
 - ✓ § 8.110.52.B.4.a.1 Colorado Medical Assistance Manual.

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Availability of Assets in Sole Benefit Trusts

Colorado FH Decision

- Appellant argued “the individual” referred to is **not the CS**, but the **IS**
- Medicaid agency agreed “individual” refers to the grantor/**IS**, but argued CS was in fact a grantor in this case, even though trust established by IS, b/c CS used her power of attorney to create the trust on behalf of the IS

HOLDING - ALJ determined that use of POA does not make the CS a grantor

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Availability of Assets in Sole Benefit Trusts

Colorado FH Decision

- Medicaid also argued that residuary payable to CS estate renders trust assets available
 - ✓ Since IS has elective share, he will have access to the assets at that time
- ALJ reasoned that these assets would then be payable from CS estate, and not the trust
- Therefore, no violation of the “any circumstances” rule

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Availability of Assets in Sole Benefit Trusts

Colorado FH Decision

- ALJ discussed *McNamara* decision re: limit on transfers to CSAT up to CSRA amount
- “Regardless of the merit of the *McNamara* opinion, the ALJ is bound to apply the State Department’s regulations as written, and is not at liberty to disregard them.”

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Availability of Assets in Sole Benefit Trusts

Colorado FH Decision

Holding – Further Analysis

- Trust corpus not owned by IS or CS, individually
- Trust corpus IS owned solely by the CSAT
- Although CS is a beneficiary, she is not “the individual” for purposes of applying the attribution rule under “any circumstances” test
- No Transfer Penalty - b/c trust was for sole benefit of CS, no transfer penalty applies
- Not Available Resource - b/c trust corpus was not owned by IS or CS, it is not an available resource

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Availability of Assets in Sole Benefit Trusts

BUT

- In Colorado, state can overrule ALJ decision
- That they did in this case!
- State advised they would do so in all such cases.
- Regulations were revised to remove exempt transfer provisions for sole benefit of CS
- Thus, not a viable planning tool in Colorado
- However, commercial annuities still work

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Availability of Assets in CS Sole Benefit Trusts

Conclusion Regarding CSATs/CS SBTs

No point in going through the effort in creating a CSAT/CS SBT if the assets are going to be deemed available to the CS anyway

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Trusts for the Sole Benefit of a Blind or Disabled Child or Disabled Individual

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Beneficiary Receiving SSI/Medicaid or SSDI

Must Review Government Benefits Received by Disabled Individual

- SSI and Medicaid – both means based benefits
- Per Streimer Letter – assets available to CS
- BUT - if SBT structured as SNT fbo disabled individual, then assets NOT available!

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Beneficiary Receiving SSI/Medicaid or SSDI

Must Review Government Benefits Received by Disabled Individual

- SSDI and Medicare – generally not means-based
- BUT – consider other benefits
 - ✓ Example – group housing

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Comparison of SBTs to 3rd Party Irrevocable Trusts

Sole Benefit Trusts

Availability

- assets available to beneficiary, **unless SNT provisions inserted into trust, AND**
- Assets **NOT available to grantor**

Transfer of Assets Penalty

- No penalty due to statutory “sole benefit” exception

Payback

- Some states require in order to be SBT
- Some states only require actuarially sound payout

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Comparison of SBTs to 3rd Party Irrevocable Trusts

Sole Benefit Trusts

▪ Estate Recovery

- ✓ No estate recovery against grantor
- ✓ If state requires payback, then that replaces recovery
- ✓ If no payback, then only estate recovery if state has broad definition of “estate” for recovery purposes

Third Party SNTs

- Assets NOT Available
- There IS a penalty period
- No payback
- No estate recovery

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Who Can Fund a Third Party Sole Benefit Trust?

- The Grantor
- And anyone else for that matter!

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Massachusetts Fair Hearing

Facts -

- Client is 79 year old woman residing in nursing home
- November 14, 2010
 - ✓ Transfer of assets to Grandson SNT
 - ✓ Grandson is disabled/named beneficiary of SNT
- December 6, 2010
 - ✓ Medicaid denies due to transfer of assets into SNT
 - ✓ Failure to establish trust as permissible under federal law

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Massachusetts Fair Hearing

State statute similar to federal law -

- The resources were transferred to a trust, a special needs trust, or a pooled trust created for the sole benefit of a permanently and totally disabled person who was under 65 years of age at the time the trust was created or funded. 130 CMR 520.019(D)(4).

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Massachusetts Fair Hearing

Trust Terms

- Distributions required on actuarial sound basis
- Life expectancy to be calculated in accordance with SSA tables
- Discretionary authority of trustee to distribute over and above mandatory distributions (per life expectancy)
- State to be paid back on death of disabled beneficiary

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Massachusetts

Medicaid Arguments

The trust fails because -

- discretionary authority of trustee is not consistent with actuarial sound requirement of HCFA 64
- the payback requirement applies to the person applying for Medicaid (grantor), and not the disabled beneficiary
- ALJ rejects both arguments and upholds trust

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Massachusetts

Massachusetts Protocol

- SBTs denied initially
- Must go to Fair Hearing to prove trust satisfies federal and MA regulations

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I. **HCFA Transmittal No. 64 Pertaining to Sole Benefit Trusts**

A. **Section 3257. Treatment of Assets and Treatment of Trusts**

1. **Section 3257.B.6. For the Sole Benefit of**

A transfer is considered to be for the sole benefit of a spouse, blind or disabled child, or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

Similarly, a trust is considered to be established for the sole benefit of a spouse, blind or disabled child, or disabled individual if the trust benefits no one but the individual, whether at the time the trust is established or at any time in the future. However, the trust may provide for reasonable compensation, as defined by the State, for a trustee or trustees to manage the trust, as well as for reasonable costs associated with investing or otherwise managing the funds or property in the trust. In defining what is reasonable compensation, consider the amount of time and effort involved in managing a trust of the size involved, as well as the prevailing rate of compensation, if any, for managing a trust of similar size and complexity.

A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not the spouse, blind or disabled child, or disabled individual is not considered to be established for the sole benefit of one of these individuals. In order for a transfer or trust to be considered for the sole benefit of one of these individuals, the instrument or document must provide for the spending of the funds involved for the benefit of the individual on a basis that is actuarially sound based upon life expectancy of the individual involved. When the instrument or document does not so provide, any potential exemption from the penalty or consideration for eligibility purposes is void.

An exception to this requirement exists for trusts discussed in §3259.7. Under these exceptions, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the State, up to the amount of Medicaid benefits paid on the individual's behalf. When these exceptions require that the trust be for the sole benefit of an individual, the restriction discussed in the previous paragraph does not apply when the trust instrument designates the State as the recipient of funds from the trust. Also, the trust may provide for disbursement of funds to other beneficiaries, provided the trust does not permit such disbursements until the State's claim is

satisfied. Finally, “pooled” trusts may provide that the trust can retain a certain percentage of the funds in the trust account upon the death of the beneficiary.

B. **Section 3258.10. Exceptions to Application of Asset Penalties**

Section 3258.10.B.

The assets were:

Transferred to the individual's spouse or to another for the sole benefit of the individual's spouse;

Transferred from the individual's spouse to another for the sole benefit of the individual's spouse;

Transferred to the individual's child, or to a trust (including a trust described in §3259.7) established solely for the benefit of the individual's child (The child must be blind or permanently and totally disabled, as defined by a State program established under title XVI, in States eligible to participate in such programs or blind or disabled as defined under SSI in all other States); or

Transferred to a trust (including a trust as discussed in §3259.7) established for the sole benefit of an individual under 65 years of age who is disabled as defined under SSI.

1. For the Sole Benefit of.—See §3257 for the definition of the term “for the sole benefit of.”

In determining whether an asset was transferred for the sole benefit of a spouse, child or disabled individual, ensure that the transfer was accomplished via a written instrument of transfer (e.g., a trust document) which legally binds the parties to a specified course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. A transfer without such a document cannot be said to have been made for the sole benefit of the spouse, child, or disabled individual, since there is no way to establish, without a document, that only the specified individuals will benefit from the transfer.

2. Blind or Disabled as Defined Under SSI Program.—When it is alleged that an asset was transferred to or for the benefit of an individual who is blind or totally and permanently disabled, you must determine that the individual in fact meets the definitions of blindness or disability used by the SSI program (which are currently the same definitions as under the title II program) or under the State plan programs established under title XVI or under the title II program. If the individual is receiving

SSI benefits or is eligible for Medicaid as a result of blindness or disability, you can accept the determination of blindness or disability as valid evidence. However, if the individual is not receiving SSI and/or Medicaid, you must make a separate determination of blindness or disability. However, if you use more restrictive criteria under §1902(f) of the Act, you may not use a more restrictive definition of blindness or disability. Instead, you must use definitions used by the SSI program.

- C. Section 3258.11. Transfers of Assets and Spousal Impoverishment Provisions. – Under §1917(c)(2)(B) of the Act, certain transfers of assets for less than fair market value are exempt from penalty. (See §3258.10 for a complete discussion of those exemptions.) Among those exemptions are transfers from an individual to a spouse, transfers from an individual to a third party for the sole benefit of a spouse, and transfers from a spouse to a third party for the sole benefit of the spouse.

Section 1924 of the Act sets forth the requirements for treatment of income and resources where there is an individual in a medical institution with a spouse still living in the community. This section of the Act provides for apportioning income and resources between the institutional spouse and the community spouse so that the community spouse does not become impoverished because the individual is in a medical institution. (See §3260 for a complete discussion of the spousal impoverishment provisions).

The exceptions to the transfer of assets penalties regarding interspousal transfers and transfers to a third party for the sole benefit of a spouse apply even under the spousal impoverishment provisions. Thus, the institutional spouse can transfer unlimited assets to the community spouse or to a third party for the sole benefit of the community spouse.

When transfers between spouses are involved, 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.

The exception for transfers to a third party for the sole benefit of the spouse may have greater impact on eligibility because resources may potentially be placed beyond the reach of either spouse and thus not counted for eligibility purposes. However, for the exception to be applicable, the definition of what is for the sole benefit of the spouse (see §3257) must be fully met. This definition is fairly restrictive, in that it requires that any funds transferred be spent for the benefit of the spouse within a time-frame actuarially commensurate with the spouse's life expectancy. If this requirement is not met, the exemption is void, and a transfer to a third party may then be subject to a penalty.

II. Federal Law Pertaining to Sole Benefit Trusts

A. The Federal Statute – 1396p(c) Taking into account certain transfers of assets

(1) (A) – In order to meet the requirements of this subsection for purposes of section 1396(a)(18) of this title, the State plan must provide that if an institutionalized individual or the spouse of such an individual (or, at the option of the State, a non-institutionalized individual or the spouse of such an individual) disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance for services described in subparagraph (C)9i) (or, in the case of non-institutionalized individual, for services described in subparagraph (c)(ii) during the period beginning on the date specified in subparagraph (D) and equal to the number of months specified in subparagraph (E).

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that –

(B) the assets –

(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,

(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,

(iii) were transferred to a trust (including a trust described in subsection (d)(4) established solely for the benefit of the individual's child described in subparagraph (A)(ii)(II), or

(iv) were transferred to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1382c(a)(3) of this title);

III. **New York Law Pertaining to Sole Benefit Trusts**

See 96 Adm-8 dated March 29, 1996 – Section III.A (page 5), Section IV.A.6. (pages 7- 8), and Attachment I for a discussion of New York State Department of Health policy regarding sole benefit trusts.

Florida Law Pertaining to Sole Benefit Trusts

A. **Rule 65A-1.712 SSI-Related Medicaid Resource Eligibility Criteria**

65A-1.712(3)(c) – No penalty period or period of ineligibility shall be imposed against an individual for transfers described in 42 USC § 1396p(c)(2).

1. In order for the transfer or trust to be considered to be for the sole benefit of the spouse, the individual's blind or disabled child, or a disabled individual under the age of 65, the instrument or document must provide that: (a) no individual or entity except the spouse, the individual's disabled child, or disabled individual under age 65 can benefit from the resources transferred in any way, either at the time of the transfer or at any time in the future; and (b) the individual must be able to receive fair compensation or return of the benefit of the trust or transfer during their lifetime.
2. If the instrument or document does not allow for fair compensation or return within the lifetime of the individual (using life expectancy tables noted in paragraph (b) above), it is not considered to be established for the sole benefit of the indicated individual and any potential exemption from penalty or consideration for eligibility purposes is void.

B. ESS Manual Section 1640.0609.07 Definition of "For the Sole Benefit of" (MSSI)

In order for the transfer to be considered to be for the sole benefit of the spouse, the individual's blind or disabled child, or a disabled individual under age 65 (and not be subject to a transfer penalty), there must be a written transfer document which legally binds the parties to a specific course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer.

The transfer instrument or document must provide that:

1. No individual or entity except the spouse, the individual's disabled child, or the disabled individual under age 65 can benefit from the assets or income transferred in any way either at the time of the transfer or at any time in the future; and
2. The spending of the funds involved for the benefit of the individual is actuarially sound based on the life expectancy of the individual involved; that is, the individual must be able to receive fair compensation or return of the benefit of the transferred asset during his lifetime. (Follow instructions in 1640.0609.02 and use life expectancy tables in Appendix A-14 to determine if the person will receive fair compensation in his lifetime.)
3. If the transfer instrument or document does not meet these requirements, it cannot be considered a transfer for the sole benefit of the spouse, the blind or disabled child, or disabled individual and any potential exemption from penalty or consideration for eligibility purposes is void. In this case, you need to compute the uncompensated value of the transferred funds, notify the individual and give him the opportunity to rebut the presumption that the transfer was done to become Medicaid eligible.

Note: There are two issues to consider. An individual who transfers assets to someone else for the sole benefit may not incur a transfer penalty if the transfer meets the above two criteria. For the individual who receives the transferred asset, the asset may or may not count. Assets transferred to a third party in the form of a trust for the sole benefit of the spouse must be evaluated under trust policies.

To qualify as being for the sole benefit of the spouse, the assets must be able to be paid to or for the benefit of the spouse over the spouse's lifetime. Assets transferred to a trust for the sole benefit of the spouse count as an available asset to the spouse and must be included in the couple's countable assets.

IV. **Case Law/Fair Hearing Decisions and Related Material Pertaining to Sole Benefit Trusts**

- A. *McNamara v. Ohio Department of Human Services*, 139 Ohio App.3d 551 holding that for Medicaid eligibility purposes, the amount of resources that an institutionalized spouse could transfer to the community spouse was limited to the maximum amount that a community spouse could retain under the Community Spouse Resource Allowance, Health Care Financing Administration Transmittal No. 64 is not controlling on the issue of whether an institutionalized spouse can transfer unlimited assets to the community spouse or to a third party for the sole benefit of the community spouse, and that a spousal annuity trust would not be treated under rules governing commercially purchased annuities.
- B. *James v. Richman*, 465 F.Supp.2d 395 – holding that a community spouse's annuity was not a countable resource for purposes of determining Medicaid eligibility for institutionalized spouse where at the time of the institutionalized spouse's Medicaid application, neither spouse had an ownership interest in funds used to an irrevocable actuarially sound commercial annuity as part of a retirement plan for the sole benefit of the community spouse, and the annuity was not an available resource to the extent of its market value on the basis of its alleged assignability or liquidity. Streimer Letter cited in the decision.
- C. *Johnson v. Guhl*, 91 F.Supp.2d 754 (D.N.J. 2000) – holding that although state officials' change of policy regarding whether community spouse annuity trusts (CSATs) were countable resource in determining applicant's eligibility for New Jersey Medicaid benefits resulted in differing treatment for applicants who had used CSATs, such treatment was rationally related to legitimate end of complying with federal Medicaid Act and Congress' intent to provide medical assistance to the needy and, thus, did not violate the equal protection clause.
- D. Letter dated April 16, 1998 from Robert A. Streimer, Disabled and Elderly Health Care Programs Group, Center for Medicaid and State Operations, to Jean Galloway Ball, Esq. – stating that there is a fundamental difference between the purchase of a commercial annuity, which is not considered an available resource for Medicaid purposes, and a community spouse annuity trust must be evaluated

under the trust rules set forth in section 1917(d) of the Medicaid Act, and which is considered an available resource.

- E. Massachusetts Fair Hearing Memorandum of Law – addressing MassHealth’s arguments against the validity of a sole benefit trust for the benefit of a community spouse, including the following: 1) that trust distributions were not mandatory (confusing discretionary authority of trustee to make distributions above and beyond actuarially sound distributions that were mandatory), and 2) the payback clause must pertain to the person who is applying for or receiving Medicaid benefits and whose eligibility is sought to be established.
- F. NAELA Amicus Brief filed in *Hughes v. Colbert* (Case Pending before the 6th Circuit Court of Appeals, Case No. 12-3765)(Lower Court Decision United States District Court, Northern District of Ohio, dated May 29, 2012) – arguing that the cap on spousal transfers is limited to bringing the community spouse up to community spouse resource allowance and applies only to post-eligibility transfers of resources between spouses under 42 USC § 1396r-5(f)(1), and that 42 USC § 1396p(c)(2)(B)(i), which permits unlimited transfers between spouses without there being a resulting penalty period, is the rule that must apply to the purchase of DRA compliant annuities with IRA funds of the community spouse.
- G. Colorado Fair Hearing Decision Dated May 14, 2008 – holding that the assets in a community spouse annuity trust were NOT countable resources of the community spouse.
- H. Letter from Thomas E. Hamilton, Director, Disabled and Elderly Health programs Group, Health Care Financing Administration, Dated January 19, 2001 – stating that a trust providing for the sole benefit of a spouse or other individual may provide that any remaining funds in the trust would go to a designated beneficiary without violating the rule that the trust be for the sole benefit of the individual in question.
- I. Delaware *Department of Health and Social Services v. Dean* (Superior Court of the State of Delaware, New Castle County, May 15, 2001) –holding that the purchase of an annuity by the community spouse was neither the transfer of an asset nor a resource for purposes of determining the Medicaid eligibility of the institutionalized spouse.



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EXHIBIT A

*Hamilton Letter – Letter dated January 19, 2001, from
Thomas E. Hamilton, Director, Disabled and Elderly
Health Programs Group, Health Care Financing
Administration*

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

JAN 19 2001

Raymon B. Harvey, P.A.
One Financial Centre
650 South Shackleford Road, Suite 400
Little Rock, Arkansas 72211

Dear Mr. Harvey:

This is in response to your letter dated August 31, 2000 following up on our letter to you dated May 26, 2000 concerning Medicaid rules pertaining to treatment of trusts, transfers of assets for less than fair market value, spousal impoverishment, and time standards for determining eligibility. Your August 31 letter asked some additional questions on some of these subjects. Also, I am responding to a subsequent letter from you dated December 1, 2000 concerning the definition of "for the sole benefit of" in the context of treatment of annuities under Medicaid. I apologize for the delay in my response.

Following are responses to the questions you ask in each of the letters mentioned above. In the interest of brevity we will summarize your questions rather than repeat them in their entirety.

August 31 Letter

In our May 26 letter, we explained that if assets are transferred from one spouse to another before an eligibility determination is made under the spousal impoverishment rules, the transferred assets would still be considered available to the institutionalized spouse. Your August 31 letter asks the following questions.

- What exactly is meant by "considered available"? Does this mean that the resources continue to be counted for resource eligibility purposes no matter what happens to them?

• How would the transferred resources be considered if, prior to the institutionalized spouse's eligibility determination, the community spouse used the resources to purchase items solely for the benefit of the community spouse?

Page -2- Mr. Raymon B. Harvey, P.A.

For example, the couple's combined countable resources are \$100,000. The entire amount is transferred to the community spouse, who then uses \$50,000 to purchase an annuity that benefits only the community spouse, and to replace the couple's only automobile with a new one titled only in the community spouse's name. This leaves \$50,000 held solely in the name of the community spouse.

Under the statute (section 1924(c)(2) of the Social Security Act) all of the couple's resources, regardless of ownership, are considered in determining eligibility for the institutionalized spouse. Resources for purposes of spousal impoverishment are counted the same way they are counted under the Supplemental Security Income (SSI) program. However, section 1924(c)(5) of the Act provides that certain specific items are excluded when counting the couple's resources, including the couple's home, a small amount set aside for burial expenses and, regardless of value, household goods, personal possessions, and one automobile. Thus, the new automobile you cite in your example would be excluded from being counted as an available resource regardless of which member of the couple owns it.

With regard to the annuity purchased by the community spouse, irrevocable annuities are not considered to be available resources under the SSI program because the individual cannot access the funds in the annuity. However, purchase of an annuity by the community spouse may constitute a transfer of assets for less than fair market value (with a potential imposition of a penalty on the institutionalized spouse) under Medicaid unless certain conditions are met.

Transfers of assets by a spouse to a third party for the sole benefit of the spouse are not subject to penalty. The purchase of an annuity would constitute a transfer to a third party (the entity selling the annuity). However, to be exempt from penalty the annuity must be both actuarially sound (as explained in State Medicaid Manual section 3258.9.B., cited in your letter) AND for the sole benefit of the community spouse (see section 3257.B.6. of the State Medicaid Manual). When applied to an annuity which benefits the community spouse, this means that the annuity must be structured so that it pays the entire value of the annuity, plus any interest earned by the annuity, as income to the community spouse during that spouse's expected life time. If the annuity is not so structured, it would be considered a transfer of assets for less than fair market value and thus subject to penalty.

To summarize, if the annuity in your example meets the requirements discussed above, it would not be counted as an available resource in determining the institutionalized spouse's eligibility, nor would it be treated as a transfer of assets for less than fair market value. Also,

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Page -3- Mr. Raymon B. Harvey, P.A.

the new automobile cited in your example would not be counted as a resource. That would leave the \$50,000 held solely in the community spouse's name as resources that would be counted in determining the institutionalized spouse's eligibility.

December 1 Letter

This letter cites section 3257 of the State Medicaid Manual concerning the definition of the phrase "for the sole benefit of" a spouse or other designated individual. You ask whether a trust or annuity which provides that, upon the death of the beneficiary of the trust or annuity, any remaining funds would go to a designated beneficiary would violate the requirement that the trust or annuity be for the sole benefit of the individual in question.

The designation of a beneficiary to receive any funds remaining in an annuity after the death of the primary beneficiary would not, by itself, violate a requirement that the annuity be for the sole benefit of the primary beneficiary. However, as explained more fully in our above response to your August 1 letter, an annuity would violate the sole benefit requirement if it were not structured so as to pay the entire value of the annuity, plus interest, to the primary beneficiary during the beneficiary's expected lifetime.

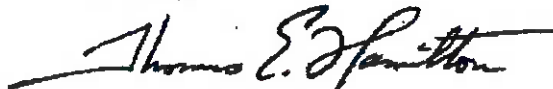
With regard to how this would apply to a trust, again the designation of a remainder beneficiary would not, by itself, violate the sole benefit requirement. However, as explained in section 3257.B.6 of the State Medicaid Manual a trust, like an annuity, must provide for disbursement of the funds in the trust either to or for the benefit of the trust beneficiary within the beneficiary's expected lifetime. If the trust is not so structured it is not for the sole benefit of the primary beneficiary, but rather is established to at least partially benefit any designated remainder beneficiary.

Also, as explained in the manual section referenced above, a trust that is exempt from being counted under the normal Medicaid trust rules (see sections 1917(d)(4)(A), (B) and (C) of the Act) must provide that upon the death of the beneficiary the State will receive any funds remaining in the trust, up to the amount of Medicaid benefits paid for on the beneficiary's behalf. While such a trust may also designate a remainder beneficiary in addition to the State, the State must be identified as having first claim on any funds remaining in the trust upon the death of the beneficiary. Otherwise, the trust does not meet the statutory requirements for exemption from being counted under the normal Medicaid trust rules.

Page -4- Mr. Raymon B. Harvey, P.A.

I hope this information is useful to you. If you have any questions, please contact Roy Trudel of my staff at 410-786-3417.

Sincerely,

A handwritten signature in cursive script, reading "Thomas E. Hamilton". The signature is written in dark ink and is positioned above the printed name.

Thomas E. Hamilton

Director

Disabled and Elderly Health Programs Group



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EXHIBIT B

96 ADM-8

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 96 ADM-8

TO: Commissioners of
 Social Services

DIVISION: Health and
 Long Term Care

DATE: March 29, 1996

SUBJECT: OBRA '93 Provisions on Transfers and Trusts

 SUGGESTED
 DISTRIBUTION:

Medical Assistance Staff
 Public Assistance Staff
 Legal Staff
 Fair Hearing Staff
 Staff Development Coordinators

CONTACT
 PERSON:

Transfers-Robin Johnson -1-800-343-8859, ext. 67454
 Trusts-Barbara Crumb - 1-800-343-8859, ext. 32237
 NYC: Call (212) 383-2512

ATTACHMENTS:

Attachment I Sole benefit statement (available on-line)
 Attachment II Procedures for Monitoring Exception Trusts (available on-line)
 Attachment III Explanation of the Effect of Transfer of Assets on MA Eligibility (available on-line)
 Attachment IV Life Expectancy/Actuarial Tables (available on-line)
 Attachment V Life Estate and Remainder Interest Table (available on-line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref. Section OBRA '93
95 ADM-17					13611 of
92 ADM-53		360-4.4 (c)	SSL 366	MARG page,	
92 ADM-45		360-4.5	SSA 1915 (c)	356	GIS '94-
92 ADM-44			& (d)		MA/018
91 ADM-37			Executive		GIS '94-
91 ADM-31			Law Sec 63		MA/031
90 ADM-29					GIS '95-
89 ADM-45					MA/038

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ATTACHMENT V, LIFE ESTATE AND REMAINDER INTEREST TABLE	

I. PURPOSE

This Administrative Directive (ADM) informs social services districts of changes in the treatment of transfers and trusts in the Medical Assistance (MA) program as a result of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93).

II. BACKGROUND

Section 1917 of the Social Security Act (42 U.S.C. 1396p) requires a period of ineligibility for MA coverage of nursing facility services (penalty period) when the MA applicant/recipient (A/R) or his/her spouse transfers assets for less than fair market value within or after a specified look-back period. Prior to the enactment of OBRA '93, Section 1917(c): provided for a 30-month look-back period; provided for a maximum penalty period of 30 months; referred to transfers of "resources" rather than "assets"; and did not contain any exceptions for transfers of assets into trusts. OBRA '93 made a number of amendments to Section 1917(c).

Prior to the enactment of OBRA '93, Section 1902(k) of the Social Security Act (42 U.S.C. 1396a(k)) provided that in the case of a trust created by an A/R or his/her spouse, other than by will, the maximum amount of payments which the trustee had discretion to distribute to the A/R would be deemed available for purposes of determining MA eligibility. OBRA '93 repealed Section 1902(k) and amended Section 1917 to more fully address the availability of assets held in trust and the applicability of the transfer rule to assets transferred into trusts.

Chapter 170 of the Laws of 1994 amended Section 366 of the Social Services Law to conform to the aforementioned OBRA '93 amendments. In addition, the Department amended 18 NYCRR 360-4.4(c) and 360-4.5 to implement the provisions of Chapter 170.

III. PROGRAM IMPLICATIONS

As a result of the enactment of OBRA '93 and Chapter 170 of the Laws of 1994, a number of changes and clarifications are being made to the MA rules concerning transfers and trusts. These changes apply to MA applications and recertifications on or after September 1, 1994, and apply to transfers made and trusts created or funded on or after August 11, 1993.

A. Transfers:

- the transfer rules apply to both income and resources;
- the look-back period is increased from 30 to 60 months in the case of trust-related transfers, as described in Section IV.B of this ADM, and from 30 to 36 months for all other transfers;
- there is no 30 month cap on the length of the penalty period;

- there is no penalty for transferring assets to a trust established solely for the benefit of a person certified as disabled and under 65 years of age;
- when either spouse makes a prohibited transfer that results in a penalty period for the institutionalized spouse, the penalty period must be apportioned equally between the spouses if the community spouse subsequently becomes in need of nursing facility services;
- a penalty period is imposed for a partial month;
- clarification is provided concerning when a transfer by an individual to another is considered to be for the "sole benefit" of the individual's spouse;
- clarification is provided on the treatment of jointly held assets;
- the "Explanation of the Effect of Transfer of Assets on Medical Assistance Eligibility" has been revised to reflect the changes resulting from OBRA '93; and
- the penalty period will now begin on the first day of the month following the month of transfer.

B. Trusts:

- for a revocable trust, the total principal and income of the trust is considered available;
- for irrevocable trusts, payments actually made from the trust to or for the benefit of the A/R are available income in the month received; portions of the trust principal and income which can be paid to or for the benefit of the A/R are considered to be an available resource; and any portions of the trust principal and income which can never be paid to or for the benefit of the A/R under the terms of the trust are considered to be transferred assets for purposes of the transfer rule; and
- exceptions are made for certain trusts created for the benefit of disabled A/Rs using the A/R's assets.

IV. REQUIRED ACTION

A. Definitions

1. Assets

Assets include all income and resources of the individual and the individual's spouse. This includes income or resources which the individual or the individual's spouse is entitled to but does not receive because of any action or inaction by;

- the individual or the individual's spouse;
- a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or
- any person, including a court or administrative body, acting at the direction of or upon the request of the individual or the individual's spouse.

Examples of actions which would cause income or resources not to be received are:

- irrevocably waiving pension income;
- renouncing an inheritance or refusing to assert one's right of election against an inheritance;
- not accepting or accessing injury settlements (however, A/Rs cannot be required to initiate litigation);
- settling a tort (personal injury) action so as to have the defendant place settlement funds directly into a trust or similar device to be held for the benefit of the A/R; or
- refusing without good cause to take action to obtain a court ordered payment that is not being paid, such as an alimony award or other judgment against an individual. In the case of alimony, good cause is defined in Department Regulation 369.2(b).

NOTE: The date of transfer is the date the asset was actually available and waived. In the case of a trust, the date of the transfer is the date the trust is actually funded, regardless of the date it was created.

2. Blind or disabled:

For purposes of this directive, the terms "blind" and "disabled" mean certified blind or certified disabled, according to the requirements of the Social Security Administration.

3. Fair Market Value

Fair market value (FMV) is the estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred.

Fair market value of real property or other assets may be established by means of an appraisal by a real estate broker or other qualified dealer or appraiser.

4. Individual

When the ADM refers to the creation of a trust or to a transfer of assets, the term individual or A/R includes: the individual; the individual's spouse; any person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or any person, including a court or administrative body acting at the direction of or upon the request of the individual or the individual's spouse.

5. Nursing Facility Services

Nursing facility services means:

- nursing care and health related services provided in a nursing facility (including residential health care facilities, residential treatment facilities, intermediate care facilities, and intermediate care facilities for the developmentally disabled);
- a level of care provided in a hospital which is equivalent to the level of care provided in a nursing facility; and
- care, services, or supplies furnished pursuant to a waiver under section 1915(c) or (d) of the Social Security Act, including: the Long Term Home Health Care Program, the OMRDD Home and Community-Based Services Waiver, the Traumatic Brain Injury Waiver or the Care At Home Program.

6. Sole Benefit

A transfer by an individual or the individual's spouse to another is for the sole benefit of the individual's spouse if the terms and conditions of the transfer are specified in a written instrument of transfer (such as a trust document, deed, or other signed and acknowledged statement), which is executed at or about the time of transfer, clearly limiting the use and enjoyment of the transferred property to the individual's spouse.

In the absence of a written instrument of transfer, a transfer must be considered a transfer for the sole benefit of the individual's spouse only if, at the time of application:

- the person who transferred the assets signs a statement attesting that the transfer was intended for the sole benefit of the individual's spouse; (districts may develop their own form for this purpose, or use the sample form included as Attachment I to this ADM); and
- other evidence is presented (such as evidence of a continuous course of conduct by the person to whom the assets were transferred) which establishes that the use and enjoyment of the transferred property has in the past been limited to the individual's spouse.

In addition, in order for a transfer to be considered to be for the sole benefit of the individual's spouse (regardless of whether there is a written instrument of transfer), the social services district must conclude, based on the age of the individual's spouse, the amount of assets transferred, and the rate and amount of expenditures from the transferred assets for the benefit of the individual's spouse, that the

transferred assets are likely to be totally expended within the spouse's lifetime.

The establishment of a trust for the benefit of a spouse will not be considered a transfer for the sole benefit of such spouse if: during the life of the trust, the trustee has the authority to make distributions for the benefit of anyone other than the spouse; or the trust provides that upon its termination, all or part of the remaining principal and income is to be distributed to someone other than the MA applicant/recipient, or the spouse's estate.

Note: Any subsequent action by the individual's spouse, or by the person to whom the assets were transferred for the spouse's benefit, which reduces or eliminates the spouse's beneficial use of the transferred property, or the ownership or control of the person to whom the assets were transferred, may be considered a transfer of assets by the individual's spouse on the date such action is taken. Such a transfer may affect the eligibility of either or both spouses, depending on the circumstances of the transfer.

Note: When assets are transferred by an individual or the individual's spouse to another for the sole benefit of the individual's spouse, the assets continue to be considered part of the couple's total resources for purposes of determining the amount of the community spouse resource allowance.

7. Trusts

In general, a trust is a legal instrument by which an individual gives control over his/her assets to another (the trustee) to disburse according to the instructions of the individual creating the trust. There are a number of different types of trusts, including escrow accounts and investment accounts.

- a. Annuity - An annuity is an investment vehicle whereby an individual establishes a right to receive fixed periodic payments, either for life or a term of years. To the extent to which the anticipated return is commensurate with the money invested, the purchase of an annuity shall be considered a compensated transfer of assets; to the extent that the anticipated return is less than the amount invested, it shall be considered to be a trust-related transfer for less than fair market value.
- b. Exception trusts - Exception trusts are trusts which are required to be disregarded as available income and resources for purposes of determining MA eligibility pursuant to the provisions of Section 366(2)(b)(2)(iii) of the Social Services Law and 18 NYCRR 360-4.5(b)(5).

Exception trusts generally will conform to the definition of supplemental needs trusts found in Section IV.A.7.e of this ADM. There are two types of exception trusts.

i. One type of exception trust is a trust created for the benefit of a disabled person under the age of 65. It must:

- be created with the individual's own assets,
- be created by the disabled person's parent or grandparent, legal guardian of the individual, or by a court of competent jurisdiction, and
- include language specifying that upon the death of the disabled person, the social services district will receive all amounts remaining in the trust, up to the amount of MA paid out on behalf of the individual.

Once established, additional funds can be added to the trust until the person reaches age 65. However, any additions to the trust made after the person reaches age 65 would be treated as a transfer of assets, and would require the imposition of a penalty period. It is the Department's position that if a district has imposed a Social Services Law Section 104-b or Section 369 lien against assets to be used to establish an exception trust, the district should attempt to have the lien satisfied (or, in the district's discretion, compromised) before the trust is established. Litigation is pending on the issue of whether enforcing such liens is allowed when the assets are to be put into an exception trust; when this litigation is concluded, the Department will notify districts promptly of the outcome and of any necessary policy changes.

ii. The other type of exception trust is a trust created for the benefit of a disabled person of any age, and is a pooled trust, as described below:

- the trust is established and managed by a non-profit association per Section 1917 (d) (4) (C) (i) of the Social Security Act;
- the assets are pooled with other assets and are managed by a non-profit organization which maintains separate accounts for each person whose assets are included in the pooled trust;
- the disabled individual's account in the trust is established by the disabled individual, by the disabled individual's parent, grandparent, or

legal guardian, or by a court of competent jurisdiction;

- the trust will be disregarded for MA purposes regardless of the age of the individual when the pooled trust account is established, or when assets are added to the pooled trust account; however, there is no exception to the transfer rules for transfers of assets to trusts created for the benefit of persons 65 years of age or older;
- upon the death of the individual, the district's right of recovery is limited to those funds not retained by the non-profit organization; and
- if the trust is subject to oversight by the Attorney General's office, no bonding (as specified in Section IV.F of this ADM) is required.

NOTE: Although exception trusts created in accordance with the criteria set forth above are exempt as resources in the eligibility determination process regardless of the disabled individual's age, for purposes of the transfer provisions, any additions to the trust after the individual becomes 65 years of age are subject to applicable transfer penalties.

It is the responsibility of the trustee of an exception trust to ensure that the funds are expended for the benefit of the chronically impaired or disabled person. In some cases, this disbursement of funds may indirectly benefit someone other than the beneficiary. Such disbursements are valid, as long as the primary benefit accrues to the chronically impaired or disabled person. For example, payment of travel expenses for a companion to a chronically impaired or disabled person going on vacation may be appropriate. Also, the abilities and capabilities of the person should be taken into account. The purchase of sophisticated computer equipment to assist a physically disabled person to communicate would be considered appropriate, while purchase of the same type of equipment for an individual who could not be trained to use it would not.

- c. Irrevocable Trust - An irrevocable trust is a trust created by an individual, over which the individual may or may not be able to exercise some control, but which may not be cancelled under any circumstances.
- d. Revocable Trust - A revocable trust is a trust created by an individual which the individual has the right to cancel.

e. Supplemental Needs Trust (SNT) - A supplemental needs trust, as defined in Section 7-1.12 of the Estates, Powers and Trusts Law, is a trust established for the benefit of an individual of any age with a severe and chronic or persistent impairment, designed to supplement government benefits for which the individual is otherwise eligible. Under the terms of such a trust:

i. the beneficiary does not have the power to assign, encumber, direct, distribute, or authorize distributions from the trust; and

ii. the trust document generally prohibits the trustee from expending funds in any way that would diminish the beneficiary's eligibility for or receipt of any type of government benefit.

f. Testamentary Trust - A testamentary trust is any trust established by will. Testamentary trusts are third party trusts, as defined below.

g. Third Party Trusts - A third party trust is a trust established with the funds of someone other than the A/R. A third party trust may or may not be a supplemental needs trust, as defined in Section 7-1.12 of the Estates, Powers and Trusts Law. For purposes of determining the eligibility of an A/R who is a beneficiary of a third party trust, the principal and accumulated income of the trust are not considered available to the A/R. However, any distributions of trust assets actually made to the A/R are counted as income in the month received.

Social services districts are authorized, but not required, to commence court proceedings on behalf of A/Rs who are beneficiaries of third party trusts, seeking to compel the trustee to use trust assets to pay for necessary medical care. However, if the terms of the trust specifically prohibit the trustee from using trust assets for medical care, as will be the case with trusts conforming to Section 7-1.12 of the Estates, Powers and Trusts Law, it is extremely unlikely a court will order the trustee to do so.

8. Uncompensated Value

The uncompensated value is the difference between the FMV at the time of transfer (less any outstanding loans, mortgages, or other encumbrances on the asset) and the amount received for the asset.

If the client's resources are below the appropriate MA resource level, the amount by which the MA resource level exceeds the client's resources must be deducted from the uncompensated value of the transfer. Likewise, amounts

specified in Department regulations for burial funds, but not for burial space items, also must be deducted.

Note: A transfer for "love and consideration" is not considered a compensated transfer. Also, while relatives and family members legitimately can be paid for care they provide to the individual, there is a presumption that services provided for free at the time were intended to be provided without compensation. Thus, a transfer to a relative for care provided for free in the past, normally is not a transfer of assets for FMV. However, an individual can rebut this presumption with tangible evidence. An example of acceptable evidence would be a promissory note executed at the time services were provided.

B. Look-Back Date

In the case of the transfer of assets by an individual in receipt of or applying for nursing facility services, the look-back date is 36 months prior to the first day of the month in which the individual was:

- institutionalized; and
- submitted an application for full Medical Assistance coverage, including coverage of nursing facility services.

For trust-related transfers on or after August 11, 1993, the look-back period is 60 months. Funding a new trust is a trust-related transfer. Trust-related transfers also include transfers to already existing trusts, distributions from existing trusts to someone other than the A/R, and the foreclosure of a trustee's ability to distribute trust assets to the A/R due to a "trigger provision" in the trust agreement. Thus, even though a trust is established prior to August 11, 1993, subsequent trust-related transfers which occur on or after August 11, 1993 may be subject to the new transfer provisions.

EXAMPLE: Mrs. Jones created a revocable trust in 1988. She applies for MA in December 1994. The district determines that \$10,000 was removed from the trust and given to Mrs. Jones' son in October 1993. In such a situation, even though the trust was created more than 60 months ago, the social services district would consider the \$10,000 to be a transfer since the activity occurred after August 10, 1993, but within the 60 months preceding the month of application. In addition, because the trust is revocable, any balance remaining in the trust is considered an available resource.

When an individual has multiple periods of institutionalization, or multiple applications (whether or not they resulted in the provision of assistance), the look-back period begins 36 months (or 60 months in the case of trust-related transfers) prior to the first day of the month in which the individual both: is in receipt of nursing facility services AND has submitted an application for full MA coverage.

NOTE: As explained in 18 NYCRR 360-4.5, certain "trigger provisions" are null and void under State law. With respect to these provisions, the triggering event has no effect on the trustee's powers and thus no transfer of assets occurs; instead, the trust assets subject to the trigger provision continue to be considered an available resource.

C. Treatment of Revocable Trusts

In the case of revocable trusts established by the A/R, the entire value of the trust is considered as an available resource.

- (1) All payments made from the trust to or for the benefit of the A/R are considered available income in the month received.
- (2) All payments made from the trust to a person other than the A/R are considered to be assets transferred for less than FMV for purposes of the transfer of assets rule.

D. Treatment of Irrevocable Trusts

In the case of an irrevocable trust established by the A/R, any portion of the trust principal, and income generated by the trust principal, from which no payments may be made to or for the benefit of the A/R is considered to be an asset transferred for less than FMV for purposes of the transfer of assets rule.

- (1) Payments made from the trust to or for the benefit of the A/R shall be considered available income in the month received.
- (2) Any portion of the principal of the trust, or the income generated from the trust, which can be paid to or for the benefit of the A/R, is considered an available resource. If the language of the trust specifies that money can be made available for a specific event, that amount shall be considered an available resource, whether or not that event has occurred.
- (3) Payments which are made from trust assets considered available to the A/R, as described in paragraph (2) above, and which are not made to or for the benefit of the A/R, are considered to be assets transferred for less than FMV for purposes of the transfer of assets rule.

Note: In the case of trusts, the date on which the penalty begins is the first day of the month following the month in which the trust was funded (or a revocable trust made irrevocable), or assets were transferred for less than FMV.

E. Treatment of Exception Trusts and Third Party Trusts

In the case of exception trusts and third party trusts, the principal and accumulated income are disregarded in determining MA

eligibility. However, any trust assets actually distributed to the A/R are counted as income in the month received and as a resource if retained into subsequent months. In addition, as indicated in Section IV.A.7.g of this ADM, the social services district can go to court to compel the trustee of a third party trust to make trust assets available to a trust beneficiary, where the trustee is required or granted the discretion to make such distributions under the terms of the trust agreement.

With respect to a disabled person under age 65, a lump sum payment, such as a personal injury award or settlement, or an inheritance, will be disregarded as income or resources from the date the person has the right to take possession of the assets until the first day of the second month following that date, if the person intends to place such assets in an exception trust. In addition, assets of a disabled person under age 65 will be disregarded from the date of commencement of a court proceeding necessary to allow the assets to be placed in an exception trust until the resolution of such proceeding, assuming the disabled person or his or her representative promptly pursues the resolution of the proceeding.

In the case of a trust created from the proceeds of retroactive payments received as a result of a court settlement due the beneficiary under the SSI program, the Department shall first be entitled to reimbursement of any interim assistance paid out pending the court decision, and the representative payee shall be entitled to reimbursement of any expenses incurred in the pursuit of the settlement.

F. Oversight Responsibilities

Districts are responsible for notifying trustees of exception trusts of the information they need to maintain in order to monitor the trust activity, including but not limited to:

- providing notification to the district of the death of the beneficiary of a trust;
- providing notification to the district of any transactions made that would substantially deplete the value of the corpus (principal) of the trust;
- providing documentation to the district that there have been no transfers of assets from the trust nor any transactions from the corpus of the trust that involve transfers for less than fair market value;
- providing proof of bonding in all situations involving trusts of more than one million dollars, or when required by the court (pooled trusts subject to oversight by the Attorney General's Office do not require bonding);
- information ensuring, with respect to pooled trusts, that all trust activity is posted to the appropriate account.

Suggested procedures for meeting these responsibilities are included in Attachment II of this ADM.

In the event that a district considers any acts, omissions, or failures of the trustee to be contrary to the terms of the trust, applicable laws and regulations, or the trustee's fiduciary obligations, it can refer the matter to the Attorney General to commence a proceeding against the trustee under Section 63 of the Executive Law. It may do so by contacting:

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL AFFAIRS
BUREAU OF HEALTH AND LONG TERM CARE LAW
40 NORTH PEARL STREET
ALBANY, NEW YORK 12243-0001
Attn: Trust Review

G. Penalty Period

The penalty period is the period of time that an individual is ineligible for MA coverage of nursing facility services as a result of an uncompensated transfer of a non-exempt asset or homestead. As a result of the enactment of OBRA '93 and Chapter 170 of the Laws of 1994, there is no longer a maximum penalty period.

1. Calculation

The length of the penalty period is calculated by dividing the uncompensated value of all assets transferred during or after the look-back period (except as provided in Section IV.G.5. concerning multiple transfers) by the MA regional rate established for the region in which the person is institutionalized. The regional rates are revised by this Department annually in an Administrative Directive. In addition, social services districts must reduce the uncompensated value as necessary to take into account the appropriate MA resource level, any allowable burial funds, and any allowable income deductions or disregards as defined in Section IV.H.1. or 2. of this ADM.

NOTE: Except as provided in Section IV.G.2. concerning multiple transfers, the penalty period begins on the first day of the month following the month of transfer, provided that the date does not occur during an existing penalty period.

2. Multiple Transfers

For multiple transfers during the look-back period, where assets have been transferred in amounts and/or frequency that would make the calculated penalty periods overlap, add together the uncompensated value of all assets transferred, and divide by the MA regional rate. The period of ineligibility begins with the first day of the month following the month in which the first transfer occurred.

Example: An individual transfers \$20,000 in January 1994, \$20,000 in February, and \$20,000 in March, all of which are uncompensated. Calculated individually, based on a regional rate for nursing facility care of \$5,000 a month, the penalty period for the first transfer is from February through April (February is the first month following the month of transfer), the second transfer is from March through June, and the third is from April through July. Because these periods overlap, calculate the penalty period by adding the transfers together (a total of \$60,000) and dividing by the nursing home cost (\$5,000). The penalty period would run from February 1994 through January 1995.

When a penalty period ends at any time during a month and a subsequent transfer occurs at any time during that same month, the subsequent transfer is considered to have occurred in an overlapping penalty period and would be treated as a multiple transfer.

When multiple transfers are made in such a way that the penalty periods for each do not overlap, treat each transfer as a separate event with its own penalty period.

Example: An individual transfers \$10,000 in January, \$10,000 in May, and \$10,000 in October. Assuming that the regional rate for nursing facility care is \$5,000 a month, the penalty periods for transfers are, respectively, February through March, June through July, and November through December.

3. Partial Month

If the uncompensated value of the transferred assets is less than the regional rate, or the penalty period results in a partial month penalty, districts must count the uncompensated value attributable to the partial month as part of the Net Available Monthly Income (NAMI) or, in the case of a person receiving waived services in the community, spenddown liability for the month.

4. Apportioning Penalty Periods Between Spouses

If either spouse transfers an asset (before eligibility is established) that results in a penalty for the institutionalized individual, the penalty must be apportioned equally between the spouses if the community spouse subsequently becomes in receipt of nursing facility services and applies for MA. If one spouse is no longer subject to a penalty (e.g., the spouse dies), the remaining penalty period for both spouses must be applied to the remaining spouse.

Example: Mr. Smith enters a nursing home and applies for MA, while Mrs. Smith remains in the community and is not in receipt of MA. Mrs. Smith transfers assets before Mr. Smith is determined eligible for MA and a 10-month penalty period is imposed on Mr. Smith's care. Four months into the penalty

period Mrs. Smith enters a nursing home and applies for MA. The remaining 6 months of the penalty period must be divided equally between the two spouses.

In the above example, if Mr. Smith leaves the nursing home, but his wife remains, the remaining penalty period that had been apportioned to Mr. Smith must be imposed on Mrs. Smith. If Mr. Smith returns to the nursing home, any remaining penalty is again apportioned between the two spouses.

5. Continuity of Penalty

A penalty period imposed for a transfer of assets runs continuously from the first date of the penalty period regardless of whether the A/R continues to receive nursing facility services (except as noted above when a penalty is apportioned between spouses). Thus, if an A/R leaves a nursing facility, the penalty period nevertheless continues until the end of the calculated period.

If during the interview or clearance process it becomes known that the individual had previously applied for MA in another district, contact the former district to determine if it had any knowledge of a possible transfer or to determine whether the A/R is currently in a penalty period.

After the submission of a written application, but before the applicant is notified by the social services district of his/her eligibility determination, the applicant may withdraw his/her request for Medical Assistance. Once the applicant is notified in writing of the MA eligibility determination, the application may not be withdrawn, and any penalty period imposed will remain in effect, even if the applicant subsequently re-applies for MA.

H. Treatment of Income as an Asset

The transfer rules apply to transfers of income. Absent some reason to believe otherwise, districts should assume that ordinary household income of an A/R and his or her spouse during the look-back period was legitimately spent on the normal costs of daily living. However, districts should determine whether the A/R or the A/R's spouse transferred a lump sum income payment or a stream of income during the look-back period.

1. Lump Sum Income Payments

If a countable lump sum income payment is transferred in the month received, a penalty period must be imposed (if no exceptions apply). To calculate the uncompensated value of the transfer, the income deductions and disregards of the Supplemental Security Income (SSI) program must be applied. If the lump sum payment is transferred in the month after receipt, it is treated as a resource and the appropriate resource disregards (not income disregards) would be allowed.

2. Stream of Income

If a stream of income (i.e., income received on a regular basis, such as a pension) or the right to a stream of income is transferred, districts must treat it as a transfer of a resource. The amount transferred is the total amount of income expected to be received during the transferor's lifetime, based on an actuarial projection of the transferor's life expectancy. Districts must reduce the uncompensated value of the transfer as necessary to take into account the appropriate MA resource level and any allowable burial funds.

- I. Jointly Held Assets. The general rule is that joint property held by an A/R is considered available to the A/R to the extent of his or her interest in the property. In the absence of documentation to the contrary, it is presumed that all joint owners possess equal shares. However, there are special rules for SSI-related A/Rs concerning the availability of financial institution accounts, which are described in paragraph 1 below. In addition, with respect to an A/R who converts his or her assets into joint assets, OBRA '93 and Chapter 170 of the Laws of 1994 indicate when such a conversion constitutes a transfer of assets, as explained in paragraph 2 below.

1. Financial Institution Account Owned by an SSI-Related A/R

In accordance with SSI regulations issued on May 31, 1994, ownership of financial institution accounts (including savings, checking, and time deposits or certificates of deposit) involving an SSI-related A/R must be determined as outlined below. There is no change in MA policy to determine ownership of other types of resources.

a. SSI-Related A/R is the Sole Owner

As long as an SSI-related A/R is designated as the sole owner by the account title, and can withdraw funds and use them for his or her support and maintenance, the A/R is presumed to own all of the funds in the account, regardless of their source. This presumption cannot be rebutted.

b. SSI-Related A/R is a Joint Owner

In the absence of evidence to the contrary, if an SSI-related A/R is a joint account holder, it is presumed that all of the funds in the account belong to the A/R. If there is more than one SSI-related A/R who is a holder of the joint account, it is presumed that the funds in the account belong to the A/Rs in equal shares. To rebut this presumption, the SSI-related A/R must:

- i. submit a written statement, along with corroborating written statements from the other account holders,

regarding who owns the funds, why there is a joint account, who has made deposits and withdrawals, and how withdrawals have been spent;

ii. submit account records for the months for which ownership of funds is at issue; and

iii. separate the funds owned by the SSI-related A/R from the funds of the other account holders.

2. Conversion of Individual's Assets to Jointly Held Assets

When an asset belonging to an individual is jointly held in common with another person or person in a joint tenancy, tenancy in common, or similar arrangement, the asset is considered to be transferred by the individual when any action is taken, either by the individual or any other person, that reduces or eliminates the individual's ownership or control of the asset. Merely placing another person's name on an account or asset as a joint owner does not necessarily constitute a transfer of assets. The individual may still possess ownership rights to the account or asset and have the right to withdraw all of the funds in the account at any time. However, actual withdrawal of funds from the account, or removal of the asset, by the other person would remove the funds or property from the control of the individual and so would constitute a transfer of assets. Also, if placing another person's name on the account or asset actually limits the individual's right to sell or otherwise dispose of the asset (e.g., the addition of another person's name requires that the person agree to the sale or disposal of the asset, where no such agreement was necessary before), such placement would constitute a transfer of assets.

J. Life Estates

1. Definitions

a. Life Estate

A life estate is a limited interest in real property. A life estate holder does not have full title to the property, but has the use of the property for his or her lifetime, or for a specified period. Generally, life estates are in the form of a life lease on property that the person is using, or has used, for a homestead.

b. Value of a Life Estate

Social services districts must use a reasonable method of calculating the value of a life estate, based on the current fair market value of the property and the age of the person. A life estate and remainder interest table

published by the federal Health Care Financing Administration in its State Medicaid Manual is attached for districts' information (Attachment V). This table sets forth percentages of fair market value corresponding to the values of the life estate and the remainder interest, based on the age of the person possessing the life estate. Districts may, but are not required, to use this table in calculating the value of life estates and remainder interests.

c. Value of the Remainder Interest

The value of the remainder interest is the current market value of the property less the value of the life estate.

d. Remainderperson

A remainderperson is an individual who has the right to possession or ownership of the property after the life estate holder dies or surrenders the life estate.

2. Transfers

Transferring property while retaining a life estate within the look-back period is a partially uncompensated transfer. The uncompensated value of the transfer is the value of the remainder interest at the time the life estate is created. If the remainderperson of a life estate is an individual to whom the property could be transferred without penalty, the establishment of the life estate is not a prohibited transfer.

If the holder of a life estate transfers the life estate during the look-back period, it must be determined if FMV was received for the life use. If FMV was not received, a transfer penalty must be imposed.

When an individual both transfers property (retaining a life estate) and transfers the life estate interest within the look-back period, the uncompensated value of the transfers are the value of the remainder interest at the time the life estate is created plus the value of the life estate at the time it is transferred.

Examples (using table in Attachment V)

a. Transfer of a home:

\$92,000 value of the home at the time the life estate was created

x.62086 age 69

\$57,119.12 value of the life estate

\$92,000.00

- \$57,119.12

\$34,880.88 (remainder interest) uncompensated value of transfer of the home

b. Transfer of a life estate (same situation as above, but two years later):

\$94,000 value of the home at the time the life estate was transferred

x.58914 age 71

\$55,379.16 value of the life estate at the time the life estate was transferred

3. Availability

For the purpose of determining an A/R's net available resources, a life estate will not be considered a countable resource, and no lien may be placed on the life estate. Social services districts cannot require an A/R possessing a life estate to try to liquidate the life estate interest or to rent the life estate property.

If an A/R possessing a life estate sells the life estate interest, the proceeds of this liquidation is a countable resource for purposes of the A/R's MA eligibility. If the A/R sells the life estate interest for less than fair market value, the uncompensated value of the life estate interest is the amount transferred for purposes of the MA transfer-of-assets rule.

If an A/R possessing a life estate rents the life estate property, any net rental income received is counted in determining eligibility. If under the terms of the life estate, the life estate holder must pay taxes and maintenance, these costs can be deducted from the rental income. On the other hand, if the life estate holder does not have to pay any taxes or maintenance, a gross rental figure must be used.

The provisions of this ADM supersede any previous instructions or policies issued by this Department with respect to the MA treatment of life estates.

K. New York State Partnership for Long Term Care

Under the New York State Partnership for Long Term Care, resources are exempt. Therefore, a transfer of resources by those individuals who have purchased policies under this program (and have received three years of nursing home coverage, or six years of home care services, or a combination of nursing home care and home care services where one nursing home day equals 2 home care days) will have no effect on their eligibility for nursing facility services. Since income is not exempt, a transfer of income must be treated as specified in this directive. However, when an exempt resource that generates income is transferred, no transfer penalty is imposed.

L. Exceptions

Exceptions to the application of transfer of asset penalties are:

1. The asset transferred is the individual's home, and title to the home is transferred to;
 - the spouse of the individual;
 - a child of the individual who is under age 21;
 - a child of the individual who is certified blind or certified disabled, regardless of age;
 - the sibling of the individual who has an equity interest in the home, and who has been residing in the home and using it as their primary lawful residence for a period of at least one year immediately before the date the individual becomes institutionalized (see 89 ADM-45 page 16, for a definition of equity interest); or
 - a son or daughter of the individual (other than a child as described above) who was residing in the homestead, using it as their primary lawful residence for a period of at least two years immediately before the date the individual becomes institutionalized, and who provided care to the individual which permitted the individual to reside at home, rather than in an institution or facility.
2. An asset other than the individual's home was transferred:
 - to the individual's spouse, or to another for the sole benefit of the individual's spouse;
 - from the individual's spouse to another for the sole benefit of the individual's spouse;
 - to the individual's child who is certified blind or certified disabled; or
 - to a trust established solely for the benefit of an individual under 65 years of age who is disabled.
3. The individual or spouse intended to dispose of the assets either at FMV or for other valuable consideration.

In determining whether an individual or the individual's spouse intended to dispose of an asset for FMV, or for other valuable consideration, the individual must establish the circumstances which caused the asset to be transferred for less than FMV. An example would be the sale of a home when the realtor appraised the property and the home was subsequently sold based on that appraisal, which was less than FMV. Generally, the individual would be required to provide written evidence of attempts to dispose of the asset for FMV, as well as evidence to support the value at which the asset was disposed.

4. The assets were transferred exclusively for a purpose other than to qualify for MA.

The individual must establish that the asset was transferred for a purpose other than to qualify for MA coverage for nursing facility services. Factual circumstances supporting a contention that assets were transferred for a purpose other than to qualify for MA include, but are not limited to: the unexpected onset of a serious medical condition subsequent to the transfer; the unexpected loss, subsequent to the transfer, of income or resources which would have been sufficient to pay for nursing facility services; or the existence of a court order specifically requiring the transfer of a certain amount of assets.

At the time of the personal interview, the A/R must be given the opportunity to establish that the transfer was made for a purpose other than to qualify for MA coverage for nursing facility services. Social services districts must not take any adverse action on an MA-only A/R who has transferred assets without first advising the client in writing of his/her right to make such a showing. Attachment III must be used to meet this requirement.

5. All or part of the assets transferred for less than FMV have been returned to the individual.

If all transferred assets are returned to the individual prior to the MA eligibility determination, no transfer penalty is imposed. If a portion of the transferred assets is returned prior to the MA eligibility determination, the uncompensated value of the transfer is reduced by the amount of assets returned.

If all transferred assets are returned after the MA eligibility determination, the existing penalty period is rescinded and the individual's eligibility for MA during such period must be redetermined as though the assets were never transferred. If a portion of the transferred assets is returned after the MA eligibility determination, the existing penalty period is recalculated, reducing the uncompensated value of the transfer(s) by the amount of assets returned; if the recalculated penalty period has already elapsed, the individual's eligibility for MA subsequent to the penalty period must be redetermined as though the returned assets were never transferred.

For purposes of these rules, transferred assets shall be considered to be returned if the person to whom they were transferred: uses them to pay for nursing facility services for the MA applicant/recipient; or provides the MA applicant/recipient with an equivalent amount of cash or

other liquid assets.

6. Imposition of a penalty would work an undue hardship.

Undue hardship exists when:

- the individual applying for nursing facility services is otherwise eligible for MA; and
- despite his/her best efforts, as determined by the social services district, the individual or the individual's spouse is unable to have the transferred asset(s) returned or to receive FMV for the asset or to void the trust; and
- the institutionalized individual is unable to obtain appropriate medical care such that the individual's health or life would be endangered without the provision of MA for nursing facility services or for home or community-based services furnished under a waiver granted under section 1915(c) or (d) of the Social Security Act.

Undue hardship cannot be claimed:

- if the client failed to fully cooperate, to the best of his/her ability, as determined by the social services district, in having all of the transferred assets returned or the trust declared void. Cooperation may include, but is not limited to, assisting in providing all legal records pertaining to the transfer or creation of the trust, assisting the district, wherever possible, in providing information regarding the transfer amount, to whom it was transferred, any documents to support the transfer or any other information related to the circumstances of the transfer; or
- if after payment of medical expenses, the individual's or couple's income and/or resources is at or above the allowable MA exemption standard for a household of the same size; or
- if the only undue hardship that would result is the individual's or the individual's spouse's inability to maintain a pre-existing life style.

M. Community Coverage

Social Services districts may elect to offer community coverage only, in cases where an individual does not anticipate the need for nursing facility services. If the district elects to provide community coverage, they must provide it as an option to the client. If the client requests full coverage, the district must complete the resource investigation. If the client requests community coverage only, the district may make their determination

based on the applicant's current resources only (see 95 ADM-17).

V. NOTICE REQUIREMENTS

Local districts must make Attachment III, "EXPLANATION OF THE EFFECT OF TRANSFER OF ASSETS ON MEDICAL ASSISTANCE ELIGIBILITY", available to all individuals who wish to establish that the transfer was made for a purpose other than to qualify for nursing facility services. In addition, this form must be given to all MA-only applicants at the time of (re)application. A copy of Attachment III must also be sent when an A/R's (re)application is denied/discontinued due to a prohibited transfer. The form must be enclosed with the appropriate mandated client notice. This notice must be reproduced by the social services district until such time as it becomes available from this Department. If a local district elects to provide community coverage, they must use the appropriate notice contained in 95 ADM-17, Community Coverage Option, along with Attachment III.

VI. SYSTEM IMPLICATIONS

Upstate: Currently, coverage code 10 (All Services Except Long-Term Care) is used in conjunction with an Anticipated Future Action (AFA) code of 505 (End of Property Transfer Prohibition) with a specific end date to indicate an individual for whom a penalty period has been established. Until a separate coverage code is established for persons electing community coverage, for all cases determined eligible for the community benefit package, enter coverage code 10, and do not make a corresponding entry into the AFA field. For those recipients who are currently in a penalty period, or receive one in the future, continue to use an AFA code 505. The presence of coverage code 10 in combination with the AFA code 505 will allow social services districts to track those recipients who are in a penalty period.

New York City: Currently, coverage code 10 (All Services Except Long-Term Care) is used to indicate an individual for whom a penalty period has been established. Until a separate coverage code is established for persons electing community coverage, for all cases determined eligible for the community coverage package, enter coverage code 10 for those persons, as well.

VII. EFFECTIVE DATE

For applications and recertifications for MA submitted on or after September 1, 1994, determine if any trust was created or a transfer occurred at any time after August 10, 1993. If so, then the provisions of this ADM must be utilized. However, the 36 month look-back period does not become fully effective until August 11, 1996 for non-trust-related transfers and August 11, 1998 for trust-related transfers, since prior to that date a full 36 month or 60 month look-back period could include a period of time prior to August 11, 1993. Any trusts created or transfers occurring prior

to August 11, 1993, are to be treated in accordance with Department Regulation 360-4.4(c). However, in the case of trusts created before August 11, 1993, districts will look at any trust activity that occurred after that date.

Richard T. Cody
Division of Health & Long Term Care

day of _____, 19____

SUGGESTED PROCEDURES FOR MONITORING EXCEPTION TRUSTS

- 1) The district should establish a file of all exception trusts identified within the district. This file can be created and maintained manually, or within a PC based system.
- 2) The file should contain, at a minimum, the name of the client, CIN and case number, name of the trustee, amount of the trust, and the expected annual payments to be made according to the terms of the trust. It should also include an area to record additions to and disbursements from the fund on an annual basis.
- 3) At the time that the agency is made aware of the existence of an exception trust, (generally at application or recertification) they should add the trust to the file and should request the trustee to provide copies of any accountings that he is required to produce.
- 4) Upon receipt of this information, the district should update their file, and should evaluate the activity to ensure that no monies have been inappropriately transferred.
- 5) Upon notification of the death of the client, the district should forward any information on exception trusts to their recovery unit for estate recovery evaluation.

EXPLANATION OF THE EFFECT OF TRANSFER OF ASSETS
ON MEDICAL ASSISTANCE ELIGIBILITY

This explains how a transfer of assets may affect your eligibility for Medical Assistance. Assets include all of your and your spouse's income and resources, including any income or resource which you or your spouse are entitled to receive but do not receive because of any action or inaction by you or your spouse. A transfer is when property or assets are given or sold from one person to another. For Medical Assistance purposes, a prohibited transfer is the voluntary giving or sale of your property or assets to another person without receiving something of equal value in return, in order to qualify for:

- nursing facility services provided in hospitals, residential health care facilities or intermediate care facilities for the developmentally disabled;
- care, services, or supplies furnished pursuant to a waiver under section 1915(c) or (d) of the Social Security Act, including: the Long Term Care Program, the OMRDD Home and Community Based Waiver, the Traumatic Brain Injury Waiver or the Care At Home Program.

The information contained in this document is applicable to all transfers made after August 10, 1993. For information on transfers made prior to that date, ask your Medical Assistance Eligibility Examiner.

The Medical Assistance Program will not pay for any of the services listed below if a prohibited transfer of countable assets (the total value of property, resources and income that are in excess of the allowable Medical Assistance resource standard) for less than fair market value is made within the 36 months before your application for Medical Assistance, or at any time after you apply for Medical Assistance to pay for the services listed in the "limited coverage" section below. In the case of trusts, we will look back for a period of 60 months. (In most cases, once you are found to be eligible for these services, a transfer by your spouse does not affect your Medical Assistance coverage.) If we decide that a prohibited transfer has been made within this time period, and you meet all other eligibility requirements, your Medical Assistance coverage will be limited for a period of time.

What does limited coverage mean?

Limited coverage means that for a period of time you will not be able to receive Medical Assistance coverage for the following types of care and services:

- nursing facility services provided in hospitals, residential health care facilities or intermediate care facilities for the developmentally disabled;

- care, services, or supplies furnished pursuant to a waiver under section 1915(c) or (d) of the Social Security Act, including: the Long Term Care Program, the OMRDD Home and Community Based Waiver, the Traumatic Brain Injury Waiver or the Care At Home Program. Examples of some of these services are:

- Congregate/home delivered meals
- Home maintenance tasks
- Housing improvement
- Social transportation
- Respite care
- Social day care
- Personal emergency response system services
- Moving assistance
- Medical social services
- Respiratory therapy
- Nutritional counseling/education services

How is the limited coverage period determined?

When you or your spouse make a transfer of assets for less than they are worth, you cannot get Medical Assistance for the services listed above for a period of time, depending upon the amount of transferred assets. We determine the number of months you are ineligible for these services by dividing the uncompensated value of the assets transferred by the average monthly rate for nursing facility services in the region where you live. The penalty period would begin the month following the month in which you made the transfer. Information on average monthly rates is available upon request from your social services district.

How do we determine the uncompensated value of the transferred assets?

We estimate the fair market value of the asset at the time it was transferred. We deduct any outstanding loans, mortgages or other encumbrances on the asset and the amount of compensation received in exchange for the asset. In addition, certain resource or income disregards may be deducted, if applicable.

What transfers do not affect your eligibility for Medical Assistance?

There are exceptions to the transfer rules. Your Medical Assistance coverage is not limited when a transfer has been made if:

1. the asset(s) was transferred to (or for the sole benefit of) your spouse, or from your spouse to you; or
2. the asset(s) was transferred from your spouse to another person for the sole benefit of your spouse; or
3. the asset(s) was transferred to your child of any age who is certified blind, or certified disabled, or to a trust established solely for the benefit of that child; or

4. the asset(s) was transferred to a trust established solely for the benefit of an individual under 65 years of age who is certified disabled.
5. the asset(s) transferred was your homestead (for example: a house or an apartment that you own), and the homestead was transferred to:
 - your spouse;
 - your minor child under age 21, or your child of any age who is certified blind or certified permanently and totally disabled;
 - your brother or sister who also has an equity interest in the home and who lived in the home for at least one year immediately before you entered a nursing facility;
 - your child (other than a child who is under 21 or who is certified blind/disabled) who was living in your home for at least two years immediately before you entered a nursing facility and who provided care which permitted you to reside at home rather than in a nursing facility.

NOTE: Although the Department does not treat a life estate possessed by you as a countable resource for purposes of determining your Medical Assistance eligibility, a life estate has value and you may be subject to a transfer penalty if you transfer your life estate interest to another person.

What other transfers do not affect your eligibility for Medical Assistance?

If you or your spouse transferred assets for less than fair market value you can still get full Medical Assistance coverage if you can prove that:

1. you or your spouse intended to sell the asset(s) at fair market value or to receive other valuable consideration in exchange for the asset(s); or
2. the asset(s) was transferred exclusively for a purpose other than to qualify for nursing care and related services as described above; or
3. all of the transferred assets have been returned.

In the absence of the evidence described in 1. or 2. above, we will not limit your Medical Assistance coverage if we determine that despite your best efforts, as determined by the social services district, you are unable to have the transferred asset(s) returned or to receive fair market value for the asset.

We will not limit your Medical Assistance coverage if we determine that such limitation will result in undue hardship for you. We will consider undue hardship to exist if you: (a) meet all other eligibility requirements, and (b) are unable to obtain appropriate medical care without which your health or life would be in danger or if application of the transfer penalty would deprive you or your spouse of food, clothing, shelter or other necessities of life.

How can you prove the transfer was not made to qualify for these medical services?

We will presume that any prohibited transfer of assets made within 36 months (60 months for trusts), that occurred immediately before or when you became in need of nursing care and related services was made for the purpose of qualifying for Medical Assistance. If you disagree with this presumption, you should present evidence to your Medical Assistance eligibility examiner which proves that the transfer was made for some other purpose. Some factors which may establish that a transfer was made for a purpose other than to obtain Medical Assistance eligibility are:

1. sudden, unexpected onset of serious illness or disability after the transfer occurred;
2. unexpected loss of other resources or income which would have made you ineligible for Medical Assistance, after the transfer occurred;

These are examples only. All of the circumstances of the transfer will be considered as well as factors such as your age, health and financial situation at the time the transfer was made. It is important to note that you have the burden of providing this agency with complete information regarding all assets and any other relevant factors which may affect your eligibility.

What appeal rights do you have?

You will receive a written notice if we determine that your Medical Assistance coverage is to be limited based on a transfer of assets for less than fair market value. If you are in a nursing facility or require the services listed under the "limited coverage" section at the time we make our decision, the notice will tell you how long you will have limited coverage. This period will be based on the amount of assets you or your spouse has transferred for less than fair market value and the average rate for nursing facility services in the region in which you reside.

You have the right to appeal our decision to limit your coverage. Our written notice will provide you with information on how to request a conference with us to review our actions. Our notice will also provide you with information on your right to a State Fair Hearing if you believe our action is wrong.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR
MEDICAL ASSISTANCE ELIGIBILITY EXAMINER.

LIFE EXPECTANCY TABLE
FOR FEMALES

<u>AGE</u>	<u>LIFE EXPECTANCY</u>	<u>AGE</u>	<u>LIFE EXPECTANCY</u>	<u>AGE</u>	<u>LIFE EXPECTANCY</u>
0	78.79	40	40.61	80	9.11
1	78.42	41	39.66	81	8.58
2	77.48	42	38.72	82	8.06
3	76.51	43	37.78	83	7.56
4	75.54	44	36.85	84	7.08
5	74.56	45	35.92	85	6.63
6	73.57	46	35.00	86	6.20
7	72.59	47	34.08	87	5.79
8	71.60	48	33.17	88	5.41
9	70.61	49	32.27	89	5.05
10	69.62	50	31.37	90	4.71
11	68.63	51	30.48	91	4.40
12	67.64	52	29.60	92	4.11
13	66.65	53	28.72	93	3.84
14	65.67	54	27.86	94	3.59
15	64.68	55	27.00	95	3.36
16	63.71	56	26.15	96	3.16
17	62.74	57	25.31	97	2.97
18	61.77	58	24.48	98	2.80
19	60.80	59	23.67	99	2.64
20	59.83	60	22.86	100	2.48
21	58.86	61	22.06	101	2.34
22	57.89	62	21.27	102	2.20
23	56.92	63	20.49	103	2.06
24	55.95	64	19.72	104	1.93
25	54.98	65	18.96	105	1.81
26	54.02	66	18.21	106	1.69
27	53.05	67	17.48	107	1.58
28	52.08	68	16.76	108	1.48
29	51.12	69	16.04	109	1.38
30	50.15	70	15.35	110	1.28
31	49.19	71	14.66	111	1.19
32	48.23	72	13.99	112	1.10
33	47.27	73	13.33	113	1.02
34	46.31	74	12.68	114	0.96
35	45.35	75	12.05	115	0.89
36	44.40	76	11.43	116	0.83
37	43.45	77	10.83	117	0.77
38	42.50	78	10.24	118	0.71
39	41.55	79	9.67	119	0.66

LIFE EXPECTANCY TABLE
FOR MALES

<u>AGE</u>	<u>LIFE EXPECTANCY</u>	<u>AGE</u>	<u>LIFE EXPECTANCY</u>	<u>AGE</u>	<u>LIFE EXPECTANCY</u>
0	71.80	40	35.05	80	6.98
1	71.53	41	34.15	81	6.59
2	70.58	42	33.26	82	6.21
3	69.62	43	32.37	83	5.85
4	68.65	44	31.49	84	5.51
5	67.67	45	30.61	85	5.19
6	66.69	46	29.74	86	4.89
7	65.71	47	28.88	87	4.61
8	64.73	48	28.02	88	4.34
9	63.74	49	27.17	89	4.09
10	62.75	50	26.32	90	3.86
11	61.76	51	25.48	91	3.64
12	60.78	52	24.65	92	3.43
13	59.79	53	23.82	93	3.24
14	58.82	54	23.01	94	3.06
15	57.85	55	22.21	95	2.90
16	56.91	56	21.43	96	2.74
17	55.97	57	20.66	97	2.60
18	55.05	58	19.90	98	2.47
19	54.13	59	19.15	99	2.34
20	53.21	60	18.42	100	2.22
21	52.21	61	17.70	101	2.11
22	51.38	62	16.99	102	1.99
23	50.46	63	16.30	103	1.89
24	49.55	64	15.62	104	1.78
25	48.63	65	14.96	105	1.68
26	47.72	66	14.32	106	1.59
27	46.80	67	13.70	107	1.50
28	45.88	68	13.09	108	1.41
29	44.97	69	12.50	109	1.33
30	44.06	70	11.92	110	1.25
31	43.15	71	11.35	111	1.17
32	42.24	72	10.80	112	1.10
33	41.33	73	10.27	113	1.02
34	40.23	74	9.27	114	0.96
35	39.52	75	9.24	115	0.89
36	38.62	76	8.76	116	0.83
37	37.73	77	8.29	117	0.77
38	36.83	78	7.83	118	0.71
39	35.94	79	7.40	119	0.66

LIFE ESTATE AND REMAINDER INTEREST TABLE

<u>AGE</u>	<u>LIFE ESTATE</u>	<u>REMAINDER</u>	<u>AGE</u>	<u>LIFE ESTATE</u>	<u>REMAINDER</u>
0	.97188	.02812	35	.93868	.06132
1	.98988	.01012	36	.93460	.06540
2	.99017	.00983	37	.93026	.06974
3	.99088	.00992	38	.92567	.07433
4	.98981	.01019	39	.92083	.07917
5	.98938	.01062	40	.91571	.08429
6	.98884	.01116	41	.91030	.08970
7	.98822	.01178	42	.90457	.09543
8	.98748	.01252	43	.89855	.10145
9	.98663	.01337	44	.89221	.10779
10	.98565	.01435	45	.88558	.11442
11	.98453	.01547	46	.87863	.12137
12	.98329	.01671	47	.87137	.12863
13	.98198	.01802	48	.86374	.13626
14	.98066	.01934	49	.85578	.14422
15	.97937	.02063	50	.84743	.15257
16	.97815	.02185	51	.83674	.16126
17	.97700	.02300	52	.82969	.17031
18	.97590	.02410	53	.82028	.17972
19	.97480	.02520	54	.81054	.18946
20	.97365	.02635	55	.80046	.19954
21	.97245	.02755	56	.79006	.20994
22	.97120	.02880	57	.77931	.22069
23	.96986	.03014	58	.76822	.23178
24	.96841	.03159	59	.75675	.24325
25	.96678	.03322	60	.74491	.25509
26	.96495	.03505	61	.73267	.26733
27	.96290	.03710	62	.72002	.27998
28	.96062	.03938	63	.70696	.29304
29	.95813	.04187	64	.69352	.30648
30	.95543	.04457	65	.67970	.32030
31	.95254	.04746	66	.66551	.33449
32	.94942	.05058	67	.65098	.34902
33	.94608	.05392	68	.63610	.36390
34	.94250	.05750	69	.62086	.37914

LIFE ESTATE AND REMAINDER INTEREST TABLE (cont.)

<u>AGE</u>	<u>LIFE ESTATE</u>	<u>REMAINDER</u>	<u>AGE</u>	<u>LIFE ESTATE</u>	<u>REMAINDER</u>
70	.60522	.39478	90	.28221	.71779
71	.58914	.41086	91	.26955	.73045
72	.57261	.42739	92	.25771	.74229
73	.55571	.44429	93	.24692	.75308
74	.53862	.46138	94	.23728	.76272
75	.52149	.47851	95	.22887	.77113
76	.50441	.49559	96	.22181	.77819
77	.48742	.51258	97	.21550	.78450
78	.47049	.52951	98	.21000	.79000
79	.45357	.54643	99	.20486	.79514
80	.43659	.56341	100	.19975	.80025
81	.41967	.58033	101	.19532	.80468
82	.40295	.59705	102	.19054	.80946
83	.38642	.61358	103	.18437	.81563
84	.36998	.63002	104	.17856	.82144
85	.35359	.64641	105	.16962	.83038
86	.33764	.66236	106	.15488	.84512
87	.32262	.67738	107	.13409	.86591
88	.30859	.69141	108	.10068	.89932
89	.29526	.70474	109	.04545	.95455



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EXHIBIT C

***Streimer Letter - HCFA Letter Dated April 16,
1998, to Jean Galloway Ball, Esq.***

ELDER LAW ASSOCIATES PA

**HCFA LETTER CONCERNING TRUSTS FOR THE SOLE BENEFIT
OF THE COMMUNITY SPOUSE**

April 16, 1998

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

7500 SECURITY BOULEVARD
BALTIMORE, MD 21244-1850

Jean Galloway Ball
Galloway, Ball & Cozza, P.L.C.
10300 Eaton Place
Suite 250
Fairfax, Virginia 22030-2239

Dear Ms. Ball:

I am responding to your letter to Sally Richardson concerning trusts established for the sole benefit of the community spouse under the Health Care Financing Administration's (HCFA) Transmittal No. 64. Your letter was referred to this office for reply.

At issue is a trust you prepared for a community spouse, with the community spouse as the sole beneficiary. The trust was funded using resources belonging to the community spouse and the Medicaid applicant. The son of the community spouse was named as the trustee. The trust provided for distributions on an actuarially sound basis that would result in distribution of the trust assets within the beneficiary's expected lifetime. In preparing the trust in this manner you sought to create a private annuity in the form of a trust, rather than purchase a more standard annuity from an insurance company or similar entity.

You believe, based on your reading of HCFA Transmittal No. 64 (which sets forth HCFA's interpretation of the transfer of assets and treatment of trusts provisions of the Medicaid statute), that an "annuitized" trust of the sort you prepared would protect the couple from transfer of assets penalties and protect the assets in the trust itself from being counted as an available resource in determining the Medicaid eligibility of the institutionalized spouse. The Virginia Department of Social Services agrees to the extent that establishment of the trust does not subject the institutionalized spouse to a penalty for transferring assets for less than fair market value because transfers between spouses are exempt from such penalties.

However, the Department of Social Services has held that the corpus of the trust must be counted as available to the institutionalized spouse under the provisions of section 1917(d) of the Social Security Act. The Department reasoned that under section 1917(d) a trust falls under the jurisdiction of that section if the trust was established by either member of the couple, using at least some of the Medicaid applicant's assets. Section 1917(d) applies without regard to the purpose for which the trust was established, or any restrictions on the distributions from the trust. The Department held that the trust you prepared is an irrevocable trust, the corpus of which can be paid at some point in time to the community spouse. Under

section 1917(d)(2)(B), the corpus of such a trust is considered an available resource to the beneficiary, and thus must be included as a countable resource in determining Medicaid eligibility for the institutionalized spouse under the Medicaid spousal impoverishment provisions (section 1924 of the Act).

You disagree with the Department's ruling. In an attached "Memorandum Re Community Spouse Resource Trust," you argue that the Department is creating an unreasonable distinction between private annuities of the sort your trust attempted to establish, and the more standard annuity purchased through an insurance broker. Under your interpretation, the trust you established meets the definition of an annuity because it provides for an actuarially sound schedule of payments to the trust beneficiary. You believe that "actuarial soundness" is the sole criterion under which annuities (or annuitized trusts) should be judged; thus, the funds placed in a trust such as you established should be protected from transfer of assets penalties, and from being counted as a resource in determining the institutionalized spouse's eligibility.

Although you attempt to combine the issues in question under the broad umbrella of "actuarial soundness" (citing section 3258.9.B of Transmittal No. 64), in reality the issues are separate and distinct and not subject to the connection you attempt to make. The first issue is whether the trust you prepared subjects the institutionalized spouse to a penalty under the transfer of assets provisions of section 1917(c) of the Act. It is to this issue, and only this issue, that "actuarial soundness" applies. "Actuarial soundness" is one means of determining that a transfer made to a third party was in fact made for the sole benefit of the spouse. However, it has no bearing on whether an asset is or is not a countable resource, and in fact the plain language of section 3258.9.B in no way makes such a connection. Section 3258.9.B speaks only to whether a purchase of an annuity constitutes a transfer of assets for less than fair market value.

The Department of Social Services has stipulated that no transfer penalty is applicable because transfers from one spouse to another, including transfers to a third party for the sole benefit of the spouse, are not subject to penalty. In so stipulating the Department presumably found that the trust you prepared met the requirement that the transfer be for the sole benefit of the community spouse. Thus, there is no disagreement with regard to the applicability of transfer of assets penalties in this case, and so no issue to which "actuarial soundness" is pertinent.

The only remaining issue is whether the trust you prepared protects the assets placed in the trust from being counted as resources in determining the institutionalized spouse's eligibility. As noted previously, you argue that the "annuity" aspect of the trust protects it from being counted as a resource, and the only difference between a standard annuity and your trust is the lack of involvement of an insurance broker in the establishment of your trust. While we understand the argument you make, we cannot agree with your conclusion that there is no material difference between a standard annuity and your "annuitized" trust.

A standard annuity can protect the funds used to purchase the annuity from being counted as resources in determining eligibility for Medicaid. However, there is a fundamental difference between a standard annuity and the "annuitized" trust you established. A standard annuity requires the actual purchase of a commodity; i.e., the annuity itself. A specific amount of

money is given to the entity selling the annuity, in return for which the entity contractually agrees to provide an income stream for a specified period of time. Upon completion of the transaction, the buyer no longer owns the funds used to purchase the annuity. Instead, he or she owns the annuity itself. If the annuity is irrevocable, as most annuities are, the buyer cannot reclaim ownership of the funds used to purchase the annuity. He or she is only entitled to the income stream purchased, and only for as long as the annuity stipulates. This is essentially the same as the purchase of any item or product where funds are exchanged for ownership of something else.

By contrast, the trust you prepared was not an annuity, but an irrevocable trust within the meaning of section 1917(d) of the Act, and the definition of a trust set forth in Transmittal No. 64. Section 3259.1.A.1 of that transmittal defines a trust as follows: "For purposes of this section, a trust is any arrangement in which a grantor transfers property to a trustee or trustees with the intention that it be held, managed, or administered by the trustee(s) for the benefit of the grantor or certain designated individuals (beneficiaries)." The only similarity between your trust and an annuity was the establishment of a schedule income stream under the trust, as opposed to some other means of distribution. Otherwise, establishment and funding the trust did not involve the exchange of the beneficiary's funds for a specific item or product, but merely transfer of those funds to the trustee for the benefit of the grantor, who was also the beneficiary of the trust. It is this latter arrangement that section 1917(d) and Transmittal No. 64 were specifically intended to address.

In summary, then, we must conclude with the Virginia Department of Social Service's ruling in this case. The trust you prepared was not an annuity, but rather an irrevocable trust subject to treatment under section 1917(d) of the Act, and HCFA's implementing instructions in Transmittal No. 64. While the trust you prepared met the definition of "actuarial soundness," "actuarial soundness" only pertains to whether a penalty can be imposed for transferring assets for less than fair market value when an annuity is purchased, or funds are transferred to a third party for the sole benefit of a spouse. "Actuarial soundness" does not affect the countability as resources of funds placed in a trust. The Department of Social Services correctly found that while no transfer penalty was applicable, the corpus of the trust was countable as a resource in determining the eligibility of the institutionalized spouse.

I regret that my response could not be more favorable. If you have any questions, please contact Roy Trudel of my staff at 410-786-3417.

Sincerely,



Robert A. Streimer
Disabled and Elderly Health Programs Group
Center for Medicaid and State Operations

cc: Virginia Department of Social Services, Medical Assistance Unit

DELAWARE DEPARTMENT OF \$
HEALTH AND SOCIAL \$
SERVICES, DIVISION OF \$
SOCIAL SERVICES, \$

Defendant Below, §
Appellant, §

 V_4

C. A. No. 00A-05-006

Submitted: May 15, 2001

Before **HOLLAND, BERGER** and **STEELE**, Justices.

This 15th day of May, 2001, upon consideration of the briefs of the parties, it appears to the Court that the judgment of the Superior Court should be affirmed on the basis of and for the reasons set forth in its decision dated December 6, 2000.

BY THE COURT:

Justice

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2000 Del. Super. LEXIS 490, *

ETHELDA DEAN, by her attorney-in-fact, William Dean, Appellant, v. DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES, DIVISION OF SOCIAL SERVICES, Appellee.

C.A. NO. 00A-05-006

SUPERIOR COURT OF DELAWARE, NEW CASTLE

2000 Del. Super. LEXIS 490

November 29, 2000, Submitted

December 6, 2000, Decided

SUBSEQUENT HISTORY: [*1] Released for Publication by the Court March 1, 2001.

DISPOSITION: Appeal From a Decision of the Delaware Department of Health and Social Services, Division of Social Services Decision Reversed. Motion to Supplement the Record Granted.

COUNSEL: Thomas Herlihy, III, Esquire, Herlihy, Harker & Kavanaugh, Wilmington, Delaware, for the Appellant.

Lynn D. Wilson, Esquire, Department of Justice, Wilmington, Delaware, for the Appellee.

JUDGES: Norman A. Barron, Judge.

OPINIONBY: Norman A. Barron

OPINION: MEMORANDUM OPINION

BARRON, Judge

This is the Court's decision on an appeal by William Dean, as husband and attorney-in-fact of Ethelda Dean, of a final decision of the Delaware Division of Social Services (DSS) denying Mrs. Dean's application for Medicaid benefits. Having reviewed the parties' submissions, as well as the record below, the Court concludes that the decision must be reversed.

POSTURE

Ethelda Dean, a resident of Parkview Nursing Home since January 1999, applied for Medicaid benefits to cover the costs of her long-term care. On July 15, 1999, DSS determined that Mr. and Mrs. Dean's resources exceeded the limit for Medicaid eligibility and that Mrs. Dean was therefore not eligible for [*2] Medicaid benefits at that time. On July 30, 1999, Mr. Dean reapplied for

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benefits on his wife's behalf. On February 23, 2000, DSS denied her application. At Mr. Dean's request, DSS conducted a hearing on the matter on April 26, 2000. On April 28, 2000, DSS issued its final decision denying Ethelda Dean's request for a reversal of the denial of her application for benefits. Dean filed a timely appeal to this Court. Briefing is complete, and the issues are ripe for decision.

FACTS

In January 1999, Ethelda Dean was admitted to Parkview Nursing Home. Her husband, William Dean, continued to live in the marital home in Wilmington. Ethelda Dean first applied for Medicaid assistance on April 22, 1999. To help determine his wife's eligibility for Medicaid benefits, William Dean sought from DSS an assessment of the couple's assets, referred to as a "snapshot" in Medicaid parlance. The snapshot revealed that as of July 15, 1999, the couple's assets totaled \$ 183,724.41, not including the Deans' home, car or other noncountable resources. n1 As the community spouse, Mr. Dean was entitled a community spouse resource allowance (CSRA) without jeopardizing his wife's eligibility for Medicaid. [*3] n2 The maximum amount of the CSRA is onehalf of the couple's combined countable resources, not to exceed an amount which Congress adjusts annually. In 1999, when Mrs. Dean applied for benefits, the cap was \$ 81,960. n3 DSS determined that Dean's countable assets equaled \$ 91,862.21, significantly in excess of the statutory cap. n4

-----Footnotes-----

n1 DSS Spousal Impoverishment Resource Calculation Sheet, included in Appendix to Opening Brief at A-40 through A-43. Subsequent references to this Appendix appear as "App. to Op. Br."

n2 The issues in this case pertain to Mr. Dean's resources but not to his income. In Delaware, a married applicant's eligibility for Medicaid is "determined by considering the income of the institutionalized spouse only." State of Delaware Department of Health and Social Services, Division of Social Services Medical Assistance Program (Medicaid) Manual (DSSM) § 20990, included in Appendix to Reply Brief at C-46. Subsequent references to this Appendix appear as "App. to Rep. Br." The community spouse's income becomes an issue only when he or she does not receive sufficient income to cover the basic costs of living, in which case, he or she may seek to obtain a portion of the institutionalized spouse's income to help defray necessary costs. Mr. Dean makes no such application. [*4]

n3 Spousal Impoverishment Resource Sheet, App. to Op. Br. at A-40 through A-43.

n4 Id.

-----End Footnotes-----

On September 9, 1999, William Dean and his attorney met with Tamara Ince, a DSS case manager, to reapply for Medicaid on Ethelda Dean's behalf. At that time, it was determined that the Deans' countable resources had decreased to \$ 135,704, apparently due in part to payment of nursing home costs. However, the total still exceeded the allowable limit by approximately \$ 51,743, which DSS expected the Deans to spend on Mrs. Dean's nursing home costs. Dean indicated instead that he was purchasing a \$ 53,000 annuity in order to spend down his resources to within the limit. Dean stated that he had cashed a certificate of deposit and had placed the funds in a checking account to pay for the annuity. Shortly thereafter, DSS again denied Mrs. Dean's application, and Mr. Dean requested a fair hearing.

At the hearing, Dale Krause, an attorney who specializes in "putting together

Medicaid annuities for purposes of Medicaid qualification," n5 testified at the hearing that annuity rules are established by the federal [*5] Health Care Financing Administration (HCFA), which issued a document known as HCFA Transmittal 64 (Tr. 64). According to Krause, Tr. 64 provides that a properly structured annuity can be used to spend down resources in order to ensure Medicaid eligibility. Krause further stated that he had helped Dean prepare such an annuity.

-----Footnotes-----

n5 Transcript of the Fair Hearing at 19. Subsequent references to the transcript appear as "Tr. at page no."

-----End Footnotes-----

Krause testified that Mr. Dean's annuity was irrevocable, nonassignable, immediate and actuarially sound, thus rendering it a non-countable resource for purposes of Medicaid. Krause stated that Dean purchased the annuity "to guarantee Mr. Dean that he'll have X number of dollars coming over a specified period of time." n6

-----Footnotes-----

n6 Tr. at 29.

-----End Footnotes-----

Tamara Ince, the DSS case manager who had met with Dean to review his [*6] application, testified at the hearing on behalf of DSS. She stated that DSS typically expects excess resources to be spent on health care costs, not resource shelters such as annuities. She stated that after the amount of the community spouse resource allowance is determined, "all other resources are to be spent on a client's care or what we consider the spending out process." n7 Ince also made it clear that DSS had concluded that Dean bought the annuity to protect his assets while simultaneously ensuring his wife's eligibility for Medicaid benefits:

I was under the impression it was done in preparation of making him eligible for Medicaid and that was his sole purpose only. So, in that case we usually look at things of that nature. When a client spends down money or transfers money or gives money away for the sole purpose of becoming eligible for Medicaid when they actually have the resources to pay for nursing home care, we look at that as a transfer of assets. Um, again, in lieu of just being denied for being over resourced. n8

This statement clearly reflects Ince's belief that the annuity was a transfer of assets that would subject the Deans to a penalty of delaying [*7] coverage for long-term care, as opposed to being found over-resourced and therefore ineligible. The hearing officer asked if he had to concern himself with the transfer of assets rule, n9 and Dean's attorney led Ince into agreeing that there was no transfer problem because Dean did not transfer the \$ 53,000 to a third party. He then led her to agree that the only issue is whether the annuity is countable or not. n10

-----Footnotes-----

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n7 Tr. at 4.
n8 Tr. at 14.
n9 Tr. at 15.
n10 Tr. at 16-18.

-----End Footnotes-----

On April 28, 2000, DSS issued its final decision upholding the denial of Ethelda Dean's application for Medicaid assistance. The hearing officer reasoned that Tr. 64 did not govern the case because Delaware does not operate a "medically needy" Medicaid program. He further found that the purchase of the annuity was an abusive shelter of assets calculated to ensure Mrs. Dean's eligibility for Medicaid. Mr. Dean filed a timely appeal to this Court.

STANDARD OF REVIEW

On appeal of a DSS decision, "the Court shall decide [*8] all relevant questions and all other matters involved, and shall sustain any factual findings of the administrative hearing decision that are supported by substantial evidence of the record as a whole." n11 Such review "necessarily aim[s] at the potential for misapplication of governing law by a State when determining the qualifications of applicants for Medicaid assistance." n12

-----Footnotes-----

n11 Title 31 Del. C. § 520. See also *Dolinger v. Delaware Dep't of Health and Social Services*, Del. Super., C.A. No. 98A-06-003, Gebelein, J. (Jan. 7, 1999).

n12 *Bowden v. Delaware Dep't of Health & Social Servs., Div. of Social Servs.*, 1993 Del. Super. LEXIS 304, *5, Del. Super., C.A. No. 92A-08-001, Graves, J. (Aug. 25, 1993) (Letter Op.), *aff'd sub nom. Parsons v. Delaware Dep't of Health & Social Servs., Div. of Social Servs.*, Del. Supr., 642 A.2d 837, cert. denied 513 U.S. 875, 115 S. Ct. 203, 130 L. Ed. 2d 133 (1994).

-----End Footnotes-----

ISSUES

Dean argues first that the hearing officer erred as a matter of law when he concluded [*9] that Tr. 64 does not apply to Delaware's Medicaid program. Dean also argues that the hearing officer erred as a matter of law when he ruled that William Dean's annuity was a countable resource for purposes of Ethelda Dean's Medicaid eligibility. Finally, Dean asserts that DSS violated her rights under the due process clause and the commerce clause of the federal constitution.

DSS responds that the hearing officer was correct in his rulings that Tr. 64 is inapplicable in Delaware and that Ethelda Dean was not eligible for Medicaid benefits because the Deans had excess resources. DSS also asserts that the Deans were afforded their full panoply of constitutional rights.

Because the statutory mandate requires this Court to decide "all relevant matters and all other matters involved," the Court reframes the issues in this case to ensure that all matters are addressed in a coherent manner. This Opinion addresses each of the following questions. First, does Tr. 64 apply to the case at bar? Second, if so, how does Tr. 64 affect an applicant's eligibility for Medicaid? Third, if Tr. 64 is applicable, does it require that

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a penalty be imposed on the Deans for the purchase of the \$ 53,000 annuity?
 [*10] Fourth, is the \$ 53,000 countable as a resource in determining Ethelda Dean's eligibility for Medicaid?

DISCUSSION

The Medicaid program was established in 1965 n13 to provide federal funds to help pay for the medical treatment of needy persons. n14 The federal government shares the costs of Medicaid with states that elect to take part in the program; in return, participating states must comply with the requirements imposed by the Act and by the Secretary of Health and Human Services, who administers the program through the Health Care Financing Administration (HCFA). n15

-----Footnotes-----

n13 Title XIX of the Social Security Act, 42 U.S.C. §§ 1396--1396r.

n14 *Martin v. Ohio Dept. of Human Serv.*, Ohio Ct. App., 130 Ohio App. 3d 512, 720 N.E.2d 576 (1998). See also *West Virginia Univ. Hosps., Inc. v. Casey*, 3d Cir., 885 F.2d 11, 15 (1989). (observing that the purpose of the Medicaid program is to provide a nationwide program of medical assistance for low income families and individuals).

n15 See 42 U.S.C. § 1396a (1982 ed. and Supp. II); *Schweiker v. Gray Panthers*, 453 U.S. 34, 36-37, 69 L. Ed. 2d 460, 101 S. Ct. 2633 (1981).

-----End Footnotes-----

Each state Medicaid program, which must be approved by the Secretary, is basically administered by the "state within certain broad requirements and guidelines." n16 In Delaware, the Medicaid program is generally overseen by the Department of Health and Social Services, but is administered by the Division of Social Services (DSS). n17 Of the several types of programs a state may choose from, Delaware has opted for the Supplemental Security Income for the Aged, Blind and Disabled (SSI) program, with additional coverage under the optional categorically needy provision. n18 Under this program, individuals who receive (or who qualify for) SSI are automatically eligible for Medicaid, while other applicants must meet additional state and federal requirements. As long as the state criteria comport with the federal regulations governing eligibility, they will be deemed valid and enforceable. n19

-----Footnotes-----

n16 *West Virginia Univ. Hosps., Inc. v. Casey*, 885 F.2d at 15.

n17 *Milne v. Dept. of Health and Social Servs.*, Del. Super., 679 A.2d 1010, 1013 (1995).

n18 See *Bowden v. Delaware Dept. of Health and Social Servs., Div. of Social Servs.*, 1993 Del. Super. LEXIS 304, Del. Super., Graves, J. (Aug. 25, 1993). [*12]

n19 *Id.* (citing *Schweiker v. Gray Panthers*, 453 U.S. 34, 36-37, 69 L. Ed. 2d 460, 101 S. Ct. 2633 (1981)).

-----End Footnotes-----

Prior to 1988, a married person living in a nursing home had to "spend down" all of the couple's jointly held assets to the eligibility limit in order to

receive assistance, often reducing both husband and wife to poverty from medical expenses. n20 However, married couples often transferred their assets into the name of the spouse not seeking Medicaid benefits because only jointly held assets were considered to be available for the institutionalized spouse's medical needs. n21

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n20 *Martin v. Ohio Dep't of Human Servs.*, Ohio Ct. App., 130 Ohio App. 3d 512, 720 N.E.2d 576, 581 (1998).

n21 *Id.*

-----End Footnotes-----

Congress addressed both of these problems when it enacted § 1396r-5 of the Medicare Catastrophic Coverage Act of 1988 (MCCA). n22 Pursuant to § 1396r-5(c) (1)(A), a "snapshot" of the total value of the couple's resources is taken prior to [*13] filing a formal application. To avoid impoverishment of the community spouse, he or she is entitled to a community spouse resource allowance (CSRA) without affecting the applicant's eligibility for Medicaid. This allowance is not available to pay for the care of the institutionalized spouse, and it need not be spent down in order for the institutionalized spouse to qualify. The cap on the CSRA is one-half of the couple's combined resources up to a limit which Congress adjusts annually. Any resources exceeding the CSRA (and the \$ 2000 allocated to the institutionalized spouse) are deemed available for the care of the institutionalized spouse. n23

-----Footnotes-----

n22 42 U.S.C. § 1396r-5.

n23 The parties agree that the issues in this case pertain to resources rather than income. In Delaware, "income eligibility is determined by considering the income of the institutionalized spouse only." DSSM § 20990.

-----End Footnotes-----

To assist caseworkers at the state level, the HCFA has issued a document entitled the State Medicaid [*14] Manual. At issue in the case at bar is the so-called "Transmittal 64" (Tr. 64), which is an amendment to the eligibility section of the State Medicaid Manual. Tr. 64 provides instructions to Medicaid caseworkers at the state level regarding trusts as well as transfers of assets for less than fair market value. At issue in the case at bar is Tr. 64, § 3258, Transfers of Assets for Less Than Fair Market Value, which was intended to "interpret § 1917(c) of the [Social Security] Act, as amended by § 13611 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), on the treatment of transfers of assets for less than fair market value." n24 HCFA guidelines such as Tr. 64, although not statutes or regulations, are entitled to deference by the courts as long as "they are consistent with the plain language and purposes of the statute and if they are consistent with prior administrative views." n25

-----Footnotes-----

n24 Introductory language to Tr. 64, presented on the unnumbered first page, included in App. to Op. Br. at A-61.

n25 *Cleary v. Waldman*, 3d. Cir., 167 F.3d 801, 808, cert. denied, 528 U.S. 870,

120 S. Ct. 170, 145 L. Ed. 2d 144 (1999); see also *Elizabeth Blackwell Health Center for Women v. Knoll*, 3d Cir., 61 F.3d 170 (1995) (noting that interpretive rules promulgated by an agency with lawmaking authority will receive deference even if the agency's interpretation is not made pursuant to that lawmaking authority), cert. denied, 516 U.S. 1093, 133 L. Ed. 2d 760, 116 S. Ct. 816 (1996).

- - - - -End Footnotes- - - - -
[*15]

1. Tr. 64 applies to Delaware's Medicaid program. The hearing officer in the case at bar found that Tr. 64 does not apply to Delaware's Medicaid program. He reasoned that because Delaware does not operate a "medically needy" Medicaid program which requires applicants to "spend down" their excess resources on medical costs in order to apply for Medicaid, Tr. 64 has no relevance in Delaware. n26 DSS supports the hearing officer's finding, but offers no authority for it. In fact, the plain language of Tr. 64 contradicts this conclusion. The introductory section of Tr. 64 provides in part as follows:

New Implementing Instructions--Effective Date: 12/13/94

This instruction applies to all transfers made or trusts established on or after August 10, 1993.

Section § 3258.1 is even more specific, stating that "the provisions explained in these instructions apply to all States, including those using more restrictive eligibility criteria than are used by the SSI program. . . ." Thus, it is clear that Tr. 64 applies to Delaware, which is an SSI state with additional coverage for categorically eligible individuals. The Court concludes that the hearing officer erred as [*16] a matter of law when he concluded that Tr. 64 does not apply to Delaware's Medicaid program.

- - - - -Footnotes- - - - -

n26 Final Decision of the DSS, No. 8000865183, at 4. The Court notes that Delaware does allow applicants to spend down excess resources on medical costs in order to qualify for Medicaid. Tamara Ince testified that DSS expects over-resourced applicants to pay their medical bills until their resources are within the proscribed limits.

- - - - -End Footnotes- - - - -

2. Tr. 64 provides for penalty periods but does not preclude eligibility. The introductory language to the section on transfers of assets provides that § 3258 "discusses actions which result in the denial of coverage for certain medical services to otherwise eligible institutionalized or noninstitutionalized individuals who transfer assets for less than fair market value." n27 Section 3258 further provides that, where a transfer has been made for less than fair market value, within the so-called "look back period," n28 the caseworker must impose a penalty and deny coverage of certain [*17] Medicaid services to otherwise eligible institutionalized individuals. n29 In other words, the result is a penalty, not ineligibility. This is explained in § 3258.5:

Penalty Periods. When an individual (or spouse) makes a transfer of assets for less than fair market value, payment for certain services received by the individual is denied for a specified period of time. However, the individual remains eligible for Medicaid and can have payment made for services not subject to penalty. (See § 3258.8.) For example, an institutionalized individual who transfers assets for

less than fair market value must be denied reimbursement for nursing facility services. However, he or she may still be eligible for reimbursement for physician's services, provided such services are not provided as part of the individual's nursing home care.

Thus, it is clear that Tr. 64 does not affect an applicant's eligibility for Medicaid, but may affect the coverage of certain services for a specified period of time.

-----Footnotes-----

n27 The entire text of Tr. 64 is found in the App. to Op. Br., at A-61 through A-103. The quoted language is found at A-61. [*18]

n28 Section 3258.4. The look-back period is typically of three months duration.

n29 Section 3258.1. See also § 3258.8 for a detailed description of the possible penalties.

-----End Footnotes-----

3. No penalty accrues in the case at bar. Section 3258.9(B) addresses annuities. Dean asserts that this section is of paramount importance because 42 U.S.C. § 1396a itself includes no provisions for annuities in the Medicaid context. n30 In the section governing trusts, 42 U.S.C. § 1396p(d)(6) states that the term "trust. . . includes an annuity only to such extent and in such manner as the Secretary specifies." Tr. 64 § 3258.9(B) is the only guidance the Secretary has issued regarding annuities, and Delaware has no regulation governing annuities in the Medicaid context. The Court therefore finds that the provisions of Tr. 64 require particular deference. n31

-----Footnotes-----

n30 Reply Br. at 6.

n31 See *Cleary v. Waldman*, 167 F.3d at 808; *Elizabeth Blackwell Health Center for Women v. Knoll*, 61 F.3d at 170.

-----End Footnotes-----

[*19]

Section 3258.9(B) makes it clear that the linchpin of the test for determining whether the purchase of an annuity is a valid purchase or is an abusive shelter of assets is whether the purchase was made for fair market value n32:

Annuities, although usually purchased in order to provide a source of income for retirement, are occasionally used to shelter assets so that individuals purchasing them can become eligible for Medicaid. In order to avoid penalizing annuities validly purchased as part of a retirement plan but to capture those annuities which abusively shelter assets, a determination must be made with regard to the ultimate purpose of the annuity (i.e., **whether the purchase of the annuity constitutes a transfer of assets for less than fair market value**). If the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary, the annuity can be deemed actuarially sound. (Emphasis added).

This section clearly suggests that sheltering, that is, moving or altering, assets solely in order to qualify for Medicaid is an abuse of the Medicaid system. It does so only by implication and by contrasting a valid retirement [*20] plan with a strategy to ensure eligibility. But it stops short of prohibiting such action. Worse yet, while this section appears to denounce the purchase of an annuity for the purpose of qualifying for Medicaid, it inhibits the caseworker's ability to penalize such abuse by making the single determinative factor the question of fair market value.

-----Footnotes-----

n32 "Fair market value" is defined as "an estimate of the value of an asset, if sold at the prevailing price at the time it was actually transferred." § 3258.1 (A) (1).

-----End Footnotes-----

In the case at bar, Dean relies on the above-cited provisions of Tr. 64 itself, while DSS relies on caselaw. Specifically, DSS argues that a recent Pennsylvania case supports its position that the purchase of an annuity to ensure Medicaid eligibility is inappropriate despite the provisions of Tr. 64. In *Dempsey v. Dep't of Public Welfare*, n33 Mr. Dempsey purchased an irrevocable annuity after his institutionalized wife's application for Medicaid had been denied because the couple was over-resourced. [*21] The *Dempsey* Court found that the Department of Public Welfare (the Pennsylvania equivalent of DSS) correctly presumed that the transfer was for less than fair market value and for the impermissible purpose of qualifying for Medicaid benefits. The first of these presumptions is key. It was based on a Pennsylvania statute which created a presumption that assets disposed of during the look-back period are transferred with the improper intent to qualify for Medicaid. n34 Delaware has no such statutory presumption, and until the General Assembly sees fit to enact one, DSS is not entitled to make this presumption, despite its obvious logic and utility. The Court notes that the statutory presumption is consistent with the spirit of Tr. 64, which clearly disapproves of transfers made solely for the purpose of qualifying for Medicaid, as discussed above. n35

-----Footnotes-----

n33 Pa. Cmmw.Ct., 756 A.2d 90 (2000).

n34 *Id.* at 95.

n35 The Court further notes that § 3258.9(B) implicitly presumes that a transfer of assets for less than fair market value was for the purpose of qualifying for Medicaid. One of the possible defenses to transfer of assets penalties is that the purpose of the transfer was something other than to qualify for Medicaid. In such cases, § 3258.10C.2, entitled *Transfers Exclusively for a Purpose Other Than to Qualify for Medicaid*, advises caseworkers that "verbal assurances. . . are not sufficient. Rather, convincing evidence must be presented as to the specific purpose for which the asset was transferred."

-----End Footnotes-----

[*22]

Without the statutory presumption that a transfer of assets during the look-back period is for less than fair market value, the Court turns to the guidance of Tr. 64 itself to determine whether Dean's annuity was purchased for less than fair market value. Pursuant to § 3258.9(B), if the annuitant's life

expectancy is less than or equal to the life of the annuity, the annuity is actuarially sound and is deemed to be purchased for fair market value. The inclusion in § 3258.9(B) of life expectancy tables to be used in making this determination underscores the significance of this factor. In response to the same issue, the court in *O.D. v. Div. of Medical Assistance & Health Services*, stated that, based on Tr. 64, "the sole test is whether the expected return on the Annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary. If so, the Annuity can be deemed to be actuarially sound, in accordance with the Federal mandate." n36

-----Footnotes-----

n36 N.J. Admin., Fuley, ALJ (June 12, 1995).

-----End Footnotes-----

Dean [*23] asserts that he complied with the terms of § 3258 and that he purchased the annuity for fair market value. At the time of purchase, he was 79 years old and, according to the § 3258.9 life expectancy tables, he had a life expectancy of 7.4 years. The life of the annuity was five years. By this straightforward formula, his annuity was actuarially sound and therefore was not a transfer for less than fair market value.

The Court is troubled by the fact that Tr. 64 disapproves of transfers which are made for the sole purpose of qualifying for Medicaid but offers no way to identify and penalize such transfers unless they are made for less than fair market value. The *Dempsey* Court described Tr. 64 as "simply a guideline to aid caseworkers in determining whether or not an annuity appears on its face to be a legitimate instrument as opposed to an abusive shelter for assets." n37 If Tr. 64 is a valid guideline for the front line decisionmaker, that is, the caseworker, it must also be a valid guideline for the courts which review the initial decision. The standards cannot change as a case proceeds through appellate review. Furthermore, the Tr. 64 methodology is based on § 1917 of the [*24] Social Security Act, which treats transfers of assets for less than fair market value. Other courts have found that HCFA policy guidelines such as Tr. 64 are entitled to judicial deference where they are consistent with the plain language and purposes of the statute and prior administrative views. n38 DSS has not directed the Court to any specific statutory provisions which prohibit an individual from purchasing an annuity such as the one purchased by Mr. Dean. Until the HCFA amends Tr. 64, or until the Delaware General Assembly enacts a statutory presumption that transfers of assets during the look-back period are made for less than fair market value, the Court must conclude that the purchase of an annuity such as Dean's does not subject the applicant to any penalties.

-----Footnotes-----

n37 *Dempsey* at 95-96 (emphasis added).

n38 *Johnson v. Guhl*, D.N.J., 91 F. Supp. 2d 754, 779 (2000), citing *Cleary v. Waldman*, 3d Cir., 167 F.3d 801, 808 (1999).

-----End Footnotes-----

4. The annuity, which creates an ongoing [*25] income stream for Mr. Dean, is not a countable resource for purposes of Medicaid. The hearing officer found that the purchase of the annuity was merely a change in the form of a resource and that the annuity itself is a countable resource. The hearing officer did not address the specific characteristics of an annuity and merely assumed that an annuity is always a countable resource.

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Dean argues that because the annuity is actuarially sound, it is therefore not a countable resource in determining Medicaid eligibility. n39 However, actuarial soundness is relevant only to the question of whether a transfer has been made for less than fair market value pursuant to Tr. 64. It has "no bearing on whether an asset is or is not a countable resource, and in fact the plain language of § 3258.9 in no way makes such a connection." n40 This argument has no merit.

-----Footnotes-----

n39 Op. Br. at 23.

n40 HCFA letter from Robert A. Streimer, Disabled and Elderly Health Programs Group, Center for Medicaid and State Operations, at 2; included in App. to Op. Br. at A-58.

-----End Footnotes-----

[*26]

Dean also argues that because Delaware does not prohibit the purchase of annuities and because Tr. 64 "codifies" such purchases, "Dean's purchase of an annuity with funds previously in a CD should be handled the same as if he had used the CD funds to pay off the mortgage on his house." n41 In other words, Dean argues that the annuity is the same type of resource as the statutory noncountable resources which include the home, the car, personal effects and cemetery plot. The list of noncountable resources contained in § 1917 is an exhaustive list that does not invite additions. The Court finds no support for the argument that the annuity is a noncountable resource.

-----Footnotes-----

n41 Op. Br. at 18.

-----End Footnotes-----

Resources other than those specifically excluded by statute are generally countable for purposes of determining Medicaid eligibility. Federal Medicaid law defines resources as follows:

Resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert [*27] to cash to be used for his or her support and maintenance.

(1) If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse). n42

-----Footnotes-----

n42 20 C.F.R. § 416.1201(a) (emphasis added). This regulation appears in App. to Rep. Br. at C-38.

-----End Footnotes-----

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The DSSM definition is consistent with the federal definition. Under the Delaware definition, property is considered to be a resource if the individual has the right, authority or power to liquidate his or her share of the property. n43 Stated otherwise, the individual must have some form of ownership interest in, legal right of access to and the legal ability to use the property for his or her own support and maintenance in order for the property to be considered a resource. n44

-----Footnotes-----

n43 DSSM § 410.12. [*28]

n44 DSSM § 410.12.

-----End Footnotes-----

With a standard, commercial irrevocable annuity, such as the one at issue in this case, the buyer purchases a commodity, that is, the annuity itself, and is entitled only to the income stream; the buyer does not own the purchasing funds and cannot reclaim them. n45 Applying the federal terminology, Dean's property right in the annuity cannot be liquidated, and therefore is not considered a resource. n46 Income, on the other hand, is defined as "the total amount of money authorized (designated by the payor) for the recipient's benefit. . . . [and] includes anything received by the individual, in cash or in kind, that can be used to meet needs for food, clothing or shelter." n47 Under these definitions, it is clear that Dean's property right in the annuity is in the form of income, not as a resource.

-----Footnotes-----

n45 *Johnson v. Guhl*, 91 F. Supp. 2d at 764.

n46 See 20 C.F.R. § 416.1201(a).

n47 DSSM § 20200.1.

-----End Footnotes-----

[*29]

Tr. 64 also refers to the payments from a standard commercial annuity in terms of income:

When an individual purchases an annuity, he or she generally pays to the entity issuing the annuity (e.g., a bank or insurance company) a lump sum of money, in return for which he or she is promised regular payments of income in certain amounts. These payments may continue for a fixed period of time (for example, 10 years), or for as long as the individual (or another designated beneficiary) lives. Thus creating an ongoing income stream. n48

-----Footnotes-----

n48 Tr. 64, § 3258.9(B).

123

-----End Footnotes-----

Dean also urges the Court to consider a letter from Robert H. Streimer, Director of the Disabled and Elder Health Programs Group, Center for Medicaid and State Operations, HCFA. In his letter to an attorney who had created an annuitized trust for a client, Streimer distinguishes between a standard, commercial annuity (such as Dean's) and an annuitized trust:

A standard annuity can protect the funds used to purchase the annuity from being [*30] counted as resources in determining eligibility for Medicaid. However, there is a fundamental difference between a standard annuity and the "annuitized" trust you established. A standard annuity requires the actual purchase of a commodity; i.e., the annuity itself. A specific amount of money is given to the entity selling the annuity, in return for which the entity contractually agrees to provide an income stream for a specified period of time. Upon completion of the transaction, the buyer no longer owns the funds used to purchase the annuity, instead, he or she owns the annuity itself. If the annuity is irrevocable, as most annuities are, the buyer cannot reclaim ownership of the funds used to purchase the annuity. **He or she is only entitled to the income stream purchased, and only for as long as the annuity stipulates.**

Although this letter has no precedential value, it does reinforce the Court's conclusion that Mr. Dean's annuity constitutes income for Medicaid purposes.
n49

-----Footnotes-----

n49 See *Johnson v. Guhl*, 91 F. Supp. 2d at 764 (observing that the Streimer letter, while "certainly not binding on this Court, is, at the very least, instructive").

-----End Footnotes-----

[*31]

Based on the federal and state definition of income and resources, as well as the language of Tr. 64 and the Streimer letter, the Court concludes that Mr. Dean's property right in the annuity is in the form of income, not a resource, and that the hearing officer erred in finding otherwise.

CONSTITUTIONAL ISSUES

In light of the Court's decision regarding Ethelda Dean's eligibility for Medicaid, it is not necessary to address Dean's constitutional arguments.

MOTION TO SUPPLEMENT THE RECORD

After briefing was complete, Dean filed a motion to supplement the record by adding information regarding the purchase date of the annuity in question as well as information on another annuity. Dean submitted this information because DSS questioned whether Dean had in fact purchased the \$ 53,000 annuity. The Court grants the motion to the extent that it helps document the transaction. However, because the Court finds that there was no real dispute as to whether Mr. Dean purchased the annuity, the supplemental materials and argument do not affect the outcome of the case.

Dean also submitted documentation about a \$ 30,000 annuity which he had not previously disclosed. He received information [*32] from WSFS, a Wilmington

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bank, about this annuity in September 2000. He apparently purchased the annuity in March 13, 2000, and acknowledges that it is a countable resource for purposes of Mrs. Dean's Medicaid eligibility determination. However, he argues that because he has paid more than \$ 35,000 towards his wife's nursing home costs during the same time period, these payments more than offset the value of the annuity and therefore do not significantly affect the eligibility determination. DSS points out that Dean admits being aware of the second annuity approximately one month before the fair hearing and argues that such failure to disclose is a fraud against the State. Despite the allegations of fraud, DSS offers no remedy but merely opposes supplementing the record.

The Court notes the untimely nature of the disclosure and the failure to explain this oversight. Dean had a legal obligation to disclose this information to DSS and the hearing officer. His argument that he paid an equivalent amount in health care costs for his wife conveniently sidesteps the possible implications of his failure to disclose. As a practical matter, this Court has no authority to remand to DSS to recalculate [*33] the eligibility determination, and the Court will not undertake this calculation on its own. Finally, in light of the fact that Mr. Dean has paid an equal or greater amount towards Mrs. Dean's care, the actual difference resulting from a recalculation might not be significant. The Court grants Dean's motion to supplement the record in the interests of having a complete record.

CONCLUSION

It appears that Mr. Dean managed to convert countable resources into income, which is not countable for purposes of his wife's Medicaid eligibility. Without imputing any blame to Mr. Dean, the Court reiterates its dissatisfaction with what appears to be a loophole of potentially vast proportions in the Medicaid law. However, given the current form of both state and federal law, the Court concludes that the hearing officer's decision denying Medicaid benefits to Ethelda Dean must be, and hereby is, **Reversed**.

It is So ORDERED.

Norman A. Barron

Judge

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EXHIBIT D

McNamara v. Ohio Department of Human Services

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published over the years by hard work, sacrifice and dedication." *Sethi v. WFMJ Television, Inc.* (1999), 134 Ohio App.3d 796, 812, 732 N.E.2d 451, 463. A newspaper article that fails to report a set of events with precision can easily strain that reputation. This is obviously an unpleasant occurrence. "The balance, however, is that we must have a free and unfettered public media." *Id.* I believe that in this case, that balance falls on the side of the media.

Based upon the foregoing, I would have overruled appellant's assignments of error and affirmed the grant of summary judgment.



139 Ohio App.3d 551

1551 McNAMARA, Appellant,

v.

OHIO DEPARTMENT OF HUMAN
SERVICES, Appellee.

No. 18234.

Court of Appeals of Ohio,
Second District, Montgomery County.

Decided Aug. 4, 2000.

Department of Human Services found that institutionalized spouse was ineligible to receive Medicaid nursing home vendor payments for period of thirty months upon ground that she and community spouse had improperly transferred most of their assets to "spousal annuity trust," allegedly established for sole benefit of community spouse. Institutionalized spouse appealed. The Court of Common Pleas, Montgomery County, affirmed. Institutionalized spouse again appealed. The Court of Appeals, Fain, J., held that: (1) for Medicaid eligibility purposes, amount of resources that institutionalized spouse could transfer to community spouse was limited to maximum amounts that community spouse could retain under Community Spouse Resource Allowance (CSRA) provision; (2)

Health Care Financing Administration (HCFA) transmittal was not controlling; and (3) "spousal annuity trust" would not be treated under rules governing commercially purchased annuities.

Affirmed.

1. Social Security and Public Welfare ⇨241.80

Community Spouse Resource Allowance (CSRA) limits set forth in statute governing eligibility for Medicaid nursing home vendor payments supersede any inconsistent provision in statute permitting fair market value transfers from institutionalized spouse for sole benefit of community spouse; thus, for Medicaid eligibility purposes, amount of resources that institutionalized spouse may transfer to community spouse is limited to maximum amounts that community spouse may retain under CSRA provision. Social Security Act, §§ 1917 (c)(2)(B), 1924(a)(1), (f), as amended, 42 U.S.C.A. §§ 1396p(c)(2)(B), 1396r-5(a)(1), (f); Ohio Admin. Code §§ 5101:1-39-078(A)(2), 5101:1-39-36.

1552 2. Social Security and Public Welfare ⇨241.80

In determining whether institutionalized spouse was ineligible to receive Medicaid nursing home vendor payments for period of thirty months on ground that she and her husband had improperly transferred most of their assets to "spousal annuity trust," allegedly established for sole benefit of husband, court would not defer to Health Care Financing Administration (HCFA) transmittal stating that institutional spouse can transfer unlimited assets to community spouse or to third party for sole benefit of community spouse; such interpretation of governing statutes was inconsistent with their plain language and purposes. Social Security Act, §§ 1917 (c)(2)(B), 1924(a)(1), (f), as amended, 42 U.S.C.A. §§ 1396p(c)(2)(B), 1396r-5(a)(1), (f); Ohio Admin. Code §§ 5101:1-39-078(A)(2), 5101:1-39-36.

3. Statutes $\Rightarrow$ 219(6.1)

Health Care Financing Administration (HCFA) transmittals concerning a Medicaid statute are entitled to some deference by reviewing courts if they are consistent with the plain language and purposes of the statute and prior administrative views.

4. Social Security and Public Welfare $\Rightarrow$ 241.80

"Spousal annuity trust" into which institutionalized spouse and community spouse transferred most of their assets, and which was allegedly established for sole benefit of community spouse, would not be treated under rules governing commercially purchased annuities, and thus, trust assets were countable resources for purposes of determining institutionalized spouse's eligibility for Medicaid nursing home vendor payments. Social Security Act, § 1924(a)(1), (f), as amended, 42 U.S.C.A. §§ 1396r-5(a)(1), (f); Ohio Admin. Code §§ 5101:1-39-36, 5101:1-39-228.

Michael Millonig, Dayton, for appellant.

Betty D. Montgomery, Attorney General, and Patrick W. Beatty, Assistant Attorney General, Health and Human Services Section, for appellee.

FAIN, Judge.

Plaintiff-appellant Rheba McNamara appeals from a decision of the Montgomery County Court of Common Pleas affirming an administrative determination finding her ineligible to receive Medicaid nursing home vendor payments for a period of thirty months upon the ground that she and her husband had improperly transferred most of their assets to a "spousal annuity trust," allegedly established for the sole benefit of the husband. Mrs. McNamara argues that the ^{trial} court erred in affirming the administrative decision because the trust instrument that she and her husband used to shelter their assets was "for the sole benefit of her spouse," and, therefore, was not a countable resource for purposes of determining her eligibility for Medicaid nursing home payments. She further argues that Sec-

tion 1396p(c)(2)(B), Title 42, U.S.Code, adopted in this state as Ohio Adm.Code 5101:1-39-078(A)(2), permits an individual to make an unlimited transfer of resources to his or her spouse, notwithstanding the Community Spouse Resource Allowance limits set forth in Section 1396r-5(f), Title 42, U.S.Code, adopted in this state as Ohio Adm.Code 5101:1-39-36.

We conclude that if Section 1396p(c)(2)(B) were construed to allow an unlimited transfer of resources between spouses, the Community Spouse Resource Allowance limits established under Section 1396r-5(f) would be rendered a nullity. Therefore, we hold that pursuant to the supersession clause of Section 1396r-5(a)(1), the amount of resources that one person may transfer to his or her spouse is limited to the maximum amounts the community spouse may retain under the CSRA provision in Section 1396r-5(f). Accordingly, the judgment of the trial court is affirmed.

I

On October 5, 1997, Rheba McNamara entered the Bethany Lutheran Village nursing home. Her husband, Joseph B. McNamara, resides independently at a cottage unit at Bethany. At the time Mrs. McNamara entered the nursing home, the couple had resources valued at \$256,130.87. In April 1998, Mr. McNamara, acting on the couple's behalf, created an irrevocable trust, known as the "Spousal Annuity Trust fsbo [for the sole benefit of] Joseph McNamara, dated 4/1/98." Under the terms of the trust, the monthly income from the trust corpus was to be paid to Mr. McNamara, and the principal was to be paid to Mr. McNamara in annual payments for a period of five years. Mrs. McNamara is to receive no benefit from the trust. At the time the trust was created, Mr. McNamara was seventy-six years old, and had a life expectancy of 8.76 years. He had no authority to withdraw any funds from the trust, and upon his death, any funds remaining in the trust

were to be distributed to the McNamaras' two children. Over the next several months, the McNamaras transferred over \$221,000 to the trust.

In July 1998, Mrs. McNamara applied for Medicaid benefits with the Montgomery County Department of Human Services ("MCDHS"). The MCDHS determined that the McNamaras' decision to place their assets in the trust constituted an improper transfer of resources because the assets had been transferred for less than fair market value. Accordingly, the MCDHS ruled that while Mrs. McNamara was eligible for regular Medicaid, she was ineligible to receive §54 nursing home vendor payments for a period of thirty months, running from April 1, 1998 to September 30, 2000.

Mrs. McNamara appealed the denial of nursing home vendor payments to the Ohio Department of Human Services ("ODHS"). After holding a hearing on the matter, the state hearing officer affirmed MCDHS's finding that an improper transfer had occurred. Mrs. McNamara appealed the state hearing officer's decision to the ODHS. The administrative hearing examiner affirmed the state hearing officer's decision.

In June 1999, Mrs. McNamara appealed the denial of her administrative appeal to the Montgomery County Court of Common Pleas. On February 29, 2000, the trial court affirmed the order of the ODHS, declaring Mrs. McNamara ineligible to receive nursing home vendor payments for thirty months. The trial court found that the transfer of resources to the trust was an improper transfer because under the terms of the trust, any amounts remaining in the trust at the time of Mr. McNamara's death would be passed to the McNamaras' two children, and, therefore, the trust was not for the sole benefit of Mr. McNamara. The trial court further found that even if the transfer was not improper, the trust assets were still countable resources that had to be deemed available to the McNamaras to pay for the nursing home expenses because the

amount of assets retained by Mr. McNamara through the use of the trust exceeded the maximum amount he was permitted to retain under the community spouse resource allowance provision.

Mrs. McNamara appeals from the trial court's decision affirming the administrative determination that she is ineligible to receive nursing home vendor payments for a period of thirty months.

II

Mrs. McNamara's first assignment of error states:

"The common pleas court ruling that there was an improper transfer and a period of ineligibility for nursing home vendor payments is an incorrect application of law."

Mrs. McNamara argues that pursuant to Section 1396p(c)(2)(B), Title 42, U.S.Code, a person may transfer an unlimited amount of funds to his or her spouse or to a third person for the sole benefit of the individual's spouse, notwithstanding the limits of the community spouse resource allowance provision contained in Section 1396r-5, Title 42, U.S.Code. Mrs. McNamara further contends that the funds she and her husband transferred into the Spousal Annuity Trust were for the sole benefit of Mr. McNamara despite the "mere" fact that the trust designates their two children as the remainder beneficiaries in the §55 event Mr. McNamara dies before the trust corpus has been distributed to him. Therefore, Mrs. McNamara contends, the transfer of a majority of their resources to the spousal annuity trust was not an improper transfer rendering her ineligible to receive Medicaid nursing home vendor payments for a period of thirty months. We disagree.

Medicaid was enacted in 1965 as Title XIX of the Social Security Act to provide federal funds to pay for the medical treatment of needy persons. *Martin v. Ohio Dept. of Human Serv.* (1998), 130 Ohio App.3d 512, 515, 720 N.E.2d 576, 578-579.

Prior to 1988, a married person in a nursing home had to "spend down" all of the couple's jointly held assets to the eligibility limit in order to receive assistance, thereby leaving the couple impoverished. *Id.* at 518, 720 N.E.2d at 580-581. However, during this same period, it was possible for a married couple to shelter significant amounts of their assets by transferring them into the name of the spouse not seeking Medicaid benefits, since only jointly held assets were considered available for the institutionalized spouse's needs. *Id.*

Congress addressed this problem by enacting the Medicare Catastrophe Coverage Act of 1988, Section 1396r-5, Title 42, U.S.Code. *Id.* While most of the provisions of the MCCA were repealed in 1989, this section has been retained. *Id.* Under the MCCA, all of a couple's resources are considered in determining Medicaid eligibility regardless of whether the assets are jointly or separately held. *Id.* Generally, the MCCA permits the spouse living outside the nursing home, "the community spouse," to retain one-half of the couple's resources without affecting the eligibility of the spouse living in the nursing home, "the institutionalized spouse," to receive Medicaid benefits. *Id.* After the couple's resources are divided in half, the community spouse's share cannot exceed a specified maximum amount, indexed to inflation, *id.*, which, at the time the McNamaras applied for nursing home payments, was approximately \$80,000. See Ohio Adm.Code 5101:1-39-36(C) This adjusted amount is known as the Community Spouse Resource Allowance ("CSRA"), and any of the couple's resources exceeding the CSRA that are not otherwise excluded from consideration are deemed available to the institutionalized spouse to be used for his or her care. 130 Ohio App.3d at 518-519, 720 N.E.2d at 580-582.

The institutionalized spouse may spend down any amount in excess of the eligibility levels to receive Medicaid benefits, *id.* at 519, 720 N.E.2d at 581-582; however, an individual's ability to dispose of the excess resources is limited. For instance,

if an individual transfers "his legal interest in a countable resource for less than fair market value for the purpose of qualifying for medicaid, a greater amount of medicaid, or to avoid the utilization of the resource[.]" the resource transfer is considered improper. Ohio Adm.Code 5101:1-39-07. If an individual or his or her spouse, applying for Medicaid or in receipt of Medicaid, made an ¹⁵⁵⁶improper transfer of resources, that individual is subject to a period of restricted medicaid coverage for "long term care facility (LTCF) (i.e., nursing home) vendor payments." Ohio Adm.Code 5101:1-39-07(B).

Mrs. McNamara acknowledges that, at first blush, application of the general transfer rule indicates that the transfer of resources that took place here was improper. However, Mrs. McNamara argues that the transfer of resources to the Spousal Annuity Trust fits within an exception to the improper transfer rule set forth in Ohio Adm.Code 5101: 1-39-078(A)(2), which essentially incorporates Section 1396 p(c)(2)(B), Title 42, U.S.Code. Ohio Adm.Code 5101: 1-39-078(A)(2) provides:

"[T]he individual may transfer resources * * * to:

"(a) The individual's spouse (or to another for the sole benefit of the spouse), or to the community spouse provided the spouse does not transfer the resources to another for less than fair market value[.]"

Ohio Adm.Code 5101: 1-39-05(A)(13) provides:

"A transfer for the sole benefit of means a transfer arranged in such a way that no individual or entity except the spouse * * * can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

"(a) A trust is considered to be established for the sole benefit of a spouse * * * if the trust benefits no one but that individual, whether at the time the trust is

established or any time in the future.

* * *

"(b) A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not the spouse * * * is not considered to be established for the sole benefit of [the spouse]. In order for a transfer or trust to be considered to be for the sole benefit of [the spouse], the instrument or document must provide for the spending of the funds involved for the benefit of the individual on a basis that is actuarially sound based on the life expectancy of the individual involved. When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void."

Mrs. McNamara asserts that the issue of whether a trust has been established "for the sole benefit of a spouse" turns entirely on whether the trust instrument is "actuarially sound" and further asserts that the trust in this case is. ODHS acknowledges that the trust is actuarially sound but argues that in order for the trust to meet the "sole benefit" requirement, it must satisfy several additional criteria, including that no one except the spouse can "benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future." ODHS asserts that the McNamaras' trust violates this requirement¹⁵⁵⁷ because it has remainder beneficiaries. Mrs. McNamara counters that the presence of remainder beneficiaries after Mr. McNamara's death "is a certainty under the law," whether the beneficiaries are designated in the trust, Mr. McNamara's will, or by the statute of descent and distribution contained in R.C. 2105.06. Mrs. McNamara argues that the only rational interpretation of the sole benefit requirement is that the trust must be for the sole benefit of the community spouse *during his or her lifetime*, because after the community spouse dies, he or she can no longer be a beneficiary of the trust.

Leaving aside the parties' arguments regarding whether the trust satisfied the sole benefit requirement, we conclude that

there is a more fundamental flaw in the McNamaras' argument. Section 1396r-5(a)(1), Title 42, U.S.Code, states:

"In determining the eligibility for medical assistance of an institutionalized spouse * * *, the provisions of this section supersede any other provision of this subchapter (including sections 1396a(a)(17) and 1396a(f) of this title) which is inconsistent with them."

[1] The subchapter referred to is Subchapter XIX—Grants to States for Medical Assistance Programs—and, therefore, is inclusive of all of Section 1396, Title 42, U.S.Code. It follows then that the CSRA provision contained in Section 1396r-5(f) supersedes any inconsistent provision in Section 1396p(c). As ODHS points out, if Section 1396p(c)(2)(B), which has been adopted in this state as Ohio Adm.Code 5101:1-39-078(A)(2), is construed to allow an unlimited transfer of resources between spouses, then the CSRA limits established under Section 1396r-5(f), and adopted in this state as Ohio Adm.Code 5101:1-39-36, will be rendered a nullity. Accordingly, we hold that pursuant to the supersession clause of Section 1396r-5(a)(1), the amount of funds that one person may transfer to his or her spouse under Section 1396p(c)(2)(B) is limited to the maximum amounts the community spouse may retain under the CSRA provision in Section 1396r-5(f).

[2] Mrs. McNamara raises several arguments in opposition to this view. First, she cites Health Care Financing Administration ("HCFA") Transmittal 64-3258.11, which states:

¹⁵⁵⁸"The exceptions to the transfer of assets penalties regarding interspousal transfers and transfers to a third party for the sole benefit of a spouse apply even under the spousal impoverishment provisions [contained in Section 1396r-5]. Thus, the institutional spouse can transfer unlimited assets to the community spouse or to a third party for the sole benefit of the community spouse.

“* * *

“The exception for transfers to a third party for the sole benefit of the spouse may have greater impact on eligibility because resources may potentially be placed beyond the reach of either spouse and thus not be counted for eligibility purposes. However, for the exception to be applicable, the definition of what is for the sole benefit of the spouse * * * must be fully met.”

Mrs. McNamara urges this court to find HCFA Transmittal 64-3258.11 to be controlling on the issue of whether an individual may make an unlimited transfer of resources to his or her spouse pursuant to Section 1396p(c)(2)(B). We decline to do so.

[3] HCFA is the federal agency responsible for promulgating Medicaid regulations. HCFA policy transmittals like Transmittal 64 are entitled to some deference by reviewing courts if they are consistent with the plain language and purposes of the statute and prior administrative views. *Johnson v. Guhl* (D.N.J. 2000), 91 F.Supp.2d 754, 779, citing *Cleary v. Waldman* (C.A.3, 1999), 167 F.3d 801, 808. As stated earlier, if couples like the McNamaras were permitted to make unlimited transfers of resources between them pursuant to Section 1396p(c)(2)(B), the CSRA provisions contained in Section 1396r-5(f) would be rendered a nullity. Construing Section 1396p(c)(2)(B) in the manner Mrs. McNamara requests would allow persons with unlimited resources to avail themselves of Medicaid nursing home benefits.

Mrs. McNamara acknowledges this possibility but discounts it by arguing that wealthy persons will opt for superior, private nursing home care. She further contends that Congress intentionally created this loophole in the rules governing Medicaid eligibility in order to benefit the middle class. We find both of these arguments unpersuasive. While some wealthy individuals undoubtedly will opt for private care rather than settle for nursing home services provided by Medicaid, a signifi-

cant number will not, particularly those elderly citizens who place a high premium on maximizing the legacies they leave to their children. Furthermore, if Congress had intended to benefit the middle class, this could have been achieved simply by increasing the CSRA.

[4] Mrs. McNamara also argues that her trust should be treated under the rules governing annuities found in Ohio Adm. Code 5101:1-39-228. We disagree. Despite Mrs. McNamara's assertions to the contrary, Ohio Adm.Code 5101:1-39-228 relates to commercially purchased annuities and not to “annuitized” trusts like the one established by the McNamaras. See Ohio Adm.Code 5101:1-39-228(B) (“When an individual purchases an annuity, the individual generally pays to the entity issuing the annuity [e.g., a bank or insurance company] a lump sum of money, in return for which the individual is promised regular payments of income in certain amounts.”). See, also, April 16, 1998 letter from HCFA's ¹⁵⁹Robert Streimer to private party, attached as Appendix 19 to appellant's brief (“annuitized” trust is not the same thing as a “standard” or commercially purchased annuity, since a standard annuity requires actual purchase of a commodity, i.e., the annuity itself, and upon completion of the transaction, the buyer no longer owns the funds used to purchase it).

In light of the foregoing, we affirm, though on different grounds, the trial court's ruling that the McNamaras improperly transferred the majority of their resources to the Spousal Annuity Trust, and were, therefore, subject to a thirty-month period of ineligibility for receiving Medicaid nursing home vendor payments.

Accordingly, Mrs. McNamara's first assignment of error is overruled.

III

Mrs. McNamara's second assignment of error states:

“The common pleas court ruling that the assets of the Spousal Annuity Trust FSBO

Joseph McNamara, 4/1/98, are countable resources is an incorrect application of law."

Mrs. McNamara's second assignment of error has been rendered moot in light of our disposition of her first assignment of error; therefore, it is overruled as moot. See App.R. 12(A)(1)(c).

IV

Both of Mrs. McNamara's assignments of error having been overruled, the judgment of the trial court is affirmed.

Judgment affirmed.

GRADY, P.J., and FREDERICK N. YOUNG, J., concur.



139 Ohio App.3d 560

1560 The STATE of Ohio, Appellant,

v.

LILLY, Appellee.

No. 18099.

Court of Appeals of Ohio,
Second District, Montgomery County.

Decided Aug. 4, 2000.

Defendant appealed his conviction for burglary. The Court of Appeals, Montgomery County, reversed. Discretionary appeal was allowed. The Supreme Court, Lundberg Stratton, J., reversed judgment of Court of Appeals, reinstated conviction, and remanded matter to trial court, 87 Ohio St.3d 97, 717 N.E.2d 322. On remand, the trial court granted defendant's motion to modify sentence, reducing original sentence of five years to four years. State appealed. The Court of Appeals, Fain, J., held that trial court lacked authority to modify sentence after Supreme Court reinstated conviction and remanded cause to trial court to enforce judgment of conviction.

Reversed and vacated.

1. Criminal Law ⇐1192

Trial court lacked authority on remand to modify sentence for burglary by reducing it from five to four years, following judgment of Court of Appeals that reversed conviction and subsequent judgment of Supreme Court on discretionary review that reinstated conviction and remanded cause to trial court to enforce judgment of conviction.

2. Criminal Law ⇐1192

Where an appellate court holds that a trial court has erred by failing to provide a litigant with notice and an opportunity to be heard, and remands the cause to the trial court for the purpose of holding a hearing, the mandate from the appellate court obviously encompasses reconsideration of the matters that were the subject of the hearing.

Mathias H. Heck, Jr., Montgomery County Prosecuting Attorney, and Carley J. Ingram, Assistant Prosecuting Attorney, Dayton, Appellate Division, for appellant.

Dennis J. Adkins, Dayton, for appellee.

1561 FAIN, Judge.

Plaintiff-appellant the state of Ohio appeals from an order of the trial court reducing the sentence of defendant-appellee for burglary. The state contends that the trial court was without authority to reduce the sentence.

Lilly contends that after his original conviction had been reversed by this court, and the Ohio Supreme Court subsequently reversed the judgment of this court, reinstated the conviction, and remanded the matter to the trial court, the trial court was vested with jurisdiction to modify his sentence.

We agree with the state that the trial court lacked authority, under these circumstances, to reduce Lilly's sentence. Accordingly, the order of the trial court reducing Lilly's sentence is reversed and vacated.



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1. Shepards@: McNamara v. State Dep't of Human Servs., 139 Ohio App. 3d 551, 744 N.E.2d 1216, 2000 Ohio App. LEXIS 3477(Ohio Ct. App., Montgomery County,2000)

Client/matter: -None-

Requested Categories: Appellate History - Requested
Citing Decisions - None applied
Citing Law Reviews, Treatises... - Not Requested



Shepard's®: Report Content

Appellate History: Requested

▲ Citing Decisions: None Applied

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No subsequent appellate history

Appellate History

1 - 1 of 1			
	Appellate History	Court	Date
1	★ Citation you Shepardized™ McNamara v. State Dep't of Human Servs. 139 Ohio App. 3d 551, 744 N.E.2d 1216, 2000 Ohio App. LEXIS 3477	Ohio Ct. App., Montgomery County	2000

Citing Decisions

Narrow by: None Applied		
Analysis: Distinguished by (2), Followed by (3), "Cited by" (2)		
Court: 6th Circuit (1), Ohio (3), Florida (1), New Jersey (1)		
Headnotes: HN1 (4), HN7 (4), HN3 (2), HN2 (1), HN8 (1)		
1 - 6 of 6		
 Citing Decisions	Court	Date
Ohio Court of Appeals		
1  Distinguished by: Rorick v. Ohio Dep't of Job & Family Servs. 2010 Ohio 5571, 2010 Ohio App. LEXIS 4776 <i>Headnotes: HN1</i>	Ohio Ct. App., Hamilton County	Nov. 19, 2010
2  Distinguished by: Vieth v. Ohio Dep't of Job & Family Servs. 2009 Ohio 3748, 2009 Ohio App. LEXIS 3189 <i>Headnotes: HN3, HN7</i>	Ohio Ct. App., Franklin County	July 30, 2009
3  Cited by: Kopp v. Ohio Dep't of Job & Family Servs. 2002 Ohio App. LEXIS 1628 <i>Headnotes: HN3</i> <i>Cited by: 2002 Ohio App. LEXIS 1628 p.15</i>	Ohio Ct. App., Cuyahoga County	Apr. 11, 2002
6th Circuit - U.S. District Courts		
4  Followed by: Burkholder v. Lumpkin 2010 U.S. Dist. LEXIS 11308 <i>Headnotes: HN1, HN2, HN7, HN8</i>	N.D. Ohio	Feb. 9, 2010
Florida District Court of Appeals		
5  Followed by, and  Cited by: Feldman v. Dep't of Children & Families 919 So. 2d 512, 2005 Fla. App. LEXIS 19679, 30 Fla. L. Weekly D 2805 <i>Headnotes: HN1, HN7</i> <i>Followed by: 919 So. 2d 512 p.516</i> <i>Cited by: 919 So. 2d 512 p.515</i>	Fla. Dist. Ct. App. 1st Dist.	2005
New Jersey Superior Court, Appellate Division		
6  Followed by: Estate of F.K. v. Division of Medical Assistance and Health Services 374 N.J. Super. 126, 863 A.2d 1065, 2005 N.J. Super. LEXIS 7 <i>Headnotes: HN1, HN7</i> <i>Followed by: 374 N.J. Super. 126 p.139; 863 A.2d 1065 p.1073</i>	App.Div.	2005

Legend

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EXHIBIT E

Johnson v. Guhl

ELDER LAW ASSOCIATES PA

of plaintiffs' Amended Complaint. The Court will issue an appropriate order.



Donald H. JOHNSON, et al., Plaintiffs,

v.

**Michele K. GUHL, Commissioner of
the New Jersey Department of Hu-
man Services, et al., Defendants.**

No. 99-CIV.-5403 WGB.

United States District Court,
D. New Jersey.

April 7, 2000.

Medicaid applicants residing in long-term care facilities, their non-institutionalized spouses who were beneficiaries of community spouse annuity trusts (CSATs), and prospective Medicaid applicants brought § 1983 suit against Commissioner of the New Jersey Department of Human Services and other state and county officials, challenging treatment of CSATs as countable resource in determining Medicaid eligibility. Defendants moved to dismiss and plaintiffs moved for preliminary injunction. The District Court, Bassler, J., held that: (1) court had jurisdiction over claims; (2) claims of prospective Medicaid applicants were not ripe for review; (3) plaintiffs could bring § 1983 suit to enforce provisions in Medicaid Act; (4) claims for monetary damages were barred; (5) Eleventh Amendment did not bar suit to extent that it sought injunctive and declaratory relief; (6) plaintiffs did not have property interest in benefits; (7) defendants' change in policy regarding CSATs did not violate equal protection; (8) plaintiffs were not threatened with immediate irreparable injury from state's failure to establish procedure for undue hardship hearings; and (9)

plaintiffs were not likely to succeed on merits of their claim that CSATs should not be treated as countable resource for Medicaid eligibility purposes and, thus, were not entitled to preliminary injunctive relief.

Defendants' motion granted in part and denied in part, and plaintiffs' motion denied.

1. Affidavits ⇌3

District court would ignore attorney's affidavit to extent that affidavit contained legal conclusions and would consider only those matters within attorney's personal knowledge. U.S.Dist.Ct.Rules D.N.J., Local Civil Rule 7.2.

2. Federal Civil Procedure ⇌921

District court would consider plaintiffs' over length reply brief despite plaintiffs' failure to seek leave from court to file over length brief prior to filing brief; better practice would be to comply with local rule requiring party to obtain court's permission to file over length brief prior to submission of brief. U.S.Dist.Ct.Rules D.N.J., Local Civil Rule 7.2(b).

3. Federal Courts ⇌192.5

Medicaid applicants' claim that provisions and application of state Medicaid plan conflicted with federal Medicaid statutes arose under federal law and, thus, federal district court could exercise jurisdiction over claim. 28 U.S.C.A. § 1331; Social Security Act, § 1901 et seq., as amended, 42 U.S.C.A. § 1396 et seq.

4. Federal Courts ⇌12.1

All federal actions, including those for declaratory or injunctive relief, must involve case and controversy.

5. Federal Courts ⇌12.1

Ripeness is one aspect of justiciability, which determines when proper party may bring action.

6. Federal Courts ⇌34

Unless record affirmatively shows otherwise, or plaintiffs meet their burden to clearly allege facts invoking federal court's jurisdiction, presumption is that jurisdiction is lacking.

7. Federal Courts ⇌12.1

Ripeness doctrine serves to prevent federal courts from entangling themselves in abstract disagreements.

8. Federal Courts ⇌12.1

When determining whether request for declaratory judgment is ripe, court should examine: (1) fitness of issues for judicial decision, and (2) hardship to parties of withholding court consideration.

9. Declaratory Judgment ⇌204

Prospective Medicaid applicants' challenge to provisions in state Medicaid plan, seeking declaration that funds held in community spouse annuity trusts (CSATs) should not be treated as countable resource in determining Medicaid eligibility, was not ripe for review; whether applicants would be harmed by state Medicaid plan was contingent on whether they actually applied for benefits, any threat to applicants was not real and immediate, and denial of judicial review would not result in hardship to prospective applicants. Social Security Act, § 1901 et seq., as amended, 42 U.S.C.A. § 1396 et seq.

10. Civil Rights ⇌108.1

Plaintiff may sue under § 1983 unless: (1) federal statute does not create enforceable rights, privileges, or immunities within the meaning of § 1983, or (2) Congress, in the statute itself, has foreclosed enforcement of the statute under § 1983. 42 U.S.C.A. § 1983.

11. Civil Rights ⇌108.1

New Jersey Medicaid applicants who had been denied benefits could bring action under § 1983 to enforce provision in Medicaid Act requiring states to hold undue hardship hearing if applicant is denied benefits based on financial ineligibility. 42

U.S.C.A. § 1983; Social Security Act, § 1917(c)(2)(D), as amended, 42 U.S.C.A. § 1396p(c)(2)(D).

12. Civil Rights ⇌108.1

New Jersey Medicaid applicants could bring action under § 1983 to enforce provision in Medicaid Act mandating that state plan for medical assistance comply with federal Medicaid provisions with respect to transfers of assets and treatment of certain trusts, where applicants asserted that they would be eligible for benefits if state complied those provisions. 42 U.S.C.A. § 1983; Social Security Act, § 1902(a)(18), as amended, 42 U.S.C.A. § 1396a(a)(18).

13. Civil Rights ⇌207(1)

To extent that state Medicaid applicants asserted claim against state officials for monetary damages, state officials were not "persons" who could be sued under § 1983. 42 U.S.C.A. § 1983.

See publication Words and Phrases for other judicial constructions and definitions.

14. Civil Rights ⇌207(1)

To extent that state Medicaid applicants asserted claims against state officials for injunctive and declaratory relief, state officials were "persons" who could be sued under § 1983. 42 U.S.C.A. § 1983.

15. Federal Courts ⇌265, 269

Absent consent by state, suits for money damages against state or state officials in their official capacities are barred by Eleventh Amendment. U.S.C.A. Const. Amend. 11.

16. Federal Courts ⇌269, 272

Eleventh Amendment does not bar plaintiffs from suing state officials for violations of federal law when future injunctive relief is sought. U.S.C.A. Const. Amend. 11.

17. Federal Courts ⇌272

Eleventh Amendment may bar equitable relief if it in practice is money judgment.

ment payable out of state treasury. U.S.C.A. Const.Amend. 11.

18. Federal Courts ⇨269, 272

Eleventh Amendment did not bar New Jersey Medicaid applicants' § 1983 suit against state officials challenging treatment of community spouse annuity trusts (CSATs) as countable resource in determining Medicaid eligibility, to extent that applicants sought declaratory and injunctive relief and attorney fees; although granting applicants' prospective injunctive relief would likely require state to spend more money from state treasury, such effect would be ancillary. U.S.C.A. Const. Amend. 11; 42 U.S.C.A. § 1983.

19. Federal Courts ⇨269

New Jersey Medicaid applicants' claims for compensatory damages against state officials in their official capacities were barred by Eleventh Amendment. U.S.C.A. Const.Amend. 11.

20. Constitutional Law ⇨278(1)

To establish claim for violation of constitutional procedural due process, plaintiff must show that: (1) protected property interest was taken, and (2) procedural safeguards surrounding deprivation were inadequate. U.S.C.A. Const.Amend. 14.

21. Constitutional Law ⇨277(1), 278.7(3)

When individual is recipient of direct Medicaid benefits, such benefits are protected property interest under due process clause and cannot be withdrawn without giving recipient notice and opportunity to be heard. U.S.C.A. Const.Amend. 14.

22. Constitutional Law ⇨277(1)

Applicants for New Jersey Medicaid benefits, who had never been granted benefits, did not have protected property interest in Medicaid benefits under due process clause. U.S.C.A. Const.Amend. 14.

23. Social Security and Public Welfare ⇨241.105

Medicaid regulation requiring applicants to be given notice of their right to fair hearing did not give applicants the right to notice of change in interpretation of Medicaid Act. Social Security Act, § 1901 et seq., as amended, 42 U.S.C.A. § 1396 et seq.; 42 C.F.R. § 431.206.

24. Constitutional Law ⇨278.7(3)

Social Security and Public Welfare ⇨241.105

Allegations that state officials violated state law and their own procedures in denying adequate notice and opportunity to be heard to state Medicaid applicants did not provide basis for constitutional due process claim. U.S.C.A. Const.Amend. 14.

25. Constitutional Law ⇨242.3(1)

Social Security and Public Welfare ⇨241.80

Although state officials' change of policy regarding whether community spouse annuity trusts (CSATs) were countable resource in determining applicant's eligibility for New Jersey Medicaid benefits resulted in differing treatment for applicants who had used CSATs, such treatment was rationally related to legitimate end of complying with federal Medicaid Act and Congress' intent to provide medical assistance to needy and, thus, did not violate equal protection clause. U.S.C.A. Const.Amend. 14; Social Security Act, § 1901 et seq., as amended, 42 U.S.C.A. § 1396 et seq.

26. Civil Rights ⇨209

Availability of state administrative procedures ordinarily does not foreclose resort to § 1983. 42 U.S.C.A. § 1983.

27. Injunction ⇨135

Issuance or denial of preliminary injunction is matter committed to sound discretion of trial court.

28. Injunction ⇨1

Injunction is extraordinary remedy which should be granted only in limited circumstances.

29. Injunction ⇌138.1

When ruling on motion for preliminary injunction, court must be convinced that all four of the following factors favor preliminary relief: (1) likelihood that movant will succeed on merits; (2) extent to which movant will suffer irreparable harm without injunctive relief; (3) extent to which nonmovant will suffer irreparable harm if injunction is issued; and (4) public interest.

30. Injunction ⇌138.66

New Jersey Medicaid applicants were likely to succeed on merits of their claim that state's failure to provide notice of, and establish procedures for, undue hardship hearing when applicant is denied Medicaid benefits violated federal Medicaid statute requiring such undue hardship hearings, for purposes of determining whether applicants were entitled to preliminary injunction. Social Security Act, § 1917(c)(2)(D), as amended, 42 U.S.C.A. § 1396p(c)(2)(D).

31. Injunction ⇌14

To show irreparable harm necessary for injunctive relief, plaintiff must demonstrate potential harm which cannot be redressed by legal or equitable remedy following trial; economic loss does not constitute "irreparable harm."

See publication Words and Phrases for other judicial constructions and definitions.

32. Injunction ⇌138.6

To warrant preliminary injunction, injury created by failure to issue requested injunction must be of peculiar nature, so that compensation in money cannot atone for it.

33. Injunction ⇌14

Inability to precisely measure financial harm does not make that harm irreparable or immeasurable, for purposes of granting injunctive relief.

34. Injunction ⇌138.6

To obtain preliminary injunctive relief, injury alleged must not only be irreparable, it must be imminent as well.

35. Injunction ⇌138.66

New Jersey Medicaid applicants were not threatened with immediate irreparable injury resulting from state's failure to comply with federal Medicaid statute requiring state to establish procedures for undue hardship hearings for applicants who are denied Medicaid benefits and, thus, applicants were not entitled to preliminary injunctive relief, where state officials indicated that procedures for establishing state regulations governing undue hardship hearings would soon be initiated. Social Security Act, § 1917(c)(2)(D), as amended, 42 U.S.C.A. § 1396p(c)(2)(D).

36. Injunction ⇌138.66

District court would not exercise its discretion to grant New Jersey Medicaid applicants preliminary injunction compelling state officials to comply with federal Medicaid statute by implementing regulations for undue hardship hearings, where applicants could have, but failed to, utilize New Jersey statute authorizing interested persons to petition agency to promulgate, amend or repeal any rule. Social Security Act, § 1917(c)(2)(D), as amended, 42 U.S.C.A. § 1396p(c)(2)(D); N.J.S.A. 52:14B-4(f).

37. Statutes ⇌219(6.1)

Health Care Financing Administration's (HCFA's) Guidelines and letter written by HCFA official on behalf of HCFA with respect to whether community spouse annuity trusts (CSATs) are countable resource in determining Medicaid eligibility are entitled to some deference by court interpreting Medicaid Act as long as they are consistent with plain language and purposes of statute and if they are consistent with prior administrative views, even though they are not formal regulations. Social Security Act, § 1901 et seq., as amended, 42 U.S.C.A. § 1396 et seq.

38. Injunction $\Rightarrow$ 138.66

New Jersey Medicaid applicants who were institutionalized in long term care facilities were not likely to succeed on merits of their claim that state officials violated federal Medicaid statutes by treating community spouse annuity trusts (CSATs) as countable resource when determining Medicaid eligibility and, thus, were not entitled to preliminary injunctive relief; although Medicaid Act prohibited CSATs from triggering penalty period, Act required resources from both institutionalized spouse and community spouse to be considered for eligibility purposes. Social Security Act, §§ 1917(c)(2), 1924, as amended, 42 U.S.C.A. §§ 1396p(c)(2), 1396r-5.

Donald M. McHugh, McHugh & Macri, East Hanover, NJ, for plaintiffs.

Shirley B. Whitenack, Schenck, Price, Smith & King, LLP, Morristown, NJ, for plaintiffs.

Mary F. Rubinstein, DAG, Attorney General of New Jersey, Trenton, NJ, Meredith Van Pelt, Special Deputy Atty. Gen., Mary F. Rubinstein, for defendants Michele K. Guhl, Commissioner of the New Jersey Department of Human Services, Margaret A. Murray, Director of the New Jersey Division of Medical Assistance and Health Services.

Edwin C. Eastwood, Jr., North Bergen, NJ, for defendant Edward Testa, Director of Bergen County Board of Social Services.

Donald L. Berlin, Berlin, Kaplan, Dembling & Burke, Morristown, NJ, for defendant Elizabeth Lehmann, Director of the Morris County Board of Social Services.

1. Juanita L. Johnson, William R. Fleming, Dorothy R. Mariani, Phyllis R. Schaible, Marie L. Hicks, Norman V. Silbernagel, Stanley Prystach, Anthony Mackron, Charles V. Banks, Richard C. Weiser, Mary Fillmore.

2. On January 19, 2000, this Court has issued a briefing schedule that required Defendants' motion to dismiss and Plaintiffs' motion for preliminary injunction to be completely

OPINION

BASSLER, District Judge.

"There can be no doubt but that the statutes and provisions in question, involving the financing of Medicare and Medicaid, are among the most completely impenetrable texts within human experience. Indeed, one approaches them at the level of specificity herein demanded with dread, for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase." *Rehabilitation Ass'n of Virginia v. Kozlowski*, 42 F.3d 1444 (4th Cir.1994). With this in mind, we begin.

Plaintiffs are married couples with one spouse living in the community ("community spouse") and the other residing in a skilled nursing facility ("institutionalized spouse"). Plaintiffs challenge certain provisions of the New Jersey Medicaid plan governing Medicaid eligibility to cover the cost of the institutionalized spouse's receipt of long term care.

Defendants' motion to dismiss for failure to state a claim upon which relief may be granted is **denied** on all counts, except as to the due process and equal protection claims, and except as to all claims by those Plaintiffs who have not yet applied for Medicaid benefits. Plaintiffs' motion for preliminary injunction is **denied**.

I. BACKGROUND

Some of the Plaintiffs¹ are institutionalized spouses currently residing in long-term care facilities in New Jersey. (See First Amended Compl. ¶ 4.)² Of those in-

briefed under Appendix N of the local rules by no later than February 22, 2000. Despite Plaintiffs' knowledge of that Defendants were in the process of briefing their motion to dismiss based on the First Amended Complaint, Plaintiffs filed a Second Amended Complaint on February 15, 2000, without seeking leave of Court because no responsive pleading had technically been filed yet. Be-

stitutionalized spouses, some have been denied Medicaid benefits and have filed fair hearing appeals,³ and some have Medicaid applications pending.⁴ (*Id.* at ¶ 5.) Some Plaintiffs are prospective Medicaid applicants.⁵ (*Id.* at ¶ 6.) Plaintiffs residing in the community are the beneficiaries of Community Spouse Annuity Trusts ("CSATs").⁶ (*Id.* at ¶ 7.)

In this action, Plaintiffs challenge the treatment of the CSATs as a countable resource in determining Medicaid eligibility. Because the institutionalized spouses have been denied, or will be denied benefits as a result of such treatment, Plaintiffs claim that Defendants' treatment of CSATs constitutes impermissible rule-making in violation of their rights to due process and equal protection. Plaintiffs urge this Court to order the State to implement regulations governing undue hardship hearings.

Plaintiffs are suing Michele Guhl, Commissioner of the New Jersey Department of Human Services ("DHS"), Margaret Murray, Director of the Division of Medical Assistance and Health Services ("DMAHS"), as well as the Directors of the Board of Social Services for Bergen County and Morris County (collectively referred to as "Defendants"). The first amended complaint contains six counts: (1) 42 U.S.C. § 1983; (2) Declaratory Judgment; (3) constitutional due process; (4) improper rule making; (5) equitable estoppel and equal protection; and (6) violation of New Jersey regulations. Plaintiffs seek the following relief:

cause Plaintiffs filed their amended pleading only one week before the reply briefs were complete, the Court will not consider Plaintiffs' Second Amended Complaint despite the fact that technically, no responsive pleading had yet been filed.

3. Juanita L. Johnson, Dorothy R. Mariani, and Mary Fillmore.
4. Phyllis R. Schaible, Charles V. Banks, Marie L. Hicks, Norman V. Silbernagel, Stanley Prystasch, and Anthony Mackron (the parties later stipulated to the dismissal of Bernadine and Richard C. Weiser.)

- to enjoin the fair hearings appeal of Plaintiffs' denials pending resolution of this action;
- declaratory judgment that Defendants engaged in improper rule making;
- a requirement that Defendants utilize proper standards and procedures to adopt regulations to implement undue hardship regulations;
- declaratory judgment that Defendants' denials of each of the institutionalized Plaintiffs pending Medicaid applications were illegal, null and void;
- a requirement that Defendants redetermine each Plaintiff's pending Medicaid application in accordance with current law, regulations and prior "policy" determinations;
- a declaratory judgment that prospective Medicaid applications utilizing CSATs drafted and funded prior to the adoptions of undue hardship regulations be permitted as exceptions to the transfer rules pursuant to 42 U.S.C. § 1396p(c)(2)(B)(i) and (ii);
- estoppel of Defendants from determining that Plaintiffs' contributions of available resources to CSATs constitute transfers for less than fair market value resulting in a period of ineligibility for Medicaid benefits;
- compensatory damages; and
- attorneys' fees and costs pursuant to 42 U.S.C. § 1988.

5. William R. Fleming, Gerald Benedetto, Frances C. Denman, Harold B. Whalon, Jr., Blace LaForge.

6. Donald H. Johnson, Eugene V. Mariani, Mary Lou Fleming, William C. Schaible, Lois Benedetto, Donna R. Banks, Raymond O. Denman, Jr., Charles N. Hicks, Ann B. Silbernagel, Anna Prystasch, Mary Mackron, Janet Whalon, Bernadine Weiser, Grace LaForge, and John Fillmore.

Plaintiffs move for preliminary and permanent injunctive and declaratory relief, and Defendants move to dismiss. Oral argument was held on March 27, 2000.

To understand the issues and place them in context, a brief overview of Medicaid and its eligibility requirements for institutionalized spouses is required.

II. MEDICAID

A. Overview

The Medicaid Act⁷ is a cooperative federal-state program that is jointly financed with federal and state funds. *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498, 501, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990). The purpose of the program is to "provide a nationwide program of medical assistance for low income families and individuals." *West Virginia Univ. Hosps., Inc. v. Casey*, 885 F.2d 11, 15 (3d Cir.1989).

Although participation in the program is voluntary, participating States must comply with certain requirements imposed by the Act and regulations promulgated by the Secretary of Health and Human Services (Secretary). To qualify for federal assistance, a State must submit to the Secretary and have approved a "plan for medical assistance," § 1396a(a), that contains a comprehensive statement describing the nature and scope of the State's Medicaid program. 42 C.F.R. § 430.10 (1989).

Wilder, 496 U.S. at 501, 110 S.Ct. 2510. The Medicaid program is "'basically administered by each state within certain broad requirements and guidelines.'" *West Virginia*, 885 F.2d at 15 (citation omitted).

On the federal level, the Secretary of the U.S. Department of Health and Human Services ("HHS") administers the program through the Health Care Financing Administration ("HCFA"). HCFA has issued

guidelines, known as "Transmittal 64," or the "State Medicaid Manual," interpreting the transfer of assets and treatment of trusts provisions of the Medicaid Act [hereinafter "HCFA Guidelines" or "Transmittal 64"].⁸

The New Jersey Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1, *et seq.*, authorizes New Jersey's participation in the Medicaid program. On the state level, the DMAHS, an agency contained within the DHS, is responsible for administration of the Medicaid program in New Jersey. N.J.S.A. 30:4D-4. The county welfare agencies ("CWA") assist DMAHS in administering the program by processing applications for Medicaid, including determining whether an applicant has met the income and resource eligibility standards. N.J.S.A. 30:4D-7a; N.J.A.C. 10:71-3.15. CWA staff members make their determinations based on information received from an applicant and from their own investigations to verify, supplement or clarify such information. N.J.A.C. 10:71-1.1 *et seq.*

With certain exceptions, for an individual to be eligible for Medicaid benefits, a person's income and resources must fall below a certain limit. When inventorying an applicant's income and resources to determine eligibility, Medicaid "deems" the income and resources of each spouse to be available to the other when both spouses live together in the community. When, however, one spouse enters a nursing facility ("institutionalized spouse") and is eligible for Medicaid, while the other spouse stays in the community ("community spouse"), the rules become more complex. John Bigler, Diane Archer, John Regan, *An Overview of Social Security, Medicare and Medicaid*, 65 N.Y. State Bar Journal 14 (September/October, 1993) [hereinafter "Bigler Article"]. The Medicare Catastrophic Coverage Act ("MCCA"), enacted

7. Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, was enacted in 1965.

8. Attached to Certification of Meredith Van Pelt ("Van Pelt Certif.") and found at www.hcfa.gov/pub-forms/pub45pdf/smmmtoc.htm.

in 1988, and the 1993 Omnibus Budget Reconciliation Act ("OBRA") contain provisions addressing this more complex situation.

B. *Pre-MCCA and OBRA*

Prior to enactment of the MCCA, shortly after a spouse was institutionalized, each spouse was treated as a separate household. Income, such as Social Security checks, pensions, and interest or dividends from investments, were considered to belong to the spouse whose name was on the instrument conveying the funds. Consequently, when the husband, for example, entered a nursing home and the couple's pension check had the husband's name on it, all of that income was attributed to him when determining Medicaid eligibility, leaving the wife destitute. Conversely, if the wife entered the nursing home, the husband had no obligation under federal law to contribute any of that income toward the cost of the wife's care. See H.R.Rep. No. 100-105(II), 100th Cong., 2nd Sess., at 66 (1987), reprinted in 1988 U.S.C.C.A.N. 857, 889.

A similar rule was in effect for the attribution of resources. *Ibid.* Generally, in the month following institutionalization, jointly held resources to which a spouse had unrestricted access, such as a joint savings account, or resources solely held by the institutionalized spouse, were considered available to that spouse for eligibility purposes. *Ibid.* In contrast, assets solely held by the community spouse were, after the first month, considered to belong to her and she had no obligation under federal law to contribute any amount of such resources toward the costs of care of the institutionalized spouse. *Id.* at 66-67; 1988 U.S.C.C.A.N. at 889-90.

9. The MCCA supersedes any inconsistent provision contained in § 1396. 42 U.S.C. § 1396r-5(a)(1).

10. The CSRA is the greatest of (1) \$12,000 (adjusted annually); (2) the lesser of ½ total

C. *Resource Rules Under MCCA and OBRA*

One of Congress' reasons for enacting the MCCA⁹ was to end the "pauperization" of the community spouse "by assuring that the community spouse has a sufficient—but not excessive—amount of income and resources available ... while ... [the institutionalized] spouse is in a nursing home at Medicaid expense." *Id.* at 65, 1988 U.S.C.C.A.N. at 888. Additionally, Congress intended to close the loophole where a couple could shelter resources in the community spouse's name while the institutionalized spouse received Medicaid.

To achieve those goals, the MCCA requires that at the time of institutionalization, a "snapshot" of the total value of the couple's resources owned by either the institutionalized or community spouse is inventoried or assessed. 42 U.S.C. § 1396r-5(c)(1)(A). The spousal share is equal to half of such total value. *Id.* To avoid impoverishment of the community spouse, the community spouse is permitted to retain what is termed the "community spouse resource allowance,"¹⁰ ("CSRA"). 42 U.S.C. § 1396r-5(f)(2).

The CSRA is not considered available to pay for the care of the institutionalized spouse and need not be "spent down" in order for the applicant to be Medicaid eligible.

If [the community spouse] actually owns less than this amount, a portion of the institutionalized spouse's resources must be transferred to [the community spouse] to raise her personal resources to the required level. Conversely, if her resources exceed this level, she is obliged to spend the excess on the costs of care of the institutionalized spouse. If she refuses, the state has the right to

joint resources or \$60,000 (adjusted annually); (3) an amount established pursuant to a fair hearing; or (4) an amount transferred under court order. 42 U.S.C. § 1396r-5(f)(2).

seek to enforce her obligation in the courts, but the institutionalized spouse will still qualify for Medicaid. He, too, after providing for the community spouse's MMMNA, must spend any excess for his own care. Medicaid will pay for his care only after he has spent down to the basic level of exempt resources.

Bigler Article; see 42 U.S.C. § 1396r-5(c)(2).

To illustrate, if a couple has \$100,000 in a joint savings account and jointly held stocks and mutual funds at the time the spouse is institutionalized, then \$50,000 is attributable to each spouse. If the ceiling on the community spouse's share of the couple's resources was \$48,000, as it was in 1992 when the MCCA was passed, then the \$2,000 in excess of \$48,000 would be attributed to the institutionalized spouse for the purposes of determining eligibility. Consequently, the couple would have to "spend down" \$52,000 (the institutionalized spouse's \$50,000 share, plus \$2,000 excess resources from the community spouse's share) less the resource eligibility standard (currently \$2,000) before the institutionalized spouse could qualify for Medicaid. See H.R.Rep. No. 100-105(II), at 77 (1987); 1988 U.S.C.C.A.N. at 900.

D. *Penalty Period for Transfer of Assets*

When an institutionalized individual who has transferred assets applies for Medicaid benefits, the application is subject to transfer and trust rules under the statutory scheme set forth in OBRA and the MCCA.

In addition to the new resource rules, discussed above, which closed the loophole where a couple could shelter resources in the community spouse's name, the Committee on Energy and Commerce, concerned about the fact that wealthy individuals could transfer resources in order to qualify for Medicaid nursing home coverage, instituted a new formula under the

MCCA for calculating a penalty, (i.e. a period of ineligibility), for transferring of assets. See H.R.Rep. No. 100-105(II), at 73; 1988 U.S.C.C.A.N. at 896.

Under OBRA, an institutionalized spouse may be denied Medicaid eligibility if that person (or the person's spouse) has transferred any nonexempt "asset" or his or her home for less than fair market value during the 36 month period (referred to as "look-back" period) before applying for Medicaid while institutionalized. Bigler Article; 42 U.S.C. § 1396p(c)(1)(B)(i). "The term 'asset' includes all of the countable income and resources of the individual or his or her spouse, as well as those assets which these persons are entitled to but do not receive because of their own actions or the action of another person, including a court or administrative body, with legal authority to act in place of the individual or the spouse." Bigler Article; 42 U.S.C. § 1396p(e).

If an asset is transferred during the "look-back" period, then the applicant is subject to a "penalty period," which is a period of ineligibility calculated by dividing the uncompensated amount of the assets transferred by the average monthly cost of nursing home care in the particular state. Michael Feinberg, *Medicaid After OBRA '93 As It Impacts on Long-Term Care Planning*, 164 N.J. Lawyer 24 (October, 1994) [hereinafter "Feinberg article"]. For example, if an individual transfers \$300,000 on January 1, 1995 to his respective family members and applies for Medicaid on December 1, 1997, his look-back period extends to December 1, 1994. Because the transfer was made before December 1, 1994, it will fall within the person's look-back period. Because the amount of the transfer was \$300,000, an 88 month penalty period (\$300,000 divided by \$3,376¹¹) would result. Therefore, that in-

11. \$3,376 was the average monthly cost of nursing home care in New Jersey in June

1994. Feinberg Article.

dividual would not be eligible for Medicaid until April 2002.

E. Treatment of Trusts

Next, specific rules apply for trusts created by the Medicaid applicant, the applicant's spouse, or any person, including a court or administrative body, acting "with legal authority to act in place of or on behalf of the individual or the individual's spouse" or "at the direction or upon the request of the individual or the individual's spouse."¹² The following rules apply regardless of why the trust was established; whether the trustees have or exercise any discretion under the trust; any restriction of when or whether distributions can be made from the trust; or any restrictions on the use of distributions. 42 U.S.C. § 1396p(d)(2)(C).

When a trust is revocable, under the MCCA resource rules, the corpus of the trust is considered a resource to the applicant. 42 U.S.C. § 1396p(d)(3)(A). "Because it remains available, no penalty is incurred for a transfer into a revocable trust." Peter M. Macy, *Medicaid Planning After OBRA-93: Placing the Home in a Revocable Trust*, 79 Mass.L.Rev. 2 (March 1994) [hereinafter "Macy Article"].

The treatment of an irrevocable trust in determining Medicaid eligibility depends on what type of interest the Medicaid applicant retains in the trust. If the applicant is a permitted beneficiary of an irrevocable trust, the corpus of the trust is a countable resource and any distributions to the applicant, whether made from income or principal, will be treated as income to him or her. H.R.Rep. No. 103-111(II), 103th Cong., 1st Sess., at 207-08 (1993), reprinted in 1993 U.S.C.C.A.N. 378, 534-35; 42 U.S.C. § 1396p(d)(3)(B)(i). "Any other payments from the trust are considered a transfer of assets by the individual." *Ibid.*

If, on the other hand, the applicant can in no way benefit from the trust, no part of

the corpus will be treated as a countable resource to the institutionalized spouse. See HCFA Guidelines § 3259.6(C); see also Feinberg Article. Rather, the corpus of the trust will be considered a transfer of assets for less than fair market value and trigger a 60-month look-back period. 42 U.S.C. § 1396p(d)(3)(B)(ii); 42 U.S.C. § 1396p(c)(1)(B)(i). Certain transfers, however, such as the transfer of assets between spouses "for the sole benefit of" the other spouse, do not trigger a penalty period. 42 U.S.C. § 1396p(c)(2)(B)(i). HCFA has established that a "sole benefit" transfer is one where "no individual or entity except the spouse ... can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future." HCFA Guidelines § 3257(b)(6). A trust meets this definition if the trust provides for "spending of the funds involved for the benefit of the individual a basis that is actuarially sound based on the life expectancy of the individual involved." *Ibid.*

Exhibit A attached to the Certification of Eugene Mariani ("Mariani Cert.") is typical in form and content of the CSATs at issue here. See Certification of Donald McHugh, Esq. ("McHugh Cert."), ¶ 2. The CSATs are irrevocable trusts created for the "sole benefit" of the community spouse. The purpose of the trust is to qualify the institutionalized spouse for Medicaid benefits. According to the trust document, the trust is "actuarially sound" within the meaning of OBRA and the HCFA Guidelines because the entire income and corpus will be issued to the community spouse within his/her lifetime, as determined by the actuarial tables set forth in the HCFA Guidelines. Defendants do not dispute that the CSATs at issue are actuarially sound transfers "for the sole benefit of" the community spouse and are therefore not subject to a transfer penalty. As required by DMAHS, upon the death of the beneficiary (community spouse), the trust names DMAHS as the

12. 42 U.S.C. § 1396p(d)(2)(A).

first beneficiary under the CSAT. The CSAT terminates when the first of the following occurs: the corpus is exhausted; the beneficiary dies; or the actuarial life expectancy expires.

F. *Undue Hardship Provisions*

Pursuant to the Medicaid Act, the transfer rules do not render an applicant ineligible to the extent that "the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary." 42 U.S.C. § 1396p(c)(2)(D).

G. *New Jersey Medicaid*

Defendants do not dispute that since late 1994 (when trusts had to comply with OBRA), DMAHS had approved the use of numerous CSATs so that the community spouse trust amounts were excluded from the countable resources of the institutionalized spouse. On April 16, 1998, however, a letter was issued by Robert Streimer, on behalf of HCFA, to a private attorney in Virginia ("Streimer letter") explaining that assets in a trust established solely for the benefit of the community spouse were to be viewed in two contexts: (1) whether the transfer of assets for less than fair market value subjects the institutionalized spouse to a transfer penalty; and (2) whether the asset is a countable resource. See *McHugh Certif.*, Ex. D.

While the letter is certainly not binding on this Court, it is, at the very least, instructive. In the Streimer letter, the HCFA agreed that no transfer penalty was triggered by the transferral between spouses of assets for less than fair market value. The letter provided that actuarial soundness was one means of determining that a transfer was in fact made for the sole benefit of the spouse. It disagreed, however, that actuarial soundness had any bearing on whether the trust was a countable resource.

According to HCFA, the "sole benefit of" trust did not warrant the same treatment as a standard annuity because it was an irrevocable trust subject to § 1917(d) of the Social Security Act;¹³ the Streimer letter explained that there is a fundamental difference between a standard annuity and the "annuitized" trust at issue.

A standard annuity requires the actual purchase of a commodity, i.e., the annuity itself. . . . Upon completion of the transaction, the buyer no longer owns the funds used to purchase the annuity. Instead, he or she owns the annuity itself. If the annuity is irrevocable, as most annuities are, the buyer cannot reclaim ownership of the funds used to purchase the annuity.

By contrast, the corpus of the trust established for the sole benefit of the community spouse can, at some point in time, be paid to the community spouse. *Id.* Therefore, the author of the Streimer letter concluded that while the spouse was not subject to the transfer penalty provision, the corpus of the trust at issue was a countable resource.

After learning of HCFA's position, DMAHS, by letter dated July 6, 1999, notified the Bergen County Board of Social Services that "actuarial soundness only pertains to whether a penalty can be imposed for transferring assets to a third party for the sole benefit of a spouse" and "does not affect how resources are counted in determining eligibility." See *McHugh Certif.*, Ex. A. Echoing the Streimer letter, the letter from DMAHS further explained that because CSATs can be paid at some point in time to the community spouse, the entire corpus is considered available to the community spouse. In recognition that some applications for Medicaid eligibility had been submitted in reliance on the prior approvals of CSATs and that some applications had been pending for awhile, DMAHS offered to permit the community

13. § 1917(d) of the Social Security Act is co-

defined at 42 U.S.C. § 1396p(d).

spouse to convert the CSAT into a commercially purchased annuity, naming the state as the first remaining beneficiary. See Mariani Certif., Ex. C.

III. DISCUSSION

A. Motion to Strike

1. McHugh Certification

At oral argument, Defendants made an oral motion to strike the Certification of Donald M. McHugh, Esq., alleging that it contains legal conclusions.

Local Civil Rule 7.2 provides that "[a]ffidavits shall be restricted to statements of fact within the personal knowledge of the affiant. Argument of the facts and the law shall not be contained in the affidavits. Legal arguments and summations in affidavits will be disregarded by the Court ..."

[1] To the extent that the McHugh Certification does contain legal conclusion, those portions will be ignored. Only matters within Mr. McHugh's personal knowledge shall be considered by this Court. See *San Filippo v. Bongiovanni*, 743 F.Supp. 327, 332 n. 3 (D.N.J.1990) (striking inadmissible elements of affidavit but permitting remainder), *rev'd on other grounds*, 961 F.2d 1125 (3d Cir.), *cert. denied* 506 U.S. 908, 113 S.Ct. 305, 121 L.Ed.2d 228 (1992); see also *Lombardi v. Cosgrove*, 7 F.Supp.2d 481, 492 (D.N.J. 1997) (denying motion to strike but ignoring conclusions, beliefs, and misstatements, and using the assertions based on personal knowledge).

2. Overlength Brief

[2] Local Rule 7.2(b) requires that permission to file an over length brief must be obtained from the Court "prior to submission of the brief." In violation of Local Rule 7.2(b), Plaintiffs submitted a Reply Brief to Defendants' Brief in Opposition that exceeded the 15 page limit. Although Plaintiffs sought leave of Court to file an over length reply brief in the already over

length brief itself, they did not seek leave prior to filing the over length brief as required by common sense and by the express terms of Local Rule 7.2(b). While in this instance, the Court will still consider the excess pages of Plaintiffs' reply brief, Plaintiffs are reminded that in the future, they are to abide by the court rules.

B. Defendants' Motion to Dismiss

1. Standard Governing Motion to Dismiss

Federal Rule of Civil Procedure 12(b)(6) allows a party to move for a dismissal based upon the pleader's "failure to state a claim upon which relief can be granted." Since the long-established federal policy of civil litigation is to decide cases on the proofs, district courts generally disfavor Rule 12(b)(6) motions. *Melo-Sonics Corp. v. Cropp*, 342 F.2d 856 (3d Cir.1965); *Panek v. Bogucz*, 718 F.Supp. 1228, 1229 (D.N.J.1989).

In deciding a motion to dismiss for failure to state a claim, all allegations in the pleadings must be accepted as true and the plaintiff must be given the benefit of every favorable inference that can be drawn from those allegations. See *Conley v. Gibson*, 355 U.S. 41, 48, 78 S.Ct. 99, 2 L.Ed.2d 80 (1957); *Wisniewski v. Johns-Manville Corp.*, 812 F.2d 81, 83 n. 1 (3d Cir.1987); *Markowitz*, 906 F.2d at 103. "All the rules require is a short and plain statement of the claim that gives the defendant fair notice of the plaintiff's claim and the grounds upon which it rests." *Conley*, 355 U.S. at 47, 78 S.Ct. 99.

Rule 12(b)(6) does not countenance "dismissals based on a judge's disbelief of a complaint's factual allegations." *Neitzke v. Williams*, 490 U.S. 319, 326-27, 109 S.Ct. 1827, 104 L.Ed.2d 338 (1989). "The issue is not whether a plaintiff will ultimately prevail but whether the claimant is entitled to offer evidence to support the claims." *Scheuer v. Rhodes*, 416 U.S. 232, 236, 94 S.Ct. 1683, 40 L.Ed.2d 90 (1974).

Accepting the facts in the pleadings as true and giving them all reasonable inferences, a court must dismiss under Rule 12(b)(6) "[i]f as a matter of law 'it is clear that no relief could be granted under any set of facts that could be proved consistent with the allegations.'" *Neitzke*, 490 U.S. at 326-27, 109 S.Ct. 1827.

2. Federal Question

[3] Plaintiffs allege that this Court's jurisdiction is based on 28 U.S.C. § 1331¹⁴ because their claims "arise under" federal law, namely the Medicaid provisions of the Social Security Act and the Due Process clause. Nevertheless, Defendants argue that Plaintiffs' complaint presents no federal question.

For purposes of "arising under" jurisdiction,

[a]n action arises under the laws of the United States if and only if the complaint seeks a remedy expressly granted by a federal law or if it requires the construction of a federal statute or a distinctive policy of a federal statute requires application of federal legal principles for its disposition.

Lindy v. Lynn, 501 F.2d 1367, 1369 (3d Cir.1974). Here, to determine whether the remedies sought by Plaintiffs are warranted, the Court must apply or interpret provisions of the Medicaid Act.

Plaintiffs allege that the provisions and application of the New Jersey State Medicaid plan conflict with the Federal Medicaid plan provisions as set forth in § 1396p. For example, Plaintiffs contend that contrary to § 1396p(c)(2)(D), the State has not provided for an "undue hardship" hearing for those who have been denied Medicaid benefits. Because Plaintiffs specifically assert that state law conflicts with federal law, the case relied on by Defendants, *Concourse Rehabilitation & Nursing Center Inc. v. DeBuono*, 179 F.3d 38 (2nd Cir.1999) (holding that absent assertion of

a specific conflict between the State Medicaid plan and federal law, there is no federal jurisdiction over a § 1983 claim that a State has violated provisions of its own Medicaid plan), is inapplicable. Therefore, this Court has jurisdiction over this matter pursuant to 28 U.S.C. § 1331.

3. Standing/Ripeness

Defendants suggest that some of the Plaintiffs, namely those that have not applied for Medicaid benefits, lack standing to bring this action. Without engaging in that determination, the Court concludes that this matter is not ripe with respect to those Plaintiffs who have not yet applied for Medicaid benefits. For ease of reference, "Plaintiffs," for this subsection only, will refer to those who have not yet applied for Medicaid benefits.

[4-7] All federal actions, including those for declaratory or injunctive relief, must involve a "case and controversy." *Philadelphia Federation of Teachers v. Ridge*, 150 F.3d 319, 322-23 (3d Cir.1998). Ripeness is one aspect of justiciability, which "'determines when a proper party may bring an action.'" *Id.* at 323 (citing *Travelers Ins. Co. v. Obusek*, 72 F.3d 1148, 1154 (3d Cir.1995)). Unless the record affirmatively shows otherwise, or plaintiffs meet their burden to clearly allege facts invoking a federal court's jurisdiction, the presumption is that jurisdiction is lacking. *Ibid.* The ripeness doctrine serves to prevent federal courts "from entangling themselves in abstract disagreements." *Ibid.* (citing *Abbott Labs. v. Gardner*, 387 U.S. 136, 148, 87 S.Ct. 1507, 18 L.Ed.2d 681 (1967), *overruled on other grounds*, *Califano v. Sanders*, 430 U.S. 99, 105, 97 S.Ct. 980, 51 L.Ed.2d 192 (1977)).

Ultimately, the case must involve "a real and substantial controversy admitting of specific relief through a decree of a conclusive character, as distinguished from an opinion advising what the law would be upon a hypothetical state of

14. 28 U.S.C. § 1331 provides: "The district courts shall have original jurisdiction of all

civil actions arising under the Constitution, laws, or treaties of the United States."

facts.' [citations omitted]. "A federal court's jurisdiction therefore can be invoked only when the plaintiff himself has suffered 'some threatened or actual injury resulting from the putatively illegal action . . .'" [citations omitted].

Presbytery of New Jersey of the Orthodox Presbyterian Church v. Florio, 40 F.3d 1454, 1463 (3d Cir.1994).

[8] When determining whether a request for declaratory judgment is ripe, a court should examine two factors: (1) "the fitness of the issues for judicial decision," and (2) "the hardship to the parties of withholding court consideration." *Philadelphia Federation of Teachers*, 150 F.3d at 323 (citing *Abbott Labs.*, 387 U.S. at 149, 87 S.Ct. 1507).

Under the first criterion,

various factors that enter into a court's assessment of fitness include: whether the claim involves uncertain and contingent events that may not occur as anticipated or at all; the extent to which a claim is bound up in the facts; and whether the parties to the action are sufficiently adverse. [citations omitted].

Ibid.

[9] Here, whether Plaintiffs will be irreparably harmed by Defendants' alleged wrongful conduct in determining Medicaid eligibility is contingent on numerous uncertain and contingent events including whether Plaintiffs do actually ever apply for Medicaid, whether Plaintiffs' establish a CSAT, and how many other resources Plaintiffs have. Although Plaintiffs may anticipate applying for Medicaid benefits in New Jersey, they may be unable to do so as a result of unexpected events, for example, death or moving out of New Jersey. Moreover, if and when Plaintiffs apply, there may be other unanticipated events that render this Court's decision inapplicable, such as: a change in federal or state law; a change in interpretation of federal law by the federal or state agencies administering Medicaid; or divorce, which would render the MCCA inapplicable. Fi-

nally, by the time Plaintiffs apply, Defendants may have implemented regulations governing undue hardship hearings and may, as a result, be eligible for benefits under that exception.

Additionally, there is not sufficient adversity of interests between the parties; any threat to Plaintiffs of being negatively impacted by Defendants' policies is not "real and immediate." To determine whether there is adversity of interest, which is indicative of an actual controversy, the parties must have "adverse legal interests." *Presbytery*, 40 F.3d at 1463. Although Plaintiffs need not have suffered a "completed harm" to establish adversity of interest, there must be a "substantial threat of real harm" and the "threat must remain real and immediate throughout the course of the litigation." *Ibid.* (citations omitted).

Plaintiffs do not identify a presently existing harm or threat, but rather, the threat of a threat. That is, Plaintiffs claim that even if they purchase commercial annuities in accordance with Defendants' current policy, they face the "real threat that DMAHS will again change its policy," which they conclude, is an "unacceptable" alternative to them. Should DMAHS again change its policy, Plaintiffs argue that they would then suffer the same irreparable harm that the other Plaintiffs face, namely eviction of the institutionalized spouse from the nursing home.

While the non-applicant Plaintiffs characterize their alternative to purchase a commercial annuity as "speculative," their allegations of injury based on an assumption or chance that Defendants will again change their policy is even more speculative. The Court will not render an opinion based on hypothetical facts. See *North Carolina v. Rice*, 404 U.S. 244, 246, 92 S.Ct. 402, 30 L.Ed.2d 413 (1971) (noting that ripeness doctrine requires "a real and substantial controversy admitting of specific relief through a decree of a conclusive character, as distinguished from an opinion

advising what the law would be upon a hypothetical state of facts.")

Therefore, whether the prospective Medicaid applicants are entitled to injunctive relief involve issues that are not fit for judicial decision under the first part of the test.

The second factor

focuses on the hardship that may be entailed in denying judicial review, and the determination whether any such hardship is cognizable turns on whether the challenged action creates a "direct and immediate" dilemma for the parties, such that the lack of pre-enforcement review will put the plaintiffs to costly choices. [citations omitted].

Ibid. Plaintiffs cannot claim that they will suffer hardship as a result of this Court's denial of judicial review of their claims. Should the Plaintiffs whose applications have been denied or are pending prevail in obtaining an injunction against Defendants, the non-applicant Plaintiffs will not be harmed. If, alternatively, the other Plaintiffs do not prevail, then the non-applicant Plaintiffs have the opportunity to do what is necessary to become eligible for Medicaid. Therefore, this action is dismissed as to those prospective Medicaid applicants.

4. Section 1983

[10] 42 U.S.C. § 1983 "imposes liability on anyone who, under color of state law, deprives a person 'of any rights, privileges, or immunities secured by the Constitution and laws' of the United States. *Blessing v. Freestone*, 520 U.S. 329, 341, 117 S.Ct. 1353, 137 L.Ed.2d 569 (1997). Section 1983 provides a cause of action for violations of the Constitution as well as federal statutes. *Wilder*, 496 U.S. at 508, 110 S.Ct. 2510 (citing *Maine v. Thiboutot*, 448 U.S. 1, 4, 100 S.Ct. 2502, 65 L.Ed.2d 555 (1980)). There are, however, two exceptions. A plaintiff may sue under § 1983 unless (1) the federal statute does not create enforceable rights, privileges, or immunities within the meaning of § 1983; or (2)

Congress, in the statute itself, has foreclosed enforcement of the statute under § 1983. *Ibid.*

In *Wilder*, 496 U.S. at 520-23, 110 S.Ct. 2510, the Supreme Court rejected an argument that "Congress has foreclosed enforcement of the Medicaid Act under § 1983." See *Harris v. James*, 127 F.3d 993, 997 n. 4 (11th Cir.1997).

To determine whether a federal statute creates an enforceable right under § 1983, the court must consider three factors:

First, Congress must have intended that the provision in question benefit the plaintiff. [citation omitted]. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence. [citation omitted]. Third, the statute must unambiguously impose a binding obligation on the States. In other words, the provision giving rise to the asserted right must be couched in mandatory rather than precatory terms.

Blessing, 520 U.S. at 340-41, 117 S.Ct. 1353.

a. Cause of Action Under § 1983

[11] Here, Plaintiffs claim a cause of action under several provisions of the Medicaid Act. One such provision that Plaintiffs allege creates an enforceable right is 42 U.S.C. § 1396p(c)(2)(D), which provides:

(c) Taking into account certain transfers of assets . . . (2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that— . . . (D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary; . . .

According to Plaintiffs, under that provision, Plaintiffs were entitled to, but were not provided with an "undue hardship"

hearing. Although Defendants claim that the State does offer every applicant an opportunity to apply for an undue hardship exception, for purposes of a motion to dismiss, Plaintiffs' allegations must be accepted as true.

A plain reading of this provision evidences that it is intended to benefit needy individuals for whom denial of Medicaid eligibility would work an undue hardship. Compare *Rodriguez v. DeBuono*, 44 F.Supp.2d 601, 611 (S.D.N.Y.), *rev'd on other grounds*, 197 F.3d 611 (2nd Cir.1999) (noting that § 1396(a)(10)(B), which provides that a "State plan ... provide ... that the medical assistance made available to any individual ... not be less in amount, duration, or scope than the medical assistance made available to any other such individual ...," is intended to benefit categorically needy persons) with *Harris*, 127 F.3d at 1010 (concluding that § 1396a(a)(19), which requires State plans provide "such safeguards as may be necessary to assure that ... care and services will be provided ... in a manner consistent with simplicity of administration and the best interests of the recipients," only imposed a generalized duty on the States without conferring any particular right upon the plaintiffs). Because Plaintiffs claim that they would have benefitted from an "undue hardship" hearing, the first element is met.

The second criterion, whether the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence, is also satisfied. The Medicaid Act, 42 U.S.C. § 1396p(c)(2)(D), requires that the State's procedures to determine whether the denial of eligibility would work an undue hardship must be in accordance with standards specified by the Secretary. The Secretary administers the Medicaid program through HCFA. Section 3259.8(A) of the HCFA Guidelines provides that: "Undue hardship exists when application of the trust provisions would deprive the individual of medical care such that his/her health

or his/her life would be endangered" or "when application of the trust provisions would deprive the individual of food, clothing, shelter, or other necessities of life."

According to section 3259.8(C) of the guidelines, the state has "considerable flexibility in deciding the circumstances under which [the state] will not count funds in trusts under the trust provisions because of undue hardship." Under the undue hardship provision, however, the state must, at a minimum, provide for "[n]otice to recipients that an undue hardship exception exists; [a] timely process for determining whether an undue hardship waiver will be granted; [a] process under which an adverse determination can be appealed." Section 3259.8(C).

Because the HCFA Guidelines outline how undue hardship is to be measured, enforcement of a defined standard would not "strain judicial competence." See *Wilder*, 496 U.S. at 519-20, 110 S.Ct. 2510 (rejecting argument that because Boren Amendment gives a state flexibility to adopt any rates it finds reasonable and adequate, Amendment is too "vague and amorphous" to be judicially enforceable).

Finally, the third factor is also satisfied. The use of the word "shall" in § 1396p(c)(2)(D) makes the "undue hardship" exception mandatory rather than precatory. "The language succinctly sets forth a congressional command, which is wholly uncharacteristic of a mere suggestion or 'nudge.'" *West Virginia University Hospitals, Inc. v. Casey*, 885 F.2d 11, 20 (3d Cir.1989) (citing *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 19, 101 S.Ct. 1531, 67 L.Ed.2d 694 (1981) (holding that cause of action for violation of § 1396a(a)(13)(A) of Medicaid Act arises under § 1983 in part because language of that provision is cast in the imperative)), *aff'd*, 499 U.S. 83, 111 S.Ct. 1138, 113 L.Ed.2d 68 (1991); see also *Rodriguez*, 44 F.Supp.2d at 611 (concluding that cause of action arises under § 1983 for violation of § 1396a(a)(10)(B) of Medicaid Act in part because that provision uses

mandatory, rather than precatory language); *but see Harris*, 127 F.3d at 1011 (finding that federal regulation read in conjunction with § 1396a(a)(10)(B), while it may create some federal right, does not give rise to a federal right to transportation enforceable under § 1983).

Although Plaintiffs also allege violations of subsections of § 1396a and § 1396p, they have not addressed whether those provisions give rise to enforceable rights by satisfying the three factor analysis laid out by the Supreme Court in *Blessing*.

[12] Nevertheless, just as § 1396p(c)(2)(D) provides for a cause of action under § 1983, Plaintiffs are correct that § 1396a(a)(18) also creates a federal right enforceable under § 1983. That provision mandates that “[a] State plan for medical assistance must— . . . comply with the provisions of section 1396p of this title with respect to . . . transfers of assets, and treatment of certain trusts” First, the specific purpose of this section is to assure state compliance with some federal standard of accounting for trusts and transfers of assets to determine eligibility. This benefits those who would be eligible for benefits under § 1396p. Because Plaintiffs contend that they would benefit from the State’s compliance with § 1396p, they are part of the intended beneficiaries. Second, § 1396a(a)(18) does not strain judicial competence for a court to review whether, and in what manner, certain assets were taken into account when determining an individual’s eligibility for benefits. Third, the language of this section contains mandatory rather than precatory terms.

b. *Definition of “Person” under § 1983*

Defendants argue that they cannot be sued under § 1983 because neither a state nor a state agency is a “person” under § 1983. Section 1983 states in part:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State . . . subjects, or causes to be subjected, any citizen of the United States or other person within the

jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. . . .

(emphasis added).

The Supreme Court has held that “neither a State nor its officials acting in their official capacities are ‘persons’ under § 1983.” *Will v. Michigan Dep’t of State Police*, 491 U.S. 58, 71, 109 S.Ct. 2304, 105 L.Ed.2d 45 (1989); *see also Powell v. Ridge*, 189 F.3d 387, 401 (3d Cir.) (holding that when state officials are sued for damages in their official capacities, “the suit is treated as one against the state and the official is not considered to be a ‘person’ thereby precluding reliance on § 1983”) (quoting *Will v. Michigan Dep’t of State Police*, 491 U.S. 58, 71 and n. 10, 109 S.Ct. 2304, 105 L.Ed.2d 45 (1989)), *cert. denied*, — U.S. —, 120 S.Ct. 579, 145 L.Ed.2d 482 (1999). As explained in *Will*,

Obviously, state officials literally are persons. But a suit against a state official in his or her official capacity is not a suit against the official but rather is a suit against the official’s office. *Brandon v. Holt*, 469 U.S. 464, 471, 105 S.Ct. 873, 877, 83 L.Ed.2d 878 (1985). As such, it is no different from a suit against the State itself. *See, e.g., Kentucky v. Graham*, 473 U.S. 159, 165–166, 105 S.Ct. 3099, 3104–3105, 87 L.Ed.2d 114 (1985); *Monell [v. Dept. of Social Services of City of New York]*, *supra*, [436 U.S. 658] at 690, n. 55, 98 S.Ct., [2018] at 2035, n. 55[56 L.Ed.2d 611 (1978)]. We see no reason to adopt a different rule in the present context, particularly when such a rule would allow petitioner to circumvent congressional intent by a mere pleading device.

Will, 491 U.S. at 71, 109 S.Ct. 2304.

In a footnote, however, the Supreme Court cautioned that:

Of course a state official in his or her official capacity, when sued for *injunc-*

tive relief, would be a person under § 1983 because "official-capacity actions for prospective relief are not treated as actions against the State." *Kentucky v. Graham*, 473 U.S., at 167, n. 14, 105 S.Ct., at 3106, n. 14; *Ex parte Young*, 209 U.S. 123, 159-160, 28 S.Ct. 441, 453-454, 52 L.Ed. 714 (1908).

Id. at 71, n. 10, 109 S.Ct. 2304 (emphasis added).

[13, 14] Therefore, although Plaintiffs' claim against Defendants for monetary damages must be dismissed, to the extent that Plaintiffs seek injunctive and declaratory relief, those claims withstand Defendants' motion to dismiss. Plaintiffs may also maintain their claim for attorneys' fees. *Cf. Missouri v. Jenkins*, 491 U.S. 274, 279, 109 S.Ct. 2463, 105 L.Ed.2d 229 (1989) (noting that Eleventh Amendment does not bar an award of attorney's fees ancillary to prospective relief); *Meredith v. Federal Mine Safety and Health Review Commission*, 177 F.3d 1042, 1049 (C.A.D.C.1999) ("where attorney's fees are provided for by statute, as here, qualified immunity has no application.")

5. Eleventh Amendment Immunity

Defendants claim that a suit against the New Jersey Department of Human Services, Division of Medical Assistance and Health Services, Michele K. Guhl, Commissioner of the New Jersey Department of Human Services, and Margaret A. Murray, Director of DMAHS is barred by the Eleventh Amendment.¹⁵

[15] Defendants are correct that absent consent by a state, suits for money damages against a state or state officials in their official capacities are barred by the Eleventh Amendment. *See Kentucky v. Graham*, 473 U.S. 159, 169, 105 S.Ct. 3099, 87 L.Ed.2d 114 (1985) (concluding that Eleventh Amendment barred official capacity action for damages in § 1983 suit);

Edelman v. Jordan, 415 U.S. 651, 94 S.Ct. 1347, 39 L.Ed.2d 662 (1974) (holding that suit against state official for retroactive monetary relief, which requires payment of funds from state treasury is barred by Eleventh Amendment).

[16, 17] The Amendment, however, does not bar Plaintiffs from suing state officials for violations of federal law where future injunctive relief is sought. *See Ex parte Young*, 209 U.S. 123, 28 S.Ct. 441, 52 L.Ed. 714 (1908) (holding that Eleventh Amendment does not prohibit suit to enjoin state Attorney General from enforcing state statute that allegedly violated Fourteenth Amendment); *see also Edelman*, 415 U.S. 651, 94 S.Ct. 1347. The theory of *Ex parte Young* is not without its limits. As explained in *Edelman*, under *Ex parte Young*, the Eleventh Amendment may bar equitable relief if it in practice is a money judgment payable out of the state treasury. *Edelman*, 415 U.S. at 666-67, 94 S.Ct. 1347. In *Edelman*, the district court had ordered the state to retroactively release and remit benefits wrongfully withheld. The Supreme Court reversed that decision concluding that such an order was "in practical effect indistinguishable in many aspects from an award of damages against the State." *Id.* at 668, 94 S.Ct. 1347. In so holding, the Court distinguished those cases in which injunctive or declaratory relief was not barred because such relief was likely to have only an "ancillary effect on the state treasury" such as in *Ex parte Young*. *Ibid.* In *Ex parte Young*, "the state law which the Attorney General was enjoined from enforcing provided substantial monetary penalties against railroads which did not conform to its provisions." *Id.* at 667, 94 S.Ct. 1347.

[18] Here, granting Plaintiffs prospective injunctive relief would likely require the State to spend more money from the

15. The Eleventh Amendment to the United States Constitution provides: "The Judicial Power of the United States shall not be construed to extend to any suit in law or equity

commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of a Foreign State."

state treasury than if it were left to continue its current course of conduct. Such an effect would, however, be ancillary and is therefore not barred by the Eleventh Amendment under *Ex parte Young* and *Edelman*.

[19] Therefore, Defendants' motion to dismiss is denied to the extent that Plaintiffs seek prospective injunctive relief and attorneys' fees. See *Missouri*, 491 U.S. at 279, 109 S.Ct. 2463 ("it must be accepted as settled that an award of attorney's fees ancillary to prospective relief is not subject to the strictures of the Eleventh Amendment"). Plaintiffs' claims for compensatory damages against Defendants are, however, barred by the Eleventh Amendment.

6. Due Process Claim

[20] To establish a claim for violation of constitutional procedural due process, a plaintiff must (1) show that a protected property interest was taken; and (2) that the procedural safeguards surrounding the deprivation were inadequate. See *Board of Regents v. Roth*, 408 U.S. 564, 568-69, 92 S.Ct. 2701, 33 L.Ed.2d 548 (1972).

Plaintiffs contend that they are entitled to proper notice regarding a change in policy that would deprive them of Medicaid benefits or "property" because they would have qualified for Medicaid absent the State's informal change of its policy regarding CSATs as a countable resource.

[21] First, it is clearly established that once an individual is a recipient of direct Medicaid benefits, such benefits are a protected property interest that cannot be

withdrawn without giving the recipient notice and an opportunity to be heard. See *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773, 787, 100 S.Ct. 2467, 65 L.Ed.2d 506 (1980); see also *Goldberg v. Kelly*, 397 U.S. 254, 262, 90 S.Ct. 1011, 25 L.Ed.2d 287 (1970).

[22] Although Plaintiffs have never been granted Medicaid benefits, nevertheless, without citing any supporting law, Plaintiffs contend that they have a protected property interest in Medicaid benefits. The Court disagrees. Plaintiffs are not entitled to any procedural safeguards with respect to a property interest for which they have never been deemed qualified. See *Goldberg*, 397 U.S. at 262, 90 S.Ct. 1011 (noting welfare benefits "are a matter of statutory entitlement for persons qualified to receive them"); *Board of Regents of State Colleges v. Roth*, 408 U.S. 564, 576, 92 S.Ct. 2701, 33 L.Ed.2d 548 (1972) ("The Fourteenth Amendment's procedural protection of property is a safeguard of the security of interests that a person has *already* acquired in specific benefits." (emphasis added)); see also *Oberlander v. Perales*, 740 F.2d 116, 120 (2nd Cir.1984) (recognizing that "Medicaid providers clearly have no property interest in *future* reimbursements under New York law." (emphasis added)).

[23] Even assuming Plaintiffs had a protected property interest, Plaintiffs claim that they were deprived of their right to due process in violation of the prior notice requirements set forth in 42 C.F.R. §§ 431.211,¹⁶ 435.919,¹⁷ and 447.205, is untenable.¹⁸ See First Amended Compl.

16. 42 C.F.R. § 431.211 provides in pertinent part: "The State or local agency must mail a notice at least 10 days before the date of action, . . ."

17. 42 C.F.R. § 435.919 states in relevant part: "(a) The agency must give recipients timely and adequate notice of proposed action to terminate, discontinue, or suspend their eligibility or to reduce or discontinue services they may receive under Medicaid."

18. 42 C.F.R. § 447.205 provides:

(a) *When notice is required.* Except as specified in paragraph (b) of this section, the agency must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services.

(b) *When notice is not required.* Notice is not required if—

(1) The change is being made to conform to Medicare methods or levels of reimbursement;

(2) The change is required by court order; or

¶ 56. 42 C.F.R. § 431.211 provides that notice must be mailed at least 10 days before the date of "action." "Action" is defined in § 431.201 as "termination, suspension, or reduction of Medicaid eligibility or covered services." Because Plaintiffs have not yet been deemed Medicaid eligible, their eligibility, by definition, cannot be terminated, suspended, or reduced. Consequently, § 431.211 does not apply to Plaintiffs. Moreover, in 42 C.F.R. § 431.200, *et seq.*, which governs "Fair Hearings for Applicants and Recipients," § 431.206¹⁹ only gives Plaintiffs the right to notice of their right to a fair hearing; it does not give Plaintiffs the right to notice of a change in interpretation of the Medicaid Act.

Furthermore, § 435.919 requires fair hearings for Medicaid beneficiaries who have their benefits reduced, suspended, or terminated. Because Plaintiffs are merely Medicaid applicants who have been denied benefits, potential Medicaid applicants, or individuals whose applications are pending, rather than Medicaid recipients, Plaintiffs are not entitled to the rights afforded persons already receiving benefits. Moreover, 42 C.F.R. § 447.205 requires public notice when there is a proposed change in the methods and standards for setting payment rates. Therefore, that regulation does not affect applicants or potential ap-

plicants such as Plaintiffs; such notice would only affect Medicaid providers.

Additionally, Plaintiffs argue in their motion for preliminary injunction, that Defendants' "policy change" of viewing CSATs as a countable resource constitutes impermissible rule making that fails to comply with N.J.S.A. 52:14B-1, *et seq.* and that its retroactive application violates Plaintiffs' due process rights to prior notice and appeal.

[24] Allegations that Defendants violated state law and their own procedures in denying adequate notice and opportunity to be heard do not provide the basis for a constitutional due process claim. See *Concourse Rehabilitation & Nursing Center Inc. v. DeBuono*, 179 F.3d 38, 44 (2nd Cir.1999); see also *Hartwick v. Board of Trustees of Johnson County Community College*, 782 F.Supp. 1507, 1511 (D.Kan. 1992).

Therefore, Plaintiffs' due process claims are dismissed.

7. Equal Protection

[25] While neither party has briefed this issue, the allegation in Plaintiffs' complaint that Defendants' conduct somehow violated their constitutional rights to equal protection fails as a matter of law.

(3) The change is based on changes in wholesalers' or manufacturer' prices of drugs or materials, if the agency's reimbursement system is based on material cost plus a professional fee.

(c) *Content of notice.* . . .

(d) *Publication of notice.* The notice must—

(1) Be published before the proposed effective date of the change; and

(2) Appear as a public announcement in one of the following publications:

(i) A State register similar to the **FEDERAL REGISTER**.

(ii) The newspaper of widest circulation in each city with a population of 50,000 or more.

(iii) The newspaper of widest circulation in the State, if there is no city with a population of 50,000 or more.

19. Section 431.206 provides in pertinent part:

(b) The agency must, at the time specified in paragraph (c) of this subsection, inform every applicant or recipient in writing—(1) Of his right to a hearing; (2) Of the method by which he may obtain a hearing; and (3) That he may represent himself or use legal counsel, a relative, a friend, or other spokesman.

(c) The agency must provide the information required in paragraph (b) of this section—(1) at the time that an individual applies for Medicaid; (2) At the time of any action affecting his or her claim; (3) At the time a skilled nursing facility or a nursing facility notifies a resident in accordance with § 483.12 of this chapter that he or she is to be transferred or discharged; and (4) At the time an individual receives an adverse determination by the State with regard to the preadmission screening and annual resident review requirements . . .

The Equal Protection Clause commands that no State shall "deny to any person within its jurisdiction the equal protection of the laws." This provision creates no substantive rights. Instead, it embodies a general rule that States must treat like cases alike but may treat unlike cases accordingly. *Plyler v. Doe*, 457 U.S. 202, 216, 102 S.Ct. 2382, 2394, 72 L.Ed.2d 786 (1982) ("[T]he Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same") (quoting *Tigner v. Texas*, 310 U.S. 141, 147, 60 S.Ct. 879, 882, 84 L.Ed. 1124 (1940)). If a legislative classification or distinction "neither burdens a fundamental right nor targets a suspect class, we will uphold [it] so long as it bears a rational relation to some legitimate end." *Romer v. Evans*, 517 U.S. 620, — [631], 116 S.Ct. 1620, 1627, 134 L.Ed.2d 855 (1996).

Vacco v. Quill, 521 U.S. 793, 799, 117 S.Ct. 2293, 138 L.Ed.2d 834 (1997) (citations omitted).

Here, Plaintiffs have not been identified as a suspect class and no fundamental rights are involved. To the extent that Defendants' conduct or "policy change" does not treat all applicants who have used CSATs alike, it can be argued that such treatment bears a rational relation to the legitimate end of complying with the federal Medicaid Act and Congress' intent to provide medical assistance to the needy. Plaintiffs' equal protection claim is therefore dismissed.

8. Exhaustion of State Remedies

Defendants assert that Plaintiffs' remedy for the State's denial of Medicaid eligibility is to seek redress through the State courts. If eligibility is denied, an applicant may appeal an agency's decision by obtaining a fair hearing. N.J.S.A. 30:4D-7(e); N.J.A.C. 10:49-10.3(b). If appropriate, the appeal is heard by an Administrative Law

Judge ("ALJ"). The Director of DMAHS then reviews the initial decision of the ALJ and issues a final agency decision, which is appealable to the Appellate Division. See New Jersey Court Rules Governing Appellate Practice, R. 2:2-3(a)(2) (all final state administrative agency decisions are appealable as of right); and Administrative Procedures Act, N.J.S.A. 52:14B-12.

[26] Notwithstanding those state appeals procedures, "[t]he availability of state administrative procedures ordinarily does not foreclose resort to section 1983." *Wilder*, 496 U.S. at 524, 110 S.Ct. 2510. Additionally, as argued by Plaintiffs at the March 27, 2000 hearing, they are seeking to enforce the federal mandate that States provide applicants an opportunity to have an undue hardship hearing,²⁰ which is separate and distinct from a fair hearing. See Transcript of March 27, 2000 Hearing ("Hearing Tr."), 37:1-14.

C. Plaintiffs' Motion for Preliminary Injunction

[27, 28] The issuance or denial of a preliminary injunction is a matter committed to the sound discretion of the trial court. *Penn Galvanizing Co. v. Lukens Steel Co.*, 468 F.2d 1021, 1023 (3d Cir. 1972). An injunction, however, is "an extraordinary remedy which should be granted only in limited circumstances." *Instant Air Freight Co. v. C.F. Air Freight, Inc.*, 882 F.2d 797, 800 (3d Cir.1989).

[29] In ruling on a motion for a preliminary injunction, the court must be convinced that all four of the following factors favor preliminary relief: (1) the likelihood that the moving party will succeed on the merits; (2) the extent to which the moving party will suffer "irreparable harm" without injunctive relief; (3) the extent to which the nonmoving party will suffer irreparable harm if the injunction is issued; and (4) the public interest. *Clean Ocean Action v. York*, 57 F.3d 328, 331 (3d Cir.

20. Defendants concede that the State does not currently have regulations implemented set-

ting forth procedures, such as the administrative remedies, for an undue hardship hearing.

1995); *American Tel. & Tel. Co. v. Win-back and Conserve Program, Inc.*, 42 F.3d 1421, 1426 (3d Cir.1994).

Plaintiffs allege that the New Jersey Medicaid plan does not comport with the federal Medicaid Act in the following respects:

(a) Failure to provide notice of and establish procedures for "undue hardship" hearing pursuant to 42 U.S.C. § 1396p(c)(2)(D) to provide a "final" level of appeal in the event of denial of Medicaid benefits based on financial eligibility for elderly institutionalized spouses;

(b) Application of financial standards for eligibility and transfer of asset rules that do not conform to 42 U.S.C. § 1396p and, in violation of N.J.S.A. 30:4D-3(i)(15)(b),²¹ are more restrictive in scope, duration, or amount of services than permitted;

(c) Establishing, without basis in federal or state law, a "more restrictive" condition by requiring that New Jersey be the first named beneficiary upon the death of the community spouse to the extent of full reimbursement for Medicaid benefits paid on behalf of the institutionalized spouse; and

(d) Enunciating the "new policy" to reject CSATs in violation of N.J.S.A. 52:14B-1, *et seq.* and to apply that change retroactively in violation of 42 C.F.R. §§ 431.211, 435.919, 447.205, rights to constitutional due process and equal protection.

Each contention will be addressed in turn.

21. That provision provides in pertinent part:

An individual who has, within 36 months, or within 60 months in the case of funds transferred into a trust, of applying to be a qualified applicant for Medicaid services in a nursing facility . . . , disposed of resources or income for less than fair market value shall be ineligible for assistance for nursing facility services . . . The period of ineligibility shall be the number of months resulting from dividing the uncompensated value of the transferred resources or income by the average monthly private payment rate for nursing facility services in the State as determined annually by the commissioner.

1. Undue Hardship Hearing

a. Likelihood of Success on the Merits

[30] The requirement that the State Medicaid plan include a procedure to determine whether an "undue hardship" exception applies is set forth in 42 U.S.C. § 1396p(c)(2)(D).²² It is evident from the legislative history that it is mandatory that the states provide for an undue hardship exception. Congress, specifically concerned that the states were not extending to all individuals facing hardship the protections of existing law, crafted OBRA to specifically amend existing law to require "the Secretary (1) to specify standards that State hardship determination procedures must meet, and (2) to establish criteria States must apply in determining whether a hardship exists." H.R.Rep. No. 103-111(II), 103th Cong., 1st Sess., at 207 (1993), reprinted in 1993 U.S.C.C.A.N. 378, 534.

Sections 3259.8(A) and (C) of the HCFA Guidelines provide that at a minimum, the undue hardship provision must provide for: (1) notice to a recipient that an undue hardship exists; (2) a timely process for determining whether an undue hardship waiver will be granted; and (3) a process under which an adverse determination can be appealed.

Plaintiffs contend that contrary to the mandates of 42 U.S.C. § 1396p(c)(2)(D) and the HCFA Guidelines, neither the

In the case of multiple resource or income transfers, the resulting penalty periods shall be imposed sequentially. Application of this requirement shall be governed by 42 U.S.C. § 1396p(c). In accordance with federal law, this provision is effective for all transfers of resources or income made on or after August 11, 1993. Notwithstanding the provisions of this subsection to the contrary, the State eligibility requirements concerning resource or income transfers shall not be more restrictive than those enacted pursuant to 42 U.S.C. § 1396p(c).

22. See *supra* III.B.4.a., for text of 42 U.S.C. § 1396p(c)(2)(D).

Medical Assistance Act in N.J.S.A. 30:4D-1 *et seq.* nor the numerous regulations implementing the State Medicaid provisions have defined or enacted hardship provisions to allow the over age 65, institutionalized Plaintiffs to appeal denial of their Medicaid applications. Moreover, they argue that under OBRA, 42 U.S.C. § 1395a(e)(3), all participating Medicaid states were to adopt all regulations enacting OBRA within one year of its effective date. According to Plaintiffs, even after six years, the State has failed to enact, as it was required to do, regulatory procedures to implement undue hardship exceptions in the State Medicaid plan pursuant to New Jersey's Administrative Procedure Act ("APA"), N.J.S.A. 52:14B-1, *et seq.*

Defendants do not contest that Plaintiffs must be permitted to apply for an undue hardship hearing and that provisions for a hearing on the hardship issue have not been codified in the New Jersey Administrative Code; rather, they assert that Plaintiffs were offered an undue hardship hearing, but have refused to pursue that option. Moreover, counsel for Defendants represented to the Court at the March 27th hearing, that the Commissioner of DMAHS will file with the New Jersey Office of Administrative Law proposed regulations establishing undue hardship hearings before the end of April, 2000. Hearing Tr. 13:17-16:17. Then the proposal would, in accordance with the procedures set forth in the state APA governing rule making, be published in the New Jersey Register for notice and comment. *Ibid.*

Nevertheless, Defendants have not, as they are required to do, instituted any regulations providing for: (1) notice to applicants that an undue hardship exception exists; (2) a timely process for determining whether an undue hardship waiver will be granted; and (3) a process under which an adverse determination can be appealed, Plaintiffs are likely to prevail on this issue.

b. *Irreparable Harm*

[31-33] In this Circuit, "to show irreparable harm a plaintiff must demonstrate potential harm which cannot be redressed by a legal or an equitable remedy following a trial. Economic loss does not constitute irreparable harm." *Aciermo v. New Castle County*, 40 F.3d 645, 653 (3d Cir.1994). Thus, in order to warrant a preliminary injunction, the injury created by a failure to issue the requested injunction "must be of a peculiar nature, so that compensation in money cannot atone for it." *A.O. Smith Corp. v. F.T.C.*, 530 F.2d 515, 525 (3d Cir.1976) (citation omitted) (internal quotation marks omitted). Moreover, "[a]n inability to precisely measure financial harm does not make that harm irreparable or immeasurable." *Aciermo*, 40 F.3d at 655.

[34] Additionally, the injury alleged must not only be irreparable, it must be imminent as well. *Holiday Inns of Am., Inc. v. B & B Corp.*, 409 F.2d 614, 618 (3d Cir.1969) (noting that injunctive relief "may not be used simply to eliminate a possibility of a remote future injury, or a future invasion of rights.")

[35] Defendants have represented that the procedures for establishing state regulations governing the undue hardship exception would be initiated no later than the end of April, 2000. Therefore, there is no threat of immediate irreparable injury resulting from the current absence of regulations. Furthermore, it is worth noting that even if this Court were to order Defendants to promulgate such regulations, Defendants must still follow the procedural requirements set forth in the APA to promulgate such regulations. Consequently, these regulations would not be instituted any faster than with an order from this Court.

As to these particular Plaintiffs who have not had the benefit of such regulations, Defendants have expressed a willingness to provide that hearing; moreover, despite the fact that there are not yet any state adopted standards and procedures,

section 3259.8 of the HCFA Guidelines at least provides a definition of "undue hardship" and a framework for the state standards. Therefore, Plaintiffs are, at the minimum, protected by those federal standards.

Because Plaintiffs are not subject to immediate irreparable harm, this factor weighs against granting preliminary relief.²³ Therefore, the Court need not engage in an analysis of the remaining factors to determine whether granting a preliminary injunction is appropriate.

[36] Alternatively, even if the Court were to conclude that there was the potential of immediate irreparable harm, the Court would not exercise its discretion to grant the extraordinary relief sought by Plaintiffs. Before seeking a preliminary injunction compelling Defendants to implement regulations, Plaintiffs, although not required to have done so before filing a § 1983 action, could have resorted to N.J.S.A. 52:14B-4(f), which authorizes and sets forth the procedures for an interested person to petition an agency to promulgate, amend or repeal any rule. Once such a petition is received by the agency, the agency must respond within 30 days. Plaintiffs suggest that they have not filed a petition with the DMAHS because this administrative procedure "typically results in delays of one year or more" and because DMAHS has continually been advising the Elder Law Section of the New Jersey Bar Association that proposed regulations required under OBRA, now five years over-

due, will be forthcoming "shortly." If Plaintiffs truly believed that irreparable injury would result from Defendants' failure to have implemented official regulations governing undue hardship hearing, the remedy available to Plaintiffs under N.J.S.A. 52:14B-4(f) was available during the six years since the enactment of OBRA.

Therefore, Plaintiff's motion for preliminary injunctive relief on this issue will be **denied without prejudice**. In the event, however, that Defendants do not initiate the process of implementing regulations governing the undue hardship exception by the end of April 2000, or Defendants do not provide these specific Plaintiffs the opportunity to have an undue hardship in accordance with the standards set forth in the HCFA Guidelines, Plaintiffs may seek the appropriate relief from this Court.

2. Application of Transfer Rules and Treatment of Trusts

Here, because the CSATs are irrevocable trusts that can, in no way, benefit the applicant, Plaintiffs argue that CSATs qualify as exceptions to the transfer rules set forth in 42 U.S.C. § 1396p(c)(2)(B)(i) and (ii), and N.J.A.C. 10:71-4.7(e)(1)(i).²⁴ Defendants do not contest that of the Plaintiffs who have actually submitted trusts for review, all the trusts were deemed to be actuarially sound transfers for the sole benefit of the community spouse and not subject to a transfer penalty.²⁵ Defs.' Br. in Opp. to Mot. for Prelim-

trust document specifying that the trustee(s) may use the funds solely for the benefit of the community spouse. Should the transferred funds not be so designated, the transfer shall be presumed to be for the purpose of qualifying for Medicaid in accordance with the provisions of this section;

23. Plaintiffs argue that the nursing facilities will be harmed because of the financial impact of them of not getting paid. The Court will not consider that argument because the nursing facilities are not parties to this action and Plaintiffs do not have standing to argue on behalf of those facilities.

24. N.J.A.C. 10:71-4.7(e)(1)(i) states: If funds were transferred to another individual for the sole benefit of the community spouse prior to entry into institutional care, in order that the transfer not be considered to have been for the purposes of qualifying for Medicaid, the funds must have been transferred in the form of a legally binding

25. This renders moot Plaintiffs request that the Court estop Defendants from determining that Plaintiffs' contribution of available resources to CSATs constitute transfers for less than fair market value resulting in a period of ineligibility for Medicaid benefits.

inary, Permanent Injunction and Declarative Relief, at 23. In other words, in this circumstance, the corpus of the trust is considered a transfer of assets for less than fair market value, which would normally trigger a look-back period, but in this case, does not because the transfer was for the "sole benefit of" the community spouse. Therefore, no part of the corpus of the CSAT would be treated as a countable resource to the institutionalized spouse. See Feinberg article.

Although the "sole benefit of" trust does not trigger a penalty period and is not a countable resource to the grantor or institutionalized spouse, § 1396p(d)(3)(B)(ii)²⁶ does not expressly address whether an irrevocable trust, from which the institutionalized spouse may not benefit, and created solely for the benefit of the community spouse, is a countable resource to the community spouse in calculating the spousal share and CSRA and determining Medicaid eligibility.

Plaintiffs insist that because the CSATs are actuarially sound, as defined in HCFA Guideline § 3258.9B, and are "for the sole benefit of" the spouse, as defined in HCFA Guideline § 3257.B6, the CSATs are also not countable resources for Medicaid eligibility purposes. As argued by Defendants, however, actuarial soundness is a factor in determining whether a transfer to a third party was in fact made for the sole benefit of the spouse. See HCFA Guideline § 3257.B6; Streimer letter. If a transfer was made for the sole benefit of the

spouse, then that determination impacts whether the transfer for less than fair market value triggers a transfer penalty and has no bearing on whether an asset is a countable resource.²⁷

Next, Plaintiffs conclude that the CSAT is analogous to a commercial annuity because the CSAT annuitized payout of principal and earnings meet the HCFA Guidelines for annuities set forth in § 3258.9B.²⁸ HCFA Guideline 3258.9B, however, applies to annuities. Moreover, Plaintiffs' own words belie their contention: "[s]ection 3259 of HCFA 64 defines 'annuities' and specifies that Section 3258.9B controls how annuities are to be evaluated and treated. Therefore, the 'plain meaning' is that *Section 3259 trust provisions are inapplicable to annuity trusts* since Section 3258.9B controls." Pls.' Reply Br. in Support of Mot. For Preliminary Injunction, at 9 (emphasis added).

In asserting that "sole benefit of" trusts are in fact countable resources, Defendants emphasize that such trusts are not included in 42 U.S.C. § 1382b among the list of resources that are excludable. Indeed, § 3260.1 of the HCFA Guidelines defines "countable resources" as "resources [that are] not subject to exclusion."

In further support of their position, Defendants rely on the informal statement of HCFA's views set forth in the Streimer letter that "sole benefit of" trusts are countable resources. See *supra* discussion II.G. As explained in that letter, an irrevocable

26. 42 U.S.C. § 1396p(d)(3)(B)(ii) states:

any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection (c) of this section, and the value of the trust shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date.

27. Although Defendants as well as Plaintiffs both look to different paragraphs of § 3258.11 of the HCFA Guidelines to support their respective positions, that section is inapplicable because it merely addresses when certain transfers of assets for less than fair market value are exempt from penalty, rather than when resources are countable in determining eligibility.

28. Section 3258.9B provides in part that if an annuity is not actuarially sound, then the annuity is considered a transfer of assets for less than fair market value subjecting the individual to a penalty.

cable trust is unlike a commercial annuity because in an irrevocable trust, the corpus can be paid at some point to the community spouse, but in a standard annuity, the buyer is only entitled to the income stream purchased and cannot reclaim the funds used to purchase the annuity.

Plaintiffs respond that the Streimer letter is merely a response to a private attorney on a specific set of facts unknown to DMAHS, rather than a rule, regulation, or guideline that has ever been subjected to judicial review to determine compliance with federal law.

[37] Contrary to Plaintiffs' contentions, HCFA's Guidelines and the Streimer letter, although not formal regulations, are entitled to some deference by this Court as long as "they are consistent with the plain language and purposes of the statute and if they are consistent with prior administrative views." *Cleary v. Waldman*, 167 F.3d 801, 808 (3d Cir.) (granting deference to HCFA and HHS clearly stated views, albeit in policy letters, that states have discretion to employ either income-first or resource-first method to determine Medicaid eligibility), *cert. denied*, — U.S. —, 120 S.Ct. 170, 145 L.Ed.2d 144 (1999); *see also Skidmore v. Swift & Co.*, 323 U.S. 134, 140, 65 S.Ct. 161, 89 L.Ed. 124 (1944) (stating that where an administrative agency's interpretation is registered in informal views, as long as that agency has a delegated authority to administer the statute and the views are made "in pursuance of official duty, based upon more specialized experience and broader investigations and information than is likely to come to a judge," then those views warrant some deference); *Elizabeth Blackwell Health Center for Women v. Knoll*, 61 F.3d 170 (3d Cir.1995) (noting that interpretive rules by an agency with lawmaking authority will receive deference even if the agency's interpretation is not made pursuant to that lawmaking authority), *cert. denied*, 516 U.S. 1093, 116 S.Ct. 816, 133 L.Ed.2d 760 (1996).

[38] In examining HCFA's interpretation of the treatment of irrevocable trusts, such as the CSATs at issue here, the Court determines that the agency's view is based on a permissible construction of the statute. As stated earlier in this opinion, the MCCA, discussed *supra* n. 9, supersedes any inconsistent provisions in that subchapter; therefore, to the extent that Plaintiffs argue that 42 U.S.C. § 1396p(c)(2) is inconsistent with the MCCA, the MCCA controls. 42 U.S.C. § 1396r-5(a)(1). The MCCA provides that when computing spousal share at the time of institutionalization, a "snapshot" of all of the couple's countable resources, which includes "the total value of the resources to the extent *either* the institutionalized spouse or the community spouse has an ownership interest," is taken. 42 U.S.C. § 1396r-5(c)(1). Under the plain meaning of this section, a CSAT is a resource to the community spouse, and therefore, is part of the total value of resources in determining spousal share. As discussed earlier in this opinion, if the community spouse's share exceeds the "community spouse resource allowance," then any excess must be spent down for the care of the institutionalized spouse. *See* 42 U.S.C. § 1396r-5(c)(2)(B) ("resources shall be considered to be available to an institutionalized spouse, but only to the extent that the amount of such resources exceeds" the CSRA).

Moreover, HCFA's position does not frustrate Congress' intent in enacting the MCCA to enable the community spouse to live above the poverty level. Instead, it ensures that Medicaid, as it was intended, helps the truly needy and furthers the legislature's intent to "require couples to bear a reasonable amount of the costs of institutionalized care and thus preserve Medicaid resources." *Cleary v. Waldman*, 959 F.Supp. 222, 232 (D.N.J.1997), *aff'd* 167 F.3d 801, 807 (3d Cir.), *cert. denied*, — U.S. —, 120 S.Ct. 170, 145 L.Ed.2d 144 (1999).

It is noteworthy that ten of the Plaintiffs who have submitted trusts for review have countable resources in excess of the maximum amount that federal law permits the community spouse to retain:

Denman	\$833,000
Fillmore	\$492,000
Johnson	\$288,000
Mariani	\$272,000
Mackron	\$250,000
Fleming	\$236,000
Banks	\$193,000
Hicks	\$168,000
Schaible	\$ 58,000
Silbernagle	\$ 53,000
Prystasch	\$ 15,000

See Certification of Elena Josephick, ¶ 7.

Finally, HCFA's Guidelines were issued after OBRA was enacted in 1993. Plaintiffs do not contend that the Guidelines are inconsistent with HCFA's prior administrative view. Additionally, the Streimer is consistent with the interpretation set forth in the Guidelines.

Therefore, because Defendants' policy of including the CSATs as a countable resource is based on HCFA's position, which is consistent with federal law, Plaintiffs are not likely to prevail on this issue. Accordingly, the Court need not determine the remaining factors to determine if injunctive relief on this issue is warranted.

3. *New Jersey as First Named Beneficiary*

a. *Likelihood of Success on the Merits*

According to Plaintiffs, prior to July 1999, the CSATs in the format utilized by Plaintiffs were routinely approved upon compliance with conditions imposed by DMAHS. Such conditions included a requirement that DMAHS be named as the first beneficiary of the CSAT upon the death of the community spouse to recover Medicaid assistance paid on behalf of the institutionalized spouse. Plaintiffs claim that this requirement was imposed notwithstanding that the estate recovery provisions mandated in 42 U.S.C. § 1396p(c)

and codified in N.J.S.A. 30:4D-7.2 limit estate recovery to actions against the estate of the institutionalized spouse, not the community spouse.

42 U.S.C. § 1396p(b)(1) provides that after the death of the community spouse, states must "seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan" from the recipient's estates²⁹ or "upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual." Similarly, N.J.S.A. 30:4D-7.2 also provides for the State's recovery from the estate of a deceased recipient for assistance correctly paid or to be paid on his behalf. As argued by Plaintiffs, the federal and state estate recovery provisions do not authorize recovery actions against the community spouse's estate.

Defendants do not address this argument and in effect, concede their error. At oral argument, defense counsel explained that DMAHS required it to be first named beneficiary because at that time, Defendants erroneously believed that the "sole benefit of" trust was an excludable resource. Hearing Tr. 74:22-75:7.

Because Plaintiffs' position is correct that this condition is "more restrictive" than permitted by federal law, Plaintiffs are likely to succeed on this issue.

b. *Irreparable Harm to Plaintiffs*

Plaintiffs, however, will not suffer any immediate irreparable harm. First, Defendants have explained that they required DMAHS to be the first named beneficiary because they had considered the "sole benefit of" trust to be an excludable resource. Because Defendants are now treating such trusts as includable, logic dictates that Defendants will no longer require DMAHS to be the first named beneficiary. Therefore, there is no potential of immediate irrepa-

29. The term "estate" includes all real and personal property included within the individ-

ual's estate under state probate law. 42 U.S.C. § 1396(b)(4).

rable harm to Plaintiffs. Plaintiffs' motion for preliminary injunction on this issue is **denied without prejudice**. In the event, however, that Defendants fail to eliminate this requirement, Plaintiffs may seek the appropriate relief.

IV. CONCLUSION

For the foregoing reasons, Defendants' motion to dismiss for failure to state a claim upon which relief with respect to the due process and equal protection claims, and as to all claims by Plaintiffs who are only prospective Medicaid applicants is **granted**, and Defendants' motion as to the balance is **denied**. Because Plaintiffs cannot establish immediate irreparable injury, Plaintiffs' motion for preliminary injunction is **denied**.



N.A.M.I. (NATIONAL ALLIANCE OF
MENTALLY ILL OF ESSEX),
et al., Plaintiffs,

v.

ESSEX COUNTY BOARD OF
FREEHOLDERS, et al.,
Defendants.

No. CIV.99-4605.

United States District Court,
D. New Jersey.

April 11, 2000.

Organization for advocacy for rights of mentally ill, taxpayer, and parent of mental health patient at long term care facility brought action challenging county's proposal to relocate facility. On defendants' motions to dismiss, the District Court, Hochberg, J., held that: (1) action was not ripe; (2) plaintiffs did not have standing to bring action; and (3) proposal

did not violate Americans With Disabilities Act (ADA).

Motions granted.

1. Federal Courts ⇐12.1

In determining whether case is ripe for adjudication, court looks to (1) fitness of issues for judicial resolution and (2) hardship to parties of withholding court consideration. U.S.C.A. Const. Art. 3, § 2, cl. 1.

2. Federal Courts ⇐13.25

Action challenging county's proposal to relocate long term care facility for mental health patients was not ripe for adjudication; no plan had been adopted, former site had not been sold, proposed site had not been purchased, and features of new facility were unknown. U.S.C.A. Const. Art. 3, § 2, cl. 1.

3. Associations ⇐20(1)

Asylums ⇐8

Organization for advocacy for rights of mentally ill, taxpayer, and parent of mental health patient at long term care facility did not have standing to challenge county's proposal to relocate facility, absent evidence that members of organization or individual plaintiffs had suffered injury in fact. U.S.C.A. Const. Art. 3, § 2, cl. 1.

4. Action ⇐3

Restatement of Bill of Rights for Mental Health Patients did not create private right of action to ensure that mental health patients received required protection and services. Protection and Advocacy for Mentally Ill Individuals Act of 1986, § 201, 42 U.S.C.A. § 10841.

5. Civil Rights ⇐119.1

Proposed relocation of long term care facility for mental health patients did not violate ADA due to alleged reduction of care and services, absent evidence that patients, by reason of their disabilities, were being denied care afforded to individ-



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Document(1)

1. Shepards®: Johnson v. Guhl, 91 F. Supp. 2d 754, 2000 U.S. Dist. LEXIS 4485, 68 Soc. Sec. Rep. Service 469(D.N.J.,2000)

Client/matter: -None-

Requested Categories: Appellate History - Requested
Citing Decisions - None applied
Citing Law Reviews, Treatises... - Not Requested



Shepard's®: Report Content

Appellate History: Requested

▲ Citing Decisions: None Applied

Citing Law Reviews, Treatises...: Not Requested

Shepard's®: ▲ Johnson v. Guhl 91 F. Supp. 2d 754, 2000 U.S. Dist. LEXIS 4485, 68 Soc. Sec. Rep. Service 469: (D.N.J. 2000)

No negative subsequent appellate history

Appellate History

1 - 3 of 3			
 Appellate History		Court	Date
1	★ Citation you <i>Shepardized</i> ™ Johnson v. Guhl 91 F. Supp. 2d 754, 2000 U.S. Dist. LEXIS 4485, 68 Soc. Sec. Rep. Service 469	D.N.J.	2000
Subsequent			
2	 Motion denied by, and  Injunction denied by, and  Dismissed by: Johnson v. Guhl 166 F. Supp. 2d 42, 2001 U.S. Dist. LEXIS 16058, 76 Soc. Sec. Rep. Service 332	D.N.J.	2001
3	 Affirmed by: Johnson v. Guhl 357 F.3d 403, 2004 U.S. App. LEXIS 1849	3d Cir. N.J.	2004

Citing Decisions

Narrow by: None Applied			
Analysis: Distinguished by (2), Followed by (5), "Cited by" (21)			
Court: 3rd Circuit (11), 4th Circuit (2), 8th Circuit (2), 10th Circuit (1), 6th Circuit (1), 7th Circuit (1), Other Federal Decisions (1), Arizona (1), Delaware (1), Illinois (1), Indiana (1), Massachusetts (1), Ohio (1), Rhode Island (1), Wisconsin (1)			
Headnotes: HN70 (7), HN62 (6), HN64 (6), HN21 (4), HN68 (4), HN17 (3), HN20 (3), HN24 (3), HN28 (3), HN19 (2), HN22 (2), HN23 (2), HN25 (2), HN27 (2), HN34 (2), HN35 (2), HN5 (2), HN65 (2), HN66 (2), HN71 (2), HN1 (1), HN15 (1), HN16 (1), HN18 (1), HN26 (1), HN39 (1), HN43 (1), HN48 (1), HN55 (1), HN58 (1), HN60 (1), HN63 (1), HN69 (1), HN8 (1)			
1 - 27 of 27			
	Citing Decisions	Court	Date
3rd Circuit - U.S. District Courts			
1	 Cited by: Dultz v. Velez 726 F. Supp. 2d 480, 2010 U.S. Dist. LEXIS 86596 <i>Headnotes:</i> HN19, HN71 <i>Cited by:</i> 726 F. Supp. 2d 480 p.483	D.N.J.	2010
2	 Followed by: Tristani v. Richman 609 F. Supp. 2d 423, 2009 U.S. Dist. LEXIS 24493, 77 Fed. R. Serv. 3d (Callaghan) 69 <i>Headnotes:</i> HN71 <i>Followed by:</i> 609 F. Supp. 2d 423 p.457	W.D. Pa.	2009
3	 Distinguished by, and  Followed by: Lewis v. Rendell 501 F. Supp. 2d 671, 2007 U.S. Dist. LEXIS 57009 <i>Headnotes:</i> HN17, HN18, HN19, HN20, HN23, HN27, HN28, HN39, HN62, HN63, HN69 <i>Distinguished by:</i> 501 F. Supp. 2d 671 p.692 <i>Followed by:</i> 501 F. Supp. 2d 671 p.687	E.D. Pa.	2007
4	 Cited by: James v. Richman 465 F. Supp. 2d 395, 2006 U.S. Dist. LEXIS 84846 <i>Headnotes:</i> HN8, HN34, HN62, HN64, HN66, HN70 <i>Cited by:</i> 465 F. Supp. 2d 395 p.401	M.D. Pa.	2006
5	 Cited by: Estate of Witty v. Primus Telcoms. Group, Inc. 2006 U.S. Dist. LEXIS 47898	D.N.J.	July 13, 2006

 Citing Decisions		Court	Date
6	 Cited by: Kwasnik v. Leblon 2005 U.S. Dist. LEXIS 25823 <i>Headnotes: HN5</i>	D.N.J.	Aug. 8, 2005
7	 Distinguished by: Mersmann v. Cont'l Airlines 335 F. Supp. 2d 544, 2004 U.S. Dist. LEXIS 19064, 150 Lab. Cas. (CCH) P59932 <i>Headnotes: HN5</i> <i>Distinguished by; 335 F. Supp. 2d 544 p.555</i>	D.N.J.	2004
8	 Cited by: Johnson v. Guhl 166 F. Supp. 2d 42, 2001 U.S. Dist. LEXIS 16058, 76 Soc. Sec. Rep. Service 332 <i>Headnotes: HN1, HN16, HN20, HN21, HN22, HN23, HN24, HN34, HN43, HN48, HN58, HN60, HN62, HN64, HN68, HN70</i>	D.N.J.	2001
9	 Cited by: Mertz v. Houstoun 155 F. Supp. 2d 415, 2001 U.S. Dist. LEXIS 10918 <i>Headnotes: HN20, HN22, HN62, HN64, HN70</i> <i>Cited by; 155 F. Supp. 2d 415 p.421</i>	E.D. Pa.	2001
10	 Cited by: S. Camden Citizens in Action v. N.J. Dep't of Env'tl. Prot. 145 F. Supp. 2d 505, 2001 U.S. Dist. LEXIS 5988, 52 Env't Rep. Cas. (BNA) 1571, 31 Env'tl. L. Rep. 20675 <i>Headnotes: HN15, HN28</i> <i>Cited by; 145 F. Supp. 2d 505 p.537</i>	D.N.J.	2001
11	 Cited by: Novartis Consumer Health, Inc. v. Johnson & Johnson-Merck Consumer Pharms. Co. 129 F. Supp. 2d 351, 2000 U.S. Dist. LEXIS 20269, 2001-1 Trade Cas. (CCH) P73200, 57 U.S.P.Q.2d (BNA) 1522 <i>Headnotes: HN55</i> <i>Cited by; 129 F. Supp. 2d 351 p.362</i>	D.N.J.	2000
4th Circuit - U.S. District Courts			
12	 Cited by: A.W. Irrevocable Special Needs Trust v. Cansler 2011 U.S. Dist. LEXIS 95628 <i>Headnotes: HN17</i>	M.D.N.C.	July 19, 2011

Citing Decisions		Court	Date
13	LE Cited by: Maryland Community Health Sys. v. Glendening 115 F. Supp. 2d 599, 2000 U.S. Dist. LEXIS 15873, 71 Soc. Sec. Rep. Service 558 <i>Headnotes: HN35</i> <i>Cited by: 115 F. Supp. 2d 599 p.604</i>	D. Md.	2000
6th Circuit - U.S. District Courts			
14	LE Cited by: Burkholder v. Lumpkin 2010 U.S. Dist. LEXIS 11308 <i>Headnotes: HN68, HN70</i>	N.D. Ohio	Feb. 9, 2010
7th Circuit - U.S. District Courts			
15	G Followed by: American Soc'y of Consultant Pharmacists v. Patla 138 F. Supp. 2d 1062, 2001 U.S. Dist. LEXIS 2061 <i>Headnotes: HN35</i> <i>Followed by: 138 F. Supp. 2d 1062 p.1069</i>	N.D. Ill.	2001
8th Circuit - U.S. District Courts			
16	LE Cited by: Geston v. Olson 2012 U.S. Dist. LEXIS 67926 <i>Headnotes: HN70</i>	D.N.D.	Apr. 24, 2012
17	G Followed by: Ctr. for Special Needs Trust Admin., Inc. v. Olson 2011 U.S. Dist. LEXIS 44437 <i>Headnotes: HN17, HN24, HN25</i>	D.N.D.	Apr. 25, 2011
10th Circuit - Court of Appeals			
18	LE Cited by: Morris v. Okla. Dep't of Human Servs. 685 F.3d 925, 2012 U.S. App. LEXIS 13971 <i>Headnotes: HN62, HN70</i>	10th Cir. Okla.	2012
Other Federal Decisions			
19	LE Cited by: Novartis Consumer Health Inc. v. Johnson & Johnson-Merck Consumer Pharms. Co. 57 U.S.P.Q.2d (BNA) 1522 <i>Cited by: 57 U.S.P.Q.2d (BNA) 1522 p.1530</i>	D.	Dec. 22, 2000
Arizona Court of Appeals			
20	LE Cited by: Barral v. Ariz. Health Care Cost Containment Sys. Admin. 2012 Ariz. App. Unpub. LEXIS 329 <i>Headnotes: HN64</i>	Ariz. Ct. App.	2012

 Citing Decisions		Court	Date
Other Delaware Decisions			
21	 Cited by: Dean v. Delaware Dep't of Health & Social Servs. 2000 Del. Super. LEXIS 490 <i>Headnotes: HN21, HN65, HN66, HN68</i>	Del. Super. Ct.	Dec. 6, 2000
Illinois Supreme Court			
22	 Cited by: Poindexter v. State 229 Ill. 2d 194, 890 N.E.2d 410, 2008 Ill. LEXIS 307, 321 Ill. Dec. 688 <i>Headnotes: HN21, HN62, HN70</i> <i>Cited by: 229 Ill. 2d 194 p.196; 890 N.E.2d 410 p.413; 321 Ill. Dec. 688 p.691</i>	Ill.	2008
Indiana Court of Appeals			
23	 Cited by: State v. Hammans 870 N.E.2d 1071, 2007 Ind. App. LEXIS 1730 <i>Headnotes: HN24, HN25, HN26, HN27, HN28</i> <i>Cited by: 870 N.E.2d 1071 p.1075</i>	Ind. Ct. App.	2007
Massachusetts Appeals Court			
24	 Cited by: Normand v. Dir. of the Office of Medicaid 77 Mass. App. Ct. 634, 933 N.E.2d 658, 2010 Mass. App. LEXIS 1204 <i>Headnotes: HN64</i> <i>Cited by: 77 Mass. App. Ct. 634 p.637; 933 N.E.2d 658 p.661</i>	Mass. App. Ct.	2010
Ohio Court of Appeals			
25	 Cited by: McNamara v. State Dep't of Human Servs. 139 Ohio App. 3d 551, 744 N.E.2d 1216, 2000 Ohio App. LEXIS 3477 <i>Headnotes: HN68</i> <i>Cited by: 139 Ohio App. 3d 551 p.558; 744 N.E.2d 1216 p.1221</i>	Ohio Ct. App., Mont- gomery County	2000
Other Rhode Island Decisions			
26	 Cited by: Jordan v. R.I. Dep't of Human Servs. 2007 R.I. Super. LEXIS 94 <i>Headnotes: HN64</i>	R.I. Super. Ct.	2007
Wisconsin Court of Appeals			

Citing Decisions		Court	Date
27	G Followed by: Estate of Gonwa v. Wis. Dep't of Health & Family Servs. 2003 WI App 152, 265 Wis. 2d 913, 668 N.W.2d 122, 2003 Wisc. App. LEXIS 563 <i>Headnotes: HN21, HN65</i> <i>Followed by: 265 Wis. 2d 913 p.926; 668 N.W.2d 122 p.129</i>	Wis. Ct. App.	2003

Legend

 Warning - Negative Treatment is Indicated	 Red - Warning Level Phrase
 Questioned - Validity questioned by citing references	 Orange - Questioned Level Phrase
 Caution - Possible negative treatment	 Yellow - Caution Level Phrase
 Positive - Positive treatment is indicated	 Green - Positive Level Phrase
 Analysis - Citing Refs. With Analysis Available	 Blue - Neutral Level Phrase
 Cited - Citation information available	 Light Blue - No Analysis Phrase
 Warning - Negative case treatment is indicated for statute	



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EXHIBIT F

James v. Richman

ELDER LAW ASSOCIATES PA

FERRI CASEY 8/20/2012
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James ex rel. James v. Richman, 465 F.Supp.2d 395 (2006)

465 F.Supp.2d 395
United States District Court,
M.D. Pennsylvania.

Robert A. JAMES by his next friend and
attorney in fact, Josephine A. JAMES, Plaintiff,
v.

Estelle B. RICHMAN, in her official capacity as
Secretary of the Commonwealth of Pennsylvania,
Department of Public Welfare, Defendant.

Civil Action No. 3:05-CV-2647. | Nov. 21, 2006.

Synopsis

Background: Institutionalized spouse brought action against the Secretary of the Commonwealth of Pennsylvania, Department of Public Welfare, alleging that Secretary's decision to deny him Medicaid benefits, on ground that annuity purchased by community spouse was an available resource to be counted in determining institutionalized spouse's Medicaid eligibility, violated the Medicaid Act, federal regulations governing annuities established by the United States Department of Health and Human Services, and the Supremacy Clause of the United States Constitution. Parties cross-moved for summary judgment.

Holdings: The District Court, Caputo, J., held that:

- [1] it had federal question jurisdiction over the action;
- [2] institutionalized spouse showed actual success on merits of his claim, supporting his motion to permanently enjoin the denial of Medicaid benefits;
- [3] institutionalized spouse showed that he would suffer irreparable injury if his request for a permanent injunction were not granted, supporting his motion to permanently enjoin the denial of Medicaid benefits;
- [4] institutionalized spouse showed that granting of permanent injunction would not inflict more harm upon the Secretary than the refusal to grant it would harm him;
- [5] institutionalized spouse showed that it was in the public interest to permanently enjoin the denial of Medicaid benefits; and
- [6] judgment declaring Pennsylvania statute which governs Medicaid eligibility and annuities invalid as preempted by federal law was not warranted.

Plaintiff's motion granted in part and denied in part, and defendant's motion denied.

West Headnotes (10)

[1] Federal Courts

↔ Social security, welfare, and public housing laws, generally

District Court had federal question jurisdiction over institutionalized spouse's action against the Secretary of the Commonwealth of Pennsylvania, Department of Public Welfare, alleging that Secretary's decision to deny him Medicaid benefits, on ground that annuity purchased by community spouse was an available resource to be counted in determining institutionalized spouse's Medicaid eligibility, violated the Medicaid Act, federal regulations governing annuities, and the Supremacy Clause of the United States Constitution, where the case required the Court to apply or interpret provisions of the Medicaid Act in order to determine whether remedies institutionalized spouse sought were warranted. U.S.C.A. Const. Art. 6, cl. 2; 28 U.S.C.A. § 1331; Medicaid Act, § 1901 et seq., 42 U.S.C.A. § 1396 et seq.

6 Cases that cite this headnote

[2] Injunction

↔ Grounds in general; multiple factors

In deciding whether to grant a permanent injunction, the court must consider whether: (1) the moving party has shown actual success on the merits; (2) the moving party will be irreparably injured by the denial of injunctive relief; (3) the granting of the permanent injunction will result in even greater harm to the defendant; and (4) the injunction would be in the public interest.

1 Cases that cite this headnote

[3] Injunction

↔ Health care; Medicare and Medicaid

James ex rel. James v. Richman, 465 F Supp.2d 395 (2006)

Community spouse's annuity was not a countable resource for purposes of determining Medicaid eligibility for institutionalized spouse, and, thus, institutionalized spouse showed actual success on merits of his claim that Pennsylvania Department of Public Welfare's (DPW) denial of his application for Medicaid benefits on ground that annuity was an available resource was in violation of Social Security Act, supporting his motion to permanently enjoin the denial of Medicaid benefits, where, at time of institutionalized spouse's Medicaid application, neither spouse had an ownership interest in funds used to purchase irrevocable actuarially sound commercial annuity as part of retirement plan for sole benefit of community spouse; annuity was not an available resource to extent of its market value on basis of its alleged assignability or liquidity. Medicare Catastrophic Coverage Act of 1988, § 303(a)(1)(B), 42 U.S.C.A. § 1396r-5(b)(1); 20 C.F.R. § 416.1201(a)(1).

5 Cases that cite this headnote

[4] **Health**

↔ Marital assets in general

Health

↔ Trusts

So long as the principal or corpus of an irrevocable annuity or trust cannot be reached by the Medicaid applicant or his or her spouse, the income derived from such an asset cannot be counted as a resource for Medicaid purposes, notwithstanding that income stream's market value in the eyes of a third party. Medicare Catastrophic Coverage Act of 1988, § 303(a)(1)(B), 42 U.S.C.A. § 1396r-5(b)(1).

3 Cases that cite this headnote

[5] **Injunction**

↔ Health care; Medicare and Medicaid

Institutionalized spouse showed that he would suffer irreparable injury if his request for a permanent injunction against the Secretary of the Commonwealth of Pennsylvania, Department

of Public Welfare were not granted, supporting his motion to permanently enjoin the denial of Medicaid benefits on ground that annuity purchased by community spouse was allegedly an available resource to be counted in determining institutionalized spouse's Medicaid eligibility, where institutionalized spouse would be required to privately pay for his nursing facility care at a private pay rate of \$5,000 per month or else risk being forced to leave the nursing facility, and he could not be compensated by monetary relief, since the Eleventh Amendment precluded an award of retroactive payment by a federal court. U.S.C.A. Const.Amend. 11; Medicare Catastrophic Coverage Act of 1988, § 303(a)(1)(B), 42 U.S.C.A. § 1396r-5(b)(1).

[6] **Injunction**

↔ Health care; Medicare and Medicaid

Institutionalized spouse showed that granting of an injunction to permanently enjoin the denial of Medicaid benefits on ground that annuity purchased by community spouse was allegedly an available resource to be counted in determining institutionalized spouse's Medicaid eligibility would not inflict more harm upon the Secretary of the Commonwealth of Pennsylvania, Department of Public Welfare than the refusal to grant it would harm institutionalized spouse, where the harm institutionalized spouse would suffer, if forced to privately pay \$5,000 per month in nursing facility care or else be required to vacate the nursing facility, was substantial. Medicare Catastrophic Coverage Act of 1988, § 303(a)(1)(B), 42 U.S.C.A. § 1396r-5(b)(1).

[7] **Injunction**

↔ Health care; Medicare and Medicaid

Institutionalized spouse showed that it was in the public interest to permanently enjoin the denial of Medicaid benefits by the Secretary of the Commonwealth of Pennsylvania, Department of Public Welfare, where the Secretary denied Medicaid assistance to him in violation of

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James ex rei. James v. Richman, 465 F.Supp.2d 395 (2006)

federal law, i.e., on erroneous ground that annuity purchased by community spouse was an available resource to be counted in determining institutionalized spouse's Medicaid eligibility. Medicare Catastrophic Coverage Act of 1988, § 303(a)(1)(B), 42 U.S.C.A. § 1396r-5(b)(1).

spouse's Medicaid eligibility, violated the Medicaid Act, federal regulations governing annuities, and the Supremacy Clause. U.S.C.A. Const. Art. 6, cl. 2; Medicaid Act, § 1901 et seq., 42 U.S.C.A. § 1396 et seq.; 62 P.S. § 441.6.

2 Cases that cite this headnote

[8] Declaratory Judgment

➡ Discretion of Court

Federal district courts wield broad and selective discretion in determining whether to entertain a declaratory judgment action.

2 Cases that cite this headnote

[9] Declaratory Judgment

➡ Necessity, utility and propriety

Declaratory Judgment

➡ Termination or settlement of controversy

A federal court has discretion to entertain a declaratory judgment action when it finds that the declaratory relief sought: (1) will serve a useful purpose in clarifying and settling the legal relations in issue, and (2) will terminate and afford relief from the uncertainty, insecurity, and controversy giving rise to the proceeding.

2 Cases that cite this headnote

[10] Declaratory Judgment

➡ Statutes Relating to Particular Subjects

Judgment declaring Pennsylvania statute which governs Medicaid eligibility and annuities invalid as preempted by federal law was not warranted, where such declaratory relief was neither useful nor necessary to clarifying the legal relations in issue or affording relief to institutionalized spouse in action against the Secretary of the Commonwealth of Pennsylvania, Department of Public Welfare, alleging that Secretary's decision to deny him Medicaid benefits, on ground that annuity purchased by community spouse was an available resource to be counted in determining institutionalized

West Codenotes

Validity Called into Doubt

62 P.S. § 441.6.

Attorneys and Law Firms

*398 Kevin R. Grebas, Marshall & Associates, Wilkes-Barre, PA, Matthew J. Parker, Marshall & Associates, Jersey Shore, PA, for Plaintiff.

Michael L. Harvey, Office of Attorney General, Harrisburg, PA, for Defendant.

Opinion

MEMORANDUM

CAPUTO, District Judge.

Presently before the Court are cross motions for summary judgment filed by Plaintiff Robert A. James and Defendant Estelle B. Richman, Secretary of the Commonwealth of Pennsylvania, Department of Public Welfare. (Docs. 30 and 32.) For the reasons stated below, Plaintiff's motion for summary judgment, as to his request for a permanent injunction, will be granted. Plaintiff's request for a declaratory judgment will be denied. Defendant's motion for summary judgment will be denied. The Court has jurisdiction over this matter pursuant to 28 U.S.C. § 1331.

STATUTORY BACKGROUND

Pennsylvania participates in the Federal Medicaid Program established by Title XIX of the Social Security Act, also known as the Medicaid Act, 42 U.S.C. § 1396 *et seq.* Under the Act, the states are granted federal funding to establish plans to dispense assistance to qualified needy individuals.

FERRI CASEY 8/20/2012
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James ex rel. James v. Richman, 465 F.Supp.2d 395 (2006)

On November 22, 2005, the Luzerne County Assistance Office determined that Plaintiff was not eligible for Medicaid assistance because he did not receive fair consideration for resources used to purchase the annuity. (Ex. D.)

On December 12, 2005, the Department of Public Welfare issued a new PA 162 Notice to Plaintiff, advising him that the notice he had previously received, on November 22, 2005, was rescinded, and that he was "ineligible for nursing home payment at this time. Excess resources exist due to the availability of the \$250,000 annuity. You may reapply when resources are within eligibility limits." (Doc. 28 ¶ 12.) The reason for the rejection for Medicaid assistance is that, in the view of Defendant, the annuity has a value of \$185,000.00 and therefore represents assets that are beyond the CSRA, and are therefore available for payment for nursing care. Defendant offers the declaration of Michael Goodman, Chief Executive Officer of J.G. Wentworth, a finance company specializing in the purchase of annuities, as *400 evidence of the value and marketability of the annuity, despite the non-assignment language placed in the endorsement. (Doc. 17-2.)

Plaintiff timely appealed the Department's decision to the Office of Hearings and Appeals. (Doc. 28 ¶ 14.) Plaintiff's appeal is still pending. *Id.* If denied Medicaid benefits, Plaintiff will have to privately pay for his nursing facility care at a private rate of over \$5,000 per month. (Doc. 28 ¶ 13.)

On December 21, 2005, Plaintiff filed a Complaint in this Court. (Doc. 1-1.) Plaintiff alleged that Defendant's decision to deny him Medicaid benefits, on the ground that the annuity purchased by Plaintiff's spouse is an available resource to be counted in determining Medicaid eligibility, violates the Medicaid Act, 42 U.S.C. § 1396 *et seq.*, the federal regulations governing annuities established by the United States Department of Health and Human Services under 42 U.S.C. § 1396p(d)(6), as well as the Supremacy Clause of the United States Constitution, U.S. CONST. art. VI, cl. 2. (Doc. 1-1 ¶ 1.) Plaintiff sought to enjoin Defendant from denying him Medicaid benefits and to have the recently enacted Commonwealth of Pennsylvania statute, known as Act 42, 62 PA. STAT. ANN.. § 441.6,¹ which governs Medicaid eligibility and annuities, declared preempted under the Supremacy Clause. (Doc. 1-1 ¶ 1.)

On March 6, 2006, Plaintiff filed a Request for Temporary Restraining Order and Motion for Preliminary Injunction.

(Doc. 10-1.) On March 20, 2006, this Court granted Plaintiff's request and motion, enjoining Defendant from denying Plaintiff Medicaid until a final decision on the merits of this action. (Doc. 19.)

On May 17, 2006, a Case Management Conference was conducted, wherein the parties agreed to file cross-motions for summary judgment for the Court's consideration. (Docs. 26-27.) The parties filed joint stipulations of facts and exhibits. (Docs. 28-29.) On July 31, 2006, Plaintiff filed his motion for summary judgment on his request to permanently enjoin Defendant from denying him Medicaid assistance and to obtain a declaratory judgment holding that Act 42, 62 PA. STAT. ANN.. § 441.6, is preempted under the Supremacy Clause. (Doc. 30.) Defendant filed her cross-motion for summary judgment on August 2, 2006. (Doc. 32.) Both parties filed briefs in support of their motions, as well as briefs in opposition to their adversary's motion. (Docs. 31, 33, 37, 39.) Consequently, this matter is fully briefed and ripe for disposition.

JURISDICTION

While the Medicaid Act does not guarantee rights to individuals, it compels states to draft a plan that is in conformity with federal law. *See* *401 *Sabree v. Richman*, 367 F.3d 180, 182 (3d Cir.2004). When a state drafts a plan that is not in conformity with federal law, and the plan leads to the denial of Medicaid benefits, an adversely affected Medicaid applicant has grounds to raise a federal question pursuant to 28 U.S.C. § 1331.

Here, Plaintiff claims that the Commonwealth has enacted legislation—Act 42, 62 PA. STAT. ANN.. § 441.6—that is inconsistent with federal law and one or more parts of that legislation has been relied upon in denying Medicaid assistance to Plaintiff.

However, Defendant has expressly disavowed any reliance upon Act 42, 62 PA. STAT. ANN.. § 441.6, in denying Plaintiff Medicaid benefits. (Def. Br. In Opp. 3; Doc. 37.) Rather, Defendant has relied throughout this case solely upon her construction of the federal Medicaid Act and its regulations to support her denial of Medicaid benefits to Plaintiff. Indeed, Act 42, 62 PA. STAT. ANN.. § 441.6, is not mentioned in any of Defendant's briefs submitted to this Court, nor in Defendant's PA 162 notice sent to Plaintiff,

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The federal funding is conditioned upon the state's adoption of a plan which complies with the requirements imposed by the Act and by the Secretary of the United States Department of Health and Human Services, who administers the Medicaid program through the Health Care Financing Administration ("HCFA"). The Department of Public Welfare is the regulatory body charged with administering Medicaid assistance throughout the Commonwealth of Pennsylvania. See 62 PA. STAT. ANN. § 403. The Medicare Catastrophic Coverage Act of 1988 ("MCCA"), 42 U.S.C. § 1396r-5, amended the Medicaid Act, adding 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." *Wis. Dep't of Health & Family Servs. v. Blumer*, 534 U.S. 473, 478, 122 S.Ct. 962, 151 L.Ed.2d 935 (2002). In adopting the MCCA, Congress sought to protect community spouses from becoming impoverished, yet, at the same time, preclude financially secure couples from receiving Medicaid assistance. *Id.* at 480, 122 S.Ct. 962.

The MCCA provides that "no income of the community spouse shall be deemed available to the institutionalized spouse." 42 U.S.C. § 1396r-5(b)(1). "The community spouse's income is thus preserved for that spouse and does not affect the determination whether the institutionalized spouse qualifies for Medicaid." *Blumer*, 534 U.S. at 480-81, 122 S.Ct. 962.

The MCCA, however, treats assets differently. The MCCA shelters a standard amount of assets called the "community spouse resource allowance" or "CSRA." *Id.* at 477, 122 S.Ct. 962. To determine the CSRA, the total of all the couple's resources, whether owned jointly or severally, is calculated as of the time one spouse is institutionalized; half of that total is then allocated to each spouse. 42 U.S.C. § 1396r-5(c)(1)(A). That amount is the CSRA and is subject to a ceiling. 42 U.S.C. § 1396r-5(c)(2)(B), (f)(2)(A), (g). In determining eligibility, the CSRA is not considered available to the institutionalized spouse, but all resources above the CSRA must be spent in order for the institutionalized spouse to be eligible for Medicaid. *Blumer*, 534 U.S. at 482-83, 122 S.Ct. 962.

FACTUAL BACKGROUND

The undisputed material facts, as stipulated to by the parties, are as follows. Plaintiff Robert A. James is a seventy-eight (78) year old resident of Summit Health Care nursing facility in Wilkes-Barre, Pennsylvania. (Doc. 28 ¶ 1.) Plaintiff has at all relevant times been married to Josephine A. James, who is seventy-six (76) years of age. (Doc. 28 ¶ 5.)

On August 10, 2005, Plaintiff, then seventy-seven (77) years of age, was admitted into Summit Health Care nursing facility, where he has since resided. (Doc. 28 ¶¶ 3-4.) On September 20, 2005, Plaintiff filed a Resource Assessment with the Department of Public Welfare at the Luzerne County Assistance Office. (Doc. 28 ¶ 6.) Therein, Plaintiff stated that he and his wife's available resources, as of the date of Plaintiff's admission to Summit Health Care nursing facility, totaled \$381,443.00. *Id.* After allowing for the CSRA, and the institutionalized spouse's allowance, Plaintiff and his wife had available resources totaling \$278,343.00. (Doc. 28 ¶ 7.)

In order to reduce their assets to the required level of spousal impoverishment, on September 12, 2005, Mrs. James purchased a single premium immediate irrevocable annuity from General Electric Assurance Company, a commercial insurance company licensed to sell in the Commonwealth of Pennsylvania, for \$250,000.00. (Doc. 28 ¶ 8.) This annuity was payable to Mrs. James in monthly amounts of \$2,937.71, beginning October 1, 2005 and ending on September 1, 2013, an eight (8) year period. *Id.* The terms of the endorsement to the annuity provide "[t]his Contract may not be surrendered, transferred, collaterally assigned, or returned for a return of the premium paid. This Contract is irrevocable and has no cash surrender value. An Owner may not amend this Contract or change any designation under this Contract." (Doc. 28 ¶ 9.) The parties agree that this annuity is actuarially sound.

On September 15, 2005, Plaintiff purchased a new vehicle for \$28,550.00. (Doc. 28 ¶ 10.) At this point, all resources beyond those permitted by the CSRA and the institutionalized spouse's allowance had been spent or converted to the annuity. *Id.*

Thereafter, on September 20, 2005, Plaintiff filed an application for Medicaid coverage to assist with the payment of Plaintiff's nursing facility bill, seeking eligibility for September 15, 2005. (Doc. 28 ¶ 11.)

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which instead cites 55 PA.CODE §§ 178.4 and 178.121. Moreover, Plaintiff even acknowledges that Defendant is not enforcing Section 441.6(d) against him. (Pl.'s Br. 14.) Consequently, notwithstanding Plaintiff's contentions, this case does not present the issue of whether Act 42, 62 PA. STAT. ANN. § 441.6, conflicts or frustrates the purpose of the federal Medicaid Act, and thereby would be preempted.

[1] Instead, this action is based upon Defendant's alleged misinterpretation of the pertinent federal law regarding irrevocable actuarially sound commercial annuities. As such, this case requires the Court to apply or interpret provisions of the federal Medicaid Act in order to determine whether the remedies sought by Plaintiff are warranted. *See Johnson v. Guhl*, 91 F.Supp.2d 754, 766 (D.N.J.2000). Therefore, this case presents a federal question, vesting this Court with jurisdiction under 28 U.S.C. § 1331. *See Mass. Ass'n of Older Americans v. Sharp*, 700 F.2d 749, 752–53 (1st Cir.1983) (vacating district court order denying preliminary injunctive relief in case involving a termination of Medicaid benefits based on a misinterpretation by the state of pertinent federal law and regulations regarding redeterminations of Medicaid eligibility); *see also Mont v. Heintz*, 849 F.2d 704, 709–10 (2d Cir.1988) (failure of state to employ standard of need set in compliance with federal law in calculating periods of ineligibility for AFDC recipients in manner contemplated by federal law constitutes "practice" violative of federal law); *cf. Mertz v. Houstoun*, 155 F.Supp.2d 415, 424 (E.D.Pa.2001) (holding that "there is federal jurisdiction to adjudicate a claim that despite adoption of a conforming Medicaid plan, a state routinely assesses eligibility in a manner which conflicts with federal law such that it has effectively supplanted its written plan with a contrary practice"). *See generally Lindy v. Lynn*, 501 F.2d 1367, 1369 (3d Cir.1974) (federal question jurisdiction exists if plaintiff's claim requires the construction of a federal statute).²

*402 LEGAL STANDARD

Summary judgment is appropriate if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." FED. R. CIV. P. 56(c). A fact is material if proof of its existence or nonexistence might affect the outcome of the suit under the

applicable substantive law. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986).

Where there is no material fact in dispute, the moving party need only establish that it is entitled to judgment as a matter of law. Where, however, there is a disputed issue of material fact, summary judgment is appropriate only if the factual dispute is not a genuine one. *See id.* at 248, 106 S.Ct. 2505. An issue of material fact is genuine if "a reasonable jury could return a verdict for the nonmoving party." *Id.*

Where there is a material fact in dispute, the moving party has the initial burden of proving that: (1) there is no genuine issue of material fact; and (2) the moving party is entitled to judgment as a matter of law. *See* 10A CHARLES ALAN WRIGHT, ARTHUR R. MILLER & MARY KAY KANE, FEDERAL PRACTICE AND PROCEDURE: CIVIL 2D § 2727 (2d ed.1983). The moving party may present its own evidence or, where the nonmoving party has the burden of proof, simply point out to the Court that "the nonmoving party has failed to make a sufficient showing of an essential element of her case." *Celotex Corp. v. Catrett*, 477 U.S. 317, 323, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986).

All doubts as to the existence of a genuine issue of material fact must be resolved against the moving party, and the entire record must be examined in the light most favorable to the nonmoving party. *See White v. Westinghouse Elec. Co.*, 862 F.2d 56, 59 (3d Cir.1988). Once the moving party has satisfied its initial burden, the burden shifts to the nonmoving party to either present affirmative evidence supporting its version of the material facts or to refute the moving party's contention that the facts entitle it to judgment as a matter of law. *See Anderson*, 477 U.S. at 256–257, 106 S.Ct. 2505.

The Court need not accept mere conclusory allegations, whether they are made in the complaint or a sworn statement. *Lujan v. Nat'l Wildlife Fed'n*, 497 U.S. 871, 888, 110 S.Ct. 3177, 111 L.Ed.2d 695 (1990). In deciding a motion for summary judgment, "the judge's function is not himself to weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial." *Anderson*, 477 U.S. at 249, 106 S.Ct. 2505.

DISCUSSION

A. Permanent Injunction

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[2] In deciding whether to grant a permanent injunction, the Court must consider whether: "(1) the moving party has shown actual success on the merits; (2) the moving party will be irreparably injured by the denial of injunctive relief; (3) the granting of the permanent injunction will result in even greater harm to the defendant; and (4) the injunction would be in the public interest." *Shields v. Zuccarini*, 254 F.3d 476, 482 (3d Cir.2001).

1. Actual Success on the Merits

a.

In granting Plaintiff's request for a temporary restraining order and motion for preliminary injunction, this Court found that Plaintiff was likely to succeed on the merits of his claims that he was being denied Medicaid assistance by Defendant *403 in violation of federal law and regulations, and that Act 42, 62 PA. STAT. ANN.. § 441.6, is preempted by the Supremacy Clause of the United States Constitution. (Doc. 19.) Given a second look at Plaintiff's claims, the Court is of the opinion that Plaintiff is being denied Medicaid assistance in violation of federal law. However, as Defendant has disavowed any reliance upon Act 42, 62 PA. STAT. ANN.. § 441.6, in denying Plaintiff Medicaid benefits, the Court will decline to issue a declaratory judgment that Act 42, 62 PA. STAT. ANN.. § 441.6, is preempted by the Supremacy Clause.

b.

[3] Federal law provides that an applicant can transfer assets to his or her spouse so long as they are for the spouse's benefit. 42 U.S.C. § 1396p(c)(2)(B)(i); Transmittal 64, §§ 3257.B.6 and 3258.11. Section 1396p(d)(2)(a)(ii) provides, in pertinent part, that "an individual shall be considered to have established a trust if the assets of the individual were used to form all or part of the corpus of the trust and if the individual or the individual's spouse established the trust." Section 1396p(3)(B)(i) provides that, in the case of an irrevocable 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.

"A trust includes an annuity only to the extent and in such manner as the secretary specifies." 42 U.S.C. § 1396p(d) (6). Transmittal 64 to the State Medicaid Manual contains provisions dealing with the issue of when an annuity is to be considered an irrevocable trust rather than a transfer of assets. See Transmittal 64, § 3258.9B. It also describes how annuities are treated under the trust provision, stating:

"Annuities, although usually purchased in order to provide a source of income for retirement, are occasionally used to shelter assets so that individuals purchasing them can become eligible for Medicaid. In order to avoid penalizing annuities validly purchased as part of a retirement plan but to capture those annuities which abusively shelter assets, a determination must be made with regard to the ultimate purpose of the annuity (i.e., whether the purchase of the annuity constitutes a transfer of assets for less than fair market value). If the expected return on the annuity is commensurate with a reasonable estimate of life expectancy of the beneficiary, the annuity can be deemed actuarially sound."

Id.

In *Mertz v. Houstoun*, 155 F.Supp.2d 415, 426–27 (E.D.Pa.2001), the United States District Court for the Eastern District of Pennsylvania held that available assets may become unavailable assets and not countable in determining Medicaid eligibility for the institutionalized spouse when an irrevocable actuarially sound commercial annuity is purchased for the sole benefit of the community spouse. The *Mertz* court reasoned that, "[b]ecause at the time of [the Medicaid] application[,], neither spouse has an ownership interest in the funds used to purchase such an annuity, the funds are not a countable resource in calculating the CSRA." *Id.* at 426. In purchasing the annuity to provide an income stream to the community spouse, a transfer is made to a third party for the sole benefit of the community spouse that cannot be penalized consistent with federal law. *Id.* This income stream, the court noted, is not a countable resource in calculating the CSRA, as federal law provides that no income of the community spouse *404 may be deemed available to the institutionalized spouse. *Id.* at 427;

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see also 42 U.S.C. § 1396r-5(b)(1). The court concluded that these provisions effectively allow a couple to “convert countable resources into income of the community spouse which is not countable in determining Medicaid eligibility for the institutionalized spouse by purchasing an irrevocable actuarially sound commercial annuity for the sole benefit of the community spouse.” *Mertz*, 155 F.Supp.2d at 427. The court voiced its displeasure with this loophole in federal law, which essentially enables couples to achieve eligibility outcomes inconsistent with the “purpose of the MCCA and indeed the whole thrust of the Medicaid program which is to provide assistance to those truly in need.” *Id.* This Court relied on the *Mertz* case in granting Plaintiff's requests for preliminary relief, concluding that Mrs. James' irrevocable actuarially sound commercial annuity was likely not a countable resource for purposes of determining Plaintiff's Medicaid eligibility.

c.

Defendant offers two alternative arguments in support of her decision to deny Plaintiff Medicaid benefits. Defendant asserts, first, that, notwithstanding the non-assignment provision in the annuity endorsement, Mrs. James' annuity has a market value, and, therefore, is liquid and must be considered a countable resource above the CSRA, thus precluding Plaintiff's eligibility for Medicaid. Alternatively, Defendant contends that, if the annuity is not marketable and liquid, Mrs. James' contractual right to receive payments—i.e., the stream of income derived from the annuity contract and not the annuity itself—is marketable and has a monetary value above the CSRA which makes Plaintiff ineligible for Medicaid benefits. These arguments will be taken up in turn.

i. The Annuity

Defendant contends that, while the endorsement on the annuity forbids assignments, it does not invalidate them. Therefore, this provision only eliminates Mrs. James' right to assign the annuity—it does not limit her power to assign the annuity.³ To this end, Defendant offers the unsworn declaration of Michael Goodman, Chief Executive Officer of J.G. Wentworth, as evidence that Mrs. James' annuity is readily marketable and has a monetary value of \$185,000, which J.G. Wentworth would be willing to pay to purchase the annuity, notwithstanding its non-assignment provision. Defendant has also offered a letter from Meredith G. Van

Pelt, Esq., Department of Health and Human Services, Centers for Medicare and Medicaid Services, in which Ms. Van Pelt states that under federal Medicaid rules concerning treatment of resources, “any annuity that can be sold is countable as a resource in determining eligibility.” (CMS letter from *405 Meredith G. Van Pelt, Esq., Office of Legal and Regulatory Affairs, Center for Medicaid and State Operations, at 1; Doc. 21-2 p. 1.) As such, Defendant contends that the \$185,000 fair market value of the annuity must be counted as an available resource above the CSRA, thus precluding Plaintiff from qualifying for Medicaid benefits. See 20 C.F.R. § 416.1201(a)(1) (“If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource”) (emphasis added).⁴

Defendant's argument, while attractive on the surface, would contravene the edicts of Transmittal 64, § 3258.9B, which clearly states that annuities purchased as part of a valid retirement plan—regardless of their putative marketability in the view of a third party and the generally prevailing rules of contract law—are not to be penalized. As such, if such an irrevocable actuarially sound commercial annuity were purchased as part of a retirement plan for the sole benefit of the community spouse, there can be no penalty imposed upon the Medicaid applicant.

Defendant, however, argues that “actuarial soundness is relevant only to the question of whether a transfer has been made for less than fair market value pursuant to [Transmittal 64]. It has no bearing on whether an asset is or is not a countable resource, and in fact the plain language of [section] 3258.9 in no way makes such a connection.” *Dean v. Dep't of Health & Soc. Servs.*, No. Civ. A00A-05-006, 2000 WL 33201237, *7 (Del.Super.Ct. Dec.6, 2000) (citing HCFA letter from Robert A. Streimel, Disabled and Elderly Health Programs Group, Center for Medicaid and State Operations). As such, Defendant asserts, an annuity, notwithstanding its actuarial soundness, may be a countable resource for purposes of determining Medicaid eligibility.

The Court disagrees, giving precedence to Transmittal 64, §§ 3258.9B and 3258.11 B, both of which clearly indicate that there can be no penalty on an annuity that is irrevocable and actuarially sound and is purchased for the sole benefit of the community spouse. See *Mertz*, 155 F.Supp.2d at 426 (resources may be placed beyond the reach of either

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spouse, and thus not counted for eligibility purposes, with the purchase of an actuarially sound irrevocable commercial annuity for the sole benefit of the community spouse). Consequently, Defendant's argument is rejected.

ii. The Income Stream

Alternatively, Defendant argues that, even if the annuity is not assignable, the income stream derived from the annuity is liquid and has market value, thereby making the value of the income stream a resource to be counted towards the CSRA.

Indeed, Defendant has cited precedent making this same distinction between the annuity itself and the income stream derived *406 from the annuity. In *Estate of Gross v. North Dakota Department of Human Services*, the Supreme Court of North Dakota held that, where there was evidence of a secondary market and monetary value for the income stream derived from a non-assignable annuity, the income stream is a countable asset for purposes of determining Medicaid eligibility. 687 N.W.2d 460, 466 (N.D.2004) ("Here, there is evidence from which a reasoning mind could have reasonably concluded there was a market for the monthly payments or income stream from the annuity.... We therefore conclude ... [that] the annuity was a countable asset for purposes of [determining] Medicaid eligibility").⁵

Defendant also points to the definition of "resources" contained in 20 C.F.R. § 416.1201(a), which provides that "resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance." "If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource. [Conversely, if] 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(a)(1). Defendant thus argues that, even if Mrs. James does not have the right or power to assign her annuity, she does have the right and power to liquidate her contractual right to receive annuity payments, thus making the fair market value of this contractual right—\$185,000 based on the evidence presented by Defendant—a countable resource under 20 C.F.R. § 416.1201(a)(1). Accordingly, Defendant contends that Plaintiff has resources in excess of the CSRA and is ineligible for Medicaid benefits.

The Court disagrees. Defendant essentially argues that, even if the income stream itself cannot be considered for purposes of determining Medicaid eligibility, the market value of that income stream should be a countable resource to preclude eligibility. Such a rule would completely undermine federal law, which excludes income of the community spouse from factoring into the institutionalized spouse's Medicaid eligibility. Indeed, a holding that the market value of an income stream derived from an irrevocable actuarially sound annuity is a countable resource would effectively contravene the MCCA, which provides that "no income of the community spouse shall be deemed available to the institutionalized spouse." 42 U.S.C. § 1396r-5(b)(1). To be sure, Defendant's argument blurs the distinction drawn by the MCCA between assets and income.

[4] Rather, so long as the principal or corpus of an irrevocable annuity or trust cannot be reached by the applicant or spouse, the income derived from such an asset cannot be counted as a resource for Medicaid purposes, notwithstanding that income stream's market value in the eyes of a third party. *Mertz*, 155 F.Supp.2d at 426 ("[b]ecause at the time of [the Medicaid] application[,] neither spouse has an ownership interest in the funds used to purchase such an annuity, the funds are not a countable resource in calculating the CSRA"); see also *Dean*, 2000 WL 33201237, at 7 ("the buyer [of an irrevocable *407 commercial annuity] ... is entitled only to the income stream; the buyer does not own the purchasing funds and cannot reclaim them") (citing *Johnson v. Guhl (Johnson I)*, 91 F.Supp.2d 754, 764 (D.N.J.2000)).

As such, the Court rejects Defendant's argument, and concludes that the income stream derived by Mrs. James from the irrevocable actuarially sound commercial annuity is not a countable resource, notwithstanding the evidence presented by Defendant as to its marketability and resale value. Consequently, the Court holds that Plaintiff has established actual success on the merits of his claim that he is being denied Medicaid assistance in violation of federal law.

2. Irreparable Injury

[5] The Plaintiff has shown that he will suffer irreparable injury if his request for a permanent injunction were not granted. It is undisputed that Plaintiff would be required to privately pay for his nursing facility care at a private pay rate of \$5,000 per month or else risk being forced to leave

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the nursing facility. (Doc. 28 ¶ 13; Doc. 19 p. 7.) Plaintiff cannot be compensated by monetary relief as the Eleventh Amendment, U.S. CONST. amend XI, precludes an award of retroactive payment by a federal court. See *Edelman v. Jordan*, 415 U.S. 651, 678, 94 S.Ct. 1347, 39 L.Ed.2d 662 (1974). As such, there is not an adequate remedy at law to redress the denial of Medicaid benefits. A permanent injunction is therefore appropriate.

3. Harm to Defendant and Public Interest

[6] The Court's granting of a permanent injunction will not inflict more harm upon Defendant than the Court's refusal to grant it would harm Plaintiff, as the harm Plaintiff would suffer, if forced to privately pay \$5,000 per month in nursing facility care or else be required to vacate the nursing facility, is substantial.

[7] Also, the Court finds that it is in the public interest to grant Plaintiff's request for a permanent injunction, as Defendant has denied Medicaid assistance to Plaintiff in violation of federal law, notwithstanding the fact that Plaintiff has effectively achieved a Medicaid eligibility outcome inconsistent with the "purpose of the MCCA and indeed the whole thrust of the Medicaid program which is to provide assistance to those truly in need." *Mertz*, 155 F.Supp.2d at 427. However, it is for Congress to close this loophole in federal law. Accordingly, the Court will grant Plaintiff's request to permanently enjoin Defendant from denying him Medicaid benefits based upon the \$250,000 annuity purchased by Mrs. James in September of 2005.

B. Declaratory Judgment

1. Legal Standard

[8] Under the Declaratory Judgment Act, 28 U.S.C. § 2201–2202, "[i]n a case of actual controversy within its jurisdiction ... any court of the United States, upon the filing of an appropriate pleading, may declare the rights and other legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought." 28 U.S.C. § 2201(a). The Supreme Court has explained that the Declaratory Judgment Act is "an enabling Act, which confers discretion on the courts rather than an absolute right upon the litigant." *Wilton v. Seven Falls Co.*, 515 U.S. 277, 287, 115 S.Ct. 2137, 132 L.Ed.2d 214 (1995) (internal quotations and citations omitted). Thus, federal

district courts " 'wield broad and selective discretion' in determining whether to entertain a declaratory judgment action." *408 *Canal Ins. Co. v. Paul Cox Trucking*, Civ. A. No. 1:05–CV–2194, 2006 WL 2828755, at *2 (M.D.Pa. Oct.2, 2006) (quoting *State Farm Mut. Auto Ins. Co. v. Lavanture*, Civ. A. No. 1:05–CV2523, 2006 WL 1344051, at *2 (M.D.Pa. May 16, 2006)).

[9] A federal court has discretion to entertain a declaratory judgment action when it finds that the declaratory relief sought "(i) will serve a useful purpose in clarifying and settling the legal relations in issue; and (ii) will terminate and afford relief from the uncertainty, insecurity, and controversy giving rise to the proceeding." *CGU Life Ins. Co. of Am. v. Metro. Mortgage & Secs. Co.*, 131 F.Supp.2d 670, 674 (E.D.Pa.2001).

Here, Plaintiff requests that this Court declare Act 42, 62 PA. STAT. ANN.. § 441.6, invalid as preempted by the federal Medicaid Act and the Supremacy Clause.

2. Analysis

[10] The Court will deny Plaintiff's request for a declaratory judgment that Act 42, 62 PA. STAT. ANN.. § 441.6, is invalid as preempted by federal law. As previously mentioned, Defendant has expressly disavowed any reliance upon Act 42 or section 441.6 in denying Plaintiff Medicaid benefits. (Def. Br. In Opp. 3; Doc. 37.) Rather, Defendant relies solely upon her construction of the federal Medicaid Act and its regulations to support her denial of Medicaid benefits to Plaintiff. Act 42, 62 PA. STAT. ANN.. § 441.6, is not mentioned in any of Defendant's briefs submitted to this Court, nor in Defendant's PA 162 notice sent to Plaintiff, which cites 55 PA.CODE §§ 178.4 and 178.121. Moreover, Plaintiff even acknowledges that Defendant is not enforcing Section 441.6(d) against Plaintiff. (Pl.'s Br. 14.) Consequently, notwithstanding Plaintiff's contentions, this case does not present the issue of whether Act 42, 62 PA. STAT. ANN.. § 441.6, conflicts or frustrates the purpose of the federal Medicaid Act, and thereby would be preempted. As such, declaratory relief is neither useful nor necessary to clarifying the legal relations in issue or affording relief to Plaintiff. Accordingly, the Court will deny Plaintiff's request for a declaratory judgment.

CONCLUSION

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For the above-stated reasons, the Court will grant Plaintiff's motion for summary judgment as to his request for a permanent injunction. Plaintiff's request for a declaratory judgment will be denied. Defendant's motion for summary judgment will be denied.

An appropriate Order will follow.

ORDER

NOW, this 21st day of November, 2006, **IT IS HEREBY ORDERED** that:

(1) Plaintiff Robert A. James' Motion for Summary Judgment (Doc. 30) is:

(A) **GRANTED** as to his request for a permanent injunction;

(B) **DENIED** as to his request for a declaratory judgment;

(2) Defendant is **PERMANENTLY ENJOINED** from denying Plaintiff Robert A. James Medicaid benefits based on the \$250,000 annuity purchased on September 12, 2005 by Plaintiff's wife, Josephine A. James.

(3) Defendant's Motion for Summary Judgment (Doc. 32) is **DENIED**.

Footnotes

- 1 In July of 2005, the Commonwealth passed Act 42, 62 PA. STAT. ANN. . § 441.6, which added restrictions on annuities not contained in the federal Medicaid Act, including:
 - (b) Any provisions in an annuity owned by an applicant or spouse of an applicant that has the effect of limiting the right of such owner to sell, transfer or assign the right to receive payments thereunder, or restricts the right to change the designated beneficiary thereunder, is void.
 - (c) In determining eligibility for Medical Assistance, there shall be a rebuttable presumption that any annuity or contract to receive money is marketable without undue hardship.
 - (d) An annuity will not be considered an available resource if the annuity names the Department as the residual beneficiary of any funds remaining due under the annuity at the time of death of the annuitant, not to exceed the amount of Medical Assistance expended on the individual during his or her lifetime.
- 2 While this case does not fall within the class of Medicaid cases involving a state plan that allegedly conflicts with the federal Medicaid Act, which would certainly present a federal question, *see, e.g., Johnson*, 91 F.Supp.2d at 766, neither does it fall in the class of cases in which it is only alleged that a state has violated its own Medicaid plan, which do not present a federal question, *see, e.g., Concourse Rehab. & Nursing Ctr., Inc. v. DeBuono*, 179 F.3d 38, 44 (2d Cir.1999). The Court believes this case to be closer to the former type of case, as federal law must be interpreted in order to determine whether Defendant has misinterpreted it. As such, federal question jurisdiction exists.
- 3 Under the generally prevailing rules of contract law, a contractual right can be assigned unless "the substitution of a right of the assignee for the right of the assignor would materially change the duty of the obligor, or materially increase the burden or risk imposed on him by his contract, or materially impair his chance of obtaining return performance, or materially reduce its value to him, or ... [the] assignment is validly precluded by contract." RESTATEMENT (SECOND) OF CONTRACTS § 317(2)(a)-(c) (1981). "A contract term limiting assignments gives the obligor a right to damages for breach of the terms forbidding assignment, but does not render the assignment ineffective." *Id.* § 322(2)(b); *Int'l Telecomms. Exch. Corp. v. MCI Telecomms. Corp.*, 892 F.Supp. 1520 (N.D.Ga.1995) (a nonassignability clause in a contract is treated as a personal covenant that does not invalidate an otherwise proper transfer, unless the clause expressly states that any assignment is "void").
- 4 Indeed, without so finding, the Court observes that the substitution of an assignee (possibly J.G. Wentworth) would not materially change the duty of the obligor (General Electric Assurance Company), as the only duty placed upon the obligor is to send the beneficiary of the annuity a check once a month. Assignment of the annuity would also not increase the risk imposed upon the obligor, as Mrs. James has already purchased the annuity, having remitted the full purchase price of \$250,000 to General Electric Assurance Company in September of 2005. Consequently, assignment of the annuity would not materially change its terms, nor would it impose an additional burden or risk upon General Electric Assurance Company. Moreover, the non-assignment provision, as pointed out by Defendant, merely forbids assignments—it does not render an assignment void or invalid. As such, assignment of the annuity is not precluded under contract law because all that is limited is Mrs. James' *right* to assign the annuity, not her *power* to do so.

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- 5 *See also Estate of Pladson v. Traill County Soc. Servs.*, 707 N.W.2d 473, 480–81 (N.D.2005) (suggesting that if there were evidence of an available market and resale value for the purchased annuity, the contractual right to the annuity payments or income stream would be considered an available resource for purposes of determining Medicaid eligibility); *A.B. v. Div. of Med. Assistance & Health Servs.*, 374 N.J.Super. 460, 865 A.2d 701, 706 (2005) (same); *Estate of F.K. v. Div. of Med. Assistance & Health Servs.*, 374 N.J.Super. 126, 863 A.2d 1065, 1077 (2005) (same).

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EXHIBIT G

*Hegadorn v. Department of Human Services
Director, Michigan Supreme Court 2019 WL
2064530 (May 19, 2019)*

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Syllabus

Chief Justice:
Bridget M. McCormack

Chief Justice Pro Tem:
David F. Viviano

Justices:
Stephen J. Markman
Brian K. Zahra
Richard H. Bernstein
Elizabeth T. Clement
Megan K. Cavanagh

This syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader.

Reporter of Decisions:
Kathryn L. Loomis

HEGADORN v DEPARTMENT OF HUMAN SERVICES DIRECTOR
TRIM v DEPARTMENT OF HUMAN SERVICES DIRECTOR
TINDLE v DEPARTMENT OF HEALTH AND HUMAN SERVICES

Docket Nos. 156132, 156133, and 156134. Argued October 9, 2018 (Calendar No. 3).
Decided May 9, 2019.

Plaintiffs Mary A. Hegadorn (Docket No. 156132), Dorothy Lollar (Docket No. 156133), and Roselyn Ford (Docket No. 156134) were elderly women receiving long-term care in nursing homes. In each case, the plaintiff, an “institutionalized spouse,” began receiving long-term care at a nursing home at her own expense. After their institutionalization, each plaintiff’s husband, a “community spouse,” created an irrevocable trust that was solely for his own benefit (an SBO trust). The couples then transferred a majority of their individual and marital property to each SBO trust or its trustee, giving up any claim of title to that property. A short time after each SBO trust was formed, each institutionalized spouse applied for Medicaid benefits. The Department of Health and Human Services and its director (collectively, the department) determined that the entire value of the principal of each SBO trust was a countable asset for the purpose of determining each institutionalized spouse’s eligibility for Medicaid benefits and denied their applications because the value of the trust assets put their countable resources above the \$2,000 threshold. Plaintiffs contested the department’s determinations regarding their respective applications, and in each case, an administrative law judge (ALJ) affirmed the department’s determination. Hegadorn and Lollar separately appealed the ALJ decisions in the Livingston Circuit Court, and Ford appealed in the Washtenaw Circuit Court. With respect to Hegadorn and Lollar, the court, Michael P. Hatty, J., reversed the ALJ’s decisions, as did the court, Timothy P. Connors, J., with respect to Ford. Plaintiffs all died during the appeals process, and their personal representatives—Ralph D. Hegadorn, Deborah D. Trim, and Denise Tindle—have been substituted as parties for Hegadorn, Lollar, and Ford, respectively. The Court of Appeals granted the department’s applications for leave to appeal in each case, and the Court ordered the cases consolidated. In a published per curiam opinion, the Court of Appeals, M. J. KELLY, P.J., and STEPHENS and O’BRIEN, JJ., reversed, holding that assets placed by an institutionalized individual’s spouse into an SBO trust are countable assets for determining whether an individual is eligible for Medicaid benefits. 320 Mich App 549 (2017). The Supreme Court granted plaintiffs’ application for leave to appeal. 501 Mich 984 (2018).

In a unanimous opinion by Justice BERNSTEIN, the Supreme Court *held*:

Marital assets placed in an irrevocable trust for the sole benefit of a community spouse are not automatically considered countable assets for the purpose of an institutionalized spouse's initial eligibility determination for Medicaid long-term-care benefits. Rather, such assets become countable only if circumstances exist under which the trust could make a payment to or for the benefit of the institutionalized spouse. Accordingly, the Court of Appeals judgment and the ALJ's final hearing decisions in each case were vacated.

1. The department administers Michigan's Medicaid program in accordance with policies contained in several publications, including the *Bridges Eligibility Manual*, the Social Security Administration's *Program Operations Manual System*, and the *State Medicaid Manual*. A person who falls in the optional medically needy category, like each plaintiff here, cannot qualify for Medicaid benefits if his or her countable assets and income exceed \$2,000 during the period in which he or she applies for benefits. The extent to which the principal of a trust is a countable asset depends on the terms of the trust and whether any of the principal consists of countable assets or countable income. With respect to irrevocable trusts, the department must count as the person's countable asset the value of the countable assets in the trust principal if there is any condition under which the principal could be paid to or on behalf of the person from an irrevocable trust. Additional rules applicable only to institutionalized spouses are described in the Medicare Catastrophic Coverage Act (MCCA), codified at 42 USC 1396r-5.

2. When determining an institutionalized spouse's eligibility for Medicaid benefits, a computation of the couple's total joint resources is taken as of the beginning of the first continuous period of institutionalization in order to determine the amount of the "spousal share" allocated to the community spouse. The couple's resources are divided into those that are countable and those that are exempt. One-half of the total value of their countable resources "to the extent either the institutionalized spouse or the community spouse has an ownership interest" is considered a spousal share. The spousal share allocated to the community spouse qualifies as the community spouse resource allowance (CSRA), which is the monetary value of assets that may be retained by or transferred to the community spouse without those resources being counted against the institutionalized spouse for his or her initial eligibility determination. Once the amount of the CSRA is determined, a second calculation is required to determine the resources available to the institutionalized spouse for the purpose of determining the institutionalized spouse's initial Medicaid eligibility. This calculation is based on the resources available to the institutionalized spouse on the day that the institutionalized spouse submits his or her application for Medicaid benefits. In determining the resources of an institutionalized spouse at the time of application for benefits, 42 USC 1396r-5(c) provides that all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse to the extent that they exceed the CSRA. After the month in which an institutionalized spouse is determined to be eligible for benefits, no resources of the community spouse shall be deemed available to the institutionalized spouse. While the MCCA contains provisions governing the treatment of income paid from a trust, its general resource allocation provisions are silent with regard to the treatment of assets or resources held by a trust. The MCCA also does not provide a definition for the term "resources," but the term does not include those things excluded by 42 USC 1382b(a) or (d). Assuming without deciding that the principal of an irrevocable trust constitutes a resource as that term is used in 42 USC 1396r-5, such a resource is not "held by" the institutionalized or community spouse. The property that makes up the principal of a trust is not

owned by or otherwise directly available to the beneficiary. Instead, the trustee holds title to the property that constitutes the principal of a trust and holds it in trust for the beneficiary. The trust beneficiary, on the other hand, holds a right to enforce the performance of the trust in equity. Unless the beneficiary is also a trustee, the beneficiary does not own the property forming the principal of the irrevocable trust.

3. The first two paragraphs of the Medicaid trust rules contained in 42 USC 1396p(d) describe to whom the rules apply and how to determine whether that person created a trust. Under 42 USC 1396p(d)(1), for purposes of determining an individual's eligibility for, or amount of, benefits under a state plan, subject to 42 USC 1396p(d)(4), the rules specified in 42 USC 1396p(d)(3) apply to a trust established by such individual. Because Medicaid benefits are granted only to those who apply for them and who also meet the eligibility requirements, if an eligibility determination is being made, then the "individual" referred to in 42 USC 1396p(d)(1) must be a person applying for Medicaid benefits or a person who has been approved for a yet-to-be-determined amount of benefits. Applied to the context of this appeal, the individual referred to is the institutionalized spouse, who is the Medicaid applicant. The plain language of 42 USC 1396p(d)(1) thus provides that, to determine an institutionalized spouse's eligibility for Medicaid benefits, the rules outlined in 42 USC 1396p(d)(3) govern trusts established by the institutionalized spouse. Under 42 USC 1396p(d)(2), an individual has established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will: the individual, the individual's spouse, a person with legal authority to act in place of or on behalf of the individual or the individual's spouse, or a person acting at the direction or upon the request of the individual or the individual's spouse. Therefore, when a community spouse creates a trust, other than by will, using assets of his or her institutionalized spouse, that action is legally attributed to the institutionalized spouse for the purposes of the institutionalized spouse's Medicaid eligibility determination.

4. To determine whether assets held by an irrevocable trust are available to the applicant and thus countable for his or her initial eligibility determination, the "any-circumstances rule" set forth in 42 USC 1396p(d)(3)(B) applies. This rule states in part 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. Correctly applying the any-circumstances rule requires understanding to whom "the individual" refers. The use of the definite article "the" preceding "individual" suggests that the term refers to a single person, as opposed to an open class of all people. Additionally, 42 USC 1396p(d)(1) uses "an individual" to refer to a person applying for Medicaid benefits or a person who qualifies for an amount of benefits that is yet to be determined. This provision then states that 42 USC 1396p(d)(3) applies to a trust established by that applicant or recipient. Thus, while "an individual" in 42 USC 1396p(d)(1) can be read as referring to a potential class of persons, when "such individual" establishes a trust, that class is reduced to a single person for the purposes of 42 USC 1396p(d)(3). 42 USC 1396p(d)(2) also refers to "an individual," and it contrasts that term with "the individual's spouse." Reading these provisions together, it follows that when Paragraph (3) refers to "the individual," it is referring to the same individual whose eligibility for, or amount of, benefits is being determined and who has established a trust under Paragraph (2): the applicant for or recipient of Medicaid benefits. When considering the eligibility of an institutionalized spouse for Medicaid

benefits, “the individual” must be read as referring to the institutionalized spouse to the exclusion of the community spouse, who, by definition, is not applying for or receiving Medicaid benefits. Because the *Bridges Eligibility Manual* incorporates the any-circumstances rule into Michigan’s Medicaid policies, this same restriction applies, despite the manual’s use of the term “person” in place of “individual.” The any-circumstances rule, therefore, makes assets held by an irrevocable trust available to an institutionalized spouse if there are any circumstances, whether likely or hypothetical, under which the trust could make a payment to or for the benefit of the institutionalized spouse. If an irrevocable trust can make payments only to the community spouse, then those payments will satisfy the any-circumstances rule only if there is evidence that the payments could be for the benefit of the institutionalized spouse. If application of 42 USC 1396p(d)(3)(B) makes assets held by an irrevocable trust available to an institutionalized spouse, then the value of such assets is countable for the purposes of 42 USC 1396r-5(c).

5. The language of the trust documents themselves determines whether the SBO trusts at issue allow for a payment to be made “to or for the benefit of” the institutionalized spouses. The SBO trusts at issue are irrevocable trusts, meaning the principal of each trust is not automatically rendered available to the institutionalized spouse under 42 USC 1396p(d)(3)(A) and (B). Furthermore, the property and income that make up the principal of the SBO trusts at issue are not held by the institutionalized spouses or the community spouses. Rather, title to the property that is now the principal of each trust was transferred to the trust or trustee, and the money that forms part of the principal was moved into bank accounts controlled by the trustee. There was no suggestion that the community spouses retained possession of the tangible property that forms the principals of the trusts. Therefore, the principals of the SBO trusts are not automatically considered resources available to any of the spouses under 42 USC 1396r-5(c). Accordingly, the principal of each SBO trust can be considered a resource available to the institutionalized spouse, and thus a countable asset, only if made so by operation of the any-circumstances rule in 42 USC 1396p(d)(3)(B). Each of the SBO trusts at issue instructs the trustee to deplete the entirety of the principal during the community spouse’s lifetime. Because the community spouses are not themselves applying for or receiving Medicaid benefits, they are not “the individual” referred to in 42 USC 1396p(d)(3)(B). Thus, the Court of Appeals erred by holding that the possibility of a distribution from each SBO trust to each community spouse automatically made the assets held by each SBO trust countable assets for the purposes of the respective institutionalized spouses’ initial eligibility determination. Accordingly, the Court of Appeals judgment was reversed, the final administrative hearing decision in each case was vacated, and each case was remanded to the appropriate administrative tribunal for the proper application of the any-circumstances test. If the ALJs determine that circumstances exist under which payments from the trusts could be made to or for the benefit of the institutionalized spouse, then the ALJs should explain this rationale and affirm the department’s decision. However, if no such circumstances exist, the ALJs should reverse the department’s decisions and order that the Medicaid applications be approved.

Court of Appeals judgment reversed; tribunal decisions vacated; cases remanded to the appropriate tribunals for further proceedings.

Chief Justice MCCORMACK, concurring, agreed that property held in these SBO trusts was not countable toward Medicaid’s resource limit because “the individual” in 42 USC 1396p(d)(3)(B) refers to the Medicaid applicant. She wrote separately to explain that, although

the issue was not presented in these cases, she believed the plaintiffs' transfer of assets into the trusts triggered Medicaid's divestment rules, thus undermining plaintiffs' overall planning strategy by disqualifying them from receiving benefits despite having satisfied Medicaid's threshold resource test. She stated that the majority opinion should not be interpreted as permitting a married Medicaid applicant to shelter and preserve any amount of wealth without restriction and then immediately receive financial assistance as if the applicant did not have that amount.

Justice CAVANAGH did not participate in the disposition of this case because the Court considered it before she assumed office.

OPINION

Chief Justice:
Bridget M. McCormack

Chief Justice Pro Tem:
David F. Viviano

Justices:
Stephen J. Markman
Brian K. Zahra
Richard H. Bernstein
Elizabeth T. Clement
Megan K. Cavanagh

FILED May 9, 2019

STATE OF MICHIGAN

SUPREME COURT

RALPH D. HEGADORN, Personal
Representative of the Estate of MARY
HEGADORN,

Plaintiff-Appellant,

v

No. 156132

DEPARTMENT OF HUMAN SERVICES
DIRECTOR,

Defendant-Appellee.

DEBORAH D. TRIM, Personal
Representative of the Estate of DOROTHY
LOLLAR,

Plaintiff-Appellant,

v

No. 156133

DEPARTMENT OF HUMAN SERVICES
DIRECTOR,

Defendant-Appellee.

DENISE TINDLE, Personal Representative
of the ESTATE OF ROSELYN FORD,
Plaintiff-Appellant,

v

No. 156134

DEPARTMENT OF HEALTH AND
HUMAN SERVICES,
Defendant-Appellee.

BEFORE THE ENTIRE BENCH (except CAVANAGH, J.)

BERNSTEIN, J.

In these consolidated cases, the individual plaintiffs¹ were elderly women receiving long-term care in nursing homes. In each case, the plaintiff, an “institutionalized spouse,”² began receiving long-term care at a nursing home at her own expense. One to two months later, each plaintiff’s husband, a “community spouse,”³ created an irrevocable trust that was solely for his own benefit. Such a trust is commonly called a “solely for the benefit of,” or “SBO,” trust.⁴ The couples then transferred a majority of their individual and

¹ The original plaintiffs, Mary Hegadorn, Dorothy Lollar, and Roselyn Ford, are now deceased, and the personal representatives of their respective estates have continued this action on their behalf. For ease of reference, this opinion will use “plaintiffs” to refer collectively to the original plaintiffs who **initiated** these proceedings.

² An “institutionalized spouse” is a person who is in a “medical institution or nursing facility” or who is described in 42 USC 1396a(a)(10)(A)(ii)(VI), is likely to meet these requirements “for at least 30 consecutive days,” and is married to a person who is not in such a facility. 42 USC 1396r-5(h)(1)(A) and (B).

³ A “community spouse” is “the spouse of an institutionalized spouse.” 42 USC 1396r-5(h)(2).

⁴ The parties and the Court of Appeals often refer to the SBO trusts at issue as “Medicaid trusts.” This is an accurate label under state regulations, although the label is not used in the federal Medicaid statutes. A Medicaid trust is any trust or trust-like instrument that

marital property to each SBO trust or its trustee, giving up any claim of title to that property. Distributions or payments from each SBO trust were to be made on an actuarially sound basis and solely to or for the benefit of the community spouse. The actuarially sound distribution schedule required that each trustee distribute the income and resources held by the trust to each community spouse at a rate that would deplete the trust within the community spouse's expected lifetime. A short time after each SBO trust was formed, each institutionalized spouse applied for Medicaid benefits. The Department of Health and Human Services⁵ and its director (collectively, the Department) determined that the entire value of the principal of each SBO trust was a countable asset for the purpose of determining each institutionalized spouse's eligibility for Medicaid benefits. Thus, the Department concluded that each institutionalized spouse did not show the requisite financial need because the value of the trust assets put their countable resources above the monetary threshold, and it denied each application.

meets the following five criteria: (1) "[T]he person whose resources were transferred to the trust is someone whose assets or income must be counted to determine [Medicaid] eligibility"; (2) the trust was established by the person, the person's spouse, or someone else acting in place of or at the direction of the person or the person's spouse; (3) "[t]he trust was established on or after August 11, 1993"; (4) the trust was not established by will; and (5) the trust is not a "special needs trust" or "pooled trust" as defined by state regulations. See Michigan Department of Human Services, *Bridges Eligibility Manual (BEM)* 401, BPB 2014-015 (July 1, 2014), pp 5-7. It is undisputed that the trusts at issue meet these criteria.

⁵ The Department of Community Health was merged with the Department of Human Services in 2015 after the plaintiffs in Docket Nos. 156132 and 156133 filed their complaints. The combined agency is now the Department of Health and Human Services. Executive Order No. 2015-4. See *In re Rasmer Estate*, 501 Mich 18, 26 n 3; 903 NW2d 800 (2017).

In each case, the plaintiff unsuccessfully contested the Department's decision in an administrative appeal, but each decision was then reversed on appeal in the circuit court. On appeal in the Court of Appeals, all three cases were consolidated, and the Department's denial decisions were reinstated in a published opinion.

With the cases having been appealed in this Court, we conclude that the Court of Appeals erred in its interpretation of the controlling federal statutes, which caused the Court of Appeals to improperly reinstate the Department's denial decisions. As explained in this opinion, the fact that an irrevocable trust, which includes former assets of an institutionalized spouse, can make payments to a community spouse does not automatically render the assets held by the trust countable for the purpose of an institutionalized spouse's initial eligibility determination. See 42 USC 1396p(d)(3)(B); 42 USC 1396r-5(c)(2). Accordingly, we reverse the judgment of the Court of Appeals. Because the administrative hearing decision in each case suffered from the same faulty reasoning used by the Court of Appeals, this legal error may have caused the administrative law judges (ALJs) to forgo a more thorough review of the Medicaid applications at issue or to disregard other avenues of legal analysis. Therefore, rather than order that the Medicaid applications be approved at this time, we vacate the hearing decision of the ALJ in each case and remand these cases to the appropriate administrative tribunal for any additional proceedings necessary to determine the validity of the Department's decision to deny plaintiffs' Medicaid applications.⁶

⁶ The Court of Appeals also held that it was permissible for the Department to apply changes in its application of *BEM 401* and in its reading of the federal Medicaid statutes to

I. FACTS AND PROCEDURAL HISTORY

This appeal involves three cases that have been consolidated for the purpose of appellate review. In Docket No. 156132, Mary Ann Hegadorn (Mrs. Hegadorn) began receiving long-term care at the MediLodge Nursing Home in Howell, Michigan, on December 20, 2013. Approximately one month later, her husband, Ralph D. Hegadorn (Mr. Hegadorn), established the “Ralph D. Hegadorn Irrevocable Trust No. 1 (Sole Benefit Trust).” (Hegadorn Trust). Mr. Hegadorn is the beneficiary of the Hegadorn Trust, and neither he nor his wife is the trustee or successor trustee. Section 2.2 of the Hegadorn Trust states that the “Trustee shall distribute the Resources of the Trust at a rate that is calculated to use up all of the Resources during” Mr. Hegadorn’s expected lifetime, and it includes a suggested distribution schedule that is based on the Department’s policies. The Hegadorn Trust also lists another trust as a possible residual beneficiary, stating:

At my death, if my Spouse is surviving, Trustee shall distribute the remaining trust property to the trustee of the Special Supplemental Care Trust for Mary Ann Hegadorn, created by my Will dated the same day as this Agreement, as my Will may be amended from time to time. [Hegadorn Trust, § 3.3 (formatting altered).]

On April 24, 2014, Mrs. Hegadorn applied for Medicaid benefits. The Department subsequently denied Mrs. Hegadorn’s application, determining that her countable assets, including the assets that were placed in the Hegadorn Trust, exceeded the applicable financial eligibility limit.

applications filed before such changes occurred. We need not reach this issue, because we have determined that the Court of Appeals erred in its interpretation of the controlling Medicaid statutes.

In Docket No. 156133, Dorothy Lollar (Mrs. Lollar) began receiving long-term care at the MediLodge Nursing Home in Howell, Michigan, on May 1, 2014. Approximately a month and a half later, Mrs. Lollar's husband, Dallas H. Lollar (Mr. Lollar), established the "Dallas H. Lollar Irrevocable Trust" (Lollar Trust), which provided that it was intended to "be a 'Solely for the Benefit of' trust." Mr. Lollar is the beneficiary of the Lollar Trust, and neither he nor his wife is the trustee or successor trustee. Section 2.2 of the Lollar Trust states that the Trustee "shall . . . pay or distribute" to Mr. Lollar, "or for [his] sole benefit, during [his] lifetime such part or all of the net income and principal" of the Trust "as Trustee determines is necessary to distribute the resources in [sic] an actuarially sound basis" The Lollar Trust also lists another trust as a possible residual beneficiary, stating that in the event of Mr. Lollar's death, he "give[s] all the rest, residue and remainder of this Sole Benefit Trust to the Dallas H. Lollar Revocable Trust Agreement U/A/D June 19, 2014, and administered according to the terms of that Agreement." Lollar Trust, § 3.2b (formatting altered). On July 21, 2014, Mrs. Lollar applied for Medicaid benefits. The Department subsequently denied Mrs. Lollar's application, determining that her countable assets, including the assets that were placed in the Lollar Trust, exceeded the applicable financial eligibility limit.

In Docket No. 156134, Roselyn Ford (Mrs. Ford) began receiving long-term care at the Saline Evangelical Nursing Home in Saline, Michigan, on December 5, 2013. About a month later, Mrs. Ford's husband, Herbert W. Ford (Mr. Ford), established the "Herbert Ford Irrevocable Trust" (Ford Trust), which provided that it was intended to be "a 'solely for the benefit of' trust." Mr. Ford is the beneficiary of the Ford Trust, and neither he nor his wife is the trustee or successor trustee. The Ford Trust also provides that the "Trustee

shall . . . pay or distribute to [Mr. Ford], or for [his] sole benefit, during his lifetime whatever part of the net income and principal (the Resources) of the Trust that Trustee determines is necessary to distribute the resources on an actuarially sound basis.” Section 3.2 of the Ford Trust lists as possible residual beneficiaries separate trusts to be established by Mr. Ford’s will for the benefit of his living children and the descendants of his deceased children. On January 30, 2014, Mrs. Ford applied for Medicaid benefits. The Department subsequently denied Mrs. Ford’s application, determining that her countable assets, including the assets that were placed in the Ford Trust, exceeded the applicable financial eligibility limit.⁷

Each plaintiff timely requested an administrative hearing to contest the Department’s decision. With respect to Mrs. Hegadorn’s and Mrs. Lollar’s cases, a consolidated hearing was held before ALJ Landis Y. Lain, who affirmed the Department’s decision. With respect to Mrs. Ford’s case, a hearing was held before ALJ Alice C. Elkin, who similarly affirmed the Department’s decision. Each ALJ agreed with the Department that *Bridges Eligibility Manual (BEM) 401* required the Department to count the assets held by each trust because the trust could make payments to the community spouse. The ALJs further concluded that this was consistent with the controlling federal statutes. The ALJs made no factual findings and rendered no conclusions of law regarding possible payments to the trusts that are listed as residual beneficiaries in the SBO trusts.

⁷ We note that the Ford Trust and Lollar Trust also reserve to the community spouses a special testamentary power of appointment, which allows them to appoint, by will, items or funds held by the trust directly to their children or their children’s descendants. This power does not allow for appointments to any other individuals or entities.

The plaintiff in each case appealed in the appropriate circuit court and, in each case, the circuit court reversed the ALJ's decision. The Department appealed each circuit court decision in the Court of Appeals, which consolidated the cases. In a published opinion, the panel reversed the circuit courts and reinstated the ALJs' decisions to deny benefits. Plaintiffs timely sought leave to appeal in this Court. We granted plaintiffs' application in an order entered March 7, 2018, stating:

The parties shall include among the issues to be briefed whether: (1) the Court of Appeals clearly erred in holding that the trust assets of the plaintiffs' spouses and decedent Lollar's spouse are "countable assets" for purposes of Medicaid eligibility; and (2) the Department of Health and Human Services could base its decision on the retroactive application of a department policy adopted more than 45 days after the plaintiffs' applications were filed. [*Hegadorn v Dep't of Human Servs Dir*, 501 Mich 984 (2018).]

II. STANDARD OF REVIEW

Resolution of this appeal turns on whether the federal Medicaid statutes, which govern certain aspects of the Department's Medicaid policies, allow the Department to count the assets held in a community spouse's SBO trust in determining an institutionalized spouse's eligibility for Medicaid. Final agency decisions are subject to judicial review pursuant to the Michigan Constitution, see Const 1963, art 6, § 28, and the Administrative Procedures Act (APA), MCL 24.201 *et seq.* The Michigan Constitution provides:

All final decisions . . . of any administrative officer or agency . . . which are judicial or quasi-judicial and affect private rights or licenses, shall be subject to direct review by the courts as provided by law. This review shall include, as a minimum, the determination whether such final decisions . . . are authorized by law [Const 1963, art 6, § 28.]

The APA provides that, unless a different scope of review is established by law,

the court shall hold unlawful and set aside a decision or order of an agency if substantial rights of the petitioner have been prejudiced because the decision or order is any of the following:

(a) In violation of the constitution or a statute.

* * *

(f) Affected by other substantial and material error of law. [MCL 24.306(1).]

The APA further instructs that “[t]he court, as appropriate, may affirm, reverse or modify the decision or order or remand the case for further proceedings.” MCL 24.306(2).

An administrative agency’s interpretation of a statute that it is obligated to execute is entitled to “respectful consideration,” but it “cannot conflict with the plain meaning of the statute.” *In re Rovas Complaint Against SBC Mich*, 482 Mich 90, 108; 754 NW2d 259 (2008). We review issues of statutory interpretation de novo. *Walters v Nadell*, 481 Mich 377, 381; 751 NW2d 431 (2008). “The principal goal of statutory interpretation is to give effect to the Legislature’s intent, and the most reliable evidence of that intent is the plain language of the statute.” *South Dearborn Environmental Improvement Ass’n, Inc v Dep’t of Environmental Quality*, 502 Mich 349, 360-361; 917 NW2d 603 (2018). When interpreting federal statutes, we strive to “give effect to the will of Congress[.]” *Walters*, 481 Mich at 381 (quotation marks and citations omitted.)

This case also requires us to construe language in trust documents. The proper construction of a trust, like the construction of a will, is a question of law subject to de novo review. See *In re Raymond Estate*, 483 Mich 48, 53; 764 NW2d 1 (2009). Our goal in interpreting trust language is to determine and give effect to the trustor’s intent. *Id.* at 52. We begin by examining the language of the trust itself, and, if there is no ambiguity,

we interpret it according to its plain and ordinary meaning. *Id.*; *In re Maloney Trust*, 423 Mich 632, 639; 377 NW2d 791 (1985).

III. ANALYSIS

A. OVERVIEW OF MEDICAID

The Medicaid program is governed by a complex web of interlocking statutes, as well as regulations and interpretive documents published by state and federal agencies. The program was created by Title XIX of the Social Security Act of 1965, PL 89-97; 79 Stat 343, codified at 42 USC 1396 *et seq.* Medicaid is generally a need-based assistance program for medical care that is funded and administered jointly by the federal government and individual states. *Ketchum Estate v Dep't of Health & Human Servs*, 314 Mich App 485, 488; 887 NW2d 226 (2016). At the federal level, the program is administered by the Secretary of Health and Human Services through the Centers for Medicare & Medicaid Services (CMS). The *State Medicaid Manual* is published by CMS to help guide states in their administration of the program, including how to determine an applicant's eligibility for benefits. See *Ark Dep't of Health & Human Servs v Ahlborn*, 547 US 268, 275; 126 S Ct 1752; 164 L Ed 2d 459 (2006). “ ‘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 Secretary of Health and Human Services.” *Wis Dep't of Health & Family Servs v Blumer*, 534 US 473, 479; 122 S Ct 962; 151 L Ed 2d 935 (2002), quoting *Schweiker v Gray Panthers*, 453 US 34, 36-37; 101 S Ct 2633; 69 L Ed 2d 460 (1981). “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.’ ” *Blumer*, 534 US at 479, quoting 42 USC 1396a(a)(17)(B).

Medicaid benefits are provided automatically for the “categorically needy,” meaning persons who receive welfare payments through Aid to Families with Dependent Children (AFDC), 42 USC 601 *et seq.*, or Supplemental Security Income (SSI), 42 USC 1382 *et seq.*⁸ See 42 USC 1396a(a)(10)(A); Social Security Administration, *Program Operations Manual System* (SSA POMS), SI 01715.020 (August 2, 2016), available at <<https://secure.ssa.gov/apps10/poms.nsf/lnx/0501715020>> (accessed May 2, 2019) [<https://perma.cc/E6Q9-WSMB>]. Congress has also enacted an optional program, in which states may elect to participate, for those who are deemed “medically needy.” *Ark Dep’t of Human Servs v Schroder*, 353 Ark 885, 890; 122 SW3d 10 (2003); 42 USC 1396a(a)(10)(A)(ii). Although medically needy individuals meet the nonfinancial requirements under either the AFDC or the SSI programs, they become eligible for Medicaid benefits only when their incomes and assets are reduced below certain established levels. See 42 USC 1396a(a)(10)(C); 42 CFR 435.301(b)(2) and (3) (2018);

⁸ By completing a “1634 agreement,” a state may request that the Social Security Administration (SSA) make certain Medicaid eligibility determinations when making SSI eligibility determinations and agree to provide Medicaid benefits to those individuals whom the SSA deems eligible. Social Security Administration, *Program Operations Manual System* (SSA POMS), SI 01730.010 (February 6, 2013), available at <<https://secure.ssa.gov/apps10/poms.nsf/lnx/0501730010>> (accessed May 2, 2019) [<https://perma.cc/23YU-EYDR>]. In states that execute a 1634 agreement, like Michigan, an application for SSI benefits is also an application for Medicaid benefits. SSA POMS, SI 01730.005 (February 6, 2013), available at <<https://secure.ssa.gov/apps10/poms.nsf/lnx/0501730005>> (accessed May 2, 2019) [<https://perma.cc/2L5F-6NWX>].

42 CFR 435.320 (2018). Michigan has elected to include this optional coverage for the medically needy in its state Medicaid plan. Therefore, Michigan must comply with the requirements imposed by the federal Medicaid statutes. See *In re Rasmer Estate*, 501 Mich 18, 25; 903 NW2d 800 (2017); 42 USC 1396a. Plaintiffs here fall within the medically needy category for those over the age of 65. Therefore, to be eligible for Medicaid benefits, they were required to reduce their countable incomes and assets to or below \$2,000. See *Mackey v Dep't of Human Servs*, 289 Mich App 688, 698; 808 NW2d 484 (2010); *BEM 400* (July 1, 2014), p 7; *BEM 402* (April 1, 2014), p 4.

As the United States Supreme Court has noted, “[b]ecause spouses typically possess assets and income jointly and bear financial responsibility for each other, Medicaid eligibility determinations for married applicants have resisted simple solutions.” *Blumer*, 534 US at 479. Prior to 1988, to become eligible for Medicaid benefits, a married individual who was admitted to a nursing home was required to “spend down” all the assets jointly held with his or her spouse who remained in the marital home. See HR Rep No 100-105(II), at 59, 65-67 (2d Sess 1988), as reprinted in 1988 USCCAN 857, 881, 888-890. That changed with the enactment of the Medicare Catastrophic Coverage Act of 1988 (MCCA), codified at 42 USC 1396r-5.⁹ As the Supreme Court has recently explained, the MCCA was enacted “to protect community spouses from ‘pauperization’ while preventing financially secure couples from obtaining Medicaid assistance,” which is why “Congress

⁹ Congress later repealed most of the MCCA through the Medicare Catastrophic Coverage Repeal Act of 1989, PL 101-234; 103 Stat 1979, but the spousal-impoverishment-prevention provisions contained in 42 USC 1396r-5 were retained.

installed a set of intricate and interlocking requirements with which States must comply in allocating a couple's income and resources." *Blumer*, 534 US at 480.

Since the enactment of the MCCA, Congress has made numerous additional amendments of the Medicaid statutes to adapt the program to changing economic realities while striving to prevent abuse of the program. Many of these adjustments concern the use and evaluation of estate planning tools like trusts and annuities. The Consolidated Omnibus Budget Reconciliation Act of 1985, PL 99-272; 100 Stat 82, formerly codified at 42 USC 1396a(k), instructed states to treat as countable assets the maximum amount of a trust's principal a trustee could pay to a Medicaid applicant if the trustee were to exercise his or her discretionary authority, whether or not that discretion was actually exercised. See 1 Kove & Kosakow, *Irrevocable Trusts* (4th ed, October 2018 update), § 27:9. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93), PL 103-66; 107 Stat 312, repealed 42 USC 1396a(k) and replaced it with the current Medicaid trust rules. See 42 USC 1396p(d); 1 *Irrevocable Trusts*, § 27:9.¹⁰ States that choose to participate in the Medicaid program are required to "comply with the provisions of section 1396p of [Title XIX] with respect to liens, adjustments and recoveries of medical assistance correctly paid, transfers of assets,, [sic] *and treatment of certain trusts*[" 42 USC 1396a(18) (emphasis added). As our review of these Medicaid statutes demonstrates, Congress has been

¹⁰ There are also provisions, which are not at issue here, that subject an applicant to penalties for nonexempt transfers of resources during the five-year look-back period. See 42 USC 1396p(c)(1) through (5). Additional rules governing the evaluation of annuities were added by the Deficit Reduction Act of 2005, PL 109-171; 120 Stat 4, and codified at 42 USC 1396p(c)(1)(F) and (G), but they also are not at issue here, and their enactment did not modify the Medicaid trust rules codified at 42 USC 1396p(d).

particularly active in its efforts to prevent spousal pauperization while at the same time limiting the ability of wealthier individuals to shelter income and assets using estate planning tools.

B. TREATMENT OF TRUST RESOURCES FOR AN INSTITUTIONALIZED SPOUSE'S INITIAL ELIGIBILITY DETERMINATION

The main issue in this appeal is whether assets making up the principal of an irrevocable SBO trust are countable assets for the purpose of determining an institutionalized spouse's initial eligibility for Medicaid. In Michigan, the Department administers the state Medicaid program. The Department's policies are contained in several publications, including the *BEM*, the *SSA POMS*, and the *State Medicaid Manual*.¹¹ A person who falls in the optional medically needy category, like each plaintiff here, cannot qualify for Medicaid benefits if his or her *countable assets* and income exceed \$2,000 during the period in which he or she applies for benefits. See *Mackey*, 289 Mich App at 698; *BEM 400* at 7; *BEM 402* at 4. According to *BEM 401*, “[h]ow much of the principal of a trust is a countable asset depends on” “[t]he terms of the trust” and “[w]hether any of the principal consists of countable assets or countable income.” *BEM 401* (July 1, 2014), p 10. With respect to irrevocable trusts, such as those at issue here, *BEM 401* instructs the Department to “[c]ount as the person's countable asset the value of the countable assets in

¹¹ The *State Medicaid Manual* is published by the CMS to help guide states in administering the Medicaid program. The manual is not a product of formal rulemaking and does not have the force of law. *Hobbs ex rel Hobbs v Zenderman*, 579 F3d 1171, 1186 n 10 (CA 10, 2009). However, federal courts generally consider the manual to be strong persuasive authority to the extent that it is consistent with the purpose and text of federal statutes. *Id.*; *Hughes v McCarthy*, 734 F3d 473, 478 (CA 6, 2013).

the trust principal if there is any condition under which the principal could be paid to or on behalf of the person from an irrevocable trust.” *Id.* at 11. The legal authority for *BEM 401* derives from two parts of the federal Medicaid statutes: 42 USC 1396a and 42 USC 1396p. See *BEM 401* at 17-18. However, additional rules applicable only to institutionalized spouses are described in 42 USC 1396r-5. These additional rules serve as a starting point for evaluating an institutionalized spouse’s eligibility for Medicaid benefits.

1. 42 USC 1396r-5

When determining an institutionalized spouse’s eligibility for Medicaid benefits, a computation of the couple’s total joint resources is taken “as of the beginning of the first continuous period of institutionalization,” which may or may not be the same month in which one applies for benefits. 42 USC 1396r-5(c)(1)(A). The stated purpose of this first computation is to determine the amount of the “spousal share” allocated to the community spouse. 42 USC 1396r-5(c)(1)(A)(ii). The couple’s resources are divided into those that are countable and those that are exempt.¹² One-half of the total value of their countable resources “to the extent either the institutionalized spouse or the community spouse has an ownership interest” is considered a spousal share. *Id.*

“The spousal share allocated to the community spouse qualifies as the [community spouse resource allowance or] CSRA, subject to a ceiling . . . indexed for inflation” by

¹² While 42 USC 1396r-5 does not use the terms “countable” and “exempt,” it provides that the term “resources” does not include those things excluded by 42 USC 1382b(a) or (d). See 42 USC 1396r-5(c)(5). Items excluded under those sections include the couple’s home, 42 USC 1382b(a)(1); household goods and personal effects, 42 USC 1382b(a)(2)(A); and funds set aside for burial expenses, 42 USC 1382b(d).

Congress. *Blumer*, 534 US at 482. The CSRA is the monetary value of assets that may be retained by or transferred to the community spouse without those resources being counted against the institutionalized spouse for his or her initial eligibility determination. See 42 USC 1396r-5(c)(2)(B) and (f); *Blumer*, 534 US at 482-483. Available resources in excess of the CSRA will generally disqualify an institutionalized spouse from receiving Medicaid benefits unless they are spent down prior to filing an application. 42 USC 1396r-5(c)(2); *Blumer*, 534 US at 482-483.

Once the amount of the CSRA is determined, a second calculation is required to determine the resources available to the institutionalized spouse for the purpose of determining the institutionalized spouse's initial Medicaid eligibility. 42 USC 1396r-5(c)(2). This calculation is based on the resources available to the institutionalized spouse on the day that the institutionalized spouse submits his or her application for Medicaid benefits. "In determining the resources of an institutionalized spouse at the time of application for benefits . . . , *all the resources held by* either the institutionalized spouse, community spouse, or both, shall be considered to be *available to* the institutionalized spouse" to the extent that they exceed the CSRA. 42 USC 1396r-5(c)(2)(A) and (B) (emphasis added). "[A]fter the month in which an institutionalized spouse is determined to be eligible for benefits . . . , no resources of the community spouse shall be deemed available to the institutionalized spouse." 42 USC 1396r-5(c)(4). While the MCCA contains provisions governing the treatment of income paid from a trust, see 42 USC 1396r-5(b)(2)(B),¹³ its general resource allocation provisions are silent with regard to the

¹³ Any income payable solely to a community spouse from a trust is considered to be

treatment of assets or resources held by a trust. The MCCA also does not provide a definition for the term “resources,” but the term does not include those things excluded by 42 USC 1382b(a) or (d). See 42 USC 1396r-5(c)(5).

We are asked to consider whether the principal of an irrevocable trust, created using assets of both spouses but which may distribute payments only to or for the benefit of the community spouse, is a countable asset for the purpose of the institutionalized spouse’s initial eligibility determination. Stated differently, is the principal of the irrevocable trust a “resource[] held by either the institutionalized spouse, community spouse, or both,” such that it is considered “available to the institutionalized spouse”? 42 USC 1396r-5(c)(2)(A).

Assuming without deciding that the principal of an irrevocable trust constitutes a resource as that term is used in 42 USC 1396r-5, such a resource is not “held by” the institutionalized or community spouse.¹⁴ The property that makes up the principal of a trust is not owned by or otherwise directly available to the beneficiary. Instead, the *trustee* holds title to the property that constitutes the principal of a trust and holds it in trust for the beneficiary. See MCL 700.7401; *Equitable Trust Co v Milton Realty Co*, 261 Mich 571,

income available only to that community spouse. 42 USC 1396r-5(b)(2)(B)(ii) (stating that if income is paid solely to the institutionalized spouse or the community spouse, “the income shall be considered available only to that respective spouse[.]”). Generally, the MCCA preserves a community spouse’s income for that spouse so as to avoid affecting the institutionalized spouse’s eligibility for Medicaid. See *Blumer*, 534 US at 480-481.

¹⁴ While “held” is undefined in the statute, *Merriam-Webster’s Collegiate Dictionary* (11th ed) relevantly defines “hold” as “to have possession or ownership of or have at one’s disposal[.]” “When a word or phrase is not defined by the statute in question, it is appropriate to consult dictionary definitions to determine [its] plain and ordinary meaning” *People v Rea*, 500 Mich 422, 428; 902 NW2d 362 (2017).

577; 246 NW 500 (1933) (holding that “[t]o create a trust, there must be an assignment of designated property to a trustee with the intention of passing title thereto, to hold for the benefit of others”).¹⁵ The trust beneficiary, on the other hand, holds a right to “enforce the performance of the trust in equity.” MCL 555.16. See also *Union Guardian Trust Co v Nichols*, 311 Mich 107; 18 NW2d 383 (1945). Unless the beneficiary is also a trustee, the beneficiary does not own the property forming the principal of the irrevocable trust. If either spouse retained possession and use of trust property, then the question might be closer, but that question is not raised here. In summary, the principal of an irrevocable trust generally will not be a resource available to either spouse according to 42 USC 1396r-5(c), because such property is not held by either spouse. The principal of an irrevocable trust may, however, be made legally available to an institutionalized spouse by way of the Medicaid trust rules contained in 42 USC 1396p(d).

2. 42 USC 1396p(d): THE MEDICAID TRUST RULES

The first two paragraphs of the Medicaid trust rules describe to whom the rules apply and how to determine whether that person created a trust. Paragraph (1) of the Medicaid trust rules begins by stating, “For purposes of determining an individual’s eligibility for, or amount of, benefits under a State plan under this subchapter, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such

¹⁵ *Black’s Law Dictionary* similarly defines a “trustee” as “[s]omeone who stands in a fiduciary or confidential relation to another; esp., one who, having legal title to property, holds it in trust for the benefit of another and owes a fiduciary duty to that beneficiary.” *Black’s Law Dictionary* (10th ed).

individual.”¹⁶ 42 USC 1396p(d)(1). While, generally speaking, an “individual” is “a particular being or thing,” i.e., “a single human being,” *Merriam-Webster’s Collegiate Dictionary* (11th ed), the context of a term’s usage in a statute affects its meaning, see *South Dearborn*, 502 Mich at 361. Here, the context in which “an individual” is used limits the scope of possible human beings to which 42 USC 1396p(d)(1) refers.

Paragraph (1) provides that Subsection (d) applies to determining “an individual’s eligibility for, or amount of, benefits . . .” 42 USC 1396p(d)(1). Medicaid benefits are granted only to those who apply for them and who also meet the eligibility requirements. Thus, if an eligibility determination is being made, then the “individual” referred to in Paragraph (1) must be an applicant for Medicaid; similarly, language directing the reader’s attention to the amount of benefits provided indicates that the “individual” is either an applicant for or a current recipient of Medicaid benefits. It follows that “an individual” in 42 USC 1396p(d)(1) is a person applying for Medicaid benefits or a person who has been approved for a yet-to-be-determined amount of benefits. Applied to the context of this appeal, the individual referred to here is the institutionalized spouse, who is the Medicaid applicant. The plain language of 42 USC 1396p(d)(1) thus provides that, to determine an institutionalized spouse’s eligibility for Medicaid benefits, the rules outlined in 42 USC 1396p(d)(3) govern trusts established by the institutionalized spouse.

¹⁶ Paragraph (4) provides special rules for the treatment of three types of trusts that are not at issue in this appeal. See 42 USC 1396p(d)(4).

Paragraph (2) of the same subsection provides the criteria for determining whether “an individual” has established a trust. 42 USC 1396p(d)(2). For the purposes of Subsection (d), “an individual” has

established a trust if assets^[17] of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

¹⁷ 42 USC 1396p(h) provides the following definition of “assets”:

(1) The term “assets”, with respect to an individual, includes all income and resources of the individual and of the individual’s spouse, including any income or resources which the individual or such individual’s spouse is entitled to but does not receive because of action—

(A) by the individual or such individual’s spouse,

(B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual’s spouse, or

(C) by any person, **including** any court or administrative body, acting at the direction or upon the request of the individual or such individual’s spouse.

The Court of Appeals cited this definition for the proposition that “Congress has clearly indicated that an institutionalized individual’s assets include not only those that he or she has, but *also* those that his or her spouse has, 42 USC 1396p(h)(1), and that remains true even when those assets are placed into a trust by the spouse, 42 USC 1396d(d)(2)(A)(i) and (ii).” *Hegadorn v Dep’t of Human Servs Dir*, 320 Mich App 549, 569; 904 NW2d 904 (2017). This statement is partially correct.

Generally speaking, marital assets are considered jointly and, before the trusts were formed, income and resources belonging to the community spouse would be considered assets of the institutionalized spouse. However, once resources are moved into an irrevocable trust, they cease being assets owned or held by either spouse and become assets owned and held by the trust or trustee. Moreover, transferring one’s income and property to one’s spouse or directly into a trust is not an “action . . . by the individual or such individual’s spouse” that deprives either spouse of “resources which the individual or such

- (i) The individual.
- (ii) The individual's spouse.
- (iii) A person, including any court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.
- (iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.
[42 USC 1396p(d)(2)(A).]

Therefore, when a community spouse creates a trust, other than by will, using assets of his or her institutionalized spouse, that action is legally attributed to the institutionalized spouse for the purposes of the institutionalized spouse's Medicaid eligibility determination.

Deciding that an institutionalized spouse is an individual who has established a trust does not, however, end the inquiry. Paragraph (2) only describes the conditions for when a Medicaid applicant is deemed to have established a trust. The rules described in Paragraph (3) govern whether the assets held by such a trust are available to the Medicaid applicant and thus countable for his or her initial eligibility determination.

individual's spouse is entitled to" 42 USC 1396p(h)(1). Resources that one presently has both title to and possession of are not resources that one is entitled to in the future, and transferring away such resources does not trigger 42 USC 1396p(h)(1). This is consistent with CMS's interpretation of the definition of "asset," see CMS, *State Medicaid Manual*, § 3257(B)(3) (rev 64), which lists among the examples of actions that trigger the asset rule: (a) waiving the right to payment of pension income, (b) waiving a right to receive an inheritance, (c) rejecting or refusing to accept injury settlements, and (d) diverting tort settlements. Each example presents a situation in which someone has a legal right to receive income or property in the future, but that right is never realized because of some affirmative action. Such conditions do not exist here.

3. 42 USC 1396p(d)(3)(B): THE ANY-CIRCUMSTANCES RULE

Once it is determined that a Medicaid applicant has established a trust, the question becomes whether assets held by the trust are available to the applicant. The trust rules in 42 USC 1396p(d)(3) treat revocable trusts and irrevocable trusts differently. Generally, the principal of a revocable trust is always considered an asset available to the Medicaid applicant who formed the trust. See 42 USC 1396p(d)(3). This is unsurprising, as a trustor can typically dissolve a revocable trust and reclaim title and possession of those things held by the trust.

The rules for irrevocable trusts are more intricate. Notably, the rules do not assume that assets placed in an irrevocable trust are available to the Medicaid applicant. Instead, when assessing an irrevocable trust, the “any-circumstances rule” applies:

(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, and

(II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c); and

(ii) any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual *shall be considered*, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) *to be assets disposed by the individual for purposes of subsection (c)*, and the value of the trust shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date. [42 USC 1396p(d)(3)(B) (emphasis added).]

Focusing on the statutory language, “any” is undefined within the statute itself, but is commonly defined as “one or some indiscriminately of whatever kind” or “one, some, or all indiscriminately of whatever quantity.” *Merriam-Webster’s Collegiate Dictionary* (11th ed). Thus, the use of the term “any circumstances” demonstrates that we are to consider not only obvious circumstances, but also those that are hypothetical or even unlikely. However, the rule also includes key limitations. The rule instructs us to consider only possible “payments from the trust,” indicating that there must be a nexus between the trust and the recipient or beneficiary of the payment. We are next told that only those payments that could be made “to or for the benefit of the individual” fall within the rule. If there are circumstances under which payments from the trust can be made to or for the benefit of the individual, then the portion of the principal of the trust from which such payments would come is deemed available to the individual, and thus countable for determining the individual’s eligibility for Medicaid benefits. If no such circumstances exist, then the portion of the principal derived from the applicant’s assets is not a countable asset for the applicant’s eligibility determination. See 42 USC 1396p(c).¹⁸

Correctly applying the any-circumstances rule requires understanding to whom “the individual” refers in 42 USC 1396p(d)(3)(B). The Department urges us to read “the individual” as referring to anyone whose resources must be evaluated in assessing a Medicaid application, without regard to whether that person is the Medicaid applicant or

¹⁸ If assets held by a trust are not assets available to the Medicaid applicant, then those trust assets are treated as assets transferred by the applicant, which may subject the applicant to divestment penalties. See 42 USC 1396p(c). As the Department has stated, divestment penalties are not at issue in this appeal. See Appellee’s Brief, p 14.

the applicant's spouse. Applied here, the Department reads "the individual" as referring to the person applying for Medicaid benefits (the institutionalized spouse), the community spouse, or both. This ~~was~~ also the meaning adopted by the Court of Appeals. However, we conclude that this interpretation suffers from several critical flaws.

As already discussed, the context in which a statutory term is used affects its meaning. See *South Dearborn*, 502 Mich at 361. As with Paragraphs (1) and (2) of 42 USC 1396p(d), the context in which "the individual" is used limits the scope of possible human beings to which 42 USC 1396p(d)(3)(B) refers. The first limitation is the use of the definite article "the" preceding "individual." This suggests that "the individual" referred to in 42 USC 1396p(d)(3)(B)(i) is a single person, as opposed to an open class of all people. See *Massey v Mandell*, 462 Mich 375, 382 n 5, 614 NW2d 70 (2000) (" 'The' and 'a' have different meanings. 'The' is defined as 'definite article. 1. (used, [especially] before a noun, with a specifying or particularizing effect, as opposed to the indefinite or generalizing force of the indefinite article a or an)' *Random House Webster's College Dictionary*, p 1382.>").

Additionally, Paragraph (1) of Subsection (d) begins by stating, "[f]or purposes of determining *an individual's* eligibility for, or amount of," Medicaid benefits, "the rules specified in paragraph (3) shall apply to a trust established by *such individual*." 42 USC 1396p(d)(1) (emphasis added). As discussed in Part III(B)(2) of this opinion, Paragraph (1) uses "an individual" to refer to a person applying for Medicaid benefits or a person who qualifies for benefits, but the amount of those benefits must be determined.¹⁹ Paragraph

¹⁹ The *State Medicaid Manual* generally uses the term "individual" in the same manner:

(1) then states that Paragraph (3) applies to a trust established by that applicant or recipient. Thus, while “an individual” in Paragraph (1) can be read as referring to a potential class of persons, when “such individual” establishes a trust, that class is reduced to a single person for the purposes of Paragraph (3). Paragraph (2) of Subsection (d) also refers to “an individual” when describing whether such individual established a trust, and it contrasts that term with “the individual’s spouse.” 42 USC 1396p(d)(2)(A)(i) and (ii).

Reading these provisions together, it follows that when Paragraph (3) refers to “the individual,” it is referring to the same individual whose eligibility for, or amount of, benefits is being determined and who has established a trust under Paragraph (2): the applicant for or recipient of Medicaid benefits. When considering the eligibility of an institutionalized spouse for Medicaid benefits, “the individual” must be read as referring to the institutionalized spouse to the exclusion of the community spouse, who, by definition, is not applying for or receiving Medicaid benefits.²⁰

We find further support for this reading by reference to markedly different language in the rules governing trusts under the SSI program. See 42 USC 1382b(e)(2) and (3). The SSI program contains a nearly identical any-circumstances rule with one key difference: it

“Individuals to Whom Trust Provisions Apply.--This section applies to any individual who establishes a trust and who is an applicant for or recipient of Medicaid.” CMS, *State Medicaid Manual*, § 3259.3 (rev 64), p 3-3-109.26.

²⁰ According to CMS, there may be an exception to this rule when the community spouse is acting on the applicant’s behalf. See CMS, *State Medicaid Manual*, § 3259.6(D), p 3-3-109.29 (“Payments are considered to be made to the individual when any amount from the trust . . . is paid directly to the individual *or to someone acting on his/her behalf*, e.g., a guardian or legal representative.”) (emphasis added). However, we need not reach this issue today.

explicitly differentiates between the individual and the individual's spouse. See 42 USC 1382b(e)(3)(B) (“[I]f there are any circumstances under which payment from the trust could be made to or for the benefit of *the individual (or of the individual’s spouse)*”) (emphasis added). “Where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.” *Russello v United States*, 464 US 16, 23; 104 S Ct 296; 78 L Ed 2d 17 (1983) (quotation marks and citation omitted). See also *Farrington v Total Petroleum, Inc*, 442 Mich 201, 210; 501 NW2d 76 (1993) (“Courts cannot assume that the Legislature inadvertently omitted from one statute the language that it placed in another statute, and then, on the basis of that assumption, apply what is not there.”). When Congress intended a provision of the Medicaid or SSI statutes to apply to both the applicant and the applicant’s spouse, it has stated so expressly. Moreover, the Medicaid trust rules in 42 USC 1396p(d) were added by OBRA 93, six years before Congress added the SSI trust rules in 42 USC 1382b(e) with the Foster Care Independence Act of 1999, PL 106-169; 113 Stat 1822. Had Congress intended the two rules to operate identically, as the Department suggests, then Congress likely would have used identical language in both 42 USC 1396p(d)(3)(B) and 42 USC 1382b(e)(3)(B).²¹

²¹ The Department further argues that *BEM 401* requires evaluating a Medicaid applicant’s resources under both the Medicaid and the SSI any-circumstances rules. We find no legal support for this proposition. First, as already discussed, *BEM 401* cites 42 USC 1396a and 42 USC 1396p as the legal basis for the rule, not 42 USC 1382b(e). Second, Michigan’s state Medicaid plan states that the Department “complies with the provisions of section 1917d of the [Social Security] Act, as amended by OBRA 93, with regard to trusts.”

Reading “the individual” in this manner and in the context of this appeal, 42 USC 1396p(d)(3)(B) refers only to an institutionalized spouse and not a community spouse. As *BEM 401* is based primarily on 42 USC 1396p(d)(3)(B) and incorporates the any-circumstances rule into Michigan’s Medicaid policies, this same restriction applies to *BEM 401*, despite the use of the term “person” in place of “individual.” The any-circumstances rule, therefore, makes assets held by an irrevocable trust available to an institutionalized spouse if there are any circumstances, whether likely or hypothetical, under which the trust could make a payment to or for the benefit of the institutionalized spouse. If an irrevocable trust can make payments only to the community spouse, then those payments will satisfy the any-circumstances rule only if there is evidence that the payments could be for the benefit of the institutionalized spouse.²² If application of 42 USC 1396p(d)(3)(B) makes

Michigan Department of Health and Human Services, *State Plan Under Title XIX of the Social Security Act Medical Assistance Program*, Attachment 2.6A, p 26 (effective July 1, 1996). Section 1917d is codified at 42 USC 1396p(d), not 42 USC 1382b(e). Third, the Department’s argument is foreclosed by 42 USC 1396a(a)(10)(G), which instructs a state to “disregard the provisions of subsections (c) and (e) of section [42 USC] 1382b” when it applies the “eligibility criteria of the [SSI] program under subchapter XVI for purposes of determining eligibility for medical assistance under the State plan of an individual who is not receiving [SSI]” Congress added 42 USC 1396a(a)(10)(G) and the SSI trust rules with the enactment of the Foster Care Independence Act. Plaintiffs here are medically needy applicants who are not receiving SSI; therefore, 42 USC 1382b(c) and (e) do not apply to evaluating their eligibility for Medicaid benefits.

²² The Supreme Judicial Court of Massachusetts interprets the any-circumstances rule, 42 USC 1396p(d)(3)(B)(i), in the same manner. See *Daley v Secretary of Executive Office of Health & Human Servs*, 477 Mass 188, 193; 74 NE3d 1269 (2017) (“The effect of the [any-circumstances] 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.”).

assets held by an irrevocable trust available to an institutionalized spouse, then the value of such assets is countable for the purposes of 42 USC 1396r-5(c).

There is no inconsistency created by our reading of 42 USC 1396r-5 and 42 USC 1396p(d), and therefore the preemptive provision of 42 USC 1396r-5(a)(1) does not apply.²³ As discussed before, the general resource-allocation rules of 42 USC 1396r-5(c), on their own, do not treat assets held by a trust as a resource available to either spouse. If a resource is not available to either spouse, then it is not a countable asset for the purpose of an institutionalized spouse's initial eligibility determination. See 42 USC 1396r-5(c)(2). The specific provisions governing the treatment of trusts in 42 USC 1396p(d) make the vast majority of assets held by a trust created by an institutionalized spouse available to that spouse by operation of law, while leaving open the possibility that some such assets will remain legally unavailable. The general provisions of 42 USC 1396r-5 can therefore be read in harmony with the specific provisions of 42 USC 1396p(d), and no inconsistency exists. See *People v Calloway*, 500 Mich 180, 185-186; 895 NW2d 165 (2017) (“[W]hen a statute contains a general provision and a specific provision, the specific provision controls.”); *People v Mazur*, 497 Mich 302, 313; 872 NW2d 201 (2015) (“Under the [*in pari materia*] doctrine, statutes that relate to the same subject or that share a common purpose should, if possible, be read together to create a harmonious body of law.”).

²³ 42 USC 1396r-5(a)(1) states:

In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (h)(1)), the provisions of this section supersede any other provision of this subchapter (including sections 1396a(a)(17) and 1396a(f) of this title) which is inconsistent with them.

In summary, the principal of an irrevocable trust formed solely for the benefit of a community spouse is not per se a “resource available” to an institutionalized spouse under 42 USC 1396r-5(c)(2) for the purpose of determining an institutionalized spouse’s eligibility for Medicaid benefits. Assets making up the principal of such a trust are not automatically considered countable assets for Medicaid eligibility determinations. However, the principal of an irrevocable trust *may* become a resource available to an institutionalized spouse, and thus a countable asset, if the following conditions are met: (1) assets of the institutionalized spouse are used to form the principal of the trust, 42 USC 1396p(d)(2)(A); (2) the institutionalized spouse, his or her spouse, or one of the other entities listed under 42 USC 1396p(d)(2)(A)(i) through (iv) established the trust using a means other than a will; and (3) there are “any circumstances under which payment from the trust could be made to or for the benefit of” the institutionalized spouse, 42 USC 1396p(d)(3)(B)(i).

IV. APPLICATION

To determine whether the SBO trusts at issue allow for a payment to be made “to or for the benefit of” the institutionalized spouses, we must look to the language of the trust documents themselves. 42 USC 1396p(d)(3)(B); *BEM 401* at 10. If the principal of each SBO trust at issue is rightly considered to be a countable asset, the Department properly denied plaintiffs’ applications. However, if the Department has deemed, as countable assets, property that the federal statutes do not consider available to plaintiffs, then the Department’s decisions are contrary to law.

It is undisputed that each plaintiff is an individual whose eligibility for Medicaid benefits is being determined under 42 USC 1396p(d)(1). It is also undisputed that, in each case, assets of the institutionalized spouse were used to establish the SBO trusts. Accordingly, the institutionalized spouses in these cases are individuals who have established a trust pursuant to 42 USC 1396p(d)(2). The SBO trusts at issue are irrevocable trusts, meaning the principal of each trust is not automatically rendered available to the institutionalized spouse. 42 USC 1396p(d)(3)(A) and (B). Furthermore, the property and income that make up the principal of the SBO trusts at issue are not held by the institutionalized spouses or the community spouses. Rather, title to the property that is now the principal of each trust was transferred to the trust or trustee, and the money that forms part of the principal was moved into bank accounts controlled by the trustee. There also has been no suggestion that the community spouses retain possession of the tangible property that forms the principals of the trusts. Therefore, the principals of the SBO trusts are not automatically considered resources available to any of the spouses under 42 USC 1396r-5(c). Accordingly, the principal of each SBO trust can be considered a resource available to the institutionalized spouse, and thus a countable asset, only if made so by operation of the any-circumstances rule in 42 USC 1396p(d)(3)(B).

As the Court of Appeals correctly noted, each of the SBO trusts at issue instructs the trustee to “use up” or deplete the entirety of the principal during the community spouse’s lifetime. All three SBO trusts also include language instructing the trustees to distribute the assets “on a[n] actuarially sound basis,” which means that the “spending must be at a rate that will use up all the resources during the person’s lifetime.” *BEM 405* (July 1, 2014), p 12. However, the Court of Appeals erroneously concluded that, because the

community spouses could be paid by the trusts, this automatically created a “ ‘condition under which the principal could be paid to or on behalf of the person from an irrevocable trust,’ ” meaning that “the assets in each trust were properly determined to be countable assets by the Department. *BEM 401* at 12.” *Hegadorn v Dep’t of Human Servs Dir*, 320 Mich App 549, 563-564; 904 NW2d 904 (2017). The Court of Appeals read the word “person” in *BEM 401* as referring to both the applicants and their spouses in all circumstances. As already discussed, the rule in *BEM 401* is derived from 42 USC 1396a and the any-circumstances rule in 42 USC 1396p(d)(3)(B). The any-circumstances rule makes assets in an irrevocable trust available to a Medicaid applicant only if there are circumstances under which “a payment from the trust” could be made “to or for the benefit of” the applicant. 42 USC 1396p(d)(3)(B). The Department’s contrary interpretation and application of *BEM 401*, which incorporates the federal any-circumstances rule into Michigan’s Medicaid policies, is not entitled to respectful consideration because it is foreclosed by the text of 42 USC 1396p(d)(3)(B). See *Rovas*, 482 Mich at 108.

In determining whether payments can be made from a trust to an individual or for the individual’s benefit, CMS instructs the Department to “take into account any restrictions on payments, such as use restrictions, exculpatory clauses, or limits on trustee discretion that may be included in the trust.” CMS, *State Medicaid Manual*, § 3259.6(E) (rev 64), p 3-3-109.30. The SBO trusts at issue all contain language stating that distributions or payments from the trust may only be made to or for the *benefit* of the *respective community spouse* and that the trust resources may be used only for the

*community spouse's benefit.*²⁴ The ALJs and the Court of Appeals recognized this but erred by concluding that payments to or for the benefit of the community spouses were available to the institutionalized spouses. Because the community spouses are not themselves applying for or receiving Medicaid benefits, they are not “the individual” referred to in 42 USC 1396p(d)(3)(B).²⁵ Thus, the Court of Appeals erred by holding that the possibility of a distribution from each SBO trust to each community spouse automatically made the assets held by each SBO trust countable assets for the purposes of

²⁴ See Lollar Trust, § 2.2 (“Trustee shall from time to time during the fiscal year pay or distribute to me, or for my sole benefit, during my lifetime . . . part or all of the net income and principal During my lifetime, no Resources of the Trust can be used for anyone other than me, except for Trustee fees.”); Hegadorn Trust, § 2.2 (“Trustee shall from time to time during the fiscal year pay or distribute to me, or for my sole benefit, during my lifetime . . . part or all of the net income and principal During my lifetime, no Resources of the Trust can be used for anyone other than me.”); Ford Trust, § 2.2 (“Trustee shall from time to time during the fiscal year pay or distribute to me, or for my sole benefit, during my lifetime . . . part of the net income and principal During my lifetime, no Resources of the Trust may be used for anyone other than me, except for Trustee Fees.”).

²⁵ We note that CMS has advised that “the individual” might sometimes include an applicant’s spouse when that spouse is acting on behalf of the applicant. See CMS, *State Medicaid Manual*, § 3257(B)(1), p 3-3-109 (“As used in this instruction, the term ‘individual’ includes the individual himself or herself, as well as . . . [t]he individual’s spouse, *where the spouse is acting in the place of or on behalf of the individual*.”) (emphasis added); § 3259.6(D), p 3-3-109.29 (“Payments are considered to be made to the individual when any amount from the trust . . . is paid directly to the individual *or to someone acting on his/her behalf, e.g., a guardian or legal representative.*”) (emphasis added). There are documents in the administrative record indicating that Mr. Hegadorn was made the legal guardian of his wife prior to creating the Hegadorn Trust and that Mrs. Lollar granted to her husband a durable power of attorney prior to the creation of the Lollar Trust. ALJ Lain made no findings of fact or conclusions of law with regard to these legal instruments, and the Department has not argued that these documents should affect our analysis. Accordingly, we decline to address whether these legal instruments affect plaintiffs’ eligibility for benefits at this time.

the respective institutionalized spouses' initial eligibility determination.²⁶ Accordingly, we reverse the Court of Appeals judgment because it was premised on an incorrect reading of the controlling statutes and thus was contrary to law. It follows that the ALJs' decisions are also contrary to law and cannot stand, given that they all suffer from the same faulty reasoning employed by the Court of Appeals. See MCL 24.306(1)(a) and (f).

The question now becomes what relief should be granted. The APA gives this Court some discretion in crafting relief that is appropriate to each case arising from an administrative appeal. See MCL 24.306(2) ("The court, as appropriate, may affirm, reverse or modify the decision or order or remand the case for further proceedings."). The sheer complexity of the Medicaid program and the Department's legitimate concerns about potential abuse are paramount considerations in determining what relief is warranted. We further note that, given the reasoning employed in resolving the administrative appeals, the ALJs may have forgone consideration of alternative avenues of legal analysis. In light of these concerns, we decline to order that the Department approve plaintiffs' Medicaid applications at this time. Instead, we vacate the final administrative hearing decision in

²⁶ We acknowledge that our decision on this issue is at odds with the opinion of the United States Court of Appeals for the Third Circuit in *Johnson v Guhl*, 357 F3d 403, 408-409 (CA 3, 2004) (holding that 42 USC 1396p(d)(3)(B)(i) is satisfied if "[o]nce the community spouse receives these payments, there is nothing preventing her or him from sharing them with the institutionalized spouse as well."). While the Third Circuit appears to agree that "the individual" refers to an applicant for or recipient of Medicaid benefits, its conclusory analysis disregards the statutory language requiring that the payment be a "payment *from the trust*" that "could be made *to or for the benefit of* the individual." 42 USC 1396p(d)(3)(B)(i) (emphasis added). The Third Circuit's broad language also effectively reads away any difference in the language used in the § 1396p(d)(3) any-circumstances rule and the § 1382b(e) any-circumstances rule.

each case and remand each case to the appropriate administrative tribunal for the proper application of the any-circumstances test. If the ALJs determine that circumstances exist under which payments from the trusts could be made to or for the benefit of the institutionalized spouse, then the ALJs should explain this rationale and affirm the Department's decision. However, if no such circumstances exist, the ALJs should reverse the Department's decisions and order that the Medicaid applications be approved.

V. CONCLUSION

Neither 42 USC 1396r-5 nor 42 USC 1396p(d) automatically makes marital assets placed in an irrevocable trust for the sole benefit of a community spouse countable assets for the purpose of an institutionalized spouse's initial eligibility determination. Rather, such assets become countable only if circumstances exist under which the trust could make a payment to or for the benefit of the institutionalized spouse. Accordingly, we reverse the judgment of the Court of Appeals.

Because the ALJs' decisions were largely grounded in the same flawed legal reasoning that was employed by the Court of Appeals, we vacate the final hearing decision of the ALJ in each case. We remand all three cases for any additional administrative proceedings necessary to evaluate the legal validity of the Department's decision to deny each plaintiff's Medicaid application. See MCL 24.306(2). We do not retain jurisdiction.

Richard H. Bernstein
Bridget M. McCormack
Stephen J. Markman
Brian K. Zahra
David F. Viviano
Elizabeth T. Clement

STATE OF MICHIGAN

SUPREME COURT

RALPH D. HEGADORN, Personal
Representative of the Estate of MARY
HEGADORN,

Plaintiff-Appellant,

v

No. 156132

DEPARTMENT OF HUMAN SERVICES
DIRECTOR,

Defendant-Appellee.

DEBORAH D. TRIM, Personal
Representative of the Estate of DOROTHY
LOLLAR,

Plaintiff-Appellant,

v

No. 156133

DEPARTMENT OF HUMAN SERVICES
DIRECTOR,

Defendant-Appellee.

DENISE TINDLE, Personal Representative
of the ESTATE OF ROSELYN FORD,
Plaintiff-Appellant,

v

No. 156134

DEPARTMENT OF HEALTH AND
HUMAN SERVICES,
Defendant-Appellee.

MCCORMACK, C.J. (*concurring*).

The plaintiffs¹ applied for Medicaid to help defray the costs of nursing-home services. That's what Medicaid is for, but eligibility for its financial assistance is means-tested. To satisfy Medicaid's income and resource limits while preserving their assets, the plaintiffs each formed and funded an irrevocable "solely for the benefit of" (SBO) trust. The critical feature of these SBO trusts is that during each plaintiff's *spouse's* lifetime, distributions from the trusts could be made only to that spouse. I agree with the majority that property held in these SBO trusts is not countable toward Medicaid's resource limit because "the individual" in 42 USC 1396p(d)(3)(B) refers to the Medicaid applicant.

But I also believe that the plaintiffs' transfer of assets into the trusts triggers Medicaid's divestment rules. This issue has not been presented here, for understandable procedural reasons. I believe such a discussion is necessary, however, as a caution. If I am correct, then the plaintiffs' overall planning strategy would be undermined: although they would be able to satisfy Medicaid's threshold resource test, the plaintiffs would be disqualified from receiving Medicaid benefits for a time period calculated by reference to the value of the transferred assets. And because their strategy involves irrevocable trusts, there is no way to unwind the transfer. In short, the majority opinion should not be interpreted as permitting a married Medicaid applicant to shelter and preserve any amount of wealth without restriction, and then immediately receive financial assistance as if she did not have it.

¹ "The plaintiffs" refers to the original plaintiffs who began these proceedings.

I. MEDICAID BACKGROUND

The federal Medicaid Assistance Program (Medicaid), enacted as Title XIX of the Social Security Act, 42 USC 1396 *et seq.* (the Medicaid Act or the Act), is a program through which the federal government shares, along with participating states, the cost of providing financial assistance for medical services to “families with dependent children and [to] aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services” 42 USC 1396-1. State participation in the program is optional. States that do participate, however, must comply with federal law, including those provisions set forth in 42 USC 1396p regarding “liens, adjustments and recoveries of medical assistance correctly paid[,] transfers of assets, and treatment of certain trusts[.]” 42 USC 1396a(a)(18). In Michigan, the program is administered by the Department of Health and Human Services (the Department), of which defendant is the director. MCL 400.105; see note 5 of the majority opinion.

To be eligible for Medicaid financial assistance for nursing-home services, each plaintiff’s countable assets² could not exceed \$2,000. See Part III(B)(1) of the majority opinion. The plaintiffs established these SBO trusts to reduce their countable assets to satisfy this limit.

² The term “assets” encompasses both “resources” and “income.” 42 USC 1396p(h)(1). While the parties use the term “countable assets” to refer to Medicaid’s nonincome eligibility criteria, it should be understood that, for purposes of determining financial eligibility, “resources” and “income” are evaluated differently. See 42 USC 1396r-5(b) and (c) and Part I(A) of this opinion.

A. ELIGIBILITY FOR NURSING-HOME SERVICES

For married applicants such as the plaintiffs, the eligibility rules for nursing-home services begin with the “spousal impoverishment” provisions of the Medicaid Act. See 42 USC 1396r-5. Enacted by Congress in 1988, these provisions “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’^[3]) is institutionalized, usually in a nursing home, and becomes eligible for Medicaid.” *Wis Dep’t of Health & Family Servs v Blumer*, 534 US 473, 478; 122 S Ct 962; 151 L Ed 2d 935 (2002).

Congress achieved this in two ways. First is the treatment of income. For any month in which the institutionalized spouse receives nursing-home services, the Medicaid Act provides that “no income of the community spouse shall be deemed available to the institutionalized spouse.” 42 USC 1396r-5(b)(1). “The community spouse’s income is thus preserved for that spouse and does not affect the determination whether the institutionalized spouse qualifies for Medicaid. In general, such income is also disregarded in calculating the amount Medicaid will pay for the institutionalized spouse’s care after

³ The term “institutionalized spouse” refers to “an individual who . . . is in a medical institution or nursing facility . . . and . . . is married to a spouse who is not in a medical institution or nursing facility[.]” 42 USC 1396r-5(h)(1). The “community spouse” is “the spouse of an institutionalized spouse.” 42 USC 1396r-5(h)(2). Elsewhere, Congress has used the term “institutionalized individual” to refer to “an individual who is an inpatient in a nursing facility” 42 USC 1396p(h)(3). Congress, however, has not provided a specific definition for the spouse of an “institutionalized individual,” presumably because 42 USC 1396p (unlike the spousal-impoverishment provisions) applies to Medicaid applicants regardless of their marital status. More confusing yet, Congress in 42 USC 1396p uses undefined terms such as “an individual,” “the individual,” and “the individual’s spouse.”

eligibility is established.” *Blumer*, 534 US at 480-481; see 42 USC 1396r-5(b)(2). The spousal-impoverishment provisions also establish a “minimum monthly maintenance needs allowance.” 42 USC 1396r-5(d)(3). Under 42 USC 1396r-5(d), if the community spouse’s income is ever less than the allowance, the Act permits the institutionalized spouse to reallocate her income (up to the amount of the shortfall) to the community spouse, thereby resulting in Medicaid’s paying a greater portion of the institutionalized spouse’s nursing-home expenses. *Blumer*, 534 US at 481-482.

The second way in which Congress protects a community spouse is through the Act’s treatment of marital resources and the “community spouse resources allowance” (CSRA). As the Court explained in *Blumer*:

For purposes of establishing the institutionalized spouse’s Medicaid eligibility, a portion of the couple’s assets is reserved for the benefit of the community spouse. [42 USC 1396r-5(c)(2)]. To determine that reserved amount (the CSRA), the total of all of the couple’s resources (whether owned jointly or separately) is calculated as of the time the institutionalized spouse’s institutionalization commenced; half of that total is then allocated to each spouse (the “spousal share”). [42 USC 1396r-5(c)(1)(A)]. The spousal share allocated to the community spouse qualifies as the CSRA, subject to [a statutory maximum and minimum]. The CSRA is considered unavailable to the institutionalized spouse in the eligibility determination, but all resources above the CSRA (excluding a small sum set aside as a personal allowance for the institutionalized spouse, currently \$2,000 . . .) must be spent before eligibility can be achieved. [42 USC 1396r-5(c)(2)]. [*Blumer*, 534 US at 482-483.]

Together, these rules “assur[e] that the community spouse has a sufficient—but not excessive—amount of income and resources available.” *Id.* at 480 (citation and quotation marks omitted).

B. THE MEDICAID TRANSFER RULES

To prevent an institutionalized individual from simply giving away her assets to satisfy the Medicaid Act's eligibility criteria, Congress implemented a divestment penalty. This penalty is based on a look-back date—a set time before the individual's application for Medicaid benefits. 42 USC 1396p(c)(1)(B).⁴ If an institutionalized individual or her spouse “disposes of assets for less than fair market value” at any point after the look-back date, 42 USC 1396p(c)(1)(A), she is disqualified from receiving financial assistance for nursing-home services for a length of time set by statutory formula, see 42 USC 1396p(c)(1)(D) and (E). That disqualification applies regardless of whether the individual is otherwise eligible for or even receiving Medicaid financial assistance. See *id.* The period of disqualification is determined by dividing the total uncompensated value of the transferred assets by the average monthly cost of nursing-home services. 42 USC 1396p(c)(1)(E)(i).

In plainer terms, if either spouse disposes of assets for less than fair market value after the look-back date, the institutionalized spouse is disqualified from receiving financial assistance for a period that approximates the uncompensated value of the transferred assets.

But as with most rules, there are exceptions. There are certain “permissive” asset transfers, set forth in 42 USC 1396p(c)(2), that will not trigger a penalty:

(c) Taking into account certain transfers of assets

* * *

(2) An individual shall not be ineligible for medical assistance by reason of [42 USC 1396p(c)(1)] to the extent that—

⁴ Here, 60 months before plaintiffs' dates of application.

* * *

(B) the assets—

(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,

(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,

(iii) were transferred to, or to a trust (including a trust described in [42 USC 1396p(d)(4)]) established solely for the benefit of, the individual's child described in [42 USC 1396p(c)(2)(A)(ii)(II)⁵], or

(iv) were transferred to a trust (including a trust described in [42 USC 1396p(d)(4)]) established solely for the benefit of an individual under 65 years of age who is disabled[.]⁶

The permissive transfers set forth at 42 USC 1396p(c)(2)(B)(i) and (ii) are important here. They allow unlimited transfers between an institutionalized individual and her spouse (that is, between the institutionalized spouse and the community spouse). This is sensible: as discussed, the Medicaid Act's resource rules require the Department to begin its initial resource evaluation by computing "the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest" 42 USC 1396r-5(c)(1)(A)(i); see *Blumer*, 534 US at 482-483.

⁵ That is, a child who is under 21, blind, or disabled.

⁶ Additionally, the Medicaid Act permits an individual to transfer his or her home without incurring a penalty, so long as the transferee is the individual's spouse or, under specific conditions, close relatives. 42 USC 1396p(c)(2)(A). While the value of an individual's home is generally not included in the initial resource evaluation, a home is considered an "asset" for purposes of the transfer rules. See 42 USC 1396p(c)(5); 42 USC 1382b(a)(1). Thus, a transfer of the home after the look-back date will incur a divestment penalty, unless the transfer is specifically permitted under 42 USC 1396p(c)(2)(A).

Again, in plainer terms: there is no reason to penalize an interspousal transfer of assets because resources belonging to both spouses are combined in determining an applicant's *eligibility*. Because spousal resources are accounted for in the Medicaid eligibility process no matter which spouse holds them, there is no need to penalize a transfer from one spouse to the other.

In addition to interspousal transfers, the Medicaid Act does not penalize a transfer from either spouse to a third party if the transfer is “for the sole benefit of” the Medicaid applicant's spouse (the community spouse). 42 USC 1396p(c)(2)(B)(i) and (ii). Unlike interspousal transfers, however, this exception can have a much greater impact on eligibility, because resources that are “held” by a third party might not be considered countable assets for purposes of Medicaid's financial eligibility determination. See 42 USC 1396r-5(c)(2)(A) (“In determining the resources of an institutionalized individual . . . [,] except as provided in subparagraph (B) [concerning the CSRA], all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse . . .”). This exemption is pivotal to the plaintiffs' Medicaid planning strategy; if the transfers of assets into the SBO trusts are not “for the sole benefit of” the community spouse, then the transfers should incur a divestment penalty.

Congress also provided specific transfer rules for two categories of assets: the purchase of an annuity and the purchase of a promissory note, loan, or mortgage. For annuities, 42 USC 1396p(c)(1)(F) provides that “the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value”—that is, a penalized transfer—“unless . . . (i) the State is named as the remainder beneficiary in the first position for at

least the total amount of medical assistance paid on behalf of the institutionalized individual under this subchapter; or (ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.” This provision ensures that if a community-spouse annuitant does not survive the annuity’s term, the state agency, rather than a third-party beneficiary or heir (other than a minor or disabled child), will be paid the remaining annuity payments up to the total amount of Medicaid assistance paid on behalf of the institutionalized spouse.⁷ See *Hutcherson v Arizona Health Care Cost Containment Sys Admin*, 667 F3d 1066, 1070 (CA 9, 2012) (“We will give the plain meaning to the unambiguous language in § 1396p(c)(1)(F)(i), which allows states to reach a deceased community spouse’s annuity for costs incurred on behalf of an institutionalized spouse.”).

Additionally, 42 USC 1396p(c)(1)(G) provides that an annuity “purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services” will be treated as an “asset” unless the annuity is purchased with proceeds from certain retirement accounts or the annuity contract is irrevocable and nonassignable,

⁷ Likewise, Congress has required a state payback provision to be included in any trust that is exempt from the general trust rules. See 42 USC 1396p(d)(4). Thus, while certain transfers of assets into exempt trusts are permitted penalty-free, see 42 USC 1396p(c)(2)(B)(iii) and (iv), those assets are still subject to a Medicaid payback. The only nonpenalized transfer of assets not subject to Medicaid payback, other than transfers “for the sole benefit of” the community spouse, are transfers directly to a blind or disabled child and the transfer of a home under specific conditions. See 42 USC 1396p(c)(2)(B)(iii) (incorporating the description of a blind or disabled child in 42 USC 1396p(c)(2)(A)(ii)(II)); 42 USC 1396p(c)(2)(A).

the contract is actuarially sound, and the payments are equal during the term of the annuity. The Department has interpreted these latter requirements (irrevocable and nonassignable, actuarially sound, and providing for equal monthly payments) as applying to all annuities purchased with countable resources; otherwise, the transfer is subject to penalty. See Michigan Department of Health and Human Services, *Bridges Eligibility Manual 401* (July 2014), p 5.⁸ The purchase of a community-spouse annuity that satisfies the requirements of 42 USC 1396p(c)(1)(F) and (G)—a “qualified” community-spouse annuity—will not trigger a divestment penalty, because the transfer is for “the sole benefit of” the community spouse. 42 USC 1396p(c)(2)(B)(i) and (ii).

For the purchase of a debt obligation, 42 USC 1396p(c)(1)(I) provides, for purposes of the transfer rules, that “the term ‘assets’ includes funds used to purchase a promissory note, loan, or mortgage,” unless the debt instrument: (i) has an actuarially sound repayment term, (ii) is payable in equal installments, and (iii) does not allow for cancellation of the balance upon the death of the lender. 42 USC 1396p(c)(1)(I)(i) through (iii). In plainer terms, if the debt instrument does not satisfy these requirements, the transferred assets (the assets used to purchase the note, loan, or mortgage) will be subject to a divestment penalty.

While there is considerably less caselaw addressing 42 USC 1396p(c)(1)(I) than that addressing annuities, when such transfers are challenged, courts have considered whether the transaction is bona fide or an attempt to circumvent the Medicaid eligibility and transfer rules. See *Landy v Velez*, 958 F Supp 2d 545, 554 (D NJ, 2013) (“To be bona fide, an

⁸ The Medicaid Act also requires an applicant to disclose in her application any interest she or her spouse has in an annuity, regardless of whether the annuity is countable as a resource. See 42 USC 1396p(e).

informal cash loan must (1) be enforceable under state law, (2) be in effect at the time of the transaction, (3) contain an acknowledgement of an obligation to repay and (4) have a plan for repayment (5) which is feasible in light of ‘the amount of the loan, the [borrower]’s resources and income, and the [borrower]’s living expenses.’ ”), quoting Social Security Administration, *Program Operations Manual System*, SI 01120.220(D)(1) through (5).

These annuity and debt obligation rules were added by the Deficit Reduction Act of 2005, PL 109-171; 120 Stat 4 (the DRA). In enacting the DRA, Congress “sought to further close loopholes in the Medicaid Act.” *Hutcherson*, 667 F3d at 1069. The DRA achieved this by “restrict[ing] the use of annuities by Medicaid applicants in order to prevent applicants from sheltering their assets in anticipation of Medicaid eligibility.” *Carlini v Velez*, 947 F Supp 2d 482, 486 (D NJ, 2013); see also *Morris v Oklahoma Dep’t of Human Servs*, 685 F3d 925, 935-938 (CA 10, 2012) (explaining how the conversion of spousal resources into a stream of future payments for the community spouse exploits the Act’s separate treatment of income postinstitutionalization). Such restrictions further Congress’s interest in “preventing financially secure couples from obtaining Medicaid assistance.” *Blumer*, 534 US at 480.

All these restrictions make little sense, however, if 42 USC 1396p(c) and (d) allow married couples to immediately transfer unlimited assets to a community spouse, without incurring any divestment penalty, simply by placing assets into an SBO trust.

C. MEDICAID’S TRUST RULES

Section 1396p(d) provides a “comprehensive system of asset-counting rules for determining who qualifies for Medicaid.” *Lewis v Alexander*, 685 F3d 325, 332 (CA 3,

2012). Enacted by the Omnibus Budget Reconciliation Act (OBRA) of 1993, PL 103-66; 107 Stat 312, see Part III(A) of the majority opinion, the current trust rules responded to “Medicaid’s original asset-counting rules, [under which] individuals could put large sums of money in trust, thereby vesting legal title to those assets in the trust and reducing (on paper) the amount of assets owned by the individual.” *Lewis*, 658 F3d at 332. “In the 1993 OBRA amendments, Congress established a general rule that trusts would be counted as assets for the purpose of determining Medicaid eligibility.” *Id.* at 333.

The majority has explained well the general rules for revocable and irrevocable trusts. But one feature bears emphasis: Congress has specifically exempted three types of trusts from those general trust rules. See 42 USC 1396p(d)(4)(A) through (C).⁹ Two of these “(d)(4) trusts”—special-needs trusts and pooled trusts (42 USC 1396p(d)(4)(A) and (C))—allow a *disabled* beneficiary to receive assets without disqualifying the beneficiary for Medicaid assistance. The third, a qualified-income trust (42 USC 1396p(d)(4)(B)), allows individuals in certain states to control the amount of income used to determine Medicaid eligibility. All of these trusts serve very different purposes than SBO trusts. But just as with the rules for annuities, the rules for these exempted (d)(4) trusts require that, upon the death of the trust beneficiary (or beneficiaries), any remaining trust assets must be used to pay back the state agency up to the amount of Medicaid financial assistance expended on behalf of the trust beneficiary or beneficiaries. See 42 USC 1396p(d)(4)(A), (B)(ii), and (C)(iv).

⁹ And certain transfers into these (d)(4) trusts are exempt from the divestment penalty. See 42 USC 1396p(c)(2)(B)(iii) and (iv).

The plaintiffs' Medicaid planning strategy—SBO trusts—implicates the general rules for irrevocable trusts at 42 USC 1396p(d)(3)(B). As the majority explains, any property held in an SBO trust is not an available “resource” of the married couple for purposes of Medicaid's financial eligibility determination, because the trust is irrevocable and legal title is held by the third-party trustee; the trust property is therefore not countable, because it “is not held by either spouse.” And because the terms of these SBO trusts require that any distribution be made to the plaintiffs' spouses (the community spouses) for the spouses' lifetimes, there can never be “any circumstances under which payment from the [SBO] trust could be made to or for the benefit of” these plaintiffs. 42 USC 1396p(d)(3)(B)(i).

Normally, such a transfer would trigger the divestment penalty, as the property held in trust is “assets disposed by the [institutionalized] individual for purposes of” the transfer rules. 42 USC 1396p(d)(3)(B)(ii). But according to the plaintiffs, the transfer of marital assets into these SBO trusts are exempt from the divestment penalty, because they are transfers to a third party (the trusts) “for the sole benefit of” the community spouse. See 42 USC 1396p(c)(2)(B)(i) and (ii). In short, the plaintiffs' theory is that an institutionalized individual can achieve immediate (penalty-free) eligibility for Medicaid financial assistance by simply placing any assets over the eligibility limit in an irrevocable trust, and also avoid the divestment penalty that accompanies that kind of divestment, so long as any payments from the trust are made only to the community spouse during his lifetime.

The result: a perfect loophole to Congress's carefully constructed eligibility and transfer rules.

D. THE STATUTORY TEXT: “FOR THE SOLE BENEFIT OF”

I agree with the majority that “the individual” in 42 USC 1396p(d)(3)(B) refers to the Medicaid applicant.¹⁰ But I doubt the plaintiffs’ interpretive victory will ultimately prove to be an effective Medicaid planning strategy. The strategy only works if the plaintiffs can avoid a divestment penalty. The plaintiffs believe they can do so because their transfers of assets into the SBO trusts were “for the sole benefit of” the community spouses. 42 USC 1396p(c)(2)(B). The lower courts were never presented with this question because the Department had no reason to impose a penalty, given its conclusion that these plaintiffs did not satisfy the Act’s eligibility criteria. The majority opinion sensibly declines to address the penalty issue. Because I see a significant hurdle for plaintiffs whenever this question is addressed, I write separately to explain.

¹⁰ The plaintiffs emphasize that Congress did include “the individual’s spouse” within what the majority describes as the “any-circumstances rule” of 42 USC 1396p(d)(3)(B), as Congress did with the comparable Supplemental Security Income (SSI) provision. While my analysis differs from that of the Court of Appeals, I agree with the panel that Congress intended for spousal resources to be evaluated jointly and that the interpretation urged by the plaintiffs runs counter to that intent, especially given the spousal-impoverishment provisions. The majority concludes that this was not a mere oversight because of Congress’s inclusion of “the individual’s spouse” in the rules governing the SSI program. Maybe. But I’m not as convinced as the majority that the omission was intentional. As the majority observes, “the Medicaid trust rules in 42 USC 1396p(d) were added by OBRA 93, six years before Congress added the SSI trust rules in 42 USC 1382b(e)” In other words, when Congress enacted 42 USC 1396p(d)(3)(B), it was writing on a clean slate—there was no comparable SSI statute. And Congress has not amended 42 USC 1396p(d)(3)(B) at any time since. But even if Congress intended for the SSI rules to operate differently, or if instead Congress was putting a finer point on what it thought to be the existing Medicaid rule (and should have also amended that rule), I nevertheless agree with the majority that the Act’s reference to “the individual” in 42 USC 1396p(d)(3)(B) unambiguously refers to the Medicaid applicant.

Congress has not defined “for the benefit of [the institutionalized spouse]” in the trust rules. 42 USC 1396p(d)(3). Likewise, Congress has not defined “for the sole benefit of [the community spouse]” in the transfer rules. 42 USC 1396p(c)(2)(B). If words are not defined by statute, we give them their ordinary meaning. The definitions of “sole” and “benefit” are uncontroversial. For example, *Merriam-Webster’s Collegiate Dictionary* (11th ed) defines the term “benefit” as “something that promotes well-being” and “useful aid.” “Sole” is defined as “having no sharer” and “being the only one.” *Id.* Other dictionaries agree. And the statutory text gives us another clue: a payment “for the benefit of” an individual must mean something different than a payment “to” an individual, given Congress’s use of both connected by “or” in 42 USC 1396p(d)(3)(B) (“to *or* for the benefit of the [institutionalized] individual”) and 42 USC 1396p(c)(2)(B)(i) (“to the individual’s spouse *or* to another for the sole benefit of the individual’s spouse”) (emphasis added).

So is a transfer of assets to a third-party trustee “for the sole benefit of” the community spouse if that transfer “benefits” the institutionalized spouse by allowing her to satisfy Medicaid’s eligibility limits while avoiding the specific rules that apply to community-spouse annuities? And if the community spouse receives a payment from an SBO trust and then shares that payment with the institutionalized spouse, is that a circumstance in which “payment from the trust” is “made . . . for the benefit of” the institutionalized spouse?¹¹

¹¹ So thought the United States Court of Appeals for the Third Circuit in *Johnson v Guhl*, 357 F3d 403, 408-409 (CA 3, 2004). *Johnson* concerned the use of so-called “community spouse annuity trusts” (CSATs) in the state of New Jersey. CSATs, like these SBO trusts, were irrevocable and “designed to provide a stream of annuity payments to the community spouse for the duration of his or her life.” *Guhl*, 357 F3d at 406. If the trust named the

Even harder: what if an SBO trust names as a remainder beneficiary a person or entity other than the state agency? That is, if a third party can receive the remainder, is the transfer “for the sole benefit of” the community spouse?

The simplest answer might be “yes”—there *are circumstances* under which a distribution from an SBO trust to a community spouse is “for the benefit of” the institutionalized spouse, and there *are persons* other than the community spouse who might “benefit” from a transfer of assets into an irrevocable SBO trust, if that transfer and trust make the institutionalized spouse eligible for benefits. If that’s right, then there are

state agency as the first remainder beneficiary, New Jersey would not consider the trust property as a countable asset. *Id.* The state changed its policy after the federal Department of Health and Human Services advised that such trusts should, in fact, be considered countable assets. *Id.* The plaintiffs challenged this interpretation. The Third Circuit agreed with the state:

As this is a question of statutory interpretation, we begin (and end) our inquiry with the relevant statute, 42 U.S.C. § 1396p(d)(3)(B). That provision provides, in subsection (i), that “[i]n the case of an irrevocable trust—if there are any circumstances under which payment from the trust could be made to or for the benefit of [the institutionalized spouse whose assets are used to establish the trust], 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. . . .” Both parties agree that CSATs are irrevocable trusts. They are generally funded with marital assets (assets that belong to both spouses). Moreover, CSATs are designed so that the corpus and the income on the corpus will provide the community spouse a stream of payments. Once the community spouse receives these payments, there is nothing preventing her or him from sharing them with the institutionalized spouse as well. Section 1396p(d)(3)(B)(i) thus squarely covers CSATs—as “circumstances [exist] under which payment from the trust could be made to or for the benefit of” the institutionalized spouse—and deems them countable resources. Accordingly, we affirm the District Court ruling that plaintiffs’ CSAT assets are countable resources. [*Guhl*, 357 F3d at 408-409 (alterations in original).]

circumstances under which a distribution from an SBO trust to a community spouse is “for the benefit of” the institutionalized spouse and the assets held in trust should be considered available resources or income for purposes of determining each plaintiffs’ eligibility for Medicaid. And if there are persons other than the community spouse who might “benefit” from a transfer of assets into an irrevocable SBO trust, then the plaintiffs should be subject to a divestment penalty.

But that expansive interpretation—one that defines becoming eligible for Medicaid as a benefit—might prove too much. That understanding would prohibit Medicaid planning strategies that Congress has endorsed. After all, the purchase of a qualified community-spouse annuity “benefits” the institutionalized spouse if the conversion of resources to income allows the institutionalized spouse to satisfy Medicaid’s financial eligibility limits without incurring a divestment penalty. See *Morris*, 685 F3d at 935-938. And, of course, the transfer rules themselves permit certain transfers to (d)(4) trusts, which might also benefit the institutionalized spouse in the eligibility determination. See 42 USC 1396p(c)(2)(B)(iii) and (iv).¹²

But the statutory requirement that the transfer be “for the *sole* benefit of” the community spouse is still a hurdle that the plaintiffs must overcome if they are to receive immediate financial assistance. On this point, the statute’s plain language, and federal guidance, are instructive.

¹² But here too, the transferred assets may be subject to a payback mechanism, because that is a condition of all the (d)(4) trust exceptions. See Part I(B) of this opinion.

There are no federal regulations interpreting 42 USC 1396p. The Centers for Medicare & Medicaid Services (CMS),¹³ however, has provided guidance on the meaning of “for the sole benefit of” in the State Medicaid Manual, which includes an explanation of the transfer rules:

For the Sole Benefit of.--A transfer is considered to be for the sole benefit of a spouse, blind or disabled child, or a disabled individual if the transfer is arranged in such a way *that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.*

Similarly, a trust is considered to be established for the sole benefit of a spouse, blind or disabled child, or disabled individual *if the trust benefits no one but that individual, whether at the time the trust is established or any time in the future.* However, the trust may provide for reasonable compensation, as defined by the State, for a trustee or trustees to manage the trust, as well as for reasonable costs associated with investing or otherwise managing the funds or property in the trust. In defining what is reasonable compensation, consider the amount of time and effort involved in managing a trust of the size involved, as well as the prevailing rate of compensation, if any, for managing a trust of similar size and complexity.

A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not the spouse, blind or disabled child, or disabled individual is not considered to be established for the sole benefit of one of these individuals. In order for a transfer or trust to be considered to be for the sole benefit of one of these individuals, the instrument or document must provide for the spending of the funds involved for the benefit of the individual on a basis that is actuarially sound based on the life expectancy of the individual involved. When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void.

An exception to this requirement exists for trusts discussed in § 3259.7 [concerning the trust exemption found at 42 USC 1396p(d)(4) for

¹³ At the federal level, the Medicaid program is administered by the Secretary of Health and Human Services, who in turn exercises his authority through CMS.

supplemental needs trusts and special-needs trusts]. *Under these exceptions, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the State, up to the amount of Medicaid benefits paid on the individual's behalf.* When these exceptions require that the trust be for the sole benefit of an individual, the restriction discussed in the previous paragraph does not apply when the trust instrument designates the State as the recipient of funds from the trust. Also, the trust may provide for disbursement of funds to other beneficiaries, provided the trust does not permit such disbursements until the State's claim is satisfied. Finally, "pooled" trusts may provide that the trust can retain a certain percentage of the funds in the trust account upon the death of the beneficiary. [CMS, *State Medicaid Manual*, § 3257(B)(6) (rev 64), p 3-3-109.2 (emphasis added).]

The manual provides the following guidance on the use of irrevocable trusts and the meaning of "to or for the benefit of":

C. Irrevocable Trust - Payments From All or Portion of Trust Cannot, Under Any Circumstances, Be Made to or for the Benefit of the Individual.--When all or a portion of the corpus or income on the corpus of a trust cannot be paid to the individual, treat all or any such portion or income as a transfer of assets for less than fair market value

* * *

D. Payments Made From Revocable Or Irrevocable Trusts to or on Behalf of Individual.--Payments are considered to be made to the individual when any amount from the trust, including an amount from the corpus or income produced by the corpus, is paid directly to the individual or to someone acting on his/her behalf, e.g., a guardian or legal representative.

Payments made for the benefit of the individual are payments of any sort, including an amount from the corpus or income produced by the corpus, paid to another person or entity such that the individual derives some benefit from the payment. For example, such payments could include purchase of clothing or other items, such as a radio or television, for the individual. Also, such payments could include payment for services the individual may require, or care, whether medical or personal, that the individual may need. Payments to maintain a home are also payments for the benefit of the individual.

* * *

G. **Use of Trust vs. Transfer Rules for Assets Placed in Trust.**--When a nonexcluded asset is placed in a trust, *a transfer of assets for less than fair market value generally takes place*. An individual placing an asset in a trust generally gives up ownership of the asset to the trust. If the individual does not receive fair compensation in return, you can impose a penalty under the transfer of assets provisions. [CMS, *State Medicaid Manual*, § 3259.6 (rev 64), pp 3-3-109.28 through 3-3-109.30 (emphasis added).]

The manual does not address the specific interpretation of 42 USC 1396p(d)(3)(B) that the plaintiffs advance,¹⁴ but it offers insight. First, when evaluating whether there is “any circumstance under which payment from the trust could be made to or for the benefit of” the institutionalized spouse, the question is whether the payment is “paid to another person or entity such that the [institutionalized] individual derives some benefit from the payment.” CMS, *State Medicaid Manual*, § 3259.6(D), p 3-3-109.29.

The manual is entitled to respectful consideration because this interpretation is entirely consistent with the statutory text and the ordinary meaning of “sole” and “benefit.” See *Skidmore v Swift & Co*, 323 US 134, 139-140; 65 S Ct 161; 89 L Ed 124 (1944) (explaining when an administrative policy is entitled to deference). The question, then, is not whether the community spouse is free to share the payment with the institutionalized spouse, but whether the payment itself results in a direct benefit to the institutionalized spouse, such as a purchase of goods or services for the institutionalized spouse. Cf. *Johnson*, 357 F3d at 408-409.

But there’s more to do. As the manual explains, “[w]hen a nonexcluded asset is placed in a trust, a transfer of assets for less than fair market value generally takes place.” CMS, *State Medicaid Manual*, § 3259.6(G), p 3-3-109.30. That is, the transfer is subject

¹⁴ See generally CMS, *State Medicaid Manual*, § 3259, pp 3-3-109.24 through 3-3-109.38.

to a divestment penalty. This is because 42 USC 1396p(d)(3)(B)(ii) directs that for “any portion of the trust from which . . . no payment could under any circumstances be made to the [institutionalized] individual,” that portion “shall be considered . . . to be assets disposed by the individual for purposes of” the transfer rules.

This point is critical. The plaintiffs believe that the transfer of assets into these SBO trusts is exempt from the divestment penalty because it was a transfer of assets “for the sole benefit of” the plaintiffs’ spouses. I am not convinced.

As the manual explains, “[a] transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not the spouse . . . is not considered to be established for the sole benefit of [the spouse].” CMS, *State Medicaid Manual*, § 3257(B)(6), p 3-3-109.2. And the relevant period for determining whether the “funds or property . . . pass to a beneficiary who is not the spouse” extends to “any time in the future.” *Id.* If there is any person (other than the community spouse) who might stand to benefit from the transfer of assets into an SBO trust, the transfer results in a penalty. This fits with the dictionary definitions, too—if there is another person who might benefit from the transfer, the transfer is not for the “sole” benefit of the community spouse.

In these cases, the plaintiffs’ SBO trusts generally reserved in the community spouse a testamentary power of appointment.¹⁵ That is, if any plaintiff’s spouse died before all

¹⁵ The Lollar Trust, for example, provided the community spouse with a special testamentary power of appointment for any balance held in trust. See Lollar Trust, Section 3.2. The Hegadorn Trust directed that, if the community spouse predeceased plaintiff Hegadorn, the “Trustee shall distribute the remaining trust property to the trustee of the *SPECIAL SUPPLEMENTAL CARE TRUST FOR MARY ANN HEGADORN*”; otherwise, any balance would be administered under the terms in the community spouse’s will. Hegadorn Trust, Sections 3.2-3.4. The Ford Trust provided the community spouse with a

property held in trust could be distributed to him, the remainder would be distributed according to the spouse's will. Thus, when the plaintiffs transferred their assets into these SBO trusts, there was the potential that, at some point in the future, a person other than the community spouses (the yet-to-be-determined remainder beneficiaries) might benefit from the transfer. Therefore, despite their name, these "solely for the benefit of" trusts were not for the sole benefit of the community spouse.¹⁶

What's more, the plaintiffs' interpretation of the Act makes little sense given the annuity rules and the (d)(4) trusts. Like these SBO trusts, an annuity presents the potential of a remainder beneficiary if the community spouse dies before the annuity's term. But Congress has written specific affirmative rules permitting the use of community-spouse annuities as a valid Medicaid planning strategy—so long as the annuity is actuarially sound

special testamentary power of appointment limited to his heirs; if that power was not fully exercised, the trustee was directed to "divide the remaining Trust property . . . into separate trusts, equal in value, one for each living Child and one for then living Descendants, collectively, of each deceased Child." Ford Trust, Section 3.2.

The payment terms of the trusts are less clear; while all the trusts require the trustee to make distributions on an "actuarially sound" basis, the trustee is not prohibited from distributing all of the trust property nearly immediately, in a lump-sum payment, contrary to the requirements placed on annuities. See Lollar Trust, Section 2.2; Hegadorn Trust, Section 2.2; Ford Trust, Section 2.2.

¹⁶ The possibility of a remainder beneficiary is always present in a trust, either as provided for in the trust instrument or by operation of law. If the plaintiffs' SBO trusts did not include a residuary clause, any property held in an SBO trust would revert to the settlor (or the settlor's heirs) upon the death of the community spouse. MCL 555.18. Perhaps, then, the transfer of assets into an SBO trust should *always* result in the imposition of a divestment penalty.

and the state agency is named as a remainder beneficiary.¹⁷ And the remainder-beneficiary rule for annuities shows that Congress did not intend to create an easy alternative with all the advantages and none of the disadvantages. See, e.g., *Breighner v Mich High Sch Athletic Ass'n, Inc*, 471 Mich 217, 232; 683 NW2d 639 (2004) (“[A] statutory term cannot be viewed in isolation, but must be construed in accordance with the surrounding text and the statutory scheme.”). Likewise, where Congress has permitted transfers to certain (d)(4) trusts free from penalty, see 42 USC 1396p(c)(2)(B)(iii) and (iv), Congress has explicitly required a payback mechanism in the recipient trust. See note 7 of this opinion.

E. THE MEDICAID ACT AS A WHOLE

As the Supreme Court explained in *Blumer*, “[e]ach 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.” *Blumer*, 534 US at 479 (cleaned up). And those standards must “comply with the provisions of [42 USC 1396p]” 42 USC 1396a(a)(18). If the plaintiffs’ interpretation of the Act is correct, SBO trusts would be available as a Medicaid planning strategy in every state that has elected to cover the medically needy. Yet no other jurisdiction has endorsed the legality of this type of Medicaid planning. Rather, the only

¹⁷ The only circumstance in which a third party might stand to “benefit” from a qualified community-spouse annuity is if that party is named as a second (or later) remainder beneficiary and the state agency is fully paid back for all financial assistance provided to the institutionalized spouse. But the annuity must also be irrevocable, actuarially sound, and paid out in substantially equal monthly payments; otherwise, the transfer will be penalized. See Part I(B) of this opinion. A community-spouse annuity is thus an unreliable strategy for passing wealth to others, to say the least, as it requires the premature death of the community spouse.

appellate court to have even considered such a theory rejected it, albeit on other grounds. *Johnson*, 357 F3d at 408-409.

If the plaintiffs were successful in avoiding the divestment penalty, their planning strategy would make meaningless the complex set of rules governing Medicaid eligibility. Consider, for example, an irrevocable trust that is funded with marital assets after the look-back date. The hypothetical trust provides that the third-party trustee must not make any distribution to the community spouse until after the Department has made a determination on the institutionalized spouse's eligibility (which must be made within 45 days from the date of application, see 42 CFR 435.912). The hypothetical trust further provides that, once an eligibility determination has been made, the trustee must immediately distribute all property to the community spouse. See 42 USC 1396p(d)(2)(C)(ii) and (iii) (providing that the trust rules "shall apply without regard to . . . whether the trustees have or exercise any discretion under the trust [or] any restrictions on when or whether distributions may be made from the trust . . ."). Such a trust would serve as a vehicle through which assets could be placed during the application, and then passed directly to the community spouse once an eligibility determination is made.

The plaintiffs argue that this transfer would not trigger a divestment penalty, because it would be for "for the sole benefit of" the community spouse. And there is no dispute that the distribution of assets to the community spouse would not be imputed to the institutionalized spouse; that part is settled. See 42 USC 1396r-5(b)(2) and (c)(4); *Blumer*, 534 US at 480-481. Thus, the value of the assets placed in the trust would be sheltered from the initial resource evaluation, and the distribution would not affect the institutionalized spouse's continued eligibility, nor would it change the level of financial

assistance provided by the Department. The only practical restriction is that the trust property would be inaccessible to the community spouse for the period it would take the Department to process the application. Aside from that minor inconvenience, a married applicant can evade virtually every restriction that Congress has placed on Medicaid financial assistance. There would be no limitation on the amount of assets that a Medicaid applicant could transfer penalty-free to her spouse, virtually immediately, not subject to the repayment requirements for (d)(4) trusts and trust-like devices such as annuities, and shielded from Medicaid's initial resource assessment. That result is inconsistent with the statute, especially given that Congress has already enacted complex rules that "shelter[] from diminution a standard amount of assets" (the CSRA). *Blumer*, 534 US at 478; see also *Breighner*, 471 Mich at 232. But our determination requires us to consider the entire text, not isolated parts lifted out of context. See Scalia & Garner, *Reading Law: The Interpretation of Legal Texts* (St. Paul: Thomson/West, 2012), p 167 ("Perhaps no interpretative fault is more common than the failure to follow the whole-text canon, which calls on the judicial interpreter to consider the entire text, in view of its structure and of the physical and logical relation of its many parts.").

II. CONCLUSION

In the Medicaid Act, Congress has balanced two competing policies: "protect[ing] community spouses from 'pauperization' while preventing financially secure couples from obtaining Medicaid assistance." *Blumer*, 534 US at 480. These policies are well reflected in the (admittedly complex) statutory scheme. I agree with the majority that "the individual" in 42 USC 1396p(d)(3)(B) refers to the Medicaid applicant. But if the

plaintiffs' transfers trigger the divestment penalty, it is not likely they will view this planning strategy as a success. The majority is correct to leave this question for a case in which it has been presented by the parties. I address it here only to caution individuals who might consider forming *irrevocable* trusts in an effort to achieve Medicaid eligibility, especially when other planning strategies are available, permission for which is well settled.

Bridget M. McCormack

CAVANAGH, J., did not participate in the disposition of this case because the Court considered it before she assumed office.

**STATE OF MICHIGAN
IN THE SUPREME COURT**

MARY ANN HEGADORN,

Plaintiff-Appellant,

vs.

DEPARTMENT OF HUMAN SERVICES
DIRECTOR,

Defendant-Appellee

Supreme Court No. 156132
Court of Appeals No. 329508
Livingston CC: 2014-028394-AA

ESTATE OF DOROTHY LOLLAR,
by DEBORAH D TRIM, Personal
Representative

Plaintiff-Appellant,

vs.

DEPARTMENT OF HUMAN SERVICES
DIRECTOR,

Defendant-Appellee

Supreme Court No. 156133
Court of Appeals No. 329511
Livingston CC: 2014-028395-AA

ROSELYN FORD,

Plaintiff-Appellant,

vs.

DEPARTMENT OF HUMAN SERVICES
DIRECTOR,

Defendant-Appellee

Supreme Court No. 156134
Court of Appeals No. 331242
Washtenaw CC: 15-000488-AA

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STATEMENT OF CORPORATE DISCLOSURE

The National Academy of Elder Law Attorneys, Inc. (NAELA), is a non-profit membership organization without corporate stock and without a corporate parent.

INTERESTS OF AMICUS CURIAE

NAELA is a professional organization of attorneys concerned with the rights of the elderly and disabled. It provides a professional center, including public interest advocacy, for attorneys whose work enhances the lives of people with special needs and of all people as they age.

RESTATEMENT OF QUESTIONS PRESENTED

- I. Does the statutory term “the individual” as used in 42 USC 1396p(d)(3)(B)(i) and (ii) mean the individual referenced in *id.* § 1396p(d)(1) whose application for Medicaid is governed by “the rules specified in paragraph (3)” [§ 1396p(d)(3)]?**

The Administrative Law Judge in effect answered this question no.

The Circuit Court’s answer: Yes

Court of Appeal’s answer: No

Appellant’s answer: Yes

Appellee’s answer: No

- II. Is treating a trust for the sole benefit of a community spouse under third party trust rules consistent with the general pattern of providing for the spouses of nursing home residents receiving Medicaid long term care benefits?**

The Administrative Law Judge in effect answered this question no.

The Circuit Court in effect answered this question yes.

Court of Appeal in effect answered this question no.

Appellant in effect answered this question yes.

Appellee in effect answered this question no.

STATEMENT OF THE CASE

This appeal involves three cases with a common fact pattern. A wife was admitted to a nursing home. Her husband then established and funded a trust for his sole benefit (“solely for the benefit of,” or “SBO”), not to be counted for his wife’s eligibility purposes, so that his remaining non-trust assets were less than the community spouse resource allowance (CSRA) in his case. Each then applied for Medicaid long term care benefits for the wife, the institutionalized spouse, and each application was denied by the local departments applying a new interpretation from the Department of Health and Human Services (the Department) of its manual paraphrasing the relevant federal statute. Two county circuit courts reversed the agency, but the Court of Appeals in turn reversed them and ruled in favor of the Department.

The Department argued that the community spouses’ trusts were governed by the self-settled trust provision, subsection (3)(B)(i), of Section 1396p(d), which its guidelines paraphrase as providing “if there are any circumstances under which the assets can be [sic; distributed] to or for the benefit of *a* person, those are countable assets for the person” (emphasis added), not limited to the applicant, Brief for Department, *Hegadorn v. Department*, p. 17 (emphasis added). Given that premise, it could then argue logically that the spousal rules would require that these trust assets be considered in assessing eligibility.

The Court of Appeals accepted that argument, indeed did not even recognize that the applicants disagreed and that the theory was contested. “At the outset, it is undisputed that each trust at issue in this case was, in fact, a Medicaid trust. ...” Decision at 7. It then quoted from the state Medicaid manual the provision drawn from the federal statute, but more broadly worded:

Count as the person’s countable asset the value of the countable assets in the trust principal if there is any condition under which the principal could be paid to or on behalf of the person from an irrevocable trust, applying 1396p(d) but not limited (as the statute is) to trusts for Medicaid applicants. With that premise, the court said the issue was to determine whether there were any such conditions allowing distribution.

SUMMARY OF ARGUMENT

The decision in this case turns entirely on the meaning of a federal statute. That statute, 42 U.S.C. § 1396p(d), exquisitely designed to frustrate Medicaid eligibility except where Congress intended, separates trusts by beneficiary and then provides clear and specific exceptions to its rules. A trust for the sole benefit of the spouse of Medicaid applicant, like the ones at issue here, is one of those exceptions.

The Department and the Court of Appeals come to a contrary result by analyzing a document that is not the statute and whose differences from the statute, if slight, are not trivial, like the difference between a horse chestnut and a chestnut

horse. Recognizing that the Medicaid statute does not support its position, the Department struggles to bring its case within the SSI trust statute, again with similar but not identical language, and where the difference goes to the very issue in dispute. The statutory language flatly rejects the Department's approach.

Finally, both of the federal agencies with responsibility for administering these trust statutes – the Social Security Administration and the Centers for Medicare and Medicaid Services – come to the opposite conclusion from the Department in how they analyze the statutes that apply.

ARGUMENT

To call something a “Medicaid trust” is not the end of analysis but the beginning.¹ It tells you nothing about what rules to apply. There are many types of trusts created by and/or for Medicaid applicants. Some thwart eligibility; some advance eligibility; some have little direct effect on eligibility. Who funded the trust, who is the beneficiary, the standards that guides the trustee, all of these and other factors can lead to diametrically different results under one provision or another. Many trusts, like the ones in this case, are the specific subject of federal legislation. In looking at Congress' action in this area, proper application of the

¹ By contrast, the notion of special needs trust as one designed to coordinate public benefits and private wealth is reasonably well understood. Ron M. Landsman, “Special Needs Trusts,” in A Practical Guide to Estate Planning, ch. 14 (Jay Soled, ed., ABA 2012); see pp. 197-198. But even there, there is a wide variety of such trusts, first- or third-party, individual or pooled, SSI-complaint or not, and so forth.

law requires both appreciating the context in which any provision sits, while paying due attention to the specific language Congress used.

I. THE DEPARTMENT AND THE COURT OF APPEALS ERR IN ANALYZING A TRUST FOR THE SOLE BENEFIT OF THE COMMUNITY SPOUSE AS THOUGH IT WERE FOR THE BENEFIT OF THE APPLICANT.

The decision in these cases turns on the meaning of subsection (d) of 42 USC 1396p, “Treatment of trust amounts,” which thoroughly and definitively addresses trusts funded by Medicaid applicants or their spouses. The question that divides the parties is whether subsection (d) directs that these “sole benefit” trusts for the husbands be treated as the self-settled trust for the wives/Medicaid applicants, as the Department argues, or whether they are to be treated as transferred for the benefit of the husbands and so subject to the transfer rules, as the husbands/community spouses argue. There appears to be little dispute beyond that. If not treated as self-settled trusts of the Medicaid applicant wives, the trusts are subject to analysis under the SSI resource rules, which undergird the spousal rules and control what constitutes an asset of the spouse for Spousal Impoverishment (SI) purposes.

A. The Federal Statute Comprehensively Governs Trusts Created or Funded by a Medicaid Applicant or his Spouse.

One cannot overstate how determined Congress was to stop the abusive use of trusts by Medicaid applicants when it enacted the Omnibus Budget Reconciliation

Act of 1993 (OBRA 1993).² A previous effort proved unsatisfactory.³ State governors and Medicaid directors, supported by the long term care insurance industry, provided Congress with extensive descriptions of how “some non-poor elderly are using ‘estate planning’ techniques to shelter assets that otherwise would have kept them from becoming Medicaid eligible.”⁴ Many aspects of Medicaid planning were addressed, including the look-back date, how to calculate penalty periods, allocation of penalties involving married couples, treatment of jointly held assets, exemptions and affirmative defenses. But trusts were the focus, “the single most offensive Medicaid estate planning vehicle,” whose use Congress “tried, in almost every manner short of criminalization, to inhibit ...”⁵

² Pub.L. 103-66, Title XIII, §§ 13611-13612, 107 Stat. 622-626 (August 10, 1993).

³ The “Medicaid qualifying trust” provision, 42 USC 1396a(k)(since repealed), provided that trust assets were available if the trustee had discretion to distribute them to the beneficiary. While one case allowed an applicant to avoid that rule by having distribution subject to consent of remainderman, *Pollak v. Department of Health and Rehabilitative Services*, 579 So 2d 786 (Fla 4th Dist App, 1991), most efforts to avoid the impact of the statute were usually rejected, e.g., *Gulick v. Department of Health and Rehabilitative Services*, 615 So 2d 192 (Fla 1st Dist App, 1993); but see *Trust Company of Oklahoma v. Department Human Services*, 825 P2d 1295 (Okla, 1992).

⁴ National Governors Association, Proposed Policy on Medicaid Transfer of Assets (NGA, Tallahassee, Fla), July 1992, Preface, quoted in Ira Stewart Wiesner, “OBRA ‘93 and Medicaid: Asset Transfers, Trust Availability, and Estate Recovery Statutory Analysis in Context,” 19 Nova Law Review (No. 2), p. 679, 693 (1995).

⁵ Wiesner, p. 703. It was not just those paying the bills, or the commercially interested insurance industry, who sought to limit the use of trusts in Medicaid planning. Advocates of Medicaid like Rep. Henry Waxman (D-CA), the primary sponsor of the initial administration bill, were sharply critical of those who sought to “tak[e] advantage of the Medicaid program ... to finance the transmission of wealth to their heirs at federal and state taxpayer expense.” Harry Margolis, U.S. Rep. Waxman Explains Role in

Notwithstanding, at the same time Congress authorized the use of trusts for spouses and certain others, and these spousal SBO trust fall squarely within that carefully crafted system. As we will show, the Department's arguments should be directed to Congress if it wants to undo what Congress has specifically authorized.

The key provision implementing this new "anti-trust" policy – subsection (d) of 42 USC 1396p – is a marvel of effective draftsmanship, exquisitely designed to frustrate those who would try to use trusts to their advantage when seeking Medicaid benefits. It not only renders all such trusts ineffectual, it makes their use counter-productive except for narrow exceptions, all of which are written to prevent abuse as vehicles for family wealth transfer.

These rules are comprehensive and all-encompassing. The trust provisions "apply to any individual who establishes a trust and who is an applicant for or recipient of Medicaid." Centers for Medicare and Medicaid Services (CMS), State Medicaid Manual, § 3259.3, p. 3-3-109.26. Provisions concerning purpose, trustee discretion, or limitations are all irrelevant. §1396p(d)(2)(D).

The question, in any case, is which aspect of subsection (d) applies. It covers all trusts created by a Medicaid applicant or her spouse, but it does not treat all such trusts the same way, and the biggest single determinant is who is the beneficiary of

Medicaid Changes," ElderLaw Report, July-Aug. 1993, p. 2, quoted in Wiesner, at 682 n. 8.

the trust. Congress divided trusts into two groups, both of which frustrate Medicaid eligibility, albeit it in opposite ways.

- ***Trusts for the Medicaid applicant*** – This comprises first-party trusts *for* the applicant, funded by the applicant or spouse. All assets in such trusts are deemed available “if there are any circumstances” allowing payment to or for the applicant. *Id.* §1396p(d)(3)(A)(i) and (3)(B)(i) (“available trusts”). These trusts thwart Medicaid eligibility by making all assets available as a matter of law. This is the provision which the Department would apply to these trusts.
- ***Trusts for anyone other than the applicant*** – These are trusts for others where the applicant can get no benefit. Where “no payment could under any circumstances be made to the individual” applicant, 42 USC 1396p(d)(3)(B)(ii) (“unavailable trusts”), or distributions to or for others are made from otherwise available trusts, 42 USC 1396p(d)(3)(A)(iii) and (B)(i)(II), those are transfers. These trusts thwart eligibility by being treated as transfers subject to analysis and penalties under subsection (c). This is the provision the spouses of the Medicaid applicants say applies.

Each of these in turn has limited exceptions.

- Self-settled trusts that meet certain requirements are exempt. These are the first-party special needs trusts, which are exempt from all of these rules if they have pay back and meet other requirements. 42 USC 1396p(d)(4)(A)-(C).
- Trusts for others for whom Congress provided additional protections. These are primarily spouses and disabled children, but can include other disabled individuals under age 65. 42 USC 1396p(c)(2)(B)(i)-(iv).

Under this general federal rule, irrevocable self-settled trusts of Medicaid applicants, if not exempt, are thus to be read – notwithstanding anything in the trust document or state law to the contrary – as though they were support trusts, which have historically been available for SSI and Medicaid purposes, *Kryzsko v. Ramsey County Social Services*, 607 NW2d 237; ND (2000), but not otherwise; *Lang v. Commonwealth*, 515 PA 428; 528 A2d 1335 (1987); *Chenot v. Bordeleau*, 561 A2d 891 (RI, 1989); *Hecker v. Stark County Social Service Board*, 527 NW2d 228; 1994 ND (1994); *In the Matter of the Leona Carlisle Trust*, 498 NW2d 260 (Minn App, 1985); *Young v. Ohio Dept. Of Human Services*, 76 Ohio St 3d 547; 668 NE2d 908 (1996); *First National Bank of Maryland v. Dep't. of Health and Mental Hygiene*, 284 Md 720; 399 A2d 891 (1979). This rule applies, in the case of an individual's application for Medicaid eligibility, if she or her spouse

established or funded a trust, subsection (d)(2)(A)(i) and (ii); (h)(1)(A), where “there are any circumstances” allowing payment “to or for the benefit of the individual” who applied for Medicaid. Subsection (d)(3)(B)(i).

This rule, imposed by Congress on self-settled trusts for the benefit of the individual who applies for benefits, reflects Congress’ choice to interfere, to a limited extent, in state trust law when federally funded Medicaid benefits are involved. In enacting OBRA 1993, Congress did not seek to establish a general body of federal trust law, *Lewis v. Alexander*, 685 F3d 325, 347 (CA 3, 2012), but it did intend to establish the rules to be applied to trusts in the Medicaid context. *Id.* at 343-344 and 347.

It bears repeating how comprehensive these provisions are. The earlier “Medicaid qualifying trust” statute attempted to define a specific group of trusts to be treated adversely. Subsequent litigation focused on whether any particular trust was within that group or not, and if not, the Medicaid planning applicant won.⁶ Congress recognized the limits of that approach and, in OBRA 1993, went in the opposite direction, covering every dollar going into or coming out of any trust used by a Medicaid applicant. But for the exceptions – for certain self-settled trusts in subsection (d), for trusts for certain others in subsection (c) – no one who uses a trust can do better than just giving the assets away, and might do worse. And the

⁶ The cases cited above, in footnote 3, are typical.

exceptions all come with limits that protect Medicaid, either payback, (d)(4)(A)-(C), or “sole benefit” of the protected beneficiary, (c)(2)(B)(i)-(iv).

Congress chose its words with great care in reaching every trust created or funded by a person who later seeks Medicaid benefits, the applicant. It included as the self-settled trust of the applicant trusts all trusts for the applicant created by the spouse of the applicant, (d)(2)(A)(ii), and those funded by the spouse of the applicant, 42 USC 1396p(h)(1), and it subjected those trusts to its own unique availability rule.

What Congress did not do is apply these rules for self-settled trusts to trusts *for* the spouse of the applicant.

B. Subsection (d) treats a trust for a spouse differently than trust for the applicant; subsection (d)’s abrogation of state law to trusts for Medicaid applicants does not apply.

There are three compelling reasons why the self-settled trust rule of subsection (d)(3)(B)(i) does not apply to trusts for the spouse. First, the plain words of the statute say so. Second, an analogous statute was specifically drafted to achieve the result the Department seeks, which negates its argument that Congress achieved the same result without saying so. And third, reading the statute as a whole, as we must, the Department’s reading renders other provisions nugatory, violating the most fundamental rules of statutory construction.

1. **The plain words of the statute rebut the idea that 42 U.S.C. 1396p(d)(3)(B)(i) applies to trusts for the community spouse.**

The statute by its plain terms applies to trusts funded by an applicant where the trustee may, under any possible circumstance, make payment to or for the benefit of the applicant. The community spouses who are the beneficiaries of these three trusts, however, are not applicants at this time.⁷

Subsection (d) provides that for “determining an individual’s [Medicaid] eligibility,” its provisions apply to trusts “established by such individual.” Subsection (d)(1). The subsection is quite clear when the “individual” is to include the spouse. Thus, a trust with the individual’s assets is “considered to [be] established” by the individual if established by “[t]he individual’s spouse.” 42 USC 1396p(d)(2)(A)(ii). Similarly, the term assets, “with respect to an individual[] includes all income and resources of the individual and of the individual’s spouse ...” *Id.*, § 1396p(h)(1). This includes income and resources of either spouse that they do not receive because of action “by the individual or such individual’s spouse.” *Id.*, § 1396p(h)(1) & (A).

By contrast, (d)(3)(B)(i) applies to trusts where payment may be made “to or for the benefit of *the* individual” who has applied for Medicaid benefits.

⁷ These trusts will thwart eligibility under (d)(3)(B)(i) if and when the husbands later apply for Medicaid benefits, as Congress intended. See pages 21-22 below.

Subsection (d)(3)(B)(i)(emphasis added). Congress's not including the spouse here, when it did so elsewhere, requires the inference that it intended not to include the spouse. "Generally, when language is included in one section of a statute but omitted from another section, it is presumed that the drafters acted intentionally and purposely in their inclusion or exclusion." *People v. Peralta*, 489 Mich 174, 184; 803 NW2d 140, 146 (2011). "Where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." *Russello v. United States*, 464 US 16, 23; 104 S Ct 296, 300 (1983) (citations omitted).

Before this Court, the Department argues for reading the word "individual" broadly to include the community spouse, claiming that "[l]imiting the word 'individual' to mean only 'applicant' changes the meaning of the statute." Brief on Appeal, p. 23 (Brief). It says "individual" is an "undefined statutory term," and that in

common usage[,] "*an individual*" is *not* an applicant for Medicaid benefits or an institutionalized individual – it is *any individual*, or *any person*.

Brief at 23 (emphasis in original). It asserts that this is in contradistinction to places elsewhere in the statutes where Congress, "when [it] intends to refer specifically to the applicant, ... uses clear and specific language." *Id.*, p. 22.

But the relevant provisions of the statute do not refer to "*an individual*."

They all – and there are numerous ones – refer to “*the* individual,” (d)(3)(A)(i), (d)(3)(B)(i), (d)(3)(B)(i)(II), and (d)(3)(B)(ii)(emphasis added), and *the* individual to which they refer is the one who applied for benefits and whose eligibility for Medicaid benefits is being determined based on (d)(3)(B)(i). *See* (d)(1).

It is difficult to see how Congress could have been more clear. When Congress meant to include the spouse, it said so. When discussing to whom trust payments may be made, it refers to “the individual,” (d)(3)(B)(i) and (d)(3)(B)(ii), not to “an individual,” as the Department misquotes it, nor to “the individual and his spouse,” as the Department would have the Court read it. Congress knew how to include the spouse, but it limited the “any circumstances” test to trusts payable to or for “the individual” whose application for benefits was at issue. *See Peralta and Russelo*, above, p. 11. The omission of “and the spouse,” when used elsewhere in the same statute, precludes reading the term in as the Department have would this Court do. This is “a general principle of statutory construction...” *Barnhart v. Sigmon Coal Co.*, 534 US.436, 440; 122 S Ct 941, 944 (2002). To claim that limiting “the individual” to the individual applicant “changes the meaning of the statute” is to argue that black is white.

2. **Closely related provisions underscore that Congress elected not to treat trusts for the benefit of the spouse as trusts for the benefit of the applicant.**

When it enacted comparable trust provisions for the closely related Supplemental Security Income (SSI) program⁸ six years later, Congress took a different approach, and that difference precludes a cavalier reading of the Medicaid trust provision as though it said the same thing.

The SSI trust statute provides that where a trust may “ma[k]e payment to or for the benefit of the individual (*or of the individual’s spouse*),” the corpus from which such payment “could be made shall be considered a resource available to the individual.” 42 USC 1382b(e)(3)(B) (emphasis added). There, Congress specifically chose to make the self-settled trust of the spouse a resource of the applicant. The SSI provision addresses what is available to the applicant, but it then brings in – as (d) does not – the trust for the benefit of the spouse of the applicant. Courts are not free to disregard such differences.

The Department would avoid the distinction by arguing that the SSI trust rules themselves apply in the face of a specific statutory provision that they do not. Brief at 18. The claim that this broadly worded trust exclusion, 42 USC 1396a(a)(10)(G), is limited to the “optional categorically needy” is utterly unsupported by legal authority. Eliminating intervening provisions, that sentence states in its entirety:

⁸ Eligibility for SSI and Medicaid are closely related. Except for those states that opted to freeze their Medicaid program in pre-SSI rules, so-called “209b States,” SSI beneficiaries in all other states are entitled to community Medicaid benefits, so-called “SSI States.” Michigan is an SSI State.

(a) A State plan for medical assistance must – (10) provide – (G) that, in applying eligibility criteria of the [SSI program] for purposes of determining eligibility for medical assistance under the State plan of an individual who is not receiving [SSI], the State will disregard the provisions of subsections (c) and (e) of section 1392b of this title...

The statute and cases cited by the Department identify or elaborate on the meaning of categorical eligibility; they do not address the trust provisions or their application; indeed, *Herweg v. Ray*, 455 US 265 (1982), could hardly address the SSI trust provisions since it was decided 17 years before they were enacted; the CFR reference, 42 CFR 434.4 (2017), concerns State plan requirements for fiscal agents.

To the contrary, the general rule is that the specific controls over the general, which is in essence what 42 USC 1396a(a)(10)(G) does, making clear that the later-enacted SSI trust rules govern SSI eligibility, while the Medicaid-specific trust rules continue to govern Medicaid eligibility. While the SSI rules generally control for determination of Medicaid in SSI States like Michigan, this provision excludes the SSI trust rules in favor of the more specific Medicaid trust rules.

There is in the statute not a hint of a whisper of a clue that it is limited as the Department theorizes.

Perhaps the most serious problem with the Department's position is that while the Department thinks the SSI and Medicaid trust rules are identical, SSI does not. Most states, including Michigan, have agreements with SSI for the

federal agency to determine Medicaid eligibility for individuals who qualify for SSI (so-called “1634 states”). The POMS, which the Department says “warrant respect” (Brief at 25), directs its staff *not* to apply the SSI trust rules to Medicaid determinations. People may qualify for SSI, but they may still be affected by the different Medicaid trust provisions. POMS SI 01730.048E. Where there is a trust, “follow the procedures in SI 01.120.200 to determine if the trust is countable *for SSI purposes.*” POMS SI 01730.048E, first unnumbered paragraph (emphasis added). These are the trust provisions that the Department says it should apply *because* it is a 1634 State. But SSI says the opposite (*id.*, emphasis in original):

If the individual resides in a section 1634 State, do **not** attempt to determine whether the trust is countable or excludable for Medicaid purposes. ... Existence of a Medicaid trust will result in a referral of the case to the Medicaid State agency for a Medicaid eligibility decision.

For 1634 States, SSI is tasked with making the Medicaid eligibility decision. It *does* determine whether a trust satisfies the SSI requirements, but it does not determine whether the trust, under different rules, satisfies the Medicaid trust requirements; it leaves that to the State agency. If the standards were identical, as the Department claims, that referral would be pointless.⁹

⁹ There are other reasons to make the referral to the State agency, e.g., determining hardship waiver, which is referred to separately *Id.*

For the same reasons, the reliance on the Social Security Administration's POMS, Brief at 24-27, is misplaced; they concern a different statute with different, indeed polar opposite, terms.

3. The exceptions for spousal trusts make no sense if (d) treats spousal trusts as trusts for the benefit of the applicant, rather than as transfers.

The broad reach of the OBRA 1993 trust rules – touching every single trust created or funded by Medicaid applicants – required that Congress also address which trusts would be exempt from those broad, comprehensive rules. Self-settled trusts were all treated as available – thus thwarting Medicaid eligibility – or exempt under subsection (d)(4). Trusts for others were all treated as transfers and referred to subsection (c), where its provisions come into play; it has its own distinct set of exemptions, aside from four affirmative defenses.¹⁰ There are eight exemptions, four related to the applicant's home and four others. Subsection (c)(2)(A) and (B). Of the latter four, the first two are for the spouse; the latter two are for the applicant's disabled child or for a trust for other disabled individuals under age 65.

¹⁰ These are (1) the individual intended to get fair market value, (2) the assets were transferred exclusively for a reason other than Medicaid eligibility, (3) the assets were returned, or (4) imposition of a penalty would impose undue hardship. Subsections (c)(2)(C) and (D). There is also the fundamental question under (c)(1)(A) of whether the applicant received fair market value.

Thus, where a Medicaid applicant establishes a trust for her disabled child and can herself get no benefit under it, (d)(3)(B)(ii) applies and refers the case to subsection (c), which exempts it from the penalty provision. (c)(2)(B)(iii). Similarly, a transfer for the community spouse, from which the applicant can get no benefit, similarly falls within (d)(3)(B)(ii), which refers it to (c), which exempts from penalty transfers by either spouse “to another for the sole benefit of the individual’s spouse.” (c)(2)(B)(i) and (ii).

In arguing that (c)(2)(B)(i) and (ii) are irrelevant, because they concern transfers, and not availability, Brief at 13-14, the Department inadvertently concedes the point because the significance of the transfer exception is the opposite of what the Department claims. If putting money into a trust for a spouse is a transfer, as the Department concedes it is, then it must be analyzed as a transfer under (c)(3)(B)(ii) and not as the self-settled trust of the applicant under (c)(3)(B)(i). To be sure, Congress could have chosen, as it did with the SSI trust rules, to specifically apply an “any circumstance” test to trusts for spouses as well as applicants. But it did not do so. The Department cannot show otherwise.

The Department and the Court of Appeals relied on application of the “any circumstances” test of (d)(3)(B)(i) to find that the SBO trust assets were available to the community spouse. The foregoing shows that that was error. The question to be answered, then, is what standard does apply. Fortunately, the law in this area is clear and indeed there is little dispute between the parties.

II.SPOUSAL IMPOVERISHMENT DIRECTS THAT THE SSI RULES APPLY.

Having applied subsection (d) to render all trust assets available, the Court of Appeals then noted that the Spousal Impoverishment or SI rules plainly bring into the eligibility analysis the available assets of the community spouse. It is the premise that is wrong, as explained in Part I, so that the next question is what rules do apply in determining whether the SBO trust assets are an available resource.

Plaintiffs-Appellants correctly set out the SSI rules that show that the SBO trust assets are not available to the community spouse. Appellants' Brief on Appeal, pp. 18-21. The Spousal Impoverishment rules specifically incorporated existing rules, whether SSI or 209b, concerning what constituted resources or "the methodology and standards for determining and evaluating ... resources." 42 USC 1396r-5(a)(3)(A) and (B). Since existing underlying rules about assessing resources and availability are specifically incorporated into the Spousal Impoverishment rules, they are not inconsistent with the terms of SI. *Cf.*, 42 USC 1396r-5(a)(1). *Keip v. Wis. Dept. of Health and Family Services*, 232 Wis 2d 380, 397-398; 2000 WI App 13; 606 NW2d 543 (1999). This means that the existing SSI or the relevant pre-SSI rules in 209b states apply. This is underscored by the provision which adopts the SSI exclusion rules, overruling any contrary provision in 209b states. 42 USC 1396r-5(c)(5).

The Court of Appeals' reference to the general Spousal Impoverishment provisions on attribution at the time of application and the definitions, Decision at 10-11, elides the underlying, more fundamental rule, that the references to "resources" is controlled by other provisions drawn from SSI law. That oversight is error.

The Department agrees that the underlying SSI rules control in the spousal context, Department's Brief on Appeal, p. 12.

III. THE SBO TRUST RULES ARE PART OF A SYSTEM DESIGNED TO PROTECT THE COMMUNITY SPOUSE WITHOUT CREATING VEHICLES FOR FAMILY WEALTH TRANSFER.

The larger policy question standing behind this analysis is who are the intended beneficiaries of the Medicaid long-term care program. The Court of Appeals posits that the program is only for low-income individuals, in contradistinction to "wealthier individuals" taking advantage of loopholes to get government assistance for costs "they otherwise could afford." Decision at 2.

This is not an accurate dichotomy. For twenty years now, Congress has been adapting the Medicaid program to accommodate the needs and interests of decidedly non-poor spouses of individuals who need long term care. The provisions at issue here are part of that system, and their use as sought by the appellants' community spouses is well within the range of options Congress has offered to community spouses. Congress' goal has always been to protect the

community spouse, not to create a mechanism for family wealth transfer, and that is exactly what SBO spousal trusts are designed to do. This is part of the larger pattern, allowing transfers for disabled children and some others without loss of Medicaid long term care, provided that the trust meets the statutory requirements set by Congress designed to assure that the funds are used as intended. All of the trust provisions, including those at issue here, are designed to that end.

That is to say, one spouse may qualify for Medicaid, preserving assets for the community spouse. But if that community spouse himself later requires long term care, all of these mechanisms for protecting him then have the opposite effect of guaranteeing that he will not also qualify for benefits, or at least won't be able to pass significant assets onto the next generation (unless disabled). Everything said above to show the SBO trust is not the trust of the applicant when it is for the community spouse merely underscores that it is the trust of the Medicaid applicant if and when that spouse later needs institutional care himself. "Sole benefit" guarantees that it is available for his or her care, forestalling Medicaid eligibility until those resources are spent. That is of course the very purpose of subsection (d) in making such trusts available as a matter of law. Subsection (c)(3)(A)(i) and (B)(i).

All of the excepted or exempt trusts serve to secure benefits for a protected individual, while limiting the benefits to the intended beneficiary, not other family

members.

The special needs trusts are probably the best known of the trusts authorized by Congress. All three of the self-settled first party special needs trusts require payback, that is, before a dollar is distributed to family members or other heirs or legatees, the Medicaid program must be reimbursed for all expenditures to the full extent of remaining trust assets at the death of the beneficiary. Subsections (d)(4)(A), (B)(ii) and (C)(iv). But even here, the provision goes beyond that, allowing pooled trusts to retain funds for their own charitable purposes in lieu of pay back. Subsection (d)(4)(C)(iv). *Lewis*, 685 F3d 325.

Similarly, the pattern for third party trusts is that they be for the sole benefit of the other person. This is true of trusts for disabled children of an applicant, for any other disabled person under age 65, and for the spouse of the Medicaid long term care applicant. Subsection (c)(2)(B)(i)-(iv). Part of the gloss on “sole benefit” is that the assets be distributed to the beneficiary on an actuarially sound basis. CMS, State Medicaid Manual, § 3258.9B, p. 3-3-109.15. That term was used in the annuity context to separate out those annuities that might be a hidden mechanism for getting assets to someone other than the beneficiary, *e.g.*, to children. An 85-year-old man might do this, for example, by purchasing a “life plus twenty years term certain”¹¹ annuity, when his life expectancy is only about 5.2 years. *Id.* p. 3-3-

¹¹ A life or “twenty years certain” annuity would pay for the period of the person’s life but not less than 20 years. Where the term is longer than the person’s life expectancy, the monthly payments are of course much less than they would be if the annuity were life

109.17 (Life Expectancy Tables – Male). That term, as used by CMS, means no longer than the life expectancy of the beneficiary. A transfer occurs if the person “is not reasonably expected to live longer than the guarantee period of the annuity,” because they will not get back fair market value for what they paid out. That is when a transfer occurs, not otherwise. *Id.*, p. 3-3-109.16.

While the Department focuses on the limitations of the Spousal Impoverishment provisions, that section hardly defines the last word in what Congress authorized to protect community spouses. Indeed, SI itself includes provisions unheard of in other public benefits programs, *e.g.*, obtaining individual, case-specific judicial determinations allowing community spouses to retain or get additional income or resources beyond the standard allowances. 42 USC 1396r-5(d)(5)(income) and (f)(3)(resources). There are less expensive administrative mechanisms for obtaining like results. Section 1396r-5(e)(2)(B) and (C).

There are yet other ways in which SI is far more generous than the Department acknowledges. For example, there is no limit on the income of a community spouse before his or her institutionalized spouse can qualify. Many states disregard the retirement plans of community spouses, which reflects accumulated pre-tax income, and which was specifically required in *Keip v. Wis. Dept. of Health and Family Services*, above. While the institutionalized spouse’s

only, or life with a shorter term certain. The reduced current benefits are the mechanism by which the transfer is made to contingent beneficiaries.

income must go toward cost of care, and may be reduced for low income community spouses, 42 USC 1396r-5(d)(3)(A), it is never increased because of how high the community spouse's income is. See § 1396r-5(d)(1)(A), providing deductions from her income, but not additions, in determining the institutionalized spouse's cost of care.

Moreover, in the wake of Spousal Impoverishment, yet other ways to protect community spouses were developed with Congress' acquiescence or approval. Community spouses are allowed to annuitize what would otherwise be excess resources, converting them to income for their sole use. 42 USC 1396p(c)(1)(F) and (G). *Hughes v. McCarthy*, 734 F3d 473 (CA 6, 2013). They are also allowed to convert assets into income streams through promissory notes. *Id.*, § 1396r-5(c)(1)(I).

The common feature of all of these provisions is either pay back (in the case of special needs trusts), sole benefit, or actuarial soundness (in the case of annuities, but also including pay back), *Singleton v. Commonwealth of Kentucky*, 843 F3d 238, 240 (CA 6, 2016). See subsection (c)(1)(G)(ii)(II), (c)(1)(I)(i), (c)(2)(B)(i)-(iv).

CMS has acknowledged that SBO trusts like the ones at issue in this case are appropriate and *may* affect eligibility, as they were intended to. In discussing

transfers and the Spousal Impoverishment rules in its State Medicaid Manual, CMS noted that unlimited transfers between spouses

should have little effect on the eligibility determination ... because resources belonging to both spouses are combined in determining eligibility for the institutionalized spouse [and] are still [to] be considered available to the institutionalized spouse for eligibility purposes.

Id., § 3258.11, p. 3-3-109.22. But, it said, this is not so with “transfers to a third party for the sole benefit of the spouse.” Those do affect eligibility, “because resources may potentially be placed beyond the reach of either spouse and thus not be counted for eligibility purposes.” *Id.*, p. 3-3-109.23. This goal, condoned by CMS, is achieved where the “sole benefit” requirement is “fully met”:

This definition is fairly restrictive, in that it requires that any funds transferred be spent for the benefit of the spouse within a time-frame actuarially commensurate with the spouse’s life expectancy. *Id.*

The decision of the Court of Appeals, and the approach of the Department, requires that such trusts not affect eligibility. Indeed, that is the policy argument the Department makes. But it is flatly contradicted by CMS, in a considered document which is, as to these provisions, clear, consistent, and true to the statutory terms, without introducing inconsistencies or odd results, and thus entitled to deference under the *Skidmore* doctrine, *United States v. Mead Corp.*, 533 US

218, 228; 121 S Ct 2164; 150 L Ed 2d 292(2001) (citations omitted) (quoting *Skidmore v. Swift & Co.*, 323 US 134, 140; 65 S Ct 161; 89 L Ed 124 (1944), because it has “the power to persuade, if lacking power to control.”

CONCLUSION

The decision in this case turns on the application of 42 USC 1396p(d) to the sole benefit trusts here. The Department’s dissatisfaction with the results amounts to a policy argument with Congress about how generous Medicaid should be with married couples. The plain and clear language of the statute, as reasonably construed by the responsible federal agency, is flatly inconsistent with the Department’s position and the decision of the Court of Appeals. That position should be rejected and the decision of the Court of Appeals reversed.

Respectfully submitted,

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EXHIBIT H

*Colorado FH Decision, Arapahoe County,
May 14, 2008*

ELDER LAW ASSOCIATES PA



COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-5654 • (303) 866-3476 Fax • (303) 866-3883 TTY

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NOTICE OF INITIAL DECISION

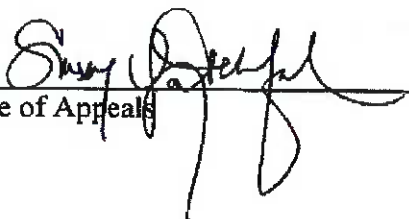
In the matter of: Appellant: **Stanley Williams**
Appeal No: **SHP 2008-0092**

Enclosed is a true copy of the Initial Decision of the Administrative Law Judge regarding the above captioned matter. If you disagree with this Initial Decision, you have the right to ask for reversal or modification of the Initial Decision by filing written exceptions with the Office of Appeals. Section 24-4-105 (14) and (15), C.R.S.

Any of the parties listed on the attached Certificate of Mailing may file exceptions to the Initial Decision. Written exceptions must be received in the Office of Appeals by 5:00 p.m. on **June 06, 2008** unless this date falls on Saturday, Sunday, or a legal holiday, in which case exceptions will be due on the following business day. Please read the enclosed instructions carefully and follow each step. You will be notified by mail if any exceptions are filed by the other parties and given an opportunity to file a response. Failure to file exceptions may waive the right to seek judicial review of the Final Agency Decision.

If you have any questions, please contact me at the above address, attention Office of Appeals or at (303) 866-5654.

Sincerely,



Office of Appeals

Date: May 19, 2008
Enclosures

CERTIFICATE OF MAILING

I hereby certify that on May 19, 2008, I placed a true and correct copy of the Notice of the Initial Decision regarding Appeal Number **SHP 2008-0092** in the U.S. Mail, postage prepaid, addressed to the following:

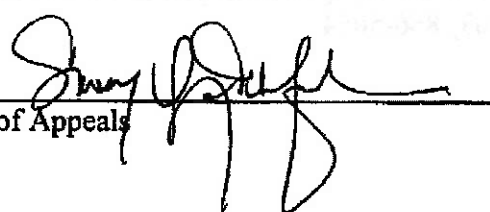
Stanley Williams
c/o W. Eric Kuhn, Esq.
Law Office of Bradley J. Frigon
6500 S. Quebec Street, Suite 330
Englewood, CO 80111

Beate Fisk
Arapahoe County DHS
14980 E. Alameda Drive
Aurora, CO 80012

Carey Christie, Esq.
Arapahoe County Attorney's Office
14980 E. Alameda Drive
Aurora, CO 80012

and via Interdepartmental mail to:

Gary Ashby
Benefits Coordination Section
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203



Office of Appeals

APPELLANT INSTRUCTIONS FOR FILING EXCEPTIONS TO THE INITIAL DECISION

If you do not agree with the findings of fact or legal conclusions in the Initial Decision, you may file written Exceptions to the Initial Decision. Exceptions are your written arguments why you believe the Initial Decision is incorrect, based on either incorrect facts or incorrect conclusions of law. This is the last step in the Administrative appeal process before the Office of Appeals issues a Final Agency Decision.

- All Exceptions must be in writing, and they must be **received** in the Office of Appeals by the due date shown on the attached letter. A written statement may be submitted to the Office of Appeals if you feel you need more time to prepare your Exceptions. Your request for more time must be **received** in the Office of Appeals before the due date shown on the attached letter. The Office of Appeals will issue an Order with a new due date.
- Always include the Name and the Appeal Number shown on the top of the Initial Decision in your written Exceptions and all correspondence.
- State in your Exceptions the specific parts of the Initial Decision you disagree with, and the reasons why.
- **FOR THE RECIPIENT OR APPLICANT (Appellant):** If you feel that a FINDING OF FACT is wrong, you must order a written transcript of the hearing. **There is no cost to you for the written transcript.** You do not need a written transcript if you disagree with the conclusion of law.

TO ORDER A WRITTEN TRANSCRIPT:

- 1) **Contact** the Office of Administrative Courts, 633 Seventeenth Street, Suite 1300, Denver, CO 80202, or call (303) 866-5626 and request a written transcript. The Court will submit the official recording of the hearing to A/V Tronics, a transcribing agency, to prepare the written transcript. The Department will pay A/V Tronics for the cost of the transcript and the cost of one copy for you.
- 2) **Notify** the Office of Appeals in writing that you ordered the written transcript, and need a new due date to file Exceptions. The Exceptions and written transcript must be **received** in the Office of Appeals by the due date. It is your responsibility to request a new due date to ensure timely filing of both your Exceptions and the transcript. Late filings will not be accepted.
- 3) A/V Tronics will submit the original written transcript directly to the Office of Appeals, and send one copy of the transcript to you.
- 4) If you have questions regarding the written transcript, contact A/V Tronics at (303) 634-2295. You must contact A/V Tronics to make sure the written transcript is submitted to the Office of Appeals by the due date for Exceptions.
- 5) **File** your written Exceptions with the Office of Appeals by the due date. The Exceptions shall state that a transcript has been requested.

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Office of Appeals
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The Office of Appeals will issue the Final Agency Decision after reviewing the hearing record and any other documents timely filed with the Office of Appeals. If you have questions, please contact us at the address or phone number above.

STATE OF COLORADO**OFFICE OF ADMINISTRATIVE COURTS**633 17th Street, Suite 1300 Denver, Colorado 80202**STANLEY WILLIAMS,**

Appellant,

vs.

**ARAPAHOE COUNTY DEPARTMENT OF HUMAN
SERVICES,**

Appellee.

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CASE NUMBER:**SHP 2008-0092****INITIAL DECISION**

This matter is before Administrative Law Judge (ALJ) Robert Spencer upon Appellant's appeal of the denial of his application for Medicaid long term care benefits. A hearing by telephone conference was held April 15, 2008. Supplemental briefs were submitted May 7, 2008, and the matter became ripe for decision at that time. Carey Christie, Assistant County Attorney, represented the Arapahoe County Department of Human Services (County Department). Appellant was represented by W. Eric Kuhn, Esq. and Alex Gury, Esq. of the Law Offices of Bradley J. Frigon.

Issue Presented

In September 2007, Appellant, as grantor, established an irrevocable trust in favor of his wife, Martha, who was the sole beneficiary. In October 2007, Appellant funded the trust with separate property in the form of shares of stock. The stock is the only trust asset.

Later in October 2007, Appellant applied for Medicaid long term care benefits. The County Department denied Appellant's application on the grounds that he was over-resourced. In so doing, the County Department relied upon the opinion of the Department of Health Care Policy & Financing (State Department) Trust Officer that because Appellant's wife was the trust beneficiary, the entire corpus of the trust was a resource countable against Appellant's financial eligibility. Because the value of the trust corpus exceeded the Community Spouse Resource Allowance plus Appellant's \$2,000 eligibility threshold, Appellant was over-resourced and ineligible for Medicaid benefits.

Appellant disagrees with the County Department's determination. Appellant contends that because the trust was funded with his separate property and the corpus is owned by the trust, it is not owned by Martha. Furthermore, it is not owned by him because he irrevocably transferred it to the trust before he filed his Medicaid application.

Because the trust corpus, as of the date of Appellant's Medicaid application, was not owned by either spouse, it was not countable as a resource. Furthermore, Appellant argues that because the transfer of the stock to the trust was for the sole benefit of his spouse, and the terms of the trust complied with the State Department's regulations restricting transfers without fair consideration, the transfer did not trigger a period of ineligibility.

The County Department agrees that Appellant's transfer of stock to the trust complied with the State Department's rules regarding transfers without fair consideration and does not trigger a period of ineligibility. The sole issue, therefore, is whether the corpus of the trust is a countable resource because Martha is a beneficiary of that trust and receives payments from the trust corpus. For the reasons explained below, the ALJ concludes that it is not a countable resource, and therefore Appellant is not over-resourced for the purposes of eligibility for Medicaid long term care.

Findings of Fact

1. Appellant is 83 years old and currently resides in an assisted living facility in Arapahoe County.
2. On September 18, 2007, Appellant established a trust entitled *An Irrevocable Trust Agreement for the Sole Benefit of Martha M. Williams Pursuant to 42 U.S.C. § 1396p(c)(2)(B)(i) and the Colorado Medical Assistance Manual, Volume 8, Section 8.110.53.F(2)(a)* (hereafter referred to as "the Trust"). Exhibit B and Joint Exhibit I, ¶ 1.
3. On October 11, 2007, Appellant transferred 3,620 shares of Proctor & Gamble stock from his Scottrade account to Elizabeth Esterl as the trustee of the Trust. The stock was and is the sole asset of the Trust. Joint Exhibit I, ¶¶ 2, 3.
4. Prior to the transfer, the stock was Appellant's separate property. Joint Exhibit I, ¶ 4.
5. Appellant was the sole grantor of the Trust. This is clear from the provisions of the Trust:
 - a. The preamble states that Appellant, referred to as "Stan," "desires to make an exempt transfer of his assets ... for the sole benefit of Martha." Exhibit B, p. 1.
 - b. Appellant is the sole source of the Trust assets. Exhibit B, ¶ 1.2.
 - c. Appellant is identified on the signature page as the grantor. Exhibit B, p. 8.
 - d. The parties stipulate that Appellant executed the Trust "individually and as grantor." Joint Exhibit I, ¶ 1.
6. Martha is the sole beneficiary, but is not a grantor. This is clear from the provisions of the Trust:

a. Martha is not identified as contributing any property to the Trust. The only property that funds the Trust is Appellant's separate property. Exhibit B, ¶ 1.2.

b. Martha signed the Trust individually and as Appellant's agent and power of attorney, but she is not identified as a grantor. Exhibit B, p. 8.

c. The parties stipulate that Martha executed the Trust "individually as spouse." Joint Exhibit I, ¶ 1.

7. The Trust is irrevocable and is for the sole benefit of Martha. No other individual or entity other than Martha can receive payments from the Trust assets, either at the time of transfer or at any time in the future. The Trust is a written instrument that legally binds Appellant and Martha to a specified course of action, sets forth the conditions under which the transfer of assets is made, and contains a statement that only Martha can benefit from the assets transferred into the Trust. The Trust provides for the spending and use of the transferred assets on a basis that is actuarially sound based upon Martha's life expectancy. Exhibit B, Art. 3.

8. Although the Trust is set up for her sole benefit, Martha is not the owner of the Trust corpus. The Trust recites that, "the Trust [is] to be named as the sole owner of all ... assets, hereafter referred to as the 'Trust Estate.'" Exhibit B, ¶ 1.2. Furthermore, Martha is specifically deprived of any ability to anticipate, assign, pledge, mortgage, sell or transfer in any manner, voluntarily or involuntarily, her beneficial interest in the Trust. Exhibit B, ¶ 5.1. She also has no right or power to terminate the Trust. Exhibit B, ¶ 7.1. She has no legal right to make the Trust corpus available except as it is paid to her by monthly stipend.

9. On October 24, 2007, Appellant applied for Medicaid long term care benefits under the Home and Community Based Services (HCBS) program. The application was initially filed in Denver County, but transferred to Arapahoe County, where Appellant was residing, on November 9, 2007. Joint Exhibit I, ¶¶ 6, 8.

10. Appellant's transfer of stock to the Trust was without fair consideration and occurred less than a month before he applied for Medicaid. The County Department, however, concedes and the ALJ finds that because the Trust is established for the sole benefit of Martha and otherwise meets the requirements of the State Department's regulations related to transfers without fair consideration, no penalty period of ineligibility applies to Appellant's transfer of stock to the Trust.

11. Nevertheless, to be financially eligible for Medicaid, Appellant and his wife's pooled assets, less a Community Spouse Resource Allowance (CSRA), had to be less than \$2,000. The CSRA at the time of application was \$101,640, therefore Appellant and his wife's pooled assets had to be less than \$103,640 for him to be eligible for Medicaid.

12. The County Department referred to the State Department the question of whether the Trust corpus was countable as a pooled asset. By letters dated January 2, 2008 and January 18, 2008, the State Department's Trust Officer opined that the Trust

corpus must be considered a countable resource because Martha was the beneficiary of the Trust. Exhibits 2 and 3. The Trust Officer relied upon § 8.110.52.B.4.a.1 of the State Department's regulations, which states that irrevocable trust assets are a countable resource "If there are any circumstances under which payments from the trust could be made to or for the benefit of the individual."¹ Exhibit 3.

13. The value of the Trust corpus as of the date of application was approximately \$223,810. Exhibit B, p. 10. If countable as a pooled resource, the value of the Trust corpus exceeds Appellant's resource eligibility threshold.

14. Without consideration of the value of the Trust corpus, Appellant and his wife's pooled assets as of the date of his Medicaid application were less than \$103,640, and therefore he would have met the resource requirement. Joint Exhibit I, ¶ 12.

15. On January 23, 2008, in reliance upon the State Department Trust Officer's opinion, the County Department issued a Notice of Proposed Action denying Appellant's application. Exhibit 1.

16. Appellant filed his appeal of the County Department's decision on January 31, 2008.

Discussion and Conclusions of Law

Burden of Proof

State Department regulation § 8.057.D states that hearings concerning Medicaid benefits are conducted according to the requirements of § 24-4-105, C.R.S. of the Administrative Procedure Act (APA). APA § 24-4-105(7) provides that the proponent of an order shall have the burden of proof. The proponent of an order is the party who seeks to change the *status quo*. *Orsinger Outdoor Advertising, Inc. v. Dept. of Highways*, 752 P.2d 55, 67 (Colo. 1988); *Renteria v. State Dept. of Personnel*, 811 P.2d 797, 803 (Colo. 1991). Here, Appellant is the party seeking to change the *status quo* by obtaining benefits he did not previously have. Appellant is therefore the proponent of the order and bears the burden of proof.

Resource Eligibility

To be eligible for Medicaid long term care, Appellant must have less than \$2000 in "countable resources." Section 8.110.51. Countable resources include the current market value of stocks. Section 8.110.51.B.2.

When the spouse applying for Medicaid is seeking long term care benefits, resource eligibility is based upon the couple's combined or pooled assets. Per regulation § 8.112.1, an assessment of the total value of the couple's resources is completed "at the time of Medicaid application," and all non-exempt resources "owned by" the married couple at that time are counted, whether owned jointly or individually.

An assessment of the total value of the couple's resources shall be

¹ The State Department's regulations are published at 10 CCR 2505-10.

completed *at the time of Medicaid application* or when requested by either spouse or a married couple. All non-exempt resources *owned by* a married couple are counted, whether owned jointly or individually. There are no exceptions for legal separation, pre-nuptial, or post-nuptial agreements.

Section 8.112.1, *italics added*.

In order to provide for the non-institutionalized or "community" spouse, a CSRA is allocated. Section 8.112.11.A. The CSRA at the time of Appellant's application was \$101,640. The CSRA is then deducted from the total value of the pooled resources to determine the resources actually available to the Medicaid applicant. Per § 8.112.13, the applicant is resource eligible for Medicaid "when the total resources *owned by* the couple are at or below the amount of the [CSRA] plus the Medicaid resource allowance for an individual of \$2000." *Italics added*.

In this case, the parties stipulate that, apart from the Trust corpus, the couple's resources do not exceed the CSRA plus \$2,000, and therefore Appellant would be eligible if the Trust corpus is not counted. On the other hand, if the Trust corpus is counted, then the couple's resources exceed the CSRA plus \$2,000, and Appellant would not be eligible. The issue, therefore, is whether "at the time of Medicaid application" the corpus of the trust was "owned by" either Appellant or his wife. The ALJ concludes that it was not owned by either individual at the time of application.

Ownership of the Trust Corpus

It is undisputed that the stock used to fund the Trust was initially Appellant's separate property. When Appellant irrevocably conveyed the stock to the Trust on October 11, 2007, the stock became the property of the Trust and Appellant no longer owned the property as of that date. Therefore, as of the date of Appellant's Medicaid application, October 24, 2007, he did not own the trust corpus.

The question of whether Martha owned, for purposes of Appellant's Medicaid eligibility, the trust corpus is less clear. The County Department, consistent with the opinion of the State Department's Trust Officer, argues that § 8.110.52.B.4.a.1 makes Martha an owner. Section § 8.110.52.B.4.a.1 reads as follows:

If there are any circumstances under which payments from the [irrevocable] trust could be made to or for the benefit of the individual, the following shall apply:

- 1) The portion of the corpus of the trust, or the income on the corpus, from which payment to the individual could be made, shall be considered as resources available to the individual.

Applying § 8.110.52.B.4.a.1, the County Department argues that because Martha is the Trust beneficiary and therefore can receive payments from the Trust, the entire Trust corpus must be considered available to her. Appellant, on the other hand, argues that § 8.110.52.B.4.a.1 does not apply to Martha because she is not "the individual"

within the meaning of that section. The ALJ agrees with Appellant's interpretation.

The reference in § 8.110.52.B.4.a.1 to "the individual" is clearly to the trust grantor. This is apparent from § 8.110.52.A.1.a, which states that "the amount of the trust property considered available to the applicant/recipient *who established the trust ...* is the maximum amount that the trustee(s) is permitted under the trust to distribute *to the individual ...*"² *Italics added.* The interpretation that "the individual" is the grantor is confirmed by § 8.110.52.B.2.a, which states that, "An individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust." Because, as used in § 8.110.52, "the individual" is the grantor and Martha is not the grantor, that section cannot be used to constructively make Martha an owner of the trust.³

During her testimony, the State Department's Trust Officer agreed that "the individual," as that term is used in § 8.11.52.A, is the grantor, but opined that Martha was a grantor because her name was on the Trust and she signed the Trust. The facts, however, do not support that opinion. As noted in Findings of Fact 5 and 6, Appellant was the sole grantor and Martha the sole beneficiary. The fact that Martha signed the Trust as Appellant's power-of-attorney does not make her the grantor. *Water, Waste & Land v. Lanham*, 955 P.2d 997, 1001 (Colo. 1998)(an agent cannot be held responsible as the principal where the existence of the agency and identify of the principal are disclosed).

The question remains, however, whether any portion of the Trust corpus is nonetheless "owned by" Martha in view of the fact that she receives a portion of the Trust corpus each month. The ALJ believes not.

First, Martha is not the owner of the Trust corpus because the Trust clearly recites that, "the Trust [is] to be named as the sole owner of all ... assets, hereafter referred to as the 'Trust Estate.'" Exhibit B, ¶ 1.2. Martha is specifically deprived of any ability to anticipate, assign, pledge, mortgage, sell or transfer in any manner, voluntarily or involuntarily, her beneficial interest in the Trust. She has no right or power to terminate the Trust. That is to say, she has no legal right to make the Trust corpus available except as it is paid to her by monthly stipend upon an actuarially sound basis defined by the Trust.

Furthermore, under § 8.110.51.E.1, resources are not considered "available" when there is no "legal ability to make such sum available." Because Martha has no legal right to access the Trust corpus it is not available to her and therefore not a countable resource.

² Although § 8.110.52.A applies to trusts established before August 11, 1993, the reference to "the individual" as being the grantor/applicant is consistent throughout § 8.110.52.

³ Furthermore, "the individual" is not only the grantor but also the "applicant/recipient" of the Medicaid benefits. See Roger A. Mceowen, *Estate Planning for Farm and Ranch Families Facing Long-Term Health Care*, 73 Neb. L. Rev. 104 (1994), discussing the treatment of non-testamentary trusts after adoption of 42 U.S.C. § 1396p(d)(3)(B). "These assets will be considered available to the applicant and/or the applicant's spouse to the extent *the applicant* derives any benefit from them." *Id.* at 122, *italics added.* Because Martha is not the Medicaid applicant/recipient, she cannot be "the individual."

Finally, the ALJ considers whether the Trust's residuary distribution clause creates "any circumstance under which payments *from the trust* could be made to or for the benefit of" Appellant, such that the corpus must be counted as a resource under § 8.110.52.B.4.a.1 (*italics added*). The residuary distribution clause, Exhibit B, ¶ 3.4, decrees that upon Martha's death, the trustee shall distribute the remaining trust estate (if any) to Martha's estate. If Appellant survives Martha, he would be entitled to at least an elective share of her estate under the terms of Article 11 of the Colorado Probate Code, §§ 15-11-101, C.R.S. et seq. Although this would give Appellant access to at least a portion of the assets remaining at Martha's death, those assets would not be paid "from the trust" as required by § 8.110.52.B.4.a.1. Rather, those assets would be paid to Appellant from Martha's estate. Because the assets would not be paid to Appellant from the trust, the residuary clause does not trigger the "any circumstance" rule. Of course, any assets that were paid to Appellant at Martha's death would trigger a redetermination of his financial eligibility for continued long term care Medicaid benefits.

Deference to Agency Interpretation

Counsel for the County Department argues that the position of the State Department, as expressed by its Trust Officer, is entitled to "great deference" and the ALJ is therefore bound by that interpretation. Although the ALJ agrees that agency interpretations of their enabling statutes and regulations are entitled to deference, that deference normally applies upon judicial review of a final agency action. *Colo. Div. of Employment & Training v. Parkview Episcopal Hosp.*, 725 P.2d 787, 790 (Colo.1986) ("construction of a statute by an administrative agency charged with its enforcement should be given great deference by the courts.") Furthermore, even a court is not bound by an agency interpretation that misconstrues or misapplies the law. *Id.*

Because the Trust Officer's opinion is not a final agency decision, it is premature to give that opinion great deference. Doing so would be an abdication of the ALJ's duty to independently apply the State Department's regulations to the facts found, and thus arrive at the agency's initial decision.

Transfer Without Fair Consideration

Although the Trust corpus was not owned by either Appellant or Martha on the date of Appellant's Medicaid application, Appellant did fund the Trust with property transferred to the Trust without fair consideration. Transfers without fair consideration may trigger a period of ineligibility for Medicaid benefits, according to the rules in § 8.110.53.

Pursuant to § 8.110.53.F.2.a, even though a transfer is without fair consideration, no period of ineligibility will be imposed if the assets were transferred "to the individual's spouse or to another for the sole benefit of the individual's spouse." For a transfer to a trust to qualify as a "sole benefit" of the individual's spouse, certain limitations apply to the nature of the trust as specified in § 8.110.53.F.3. Those limitations include the requirement that the trust instrument be arranged in such a way that no one but the

spouse can benefit from the trust at the time of transfer or any time in the future, that the trust be in writing and legally bind the parties to a specified course of action, and that it provide for the spending of the trust assets "on a basis that is actuarially sound" based upon the spouse's life expectancy. See §§ 8.110.53.F.3.a, b(1) and b(2). The County Department concedes that the Trust meets these requirements, and therefore it seeks no transfer penalty.

Although § 8.110.53.F.2.a imposes no limit on the amount that may be transferred without penalty, the question arises whether such an unlimited transfer of assets subverts the intent of the Medicaid program to assist only needy applicants. In finding that it does, at least one state court has interpreted the federal Medicaid law to limit the amount that may be transferred to the amount of the CSRA. The excess becomes a transfer without consideration subject to penalty. *McNamara v. Ohio Dept. of Human Serv.*, 139 Ohio App. 3d 551, 557-58 (2000).

In *McNamara*, the Ohio court of appeals held that the federal law which contains the unlimited transfer provision, 42 U.S.C. § 1396p(c)(2)(B), is superseded by 42 U.S.C. § 1396r-5, which contains the CSRA provision. That is to say, the limits of the CSRA provision trump the provision that allows unlimited transfers for the sole benefit of a spouse. The court arrived at this conclusion by noting that § 1396r-5(a) states, "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." Because the CSRA limit rule is found in § 1396r-5(f), it must supersede the unlimited spousal transfer exemption found in § 1396p(c)(2)(B). The court believed this construction was necessary because to construe the statute otherwise "would allow persons with unlimited resources to avail themselves of Medicaid nursing home benefits."⁴ *McNamara*, 139 Ohio App. 3d at 558.

Regardless of the merit of the *McNamara* opinion, the ALJ is bound to apply the State Department's regulations as written and is not at liberty to disregard them. Section 8.057.8.E. Section 8.110.53.F.2.a plainly states that "no period of ineligibility will be imposed" upon a transfer of an individual's assets to another for the sole benefit of the individual's spouse, and it imposes no limitation upon the amount of money that may be transferred. To the contrary, the design of § 8.110.53.F.3, which defines the term "for the sole benefit of," contemplates that transfers of more than the CSRA may be made. This is apparent from the fact that although § 8.110.53.F.3.b(1) requires the trust document to be in writing, and b(2) requires that the trust corpus be paid to the spouse on a basis that is actuarially sound, § 8.110.53.F.3.b(4) eliminates those requirements if only a CSRA is transferred:

4) A community spouse to whom a Community Spouse Resource

⁴ HCFA, the predecessor to CMS, recognized and accepted this possibility. In its State Medicaid Manual, General and Categorical Eligibility Requirements, "Transmittal 64," published in November 1994, HCFA acknowledged that the unlimited transfer exception of 42 U.S.C. § 1396p(c)(2)(B)(ii) "may have greater impact on eligibility because resources may potentially be placed beyond the reach of either spouse and thus not to be counted for eligibility purposes." See Transmittal 64, § 3258.11, found at www.sharinglaw.net/elder/Transmittal64.htm.

Allowance has been transferred does not have to provide a written document or comply with the requirement that the transfer is actuarially sound. However, the Community Spouse Resource Allowance must be for the sole benefit of the community spouse to whom it is transferred. Upon the death of the community spouse, those resources shall be made available to the surviving spouse, at least up to the amount of the elective share of the augmented estate, the family allowance and the exempt property allowance.

Given the plain wording and design of § 8.110.53.F, by which the ALJ is bound, Appellant's transfer of stock to the Trust did not trigger a period of ineligibility even though the amount transferred exceeded the CSRA.

Summary

Because the Trust corpus was, as of the date of Appellant's Medicaid application, the sole property of the Trust and was not available to either Appellant or Martha, it was not owned by either of them on that date. Although Martha is the Trust beneficiary, she is not an "individual" for the purposes of applying the attribution rule of § 8.110.52.B.4.a.1. Because the Trust corpus was not owned by Appellant or his wife as of the date of Medicaid application, it was not a countable resource. Furthermore, because Appellant transferred his assets to the Trust for the sole benefit of his spouse, in compliance with State Department regulations, the transfer did not trigger a period of ineligibility. Appellant therefore meets the resource threshold and, according to the stipulation of the parties, is financially eligible for HCBS benefits.

Initial Decision

The County Department's decision to deny Appellant's Medicaid application due to being over-resourced is REVERSED.

Pursuant to §§ 25.5-1-107 and 24-4-105(14), C.R.S., this Initial Decision shall be reviewed by the Office of Appeals, State Department of Health Care Policy and Financing. The parties shall have 15 days from the date this Initial Decision is mailed, plus 3 days for mailing, to file written exceptions with the Office of Appeals at 1570 Grant Street, Denver, Colorado 80203, unless extended by the Office of Appeals. This Initial Decision will not be implemented while pending State Department review and final agency action. Pursuant to State Department rules, the failure to file exceptions to provisions of the Initial Decision will waive the right to seek judicial review of a final agency decision that affirms those provisions.

Done and Signed
May 14, 2008


ROBERT N. SPENCER
Administrative Law Judge

Digitally recorded

Exhibits admitted

For the County Department: exhibits 1 – 6

For the Appellant: exhibits A – G

Joint Exhibit I



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EXHIBIT I

Massachusetts Fair Hearing

ELDER LAW ASSOCIATES PA

MOSCHELLA & WINSTON LLP

TO: Hearing Officer
Case Worker
FROM: Attorney Michael R. Couture, Esq.
DATE: July 25, 2011
RE: Client, Appeal No. xxxx892

POST FAIR HEARING MEMORANDUM

INTRODUCTION

This post-hearing memorandum is a response to the memorandum of law submitted by the Office of Medicaid on the date of the Fair Hearing, July 6, 2011. The Hearing Officer left the record open for the Appellant to provide supporting documentation until July 20, 2011. This deadline was extended pursuant to the Appellant's request until July 25, 2011.

I. PROCEDURAL HISTORY AND FACTS

The Appellant, Client, is a 79 year old woman who resides at the Radius Nursing Home in Lowell, Massachusetts. On November 14, 2010, Client established the Grandson Supplemental Needs Trust (the "Trust"). The Trust beneficiary is the disabled grandson of Client.

On December 6, 2010, the Office of Medicaid denied Client's MassHealth application based on the transfer of assets to the Trust. According to the MassHealth

memorandum of law, the reason for the denial was that the Appellant has not established that the Trust is permissible under federal Medicaid law and sub-regulatory guidance.

II. ISSUE PRESENTED

Whether the Appellant's transfer to the Trust is allowable pursuant to federal laws and regulations.

III. APPLICABLE LAW

MassHealth, also known as Medicaid, is a joint federal and state program established in 1965 by Title XIX of the Social Security Act, 42 U.S.C. §§1396 et seq. While administered by the states, state programs must comply with federal statutes and regulations to receive federal funding. Harris v. McRae, 448 U.S. 297 (1980). The Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Agency or "HCFA") issues federal guidelines which appear in the state Medicaid Manual. Massachusetts Hosp. Ass'n v. Department of Pub. Welfare, 419 Mass. 644 (1995). In Massachusetts, MassHealth provides coverage for long-term institutional care for individuals who meet the eligibility requirements found at 130 C.M.R. 520 et seq.

Generally, the MassHealth regulations impose a period of ineligibility for MassHealth when an applicant transfers assets for inadequate consideration. 130 C.M.R. 520.018. Exceptions to the transfer rules, however, are found at 130 C.M.R. 520.019(D). Specifically, permissible transfers include situations where:

The resources were transferred to a trust, a special needs trust, or a pooled trust created for the sole benefit of a permanently and totally disabled person who was under 65 year of age at the time the trust was created or funded. 130 C.M.R. 520.019(D)(4).

The federal statute permitting transfers to trusts for disabled individuals under 65 years of age states, in pertinent part:

An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that . . . the assets were transferred to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of an individual under 65 years of age who is disabled. 42 U.S.C §1396p(c)(2)(B)(iv).

IV. ARGUMENT

1. The transfer into the Trust is permissible because it meets the requirements set forth in "HCFA 64" as a Sole Benefit Trust

Client has demonstrated that she has transferred assets to a trust for the benefit of a disabled individual under the age of sixty-five. Therefore, the transfer to the Trust is permissible so long as the Trust is a "sole benefit" trust. The Centers for Medicare and Medicaid Services ("CMS") issued Transmittal 64 ("HCFA 64"), which illustrates the requirements of a sole benefit trust pursuant to federal law. The relevant language states the following:

For the Sole Benefit of.--A transfer is considered to be for the sole benefit of a spouse, blind or disabled child, or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

Similarly, a trust is considered to be established for the sole benefit of a spouse, blind or disabled child, or disabled individual if the trust benefits no one but that individual, whether at the time the trust is established or any time in the future....

A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not the spouse, blind or disabled child, or disabled individual is not considered to be established for the sole benefit of one of these individuals. **In**

order for a transfer or trust to be considered to be for the sole benefit of one of these individuals, the instrument or document must provide for the spending of the funds involved for the benefit of the individual on a basis that is actuarially sound based on the life expectancy of the individual involved. When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void.

An exception to this requirement exists for trusts discussed in §3259.7. Under these exceptions, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the State, up to the amount of Medicaid benefits paid on the individual's behalf. When these exceptions require that the trust be for the sole benefit of an individual, the restriction discussed in the previous paragraph does not apply when the trust instrument designates the State as the recipient of funds from the trust. Also, the trust may provide for disbursement of funds to other beneficiaries, provided the trust does not permit such disbursements until the State's claim is satisfied...(Emphasis added).

State Medicaid Manual, HCFA 64 §3257(B).6.

- A. The Trustee must make mandatory distributions to or for the benefit of the Beneficiary that are actuarially sound and the Trust is therefore compliant with the Sole Benefit requirements of HCFA 64.

First, the Trust contains express and specific language that provides for the spending of the funds for the benefit of the beneficiary, Grandson, on a basis that is actuarially sound based on his life expectancy. Article 7.2 of the Trust (Mandatory Distributions), expresses clear and unequivocal language that the Trustee “shall distribute to the Beneficiary or use on the Beneficiary’s behalf principal and income on a basis that is considered an actuarially sound manner based on the Beneficiary’s life expectancy.”

The trust further explains how the Trustee shall calculate the life expectancy of the beneficiary, which references Social Security Administration tables referred to in 42 U.S.C.

§1396. The language in the Trust is clear in that the Trustee has no discretion to withhold payments to or for the benefit of the beneficiary.

The MassHealth memorandum incorrectly argues that these distributions are not mandatory, and therefore not actuarially sound, because Article 7.3 of the Trust (“Discretionary Distributions”) provides discretionary language. This is a clear error by MassHealth because Article 7.3 is referring to any discretionary distributions to the beneficiary that are above any mandatory distributions that fall under Article 7.3. The first sentence of Article 7.3 states that “the making and the amount of any payment **above such amounts described in Article 7.2** shall be totally and solely within the discretion of the Trustee. (Emphasis added).

The MassHealth memorandum further erroneously states that the Trustee “impliedly” may not make any distributions at all because of Articles 3, 7.2, and 8 that the purpose of the trust is to supplement and not supplant public benefits...” The MassHealth memorandum has made the false assumption that the Trustee cannot make mandatory distributions without satisfying the purpose of the Trust, presumably because any payments will adversely affect public benefit eligibility. This is legally and factually incorrect because the Trustee must make the mandatory distributions and these distributions will not necessarily affect eligibility of any public benefit programs. Furthermore, the Trustee is not absolutely precluded to make payments that would affect Medicaid or SSI.

The Trustee is allowed to make payments to the beneficiary “in-kind”, and according to federal regulations, in-kind payments made on behalf of the beneficiary that are not for food and shelter will not adversely affect SSI or Medicaid eligibility. It is entirely possible that the Trustee can make purchases up to and above the amount of the mandatory distributions without

reducing the beneficiary's SSI payments or risking any other public benefit program available to the beneficiary.

Further, Article 7.4 of the Trust expressly provides that the Trustee may reduce public benefits eligibility if it enhances the beneficiary's standard of living.¹ For example, the Trustee may make in-kind support payments on behalf of the beneficiary that "would reduce the Beneficiary's SSI benefit by a maximum of the monthly Presumed Maximum Value (PMV) amount, or such equivalent distribution as allowed by the state Medicaid Program."

The trust provisions are not contradictory, as MassHealth would argue, because the trustee's mandatory distributions do not violate the purpose or any express terms of the trust. The Appellant fully agrees with MassHealth that "if the Trustee makes distributions to Grandson, there is nothing to prevent the Social Security Administration from counting any money paid from the trust on Grandson's behalf as income that "can" be used for food or shelter." This is true, but only up to the PMV, which is why the Trustee has the discretion to make payments on behalf of Grandson that are not for food or shelter, OR, to make such in-kind payments that are for food and shelter and thereby reducing his SSI payments as provided in Article 7.4 of the Trust.²

- B. The Trust provides that the State, up to the amount of Medicaid benefits paid on the individual's behalf, is the sole beneficiary after the death of Grandson, thereby satisfying the exception to the actuarially sound requirements of a Sole Benefit Trust

¹ Any allowable reduction in public benefits pursuant to Article 7.4 is "subject to the Provisions of Article 7.2, above". The mandatory distributions provided in Article 7.2, therefore, trump the discretion the Trustee has in reducing other benefits.

² MassHealth's statement that "any payments from the Trust on Grandson's behalf must necessarily be in small amounts in order to avoid supplanting SSI or MassHealth benefits" is, on the other hand, absolutely incorrect because as explained, the Trustee can either 1) make payments in-kind for non-food or shelter related items without reducing SSI, OR the Trustee can make payments for food and shelter and thereby reduce the SSI payments by the "presumed maximum value", which is expressly allowed pursuant to Article 7.4.

HCFA 64 provides that the restriction regarding mandatory distributions that are actuarially sound does not apply when the trust instrument designates the State as the recipient of funds from the trust. Therefore, as long as the trust has a beneficiary provision that “pays back” the government agency, the trust does not have to be actuarially sound. Article 10 of the Trust clearly provides such language where the state is paid back for Medicaid assistance provided to Grandson.

MassHealth has put forth the brief and confusing argument that the paragraph in HCFA 64 “is inapplicable” because according to MassHealth, “the issue in this case is not related to treatment of trust assets”. The Appellant submits that this paragraph from HCFA is relevant because the sole issue in this case is whether transfers to this Trust are permissible according to federal law. Not only does the Trust meet the requirement distributions to the disabled beneficiary are actuarially sound, but it also contains a payback provision to the State, which alone would satisfy federal requirements. HCFA 64 mandates that in order to be an allowable trust, it must be actuarially sound or have a payback provision to the State agency and this trust contains both.

MassHealth also put forth the argument in a footnote that “the payback clause must be as to the person who is applying for or receiving Medicaid benefits and whose eligibility is sought to be established.” This is incorrect. All federal laws and regulations provide that the payback clause in these trusts, whether it is a pooled trust, D4A trust, or to the sole benefit trusts, relate to the beneficiary of such a trust, not to the donor of the trust. MassHealth’s conclusion is unsupported by common practice and the intent of the regulations.

The purpose of these sole benefit trusts is to preclude anyone other than the beneficiary from benefitting from the assets in any way. The solution to an untimely death by the beneficiary is to provide that the state is first paid back for all funds paid to the beneficiary. The language in HCFA 64 supports this reasoning by providing "the trust may provide for disbursement of funds to other beneficiaries, provided the trust does not permit such disbursements until the State's claim is satisfied." This sentence only makes sense if the claim is on the Medicaid funds paid to the beneficiary, and not to the donor of the trust.

V. CONCLUSION

For the foregoing reasons, Appellant Client respectfully requests that the Board of Hearings order the Respondent Office of Medicaid to treat the transfer to the Grandson Supplemental Needs Trust as a permissible transfer, to approve MassHealth eligibility, and to provide all other remedies it deems equitable and just.

Submitted on behalf of the Appellant
Client, by his Attorney

Date: _____

/S/

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EXHIBIT J

NAELA Amicus Brief Filed in Hughes v. Colbert

ELDER LAW ASSOCIATES PA

Case No. 12-3765

**UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT**

Carole Hughes and Harry Hughes,
Plaintiff-Appellants,

v.

**Michael Colbert, in his official
capacity, as Director of the Ohio Department
of Job & Family Services,**
Defendant-Appellee.

**APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO, EASTERN DIVISION**

**BRIEF *AMICI CURIAE* OF THE NATIONAL ACADEMY OF
ELDER LAW ATTORNEYS AND THE OHIO STATE BAR
ASSOCIATION IN SUPPORT OF THE
PLAINTIFFS-APPELLANTS CAROLE HUGHES AND
HARRY HUGHES AND IN SUPPORT OF REVERSAL OF
THE LOWER COURT'S DECISION**

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F.R.A.P. 26.1 CORPORATE DISCLOSURE STATEMENT

National Academy of Elder Law Attorneys ("NAELA")

The Internal Revenue Service has determined that NAELA is organized and operated pursuant to Section 501(c)(6) of the Internal Revenue Code and is exempt from income tax. NAELA is operated as a non-profit corporation under the laws of the State of Oregon. It does not issue stock and has no parent or subsidiary corporations.

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The Internal Revenue Service has determined that the OSBA is organized and operated pursuant to Section 501(c)(6) of the Internal Revenue Code and is exempt from income tax. OSBA is operated as a not-for-profit unincorporated association under the laws of the State of Ohio. OSBA does not issue shares of stock and has no parent corporation.

Dated: September 5, 2012

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STATEMENT OF INTEREST OF *AMICI CURIAE*

The National Academy of Elder Law Attorneys (“NAELA”) is a professional organization of attorneys concerned with legal issues affecting the elderly and disabled, including eligibility for medical assistance (“Medicaid”) benefits. NAELA files this brief with the consent of both the Defendant-Appellee and the Plaintiff-Appellant. No counsel for any party authored this brief in whole or in part, and no money was contributed by anyone, other than the *amicus curiae* and its counsel, to fund preparing or submitting the brief.

NAELA’s mission statement provides that its members provide legal advocacy, guidance and service to enhance the lives of people with

special needs and people as they age. Since its inception nearly twenty-five years ago, NAELA has grown to a current membership of over 4,400 attorneys in all fifty states, the District of Columbia and several foreign countries; it has almost 150 members in Ohio, in which this case arose, and nearly 350 members within the four states in the Sixth Circuit.

The Ohio State Bar Association (“OSBA”) files this brief with the consent of both the Defendant-Appellee and the Plaintiff-Appellant. No counsel for any party authored this brief in whole or in part, and no money was contributed by anyone, other than the *amicus curae* and its counsel, to fund preparing or submitting the brief.

OSBA shares the concern of NAELA for the well-being of community spouses, often women with a lower fixed income, within the State of Ohio and throughout the country.

ISSUES OF LAW

1. The Statutes are Clear and Supported by the Views of the Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (the “CMS”)¹, the component of the Department of Health and Human Services (“HHS”) that oversees the administration of the Medicaid program by the states, has consistently and authoritatively advised that the limitation on the amount of transfers from an institutionalized spouse to a community spouse 42 U.S.C. § 1396r-5(f)(1) only applies in the post-eligibility context. The CMS has advised that prior to eligibility, such as in this case, that section does not apply; instead 42 U.S.C. § 1396p(c)(2)(B)(i) permits unlimited transfers to the community spouse. That is consistent with the terms of those statutes and the Medicaid eligibility process.

2. The Views of the CMS are Entitled to Substantial Deference

Those views of the CMS about the meaning of these statutes are entitled to substantial deference under *Skidmore v. Swift & Co.*, 323 U.S. 134 (1944) since they are well reasoned and consistent over time.

¹ Prior to July, 2001, the CMS was the Health Care Financing Administration. *See* 66 Fed. Reg. 35437 (2001). For consistency it will be referred to herein as the CMS.

3. Protecting the Community Spouse from Impoverishment is Federal Public Policy

In the “spousal impoverishment” statute, 42 U.S.C. § 1396r-5, Congress established the public policy that community spouses should have enhanced protections for their income and resources from being applied to the costs of care of their institutionalized spouses. It enacted restrictions on the use of annuities, including provisions requiring that the Medicaid program be named a remainder beneficiary, balancing the interests of community spouses and the Medicaid program.

SUMMARY OF ARGUMENT

The statutory construction applied by the court below, which substantially limits the ability of couples to provide for the needs of the community spouse when the elderly or disabled spouse enters a nursing home, is contrary to the terms of the relevant statutes, 42 U.S.C. §§ 1396p(c)(2)(B)(i) and 1396r-5(f)(1), the recent and only decision by a sister court of appeals on the issue, *Morris v. Okla. Dep’t of Human Svcs.*, 685 F.3d 925 (10th Cir. 2012), and a series of letters from the CMS to several states which had been in the record in recent prior litigation on this issue in the same court but were not brought to the attention of the district court in this case.

Those letters from the CMS, well reasoned and consistent over time, should be considered by this court and given substantial deference.

The decision below is contrary to the intent of the statute to protect community spouses to provide for their own retirement needs, particularly in the context of this case, in which the funding of individual retirement account (“IRA”) annuities resulted in the State Medicaid agency imposing a penalty period disqualifying the institutionalized spouse from Medicaid for having looked out for the needs of her husband in the community.

ARGUMENT

I. THE STATUTES ARE CLEAR AND SUPPORTED BY THE VIEWS OF THE CENTERS FOR MEDICARE AND MEDICAID SERVICES

The court below confused one statute, 42 U.S.C. § 1396r-5(f)(1) , which applies to transfers after one spouse has applied for Medicaid, and simply permits assets to be re-allocated from the institutionalized spouse to the community spouse to bring her up to the community spouse resource allowance (the “CSRA”), with another statute, 42 U.S.C. § 1396p(c)(2)(B)(i), which applies before the Medicaid application and permits unlimited transfers to the community spouse.

The Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, 102 Stat. 683, enacted the “spousal impoverishment” protections set forth in 42 U.S.C. § 1396r-5. They provide that, at the time of a Medicaid application, as a general rule the assets of both spouses shall be considered available to the institutionalized spouse. 42 U.S.C. § 1396r-5(c)(2)(A).

There is, however, one important exception. Resources are only considered available to the community spouse to the extent they exceed the community spouse resource allowance (the “CSRA”). 42 U.S.C. § 1396r-5(c)(2)(B). The CSRA is defined in 42 U.S.C. § 1396r-5(f)(2); it is, as its name implies, an allowance of resources for the community spouse that is substantially more than the allowance for the actual Medicaid applicant, which in most states is the same as the SSI resource allowance of \$2,000.

Thus, depending on the way the couple’s assets are titled at the time of the Medicaid application, the institutionalized spouse may have more than his allowance in his name while the community spouse has less than the CSRA in hers. For example, assume the CSRA is \$50,000, and the institutionalized spouse has \$40,000 in his name while the community spouse has just \$5,000 in her name.

That is the circumstance, and the only circumstance, in which the provisions of 42 U.S.C. § 1396r-5(f)(1) come into play, and the court below erroneously applied the cap on spousal transfers in that statute because it has nothing to do with transfers prior to the Medicaid application like those here. Section 1396r-5(f)(1) merely permits a couple in a situation like that above to reallocate their resources “as soon as practicable after the date of the initial determination of eligibility” so that the institutionalized spouse has no more than his own individual resource allowance and the community spouse has been brought up closer to her CSRA.

What controls here is not that statute, but rather 42 U.S.C. § 1396p(c)(2)(B)(i), which permits unlimited transfers between spouses without there being any resulting penalty period of ineligibility. That makes perfect sense given that, for purposes of Medicaid eligibility, all the resources of both spouses in excess of the CSRA are attributed to the institutionalized spouse who is applying for Medicaid. 42 U.S.C. § 1396r-5(c)(2). The transfer of assets penalty rules are intended to address gifts to others because they artificially pauperize the applicant or spouse. Transfers to spouses, on the other hand, do not have that

consequence because Medicaid will count the assets irrespective of which one of the spouses holds the assets.

This critical distinction was missed by the court below, just like the district court in *Morris v. Okla. Dep't of Human Svcs.*, 758 F.Supp. 2d 1212 (W.D. Okla. 2010), on which the court below relied. That decision in *Morris* was reversed shortly after the decision below, 685 F.3d 925 (10th Cir. 2012), and the court of appeals corrected that error because it understood that the cap on spousal transfers in § 1396r-5(f)(1) did not apply to spousal transfers prior to the Medicaid application.

II. THE VIEWS OF THE CMS ARE ENTITLED TO SUBSTANTIAL DEFERENCE

The holding in *Morris* is buttressed by a series of letters issued to various states by the CMS about this very issue. These letters are available on PACER but were not part of the record below, although they were well known to the defendant since they had been introduced in the *Burkholder v. Lumpkin*² case involving the same defendant state Medicaid official and on which the court below relied. In the alternative

² 2010 U.S. Dist. LEXIS 11308 (N.D. Ohio 2010). These letters are in docket no. 23 for that case, 09-cv-1878, on PACER.

to merely referencing these letters we respectfully request that the court consider those references as being a motion to supplement the record by including them or for the court to take judicial notice of them as public records.

They represent a consistent and well thought out explanation of the differences between these two statutes, and as such they are entitled to substantial deference under *Skidmore v. Swift & Co.*, *supra*. Both the Supreme Court and this court have given deference to such letters. *See Wis. Dep't of Health & Family Servs. v. Blumer*, 534 U.S. 473, 485, 496, 497 n. 14 (2002) [referring to several Regional State Letters]; *Chambers v. Ohio Dep't of Human Servs.*, 145 F.3d 793, 803 (6th Cir. 1998) ["given the unique nature of the statute and of HHS's power to interpret it we believe that courts may give even relatively informal interpretations by HHS some presumption of correctness."].

The earliest of these letters, to the Administrator of the Nevada State Welfare Division, sets forth a very detailed statutory analysis and explains why *McNamara v. Ohio Dep't of Human Servs.*, 139 Ohio App. 3d 551, 744 N.E.2d 1216 (2000), on which the court in *Burkholder* relied, 2010 U.S. Dist. LEXIS 11308, *17, 20-23, is incorrect. While that letter came from the Regional Office, it was copied to the

Administrator of the Division of Health Care Financing and Policy in the Central Office.

Another of the subsequent letters, to an attorney in Ohio, came directly from the Director of the Disabled and Elderly Health Programs Group in the Central Office of CMS in Baltimore. These are exactly the well reasoned and consistent policy interpretations that are entitled to deference.

The original Nevada letter also cites § 3262.4 of the State Medicaid Manual, the CMS manual that sets forth federal policy guidance for state Medicaid agencies. That section sets forth an example just like that described above, and makes clear that 42 U.S.C. § 1396r-5(f)(1), on which the court below relied, only applies to post-eligibility reallocation of resources, not the sort of pre-application transfers at issue here. The State Medicaid Manual also is entitled to *Skidmore* deference. *See Wong v. Doar*, 571 F.3d 247, 258 (2d Cir. 2009); *Dickson v. Hood*, 391 F.3d 581, 590 n. 6 (5th Cir. 2004).

In fact, a careful reading of the *Burkholder* decision indicates that it did not concern the situation in the instant case at all. In *Burkholder* the plaintiff had inherited money after Medicaid eligibility had been established; so it concerned a post-eligibility transfer, not a pre-

application transfer like the one in question here. Accordingly the court in *Burkholder* applied the post-eligibility statute, 42 U.S.C. § 1396r-5(f)(1), rather than the pre-application transfer statute, 42 U.S.C. § 1396p(c)(2)(B)(i). The court made this very clear in a subsequent Order, PACER docket no. 27, denying the plaintiff's motion for a new trial based on the newly discovered CMS letters, pointing out that they did not apply since the concerned pre-application transfers rather than the post-eligibility transfers in question there.

The court below in this action misapprehended the critical distinction between 42 U.S.C. § 1396p(c)(2)(B)(i), permitting unlimited transfers between spouses prior to applying for Medicaid, as in this case, and 42 U.S.C. § 1396r-5(f)(1) permitting otherwise eligible Medicaid recipients to make transfers re-allocating resources to bring the community spouse's resources up to the CSRA.

III. PROTECTING THE COMMUNITY SPOUSE FROM IMPOVERISHMENT IS FEDERAL PUBLIC POLICY

Each state which participates in the Medicaid program is required to provide coverage to certain categories of persons, often referred to as the "mandatory categorically needy." These persons are eligible for Medicaid because they receive some other form of public assistance,

such as Supplemental Security Income (SSI), or they fit into other specified groups of low-income persons. 42 U.S.C. §1396a(a)(10)(A)(i).

States may also elect, but are not required, to provide Medicaid coverage to other categories or groups of persons, including any group of individuals described in 42 U.S.C. §1396d(a) who are not mandatory categorically eligible or qualified Medicare beneficiaries. 42 U.S.C. §1396a(a)(10)(C). These groups of persons are commonly referred to as the "medically needy." One of the groups of individuals described in 42 U.S.C. §1396d(a) consists of adults who are 65 years of age or older, 42 U.S.C. §1396d(a)(iii), and Ohio has elected to provide Medicaid coverage to this group of individuals.

In determining income and resource eligibility for the medically needy, a state is required to use a methodology which is no more restrictive than the methodology used to determine eligibility for SSI. 42 U.S.C. §§1396a(a)(10)(C)(i)(III) and 1396a(r)(2)(A)(i). This means that the methodology used by the state may not result in persons in this category being ineligible for Medicaid if they would otherwise be eligible for SSI. 42 U.S.C. §1396a(r)(2)(B); *James v. Richman*, 547 F.3d 214, 218 (3d Cir. 2008); *Anna W. v. Bane*, 863 F.Supp. 125, 128-9 (W.D.N.Y.

1993). In addition, a state must use reasonable standards for determining eligibility which provide for taking into account only such income and resources as are available to the applicant or recipient and which would not be disregarded in determining eligibility for SSI. 42 U.S.C. §1396a(a)(17).

In the context of this statutory scheme, the state's implication that Mr. Hughes's purchase of an annuity is a "loophole" that the court should close should be rejected. For Medicaid purposes, an annuity generally counts as an "asset." *See* 42 U.S.C. § 1396p(c)(1)(G). Under 42 U.S.C. § 1396p(h)(1), "assets" include both income and resources, but an annuity that satisfies various conditions does not qualify as an available resource. *See* § 1396p(c)(1)(G).

The standards for what may be counted as a resource in determining eligibility for SSI (and therefore for determining Medicaid eligibility) are set forth in 20 C.F.R. §416.1201(a)(1): "[i]f a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse)." That the Medicaid provisions are read to treat an irrevocable and non-assignable annuity as the community spouse's income, rather than the couples' joint resource, is

the balance struck by Congress. *See* 42 U.S.C. §1396r-5. Such income would not affect Mrs. Hughes' eligibility because "no income of the community spouse shall be deemed available to the institutionalized spouse." 42 U.S.C. § 1396r-5(b)(1).

The weight of authority supports this interpretation. *See Hutcherson v. Ariz. Health Care Cost Containment Sys. Admin.*, 667 F.3d 1066, 1069 (9th Cir. 2012) (noting that the annuity provision "allow[s] the spouse to convert his or her assets, which are considered in determining the institutionalized spouse's eligibility, to income which is not considered"); *James v. Richman*, 465 F. Supp. 2d 395,403 (M.D. Pa. 2006), *aff'd*, 547 F.3d 214 (3d Cir. 2008) ("available assets may become unavailable assets and not countable in determining Medicaid eligibility for the institutionalized spouse when an irrevocable actuarially sound commercial annuity is purchased for the sole benefit of the community spouse"); *Mertz v. Houston*, 155 F. Supp. 2d 415 (E.D. Pa. 2001) ("[A] couple may effectively convert countable resources into income of the community spouse which is not countable in determining Medicaid eligibility for the institutionalized spouse by purchasing an irrevocable actuarially sound commercial annuity for the sole benefit of

the community spouse."); *Vieth v. Ohio Dep't of Job & Family Servs.*, 2009 Ohio 3748 (Ct. App. 2009) (concluding that "funds used to purchase an actuarially sound, non-revocable, non-transferable commercial annuity, for the sole benefit of the community spouse, are not countable resources for Medicaid eligibility purposes"); *see also Estate of F.K. v. Div. of Med. Assistance & Health Servs.*, 374 N.J. Super. 126,142-143, 863 A.2d 1065, 1074-1075 (App. Div. 2005) (relying on the CMS State Medicaid Manual Transmittal 64 to strike down a New Jersey regulation that capped the amount a couple could spend on an annuity at the couple's CSRA). As noted above, this is also the reading of the statute adopted by the agency (CMS) charged with administering the Medicaid program.

Despite its presumed awareness of these judicial and administrative interpretations, Congress has not revised the Medicaid statute to foreclose this option. In fact, rather than close the annuity "loophole," Congress has twice amended the Medicaid statutes to specify the types of annuities capable of producing uncountable spousal income. *See* Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, 120 Stat. 2922, 2998; Deficit Reduction Act of 2005, Pub. L. No. 109-171,

120 Stat. 4, 62–64. “Congress provided a detailed set of rules governing transactions that it considered suspicious, and the purchase of an annuity is not among them.” *James v. Richman*, 547 F. 3d at 219. There is nothing on its face suspicious, illegal, or otherwise contrary to the policy expressed in the Medicaid statutory scheme in treating an irrevocable, actuarially sound, non-assignable annuity as the community spouse’s income rather than a resource attributable to the couple. A fair reading of the statutes, in fact, compels that result.

When Mrs. Hughes becomes eligible for Medicaid assistance, essentially all of her income will be required to be paid to the nursing home providing her care, with Medicaid payments making up the difference between the cost and her payments. 42 U.S.C. §§1396r-5(b)(1) and (d). Mr. Hughes receives \$1,728.42 per month (R.E #1, Complaint, at ¶ 10) after using resources attributable to his marriage partnership to purchase a conforming annuity, in addition to his other retirement income, which would include, of course, his Social Security retirement benefits.

Therefore, the community spouse, Mr. Hughes, would not be eligible for an income allowance from his institutionalized spouse. 42

U.S.C. §1396r-5(d)(3)(A). So in the first instance, the state's payments to the nursing home on behalf of the institutionalized spouse would be reduced by the annuity payments to the community spouse. Thus, the public policy that permits a conforming annuity purchase to supplement the income of the community spouse is balanced by the institutionalized spouse's increased contribution to the cost of her nursing facility care.

The public policy balance struck by the Medicaid annuity provisions is also apparent in the restrictions governing such conforming annuities. Annuities are required to name, and Mr. Hughes did name, the institutionalized spouse as the remainder beneficiary if the community spouse does not survive the annuity's term. 42 U.S.C. 1396p(c)(1)(F)(ii); R.E. #1-2, Contract Data Page, p.2. If Mrs. Hughes survives her husband, for example, her income would increase by \$1,728.42, essentially all of which would be paid for her nursing home care and offsetting the amount that the state would pay by \$1,728.42. 42 U.S.C. 1396p(c)(1)(F).

If neither spouse survives the annuity's term, the state would be paid the remaining annuity payments up to the total amount of Medicaid assistance paid on behalf of the institutionalized spouse. 42

U.S.C. 1396p(c)(1)(F)(i). Thus, the benefit the community spouse realizes from the increased income produced by the purchase of the annuity prevents his impoverishment during his lifetime, but reduces the amount paid by Medicaid at his death because the annuity payments are either:

- consumed by the community spouse as support,
- used by the institutionalized survivor to meet the cost of nursing home care (and thereby reduce the state's outlay), or
- paid to the state to reimburse it for the Medicaid payments it made on behalf of the institutionalized spouse.

This public policy is perfectly consistent with the public policy of preventing spousal impoverishment, as the Department of Health and Human Services has pointed out in its *amicus* brief in the Second Circuit in the related *Lopes v. Starkowski* case, Docket No. 10-3741-CV (2d Cir. Dec., 2011). R.E. #15-4, Amicus Brief of HHS, pp. 19-22.

This annuity purchase was not an improper transfer of assets. Indeed, the treatment of the annuity purchase by Mr. Hughes, from his own funds, by definition could not have been a transfer from his wife, contrary to the position of the Defendant and the court below. In the

context in which it arose, the conversion of one form of IRA to another (the IRA annuity), the purchase was in furtherance of our express public policy to protect the marriage partnership from impoverishment in retirement. This is set out in the Medicaid statutory scheme expressly permitting IRA annuities that comply with certain requirements, as Mr. Hughes' annuity did.

CONCLUSION

For the foregoing reasons the judgment below should be reversed.

Dated: September 5, 2012

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH TYPEFACE AND LENGTH

Pursuant to Rule 32(a)(7)(C) of the Federal Rules of Appellate Procedure, I hereby certify that this brief complies with the limitations in Federal Rules of Appellate Procedure 29(d) and 32(a)(7)(B) because this brief contains 4764 words as determined by the word counting feature of Microsoft Word 2010. I also hereby certify that this brief complies with the typeface and typestyle requirements of Federal Rule of Appellate Procedure 32(a)(5)(A) because this brief has been prepared in a proportionally spaced typeface using 14-point Century font in Microsoft Word 2010.

Pursuant to Local Rule 25(f), I also hereby certify that an electronic version of this brief has been filed with the Clerk via the Court's CM/ECF system, the electronic version of the brief was generated by printing the original word processing file to PDF, and the file has been scanned for viruses and is virus-free.

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CERTIFICATE OF SERVICE

I hereby certify that on September 5, 2012, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Sixth Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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