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IN THIS ISSUE:

Delays in Processing of Medicaid Applications is Not Lawful

Sue Doe, a young adult with developmental disabilities including epilepsy, mild mental retardation and cerebral palsy, filed suit against the South Carolina Medicaid agency. Her claim, based on a violation of the standard of promptness, survived an earlier round of appeals. When the district court granted the Agency's motion for summary judgment she appealed again. In reviewing the facts, the Court found that the Agency had placed Doe on a waiver waiting list in December 2002 without making a final decision as to her eligibility. Doe requested a fair hearing based on the standard of promptness. Pending appeal, Doe was moved to a critical waiting list in February 2003. At a March 2003, hearing, the Administrative Law Judge dismissed the matter after determining that moving Doe to the top of the critical waiting list resolved all claims in her favor and there was nothing else he could do. A plan of care was developed calling for residential habilitation services. By June 2003, Doe still had not received any services and she initiated the present action. Thereafter, following a dispute regarding choice of providers, services were approved in a more restrictive setting than what Doe required or requested. While Doe was receiving services, a re-evaluation was performed where the Agency determined that Doe was not mentally retarded and, therefore, not eligible for services. Doe claimed the re-evaluation was in retaliation for the filing of her lawsuit. She also claimed the Agency's determination was contrary to Social Security's determination that she is mentally retarded. Doe appealed that determination, which is pending in front of the South Carolina Court of Appeals. Various claims were adjudicated and dismissed in Doe's federal suit, with only the standard of promptness claim remaining. On January 29, 2010, the district court dismissed that claim finding that the Agency was not obligated under the Medicaid Act to provide residential habilitation services with reasonable promptness. The Court of Appeals disagreed. The Medicaid act clearly requires the Agency to act with reasonable promptness. Further, a dispute regarding choice of providers does not eliminate that requirement since Section 1396a(a)(23) is clearly drawn to give Medicaid recipients the right to receive Medicaid from the provider of their choice. The provision of different care, which the Agency itself did not believe was what Doe needed, did not resolve the issue. The Court found that, notwithstanding resolution of her other claims, the district court still had equitable power to order the Agency to provide financing for appropriate care pending resolution of the State proceeding. Finding that Doe was the prevailing party on her Standard of Promptness claim, the Court found that she was a prevailing party and was entitled to attorney's fees under Section 1988. Doe v. Kidd, 2011 U.S. App. LEXIS 6067 (March 24, 2011).

Paul's Note: This case comes to us from the National Academy of Elder Law Attorneys monthly bulletin. Application delay is a major problem in Connecticut, causing cash flow problems for nursing homes and other providers and forcing the elderly to self-pay for longer than they should if the State acted promptly. No lawsuit is pending in Connecticut to address this issue and given the manpower shortages in the Department of Social Services, no favorable change is on the horizon either.

Lump Sum Personal Care Contract Is Transfer for Less Than Fair Market Value

A Massachusetts appeals court upholds the imposition of a transfer-of-assets penalty assessed against a Medicaid applicant who entered into a lump sum personal care contract with her daughter, determining that the contract's value cannot be ascertained. Forman v. Director of the Office of Medicaid (Mass. App.Ct., No. 10-P-728, April 6, 2011).

Janette Forman entered into a lump sum personal care agreement with her daughter, Fran Rachlin, in which Ms. Forman paid Ms. Rachlin $20,000 in exchange for Ms. Rachlin's agreeing to provide her mother with room, board, meal preparation, housekeeping and transportation. The contract allowed Ms. Rachlin to terminate the agreement and keep the entire lump sum payment if her mother engaged in behavior that was a threat to her own mental or physical health or if Ms. Forman was no longer able to assist with her own personal hygiene needs. The contract did not quantify the number of hours to be worked by Ms. Rachlin and it did not have a specific duration.

One year after signing the contract, Ms. Forman moved into a nursing home and filed a Medicaid application. The state Medicaid agency assessed a two-and-a-half-month transfer penalty based on its determination that the contract was a transfer for less than fair market value and that it was not reasonably enforceable by Ms. Forman or her estate. Ms. Forman appealed and a board of hearings and the Superior Court both upheld the state's decision.

The Massachusetts Court of Appeals upholds the imposition of the transfer penalty, ruling that the contract represented a transfer for less than fair market value. The court explains that it "cannot fairly estimate the value of the contract because it was self-contradictory, sketchy, and skewed in favor of the daughter's retention of the upfront payment regardless of the services provided. . . [i]f the daughter elected to terminate the contract . . . or if the mother died at any point in time following the execution of the contract, the daughter was entitled to retain the full $20,000 regardless of services performed to date." The court does temper its decision by pointing out that "we are not in any way suggesting that all lump-sum prepaid contracts or all contracts between family members for personal services are disqualified. Our decision is limited to those contracts in which compensation does not reflect fair market value, as was the case here." The court declines to address whether the contract was legally and reasonably enforceable.

Paul's Note: We have seen this before. I agree with the court that all the risk of performance cannot remain solely with the person receiving the care, but it is possible to craft an agreement in such a way as to make it work. The old adage comes in handy here: Don't overreach—pigs may get fat, but hogs get slaughtered.

Medicaid Applicant Who Was Denied Benefits After Purchasing Annuity for Spouse May Proceed with Claim Against State

A U.S. district court rules that a Medicaid applicant who purchased an annuity for his spouse may proceed with a claim against the state Medicaid agency, which had found he had transferred resources for less than fair market value. Jackson v. Selig (U.S. Dist. Ct., E.D. Arkansas, No. 3:10CV00276-WRW, Dec. 22, 2010).

Richard Jackson lived in a nursing home and applied for Medicaid benefits. The state denied Mr. Jackson's application because he had more than $300,000 in available resources. Mr. Jackson purchased an annuity for his wife for $248,949.09 and a smaller annuity for himself, and then reapplied for benefits. The state found Mr. Jackson transferred resources for less than fair market value and issued a 69-month penalty period.

Mr. Jackson sued the state in federal court, seeking a declaratory judgment that the state was in error when it found him ineligible for benefits based on his purchase of an annuity for his wife. The state filed a motion to dismiss.

The U.S. District Court for the Eastern District of Arkansas denies the motion to dismiss. The court finds "that a qualifying annuity, solely for the benefit of the community spouse, will be a considered available only to that spouse, not to the applicant, and that it would be improper for the state agency to count the income of the community spouse to determine Medicaid eligibility." The court notes that Congress could have prevented the use of annuities in Medicaid planning, but the Deficit Reduction Act allows for qualifying annuities.

Paul's Note: This is another victory for the use of spousal single premium immediate annuities as a Medicaid asset protection device. Connecticut, this past summer, in its only federal court case addressing the issue, ruled similarly, but that decision is now on appeal by the State to the Second Circuit Court of Appeals.

Ohio's High Court Lets Stand Ruling That State Violated Federal Law in Counting Community Spouse's Annuity

The Ohio Supreme Court has declined to hear the state's appeal of a November 19, 2010, ruling that the state improperly imposed a penalty period on a Medicaid applicant whose wife purchased an annuity. This lets stand a Court of Appeals holding that Ohio's regulations with respect to annuities are improperly restrictive based on the preemption of federal law. Rorick v. Ohio Dept. of Job & Family Services (Ohio, No. 2010-2290, March 16, 2011).

Paul Rorick was admitted to a nursing home in May 2008. The following month, Mr. Rorick's wife, Betty, purchased an immediate annuity for $14,562.55. When Mr. Rorick applied for Medicaid in August 2008, his application was approved but a two-and-a-half-month penalty period was imposed based on the state's claim that the annuity constituted an improper transfer. Mr. Rorick appealed the decision, arguing that the Deficit Reduction Act of 2005 provides that a properly structured immediate annuity is not an improper transfer of assets, even if purchased by the community spouse after the resource assessment ("snapshot") date.

At the trial court, the state argued that the annuity rule applies only to the Medicaid applicant, not the community spouse. The trial court ruled in Mr. Rorick's favor, holding that it was a violation of the Medicaid Catastrophic Coverage Act, federal Medicaid law and the Supremacy Clause for the annuity purchase to be treated as an improper transfer. The state appealed.

The Court of Appeals, First Appellate District of Ohio (Hamilton County) affirmed, finding that Ohio cannot use a Medicaid eligibility methodology based on resources and income in a manner that is more restrictive than the resource standards of the Supplemental Security Income program.

Paul's Note: This is just the latest in a string of rulings against various State Medicaid agencies. Several States, Connecticut included, have attempted to limit the use of single premium immediate payout annuities by community spouses. Spouses use these annuities to increase their income and to protect assets. My firm, CzepigaDalyDillman, successfully sued the State of Connecticut in 2010 on this very issue and the District Court ruled that a community spouse may use annuities to increase income and protect assets. The State of Connecticut appealed and that case is now pending before the Federal Court of Appeals for the Second Circuit.

Family Agreement Transferring Property for Medicaid Eligibility Purposes Has No Consideration

A New York trial court rules that children suing their mother for breach of a contract that transferred property in order to qualify their father for Medicaid are not entitled to a preliminary injunction because there was no consideration for the contract. Soran v. Addeo (N.Y. Sup. Ct., Nassau County, No. 19940/10, Jan. 10, 2011).

Ann Addeo, her husband, and her children entered into a "Family Agreement" in order to qualify Mr. Addeo for Medicaid. The agreement provided that Mr. Addeo would transfer his house to Mrs. Addeo. Mrs. Addeo would then transfer the house to the children after Mr. Addeo died, retaining a life estate for herself. After Mr. Addeo died, Mrs. Addeo refused to transfer the house to the children.

The children sued Mrs. Addeo for breach of contract. They asked for a preliminary injunction preventing her from selling or encumbering the property. Mrs. Addeo claimed the agreement was a scheme to commit Medicaid fraud.

The New York Supreme Court denies a preliminary injunction, holding that there was no consideration for the agreement. According to the court, there was no evidence the children are promising anything or suffering any detriment as a result of the agreement. The court notes that "the fact that the [a]greement plainly states that it was executed in order to render defendant's husband eligible for Medicaid calls into question the motivation and credibility of all of the parties to that [a]greement."

Paul's Note: This is clearly a situation where there was a second marriage and the "jilted" children are from the husband's prior marriage and the wife is taking advantage of the situation. The fact pattern does not conjure up Medicaid fraud, but is clearly a circumspect transaction. As the old adage goes," you get what you pay for" – nothing paid, nothing gained!