

## **CAN WE AVOID A MEDICAID REIMBURSEMENT CLAIM?**

Clients considering a nursing home placement for an aged parent often come to us inquiring whether they can transfer the parent's home to them in order to avoid a Medicaid reimbursement claim. Medicaid is, in essence, a program of medical welfare funded by federal dollars, administered by the various states with similar but not always identical administrative rules. A Medicaid applicant must sign a written declaration under penalty of perjury either that no significant assets have been given away or transferred for less than fair value prior to the application, or must make full disclosure of any such transfers.

In the "good old days", it was possible to simply transfer the home into the name of a child or children, stay healthy for three years, and receive Medicaid benefits free of the reimbursement claim. That "loophole" has been nearly eliminated by subsequent rule changes. At one time it was possible to simply make the gift and sit out a "period of disqualification", after which the patient could enter care free of a reimbursement claim. In other words, if a home worth \$100,000.00 were gifted away, and the monthly cost of care was \$2,500.00, you could simply make the gift, wait 40 months, and go on Medicaid. That technique worked because the period of disqualification started at the time of the gift. Under current rules, however, the period of disqualification does not begin until the Medicaid application is made, and there is a five year look back period. There are, however, four remaining exemptions to liability, discussed below.

### **THE RULE, INCLUDING ALL FOUR EXCEPTIONS:**

Oregon Administrative Rule 461-140-0242 provides as follows: If a transfer is made for less than fair market value and is not exempt from disqualification under this rule, there is a rebuttable presumption that the asset was transferred for the purpose of establishing or maintaining eligibility and is not exempt under subsection (2)(a) of this rule.

(6) To rebut the presumption in section (5) of this rule, the client must present evidence other than his or her own statement and must provide to the Department the information it requests for the purpose of evaluating the purpose of the transfer. To meet the burden, it is sufficient for the client to show one of the following:

- (a) The decision to make the transfer was not within the client's control;
- (b) At the time of transfer, the client could not reasonably have anticipated applying for medical assistance;
- (c) Unexpected loss of resources or income occurred between the time of transfer and the application for medical assistance;
- (d) Because of other, similarly convincing, circumstances, it appears more likely than not that the transfer was not made, in whole or in part, for the purpose of establishing or maintaining eligibility for benefits.

## RECENT OREGON OPINION INVOLVING TWO OF THE EXCEPTIONS:

In Vermeullen v. Department of Human Services, 231 Or. App. 410, 2009, the Oregon Court of Appeals discussed two of the four exceptions to the imposition of a Medicaid reimbursement claim against the estate of a Medicaid recipient. In this case, the Department of Human Services determined that a Medicaid applicant was not eligible because, before applying for benefits, she had transferred her home to her grandson for no consideration. The Department decided that the transfer occurred in order to establish eligibility for benefits, and denied the claim. The claimant sought judicial review of the department's decision, arguing that the department misconstrued the applicable administrative rules, and the court agreed with her.

## MEDICAID RULES:

The discussion begins with a brief overview of the applicable statutes and administrative rules to provide context for the parties' dispute. Medicaid is a federal and state health care program for low-income individuals who cannot afford health care. 42 U.S.C. § 1396-1. It is administered in Oregon by the Department of Human Services and is known as the Oregon Health Plan or the Oregon Supplemental Income Program.

To be eligible for Medicaid benefits, a claimant must not have engaged in a "disqualifying transfer of assets" to lower the claimant's income and financial resources to meet Medicaid qualifications. The pertinent rules provide that a transfer of an asset (including a home) by a client or the spouse of a client is a disqualifying transfer unless the requirements of at least one of four exceptions is met. One such exception applies if "The transfer was made exclusively for purposes other than establishing eligibility or maintaining benefits." OAR 461-140-0242(1)(a).

If a transfer is made for less than fair market value, there is a rebuttable presumption that the asset was transferred for the purpose of establishing or maintaining eligibility. The rule then sets out four ways that the presumption may be rebutted, two of which are relevant to this case: "To rebut the presumption in this rule, the client must present evidence to show one of the following: (b) At the time of transfer, the client could not reasonably have anticipated applying for medical assistance; . . . . or (d) because of other, similarly convincing circumstances, it appears more likely than not that the transfer was not made, in whole or in part, for the purpose of establishing or maintaining eligibility for benefits."

In brief, then, if a person sells his or her home for less than market value before applying for Medicaid benefits, the sale triggers a presumption that it occurred merely to create eligibility for those benefits. A claimant may, however, rebut that presumption by proving (among other things) that he or she could not reasonably have anticipated applying for medical assistance or that the transfer was not made, in whole or in part, for the purpose of establishing eligibility.

## BACKGROUND FACTS:

At the time of the hearing, claimant was 85 years old. She had suffered a stroke in 2001 and had stenosis and high cholesterol for which she took medication. Still, she remained physically active, walking 25 blocks day. She had a close relationship with her grandson, Donald, and his wife, Melissa, both of whom worked full time. They lived near by, and claimant went to their house daily to provide child care for their children, her great-grandchildren. Claimant ate her meals with their family and would return to her own home at night.

In 2004, Donald and Melissa expressed interest in moving in with claimant so that she

would not be alone and so that they could provide her with care as needed. Claimant agreed with the idea of Donald and Melissa moving in with her. Her house would need extensive remodeling, however, to accommodate the two households. Although she did not really understand all the details of the transfer of her home, in December 2004, claimant gave a quit claim deed to Donald and Melissa without consideration. At the time, the house was valued by the county assessor at approximately \$176,000, and claimant owned it free and clear.

Donald and Melissa took out a mortgage of \$186,400 on the house and had an architect draw up plans for a remodel. They did not embark on the remodel of claimant's house, however, because they were not able to sell their own house. Instead, they applied the proceeds of the loan in part to the mortgage on claimant's former house, which they now own free and clear.

In June 2006, claimant suffered another stroke and needed long-term care. On the advice of a hospital social worker, claimant submitted an application for Medicaid long-term care benefits. On her application, claimant disclosed her 2004 transfer of her house to Donald and Melissa. The department denied claimant's application on the ground that the transfer of the house for less than its fair market value disqualified her from receiving Medicaid benefits until February 2008.

In a hearing before an administrative law judge (ALJ) claimant presented evidence that she did not know at the time of the transfer—and had no reason to know—that she would need to apply for medical assistance. Second, she contended, the circumstances of the transfer make clear that its purpose was not, in whole or in part, to create eligibility. The ALJ concluded that claimant had failed to rebut that presumption by showing that she reasonably could not have known that she would require medical assistance, because a person suffering from all the physical ailments that she had should reasonably anticipate a future need for medical assistance. But the ALJ went on to conclude that because a reasonable person would have anticipated such a need, the transfer must have been made in order to establish eligibility. In other words, the ALJ found that, claimant having failed to prove the one exemption, it necessarily follows that she failed to prove the other.

#### APPELLATE COURT DECISION:

The Court ruled that this finding was an error, and because the ALJ failed to examine whether there were such "other, similarly convincing circumstances" the denial was reversed and remanded for reconsideration under a correct interpretation of the rule. In particular, the ALJ failed to consider whether the evidence that claimant and her family planned the transfer of the home so that the two families could live together and so that claimant's grandson and his wife could care for her was sufficient to defeat the presumption that they engaged in the transaction wholly for purposes other than establishing eligibility for Medicaid benefits.

#### FINAL NOTE:

There was no evidence in this case that the claimant or anyone connected to her had obtained or followed any legal advice about how to avoid a reimbursement claim. If that had happened, it would have likely been impossible to defeat the presumption that she engaged in the property transfer to establish eligibility for benefits. The claimant in this case won because of an entirely innocent coincidence of circumstances. That said, we are available to help you interpret this complex area of the law, at 541-386-2221, or “gorgelaw@gorge.net”.