

agency shall contact the USCIS by submitting a Form G-845, attaching a copy of the document presented.

5. For aliens who present themselves as on active duty or honorably discharged from the United States Armed Forces, the following serve as documentation:

i. For discharge status, an original or notarized copy of the veteran's discharge papers issued by the branch of service in which the applicant was a member;

ii. For active duty military status, an original or notarized copy, of the applicant's current orders showing the individual is on full-time duty with the U.S. Army, Navy, Air Force, Marine Corps, or Coast Guard (full-time National Guard duty does not qualify), or a military identification card (DD Form 2 (active));

iii. A self-declaration under penalty of perjury may be accepted pending receipt of acceptable documentation.

(h) An applicant who declares that he or she is a United States citizen (or national) or otherwise eligible non-citizen and who meets all other eligibility requirements will be approved immediately for benefits.

1. An applicant who makes such a declaration shall be afforded a reasonable opportunity to provide documentary evidence of citizenship or qualified immigration status. Reasonable opportunity is defined as 90 days from the time that the applicant is informed of the need to provide the necessary documentary evidence of the declared citizenship or qualified alien status.

i. The applicant shall provide documentation as described in (g) above; or

ii. The applicant shall provide a valid Social Security number, so that the Division can access the State Verification Exchange System (SVES) to obtain/confirm information related to the applicant. Any inconsistencies between the information provided by the applicant and the information obtained from SVES shall be reported to the applicant for resolution.

2. If the applicant has not submitted the required documentary evidence or resolved any inconsistencies by the end of the 90th day of the reasonable opportunity period, a termination notice shall be sent informing the applicant of termination of benefits. The termination date shall be effective no later than 30 days after the end of the 90-day reasonable opportunity period and will clearly identify which household member(s) have not complied and are being terminated from the program. Terminated applicants may re-apply for benefits once they have secured the required documentary evidence of citizenship or qualified alien immigration status.

(i) Medicaid applicants who are Medicare beneficiaries and who can provide an original and valid Medicare Identification Card are not required to provide additional

proof of identity and citizenship. A copy of the beneficiary's Medicare card shall be retained in the case record as evidence that additional documentation was not required.

Amended by R.1995 d.651, effective December 18, 1995.

See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

Amended by R.1999 d.253, effective August 2, 1999.

See: 31 N.J.R. 97(a), 31 N.J.R. 2203(b).

Rewrote (c); and added (d) through (g).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In (a), substituted "September 22, 1922" for "September 22, 1992" in the introductory paragraph; and substituted "board of social services" for "welfare agency" throughout.

Amended by R.2012 d.025, effective February 6, 2012.

See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).

Rewrote (a), (b), and (g); in (c)5, substituted "U.S. Citizenship and Immigration Services" for "Immigration and Naturalization Service"; in (c)12vi and (f), substituted "welfare agency" for "board of social services"; in (c)12vi, substituted "\$1641" for "\$ 1641"; and added (h) and (i).

10:71-3.4 Residence requirement

An applicant for or beneficiary of Medicaid Only shall be a resident of the State of New Jersey.

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

Substituted "beneficiary" for "recipient".

10:71-3.5 Resident defined

(a) The term "resident" shall be interpreted to mean a person who is living in the State voluntarily and not for a temporary purpose, that is, with no intention of presently removing therefrom.

(b) County residence is not an eligibility requirement and relates only to identification of the CWA charged by law with responsibility for the official receipts, registration and processing of applications. The CWA is responsible for institutionalized (including nursing homes, intermediate care facilities and sheltered boarding homes) applicants and recipients within its county regardless of previous county of residence.

Amended by R.1995 d.651, effective December 18, 1995.

See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In (b), substituted "CBOSS" for "CWA" throughout.

Amended by R.2012 d.025, effective February 6, 2012.

See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).

In (b), substituted "CWA" for "CBOSS" twice, and deleted a comma following "registration" and "facilities".

10:71-3.6 Change of county residence

(a) Responsibility for case management shall be transferred from one county to the other when a beneficiary moves to another county.

(b) A temporary visit by the beneficiary shall not be considered to be a change of county residence until that visit has continued for more than a three-month period.

1. Whenever it is determined that a beneficiary whose application has not been validated has changed or is planning to change his or her residence from one county to another, the CWA of origin shall continue medical assistance while completing validation, subject to the time limits set forth in the application process, then transfer the case without delay to the receiving county in accordance with (b)2 below. If the CWA of origin is in the process of obtaining medical records, it shall complete the process and forward the medical records to the receiving county.

2. Whenever it is determined that a beneficiary whose application has been validated is planning to change his or her residence from one county to another, it shall be the responsibility of the CWA directors of the two counties concerned to effect the transfer without interruption of medical assistance.

3. The county of origin shall initiate and the receiving county shall, on request, immediately cooperate in accomplishing a full investigation of the circumstances surrounding the move.

4. If the move is permanent and the case warrants continued medical assistance, transfer of the case shall be accomplished expeditiously by discontinuance of medical assistance in the county of origin and award of medical assistance in the receiving county, to occur simultaneously in the first month for which the CWA directors mutually so arranged.

5. The welfare of the client shall not be adversely affected and his or her right to uninterrupted medical assistance if in need shall not be prejudiced by disagreement or other administrative difficulty between the counties. Any adverse change in grant resulting from transfer requires timely notice.

i. Since the Medicaid Only client retains the same Medicaid number when he or she moves from one county to another, the county of origin shall not terminate the client from the Medicaid status file, but only from its own register.

(c) The county of origin shall initiate and the receiving county shall, on request, immediately undertake an investigation of the circumstances surrounding the move. If the move is permanent, each county shall execute its respective responsibilities in accordance with (d) and (e) below.

(d) Applicants: Applicants are those individuals applying for Medicaid in the county of origin who move to the receiving county before the eligibility determination has been completed.

1. County of origin: The county of origin has the responsibility to:

i. Complete the eligibility determination process;

ii. Accrete the individual to the Medicaid Status File (MSF) with the correct effective date of Medicaid eligibility and the new address (in the receiving county); and

iii. Within five working days of the eligibility determination, transfer the case record material to the receiving county in accordance with (e)1i through iv below.

2. Receiving county: The receiving county has the responsibility to:

i. Communicate promptly with the client and/or the client's authorized representative upon receipt of the case material to advise of the continued receipt of medical assistance; and

ii. Notify immediately in writing the county of origin of the date the case material was received.

(e) Beneficiaries: Beneficiaries include all individuals determined eligible for Medicaid Only.

1. County of origin: The county of origin has the responsibility to:

i. Transfer, within five working days from the date it is notified of the actual move, a copy of pertinent case material to the receiving county. Such material shall include, at a minimum, a copy of the first application and most recent PA-1G form (including all verification), Social Security numbers, the beneficiary's new address in the receiving county, and form PR-1 (formerly PA-3L), completed with the individual's circumstances current as of the month of the transfer.

ii. Send with the above case material a cover letter specifying that the case is being transferred and requesting written acknowledgment of receipt;

iii. Forward promptly to the receiving county copies of any other material mutually identified as necessary for case administration; and

iv. Notify the receiving county if there will be a delay in providing any case material described in (e)1i or iii above.

2. Receiving county: The receiving county has the responsibility to:

i. Communicate promptly with the client and/or the client's authorized representative when case material is received. Such communication shall arrange for the client and/or the client's authorized representative to make application within 10 working days of the contact to ensure uninterrupted receipt of medical assistance;

ii. Notify immediately in writing the county of origin of the date the initial case material was received;

iii. Determine eligibility for the individual. Identify and resolve questions of the eligibility determination

10:71-4.1 Financial eligibility standards; resources

(a) The resources criteria and eligibility standards of this section apply to all applicants and beneficiaries.

(b) Resources defined: For the purpose of this program a resource shall be defined as any real or personal property which is owned by the applicant (or by those persons whose resources are deemed available to him or her, as described in N.J.A.C. 10:71-4.6) and which could be converted to cash to be used for his or her support and maintenance. Both liquid and nonliquid resources shall be considered in the determination of eligibility, unless such resources are specifically excluded under the provisions of N.J.A.C. 10:71-4.4(b).

(c) Availability of resources: In order to be considered in the determination of eligibility, a resource must be "available." A resource shall be considered available to an individual when:

1. The person has the right, authority or power to liquidate real or personal property or his or her share of it;
2. Resources have been deemed available to the applicant (see N.J.A.C. 10:71-4.6 regarding deeming of resources); or
3. Resources arising from a third-party claim or action are considered available from the date of receipt by the applicant/beneficiaries, his or her legal representative or other individual acting on his or her legal behalf in accordance with the following definition and provisions.

i. Definition of "availability of resources in third-party situations": In third-party situations in which applicants/beneficiaries have brought an action or made a claim against a third party who is or may be liable for payment of medical expenses related to the cause of the action or claim, funds are considered available or countable at the moment of receipt by the applicant/beneficiary, his or her legal representative, guardian, relative or any person acting on the applicant's/beneficiary's behalf. Such funds should be considered available or countable at the earliest date of receipt by any of the aforementioned entities.

(1) In determining resource eligibility in accordance with N.J.A.C. 10:71-4.5(a), those funds actually available to the applicant/beneficiary or any person acting on his or her behalf as of the first day of the month subsequent to the month of receipt shall be considered a countable resource, unless otherwise excluded (see N.J.A.C. 10:71-4.4).

(2) If a bona fide lien or judgment exists against such funds, making all or some portion of the funds inaccessible to the applicant/beneficiary, CWAs shall deduct the encumbrances and consider the remaining amount as a countable resource.

(3) If between the date of receipt of such moneys and the first day of the subsequent month the

applicant/beneficiary pays outstanding medical expenses and/or other expenses, the CWA shall consider only the funds remaining after such payment as a countable resource.

(d) Evaluation of resources: The value of a resource shall be defined as the price that the resource can reasonably be expected to sell for on the open market in the particular geographic area minus any encumbrances (that is, its equity value).

1. Real property:

i. Sole ownership: When the eligible individual is sole owner and has the right to dispose of the property, the total equity value (see (d)iv below) shall be counted toward the resource maximum.

ii. Joint ownership or ownership in common: Under joint ownership or ownership in common, the equity value of the property shall be divided by the number of owners and the eligible individual's share counted toward the resource maximum.

iii. Ownership by the entirety: Ownership by the entirety (or tenancy by the entirety) refers to property owned by a husband and wife whereby each member has ownership interest in the whole property which is indivisible. When a married couple (either one or both are eligible) is living together, the total equity value of all nonexempt property shall be counted toward the resource maximum. The same policy shall apply to an eligible couple who have been separated less than six months. If the eligible couple has been separated for six months or more, one half of the value represents a resource to each individual. If one spouse is institutionalized and the other spouse resides in the community, the extent to which either spouse has ownership of the property shall be included pursuant to N.J.A.C. 10:71-4.8.

(1) When an eligible individual and an ineligible spouse own nonexempt property by the entirety and the couple is separated for a full calendar month, the cooperation of both owners is necessary to ascertain resource value. If the ineligible owner expresses willingness to dispose of the property, then its value is divided by the number of owners. If there is no such willingness by the ineligible owner, then no value may be assigned to the property. (See also N.J.A.C. 10:71-4.4(b)6 regarding situations in which a co-owner refuses to liquidate.)

iv. Equity value: The equity value of real property is the tax assessed value of the property multiplied by the reciprocal of the assessment ratio as recorded in the most recently issued State Table of Equalized Valuations, less encumbrance, if any. The Table is available from the State of New Jersey, Department of the Treasury, Trenton, New Jersey 08625.

v. Substantial equity value: Individuals seeking benefits with respect to nursing facility services or other long-term care services who have an equity interest in their home that exceeds \$750,000 (as indexed) shall not be eligible for benefits.

(1) Effective January 1, 2011, the home equity limits shall be indexed to the Consumer Price Index – Urban (CPIU) annually and rounded to the nearest thousand. The annual adjustment shall be published as a notice of administrative change in the New Jersey Register. As of January 1, 2011 the excess home equity limit is \$758,000.

2. Savings and checking accounts: When a savings or checking account is held by the eligible individual with other parties, all funds in the account are resources to the individual, so long as he or she has unrestricted access to the funds (that is, an “or” account) regardless of their source. When the individual’s access to the account is restricted (that is, an “and” account), the CWA shall consider a pro rata share of the account toward the appropriate resource maximum, unless the client and the other owner demonstrate that actual ownership of the funds is in a different proportion. If it can be demonstrated that the funds are totally inaccessible to the client, such funds shall not be counted toward the resource maximum. Any question concerning access to funds should be verified through the financial institution holding the account.

3. Verification of value: The CWA shall verify the equity value of resources through appropriate and credible sources. Additionally, the CWA shall evaluate the applicant’s past circumstances and present living standards in order to ascertain the existence of resources that may not have been reported. If the applicant’s resource statements are questionable, or there is reason to believe the identification of resources is incomplete, the CWA shall verify the applicant’s resource statements through one or more third parties.

i. Responsibility of applicant: If the third-party contact is required in accordance with the provisions above, the applicant shall cooperate fully with the verification process. If necessary, the applicant shall provide written authorization allowing the CWA to secure the appropriate information.

(e) Resource eligibility: Resource eligibility is determined as of the first moment of the first day of each month. If an individual or couple is resource ineligible as of the first moment of the first day of the month, subsequent changes within that month in the amount of countable resources will not affect the original determination of ineligibility. If resource eligibility is established as of the first moment of the first day of the month, resource eligibility is established for the entire month regardless of any increase in the amount of countable resources.

1. This policy applies equally to individuals and couples in the month of application. Regardless of the date of application, resource eligibility is determined as of the first moment of the first day of that month.

2. If, prior to the first moment of the first day of the month, the applicant or beneficiary has drawn a check (or equivalent instrument) on a checking or similar account, the amount of such check shall reduce the value of the account. The value of such accounts shall not be reduced by any unpaid obligations for which funds have not already been committed by the drafting of a check.

i. When checks have been drawn on an account, the CWA shall review the appropriate account registers or check stubs to ascertain the actual balance as of the first moment of the first day of the month. Full documentation of such circumstances is required.

(f) No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes.

1. In order for the cash reward to continue to be excluded, the funds shall be separately identifiable (that is, not commingled with other funds or assets), but held in a separate account. Any increase in the value of the excluded cash reward shall also be excluded.

Amended by R.1986 d.97, effective April 7, 1986 (operative May 1, 1986).

See: 17 N.J.R. 2954(a), 18 N.J.R. 691(a).
(c)3 added.

Amended by R.1986 d.165, effective May 5, 1986 (operative June 2, 1986).

See: 17 N.J.R. 2524(a), 18 N.J.R. 985(b).
(e) added.

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

Substituted references to beneficiaries for references to recipients and substituted references to CBOSSs for references to CWAs throughout.

Amended by R.2001 d.199, effective June 18, 2001.

See: 32 N.J.R. 2021(a), 33 N.J.R. 2195(a).

In (d)1i, substituted “(d)1iv” for “(d)iv” preceding “below”; in (d)1ii, substituted “shall” for “must”; in (d)1iii, added the last sentence.

Amended by R.2002 d.124, effective April 15, 2002.

See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).

Added (f).

Amended by R.2012 d.025, effective February 6, 2012.

See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).

In (b), substituted “him or her” for “him/her” and “his or her” for “his/her”; in (c)1, deleted a comma following “authority”; and substituted a semi-colon for a colon at the end; in (c)3i(2) and (c)3i(3), substituted “CWA” for “CBOSS”; added (d)1v; in (d)2, inserted a comma following the second occurrence of “individual”, and substituted “CWA” for “CBOSS”; rewrote (c)3; and in (e)2i, substituted “CWA” for “CBOSS”.

Case Notes

Expert testimony demonstrated that an annuity could be converted to cash and thus was an available resource for purposes of a nursing facility resident’s application for Medicaid benefits under the Medically Needy program; the annuity, purchased by the applicant, a widow, for \$195,710, was to pay the applicant \$1,740.85 per month for 10 years and stated on its face that it was non-assignable (adopting 2007 N.J. AGEN

determination shall be based on the most recent life expectancy tables published by the Centers for Medicare and Medicaid Services. In determining the projected amount, the county welfare agency shall strictly adhere to the life expectancy tables without adjustment for the individual's medical condition or other factors. The projection shall be based on the value of the income at the time of transfer and there shall be no attempt to account for future cost-of-living adjustments over the life expectancy of the individual.

4. In determining if there has been a transfer of income, the county welfare agency need not ascertain the individual's spending habits over the appropriate look-back period. Unless there is a reason to believe otherwise, the county welfare agency shall assume that the individual's income was legitimately spent on the normal costs of living. The county welfare agency may ask questions of the applicant and/or the applicant's representative concerning past and present sources and levels of income and whether the individual has transferred income to others.

(o) When an asset is held by an individual in common with another person or persons via joint tenancy, tenancy in common, joint ownership, or similar arrangements, the asset (or the affected share of the asset) shall be 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.

1. If the addition of another name to the ownership of an asset does not change the individual's ownership interest, the action does not constitute a resource transfer. For instance, if another name is added to an individual's account with the term "or," the individual shall not be considered to have transferred assets since he or she continues to have unrestricted access to the funds. In the event the newly added owner subsequently withdraws the funds from the account, that action shall be considered to be a transfer by the individual. The transfer shall be considered to have occurred on the date that the funds are withdrawn from the account.

2. If the addition of another name to the ownership of an asset restricts the individual's access, right to sell or otherwise dispose of the asset (for example, the addition of another name requires that the new co-owner(s) agree to the sale or disposal of the asset where no such agreement was necessary before), the addition of the name shall constitute a transfer of assets. The transfer shall be considered to have occurred on the date that the additional name was added to the account. In the case of real property for the purpose of this chapter, if another name is added to a deed, the transfer shall be considered to have occurred the date the new deed is recorded.

3. N.J.A.C. 10:71-4.1 shall apply to determine what portion of a jointly owned resource is presumed to belong to the individual. Any portion belonging to the individual that is withdrawn by another owner shall be considered a

transfer of assets. If the individual can satisfactorily establish that the withdrawn funds were, in fact, the sole property of, and were contributed to the account by the other owner, and thus never belonged to the individual, the withdrawal of those funds shall not result in the imposition of an asset transfer penalty.

(p) Annuity provisions shall be as follows:

1. Any annuity purchase in which the entity issuing the annuity is not a commercial financial institution shall be considered to be a transfer of an asset in order to qualify for Medicaid benefits, regardless of the terms of the annuity payout. The entire amount transferred into such an annuity shall be the amount considered in determining eligibility.

2. Any commercial annuity purchased which is not actuarially sound, based on the life expectancy of the individual (as set forth in life expectancy tables published by the Centers for Medicare and Medicaid Services) or term certain (the length of payout is specified and payment does not terminate upon the death of the annuitant) shall be considered to be a transfer of an asset in order to qualify for Medicaid benefits. In the event that an annuity is not actuarially sound at the time of purchase, the amount that shall be considered to have been transferred at less than fair market value shall be that proportion of the annuity purchase price which is not actuarially sound. This shall be the same proportion as the amount by which the pay-out period exceeds the life expectancy of the individual at the time of the annuity purchase. (Life expectancy divided by the pay-out period of the annuity multiplied by the purchase amount of the annuity is subtracted from the total amount of the annuity to determine the uncompensated value.)

(q) Upon imposition of a period of ineligibility for long-term care level services because of an asset transfer, the county welfare agency shall notify the applicant/beneficiary of his or her right to request an undue hardship exception. An applicant/beneficiary may apply for an exception to the transfer of asset penalty if he or she can show that the penalty will cause an undue hardship to him- or herself. The applicant/beneficiary shall provide sufficient documentation to support the request for an undue hardship waiver to the county welfare agency within 20 days of notification of the transfer penalty. Within 30 days of receipt of such documentation, the CWA shall issue notice to the applicant/beneficiary of its determination.

1. For the purposes of this chapter, undue hardship shall be considered to exist when:

i. The application of the transfer of assets provisions would deprive the applicant/beneficiary of medical care such that his or her health or his or her life would be endangered. Undue hardship may also exist when application of the transfer of assets provisions would deprive the individual of food, clothing, shelter, or other necessities of life; and

ii. The applicant/beneficiary can irrefutably demonstrate the transferred assets are beyond his or her control and that the assets cannot be recovered. The applicant/beneficiary shall demonstrate that he or she made good faith efforts, including exhaustion of remedies available at law or in equity, to recover the assets transferred.

2. Undue hardship shall not exist when the application of a transfer penalty merely causes the applicant/beneficiary an inconvenience or restricts his or her lifestyle.

3. In the event that a waiver of undue hardship is denied, neither the Department of Human Services, the Department of Health and Senior Services, nor the county welfare agencies shall have any obligation to take any action to assure that payment of services is provided during the penalty period.

4. If the request for undue hardship consideration is denied by the CWA, the CWA shall notify the applicant of the denial and that the applicant may request a fair hearing in accordance with the provisions of N.J.A.C. 10:49-10.

New Rule, R.2001 d.199, effective June 18, 2001.

See: 32 N.J.R. 2021(a), 33 N.J.R. 2195(a).

Petition for Rulemaking.

See: 35 N.J.R. 1456(a), 2532(b).

Amended by R.2004 d.401, effective November 1, 2004.

See: 36 N.J.R. 922(b), 36 N.J.R. 4982(a).

In (m), rewrote 1, and substituted "\$15,000" for "\$12,000" throughout 4.

Amended by R.2006 d.133, effective November 6, 2006.

See: 37 N.J.R. 3774(a), 37 N.J.R. 4505(a), 38 N.J.R. 4712(a).

In (m)1, substituted "2005" for "2003" and substituted "\$6,525" for "\$6,050"; and deleted (p)2i.

Petition for Rulemaking.

See: 39 N.J.R. 2157(a), 2660(a), 4453(a).

Petition for Rulemaking.

See: 42 N.J.R. 1434(a), 1918(a), 2645(a).

Amended by R.2012 d.025, effective February 6, 2012.

See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).

Rewrote the section.

Law Review and Journal Commentaries

Saving the family home. Harold L. Grodberg, 164 N.J.L.J. 1166 (2001).

Case Notes

Medicaid applicants' challenge to state-payback requirement for community spouse annuity trusts (CSATs), whereby state was required to be named first beneficiary of trust assets upon death of spouse residing in community if it had paid benefits on behalf of institutionalized spouse, was moot, where, upon its decision to count CSAT assets in determining Medicaid eligibility, state no longer imposed state-payback condition. *Johnson v. Guhl*, 357 F.3d 403 (3d Cir. N.J. 2004).

Recipient of homecare assistance sold her home to her grandson, and kept a leasehold in an apartment in the house for the term of her life. As the nature of the recipient's leasehold interest was not explained by the lease or by extrinsic evidence, whether she received fair market value for her leasehold interest, and thus for the house itself, could not be determined from the record for purposes of determining her continued eligibility for homecare assistance benefits. *B.D. v. Division of Med. Assistance & Health Servs.*, 397 N.J. Super. 384, 937 A.2d 980, 2007 N.J. Super. LEXIS 366 (App.Div. 2007).

In determining a claimant's eligibility for benefits, the Director of the New Jersey Department of Human Services has the expertise to deter-

mine the significance and sufficiency of various types of asset transfers, and when the Director's findings are supported by credible evidence and correct legal principles, they are entitled to deference by a reviewing court. *B.D. v. Division of Med. Assistance & Health Servs.*, 397 N.J. Super. 384, 937 A.2d 980, 2007 N.J. Super. LEXIS 366 (App.Div. 2007).

Decision of the Director of Division of Medical Assistance and Health Services (DMAHS), which upheld the imposition of a Medicaid transfer penalty based on an unequal equitable distribution to a non-institutionalized spouse of a Medicaid applicant in a bed and board divorce action, was reversed as there existed no regulation that authorized such a decision; furthermore, the DMAHS's in-house rule imposing such a penalty for a transfer of assets as equitable distribution of more than 50 percent to the non-institutionalized spouse was contrary to both New Jersey public policy and the law of equitable distribution. *W.T. v. DMAHS*, 391 N.J. Super. 25, 916 A.2d 1066, 2007 N.J. Super. LEXIS 59 (App.Div. 2007).

Petitioner was subject to a transfer penalty since petitioner's nephew did not meet the transfer exception for a home conveyed to a son or daughter who staved off institutionalization by at least two years. Congress clearly only applied exceptions to the penalty when the transfer was to a son or daughter who resided in the home for at least two years and provided care to the applicant, and there was no room for an interpretation that would lend itself to expand the exemption to other relatives. *V.D. v. DMAHS*, OAL Dkt. No. HMA 4044-08, 2008 N.J. AGEN LEXIS 1111, Final Decision (December 9, 2008).

Penalty period imposed by federal law (42 U.S.C.A. 1396p(c)(1)(D)), effective Feb. 8, 2006, and not that imposed by prior law, applied to institutionalized Medicaid applicant's gift transfers because sufficient funds to cover the gift checks, allegedly written before Feb. 8, 2006, were not in the account on which the checks were drawn until Feb. 13, 2006; thus, the penalty period expired Sept. 15, 2008, rather than Nov. 1, 2007, despite petitioner's contention that another bank's alleged delay in liquidating CDs to cover the checks rendered the funds outside her control. *M.M. v. DMAHS*, OAL Dkt. No. HMA 929-08, 2008 N.J. AGEN LEXIS 1017, Final Decision (July 18, 2008).

Applicant was not entitled to Medicaid assistance where she voluntarily reduced her pension income but remained able to rescind the reduction; thus, the original monthly pension benefit of \$556.34 was available to the applicant and was properly counted in the determination of Medicaid eligibility. *J.C. v. DMAHS*, OAL Dkt. No. HMA 6950-07, 2008 N.J. AGEN LEXIS 39, Initial Decision (January 17, 2008).

There is a clear conflict between federal law (42 U.S.C.A. 1396p(c)) and the New Jersey regulation (N.J.A.C. 10:71-4.10(m)) because the regulation begins the penalty period for a transfer of assets for less than fair market value with the month of the transfer, whereas federal law imposes the penalty at either the month of the transfer, the month after the transfer, or the date upon which the individual becomes eligible, whichever is later. The Division correctly applied the current federal law to petitioner's Medicaid Only application because the courts have held that states participating in a federal entitlement program must conform to federal statutes and regulations. *E.B. v. DMAHS*, OAL Dkt. No. HMA 2289-07, 2007 N.J. AGEN LEXIS 605, Initial Decision (August 23, 2007).

Medicaid applicant's irrevocable trust arrangement was void because it violated New Jersey's public policy against shielding assets to become Medicaid eligible, pursuant to N.J.S.A. 30:4D-6(f), and therefore the trust res was considered an available resource. Because public policy considered the trust null and void, it was as if the trust assets were available to the applicant throughout the duration of the trust and at the time of the Medicaid application made on February 8, 2006; thus, the transfer of assets did not occur until February 8, 2006, pursuant to N.J.A.C. 10:71-4.10(m)(1), and the penalty period for the transfer began on that date. *J.S. v. DMAHS*, OAL Dkt. No. HMA 4896-06, 2006 N.J. AGEN LEXIS 1054, Initial Decision (December 19, 2006).

(e) If either the institutionalized spouse or the community spouse is dissatisfied with the determination of the amount of the community spouse maintenance deduction, he or she may request a fair hearing in accordance with N.J.A.C. 10:71-8.4. If it is established at the fair hearing that the community spouse needs income above the amount established by the community spouse maintenance deduction due to exceptional circumstances resulting in financial duress, there shall be substituted for the community spouse maintenance deduction such amount as is necessary to alleviate the financial duress and for so long as directed in the final hearing decision.

(f) If a court has entered an order against an institutionalized spouse for monthly income for the support of a community spouse and the amount of the order is greater than the amount of the community spouse deduction, the amount so ordered shall be used in place of the community spouse deduction.

(g) A family member maintenance deduction shall be calculated for each family member of the institutionalized individual.

1. For purposes of this section, family members must reside with the community spouse and shall be limited to the following persons:

- i. Children of either member of the couple who are under the age of 21;
- ii. Children over the age of 21 who are claimed as dependents by either member of a couple for tax purposes under the Internal Revenue Code;
- iii. Parents of either member of a couple who are claimed as dependents for tax purposes under the Internal Revenue Code as dependents by either spouse; or
- iv. A brother or sister (including half-brothers and half-sisters and siblings gained through adoption) of either member of a couple and who are claimed as dependents for tax purposes under the Internal Revenue Code.

2. The family member deduction shall be computed as follows. The family member's gross income shall be subtracted from \$1,821.25. One-third of the remaining amount shall be the family member deduction for that family member.

(h) If a physician has certified that the individual will be institutionalized for a temporary period only and is likely to return to the residence within six months of the date of institutionalization, a maximum of \$150.00 may be deducted from the institutionalized individual's income for the maintenance of his or her home in the community. This deduction shall be limited to the actual costs of such maintenance (for example, mortgage or rent payments, taxes, insurance, and other incidental costs) or \$150.00, whichever is less. This deduction may be applied against the individual's income for no longer than six months. This deduction may not be applied if

a deduction has been made for the maintenance of a community spouse or other family member residing in that residence.

1. This deduction must be applied to the costs of maintaining the residence and may not be accumulated by the institutionalized individual.

(i) If the institutionalized individual has health insurance covering himself or herself, the amount of the insurance premiums shall be deducted.

1. If the premium is billed other than monthly, the amount of the premium shall be prorated and deducted accordingly.

2. If the premium covers other individuals in addition to the institutionalized individual, only that portion of the premium attributable to the institutionalized individual shall be deducted.

(j) No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes.

(k) Effective January 1, 2010, the following policy applies to post-eligibility medical deductions.

1. For necessary medical expenses as recognized by the Division and incurred during the three-month retroactive period or during a period of eligibility, the income adjustment is limited to the Medicaid fee in effect on the date of service.

2. If no Medicaid fee exists and the medical service is medically necessary and recognized by the Division, the income adjustment will be limited to the lesser of:

- i. The billed charge;
- ii. The fee under the largest commercial plan in New Jersey; or
- iii. Eighty percent of the Medicare fee schedule.

3. No deduction for medical and/or remedial care expenses shall be allowed for dates of service prior to the three-month retroactive period associated with the month of the Medicaid application.

4. No deduction for medical and/or remedial care expenses that were incurred during or as the result of the imposition of a transfer of assets penalty period shall be allowed.

New Rule, R.1991 d.32, effective January 22, 1991.

See: 22 N.J.R. 7(a), 23 N.J.R. 215(b).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In the introductory paragraph of (c) and (g)2, increased dollar amounts from \$856.00 to \$1,383; and in (c)1, increased dollar amount from \$257.00 to \$414.00.

Amended by R.2002 d.124, effective April 15, 2002.
See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).
Added (j).

Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).

In the introductory paragraph of (a), substituted "below" for "of this section" and "long-term" for "long term"; rewrote (c); in (g)2, substituted "\$1,821.25" for "\$1,383"; and added (k).

Law Review and Journal Commentaries

Marital Status and The 60+ Crowd. Elizabeth Brody. 164 N.J.Law 39 (Mag) (Oct. 1994).

Case Notes

New Jersey did not violate Medicare Catastrophic Coverage Act by employing "income-first" approach in determining Medicaid eligibility of spouse institutionalized in long-term care facility. Cleary ex rel. Cleary v. Waldman, 167 F.3d 801 (3rd Cir. N.J. 1999).

Assets of institutionalized spouse may be diverted to cover community spouse's statutory minimum needs allowance, where community spouse's income is insufficient to meet allowance, for purposes of Medicare spend down requirements; however, resources transferred to community spouse need not be adequate to cover shortfall. Cleary v. Waldman, D.N.J.1997, 959 F.Supp. 222.

Income subject to transfer from an institutionalized spouse was not limited to the income he was earning as of the date when the couple's resources were allocated for purposes of determining Medicaid Only eligibility. The other spouse's minimum monthly maintenance needs allowance deficit could be made up with the Social Security disability income the institutionalized spouse was reasonably expected to earn thereafter. N.E. v. New Jersey Div. of Med. Assistance & Health Servs., 399 N.J. Super. 566, 945 A.2d 109, 2008 N.J. Super. LEXIS 78 (App.Div. 2008).

Under the "income-first" approach, before any of the institutionalized spouse's share of the couple's countable resources could be allocated to the community spouse to meet the shortfall in her minimum monthly maintenance needs allowance (MMMNA), the institutionalized spouse's Social Security benefits had to be applied to that deficit. Moreover, because the monthly Social Security disability benefits were sufficient to meet the MMMNA deficit, there was no basis for increasing the community spouse's share of the couple's countable resources beyond the limits established by N.J.A.C. 10:71-4.8(a). N.E. v. New Jersey Div. of Med. Assistance & Health Servs., 399 N.J. Super. 566, 945 A.2d 109, 2008 N.J. Super. LEXIS 78 (App.Div. 2008).

Initial Decision (2007 N.J. AGEN LEXIS 189) adopted, which concluded that in calculating the Community Spouse Resource Allowance, repayments on home equity loans or lines of credit are not deductible as a shelter expense unless there is a direct relationship to preserving the marital home, such as when the loan proceeds are used for major repairs or capital improvements necessary to protect the home. A.F. v. DMAHS, OAL Dkt. No. HMA 12301-06, 2007 N.J. AGEN LEXIS 330, Final Decision (May 24, 2007).

In an institutionalization case, although the community spouse's income clearly exceeded the minimum monthly maintenance needs allowance (MMMNA), and although rental property is not an excluded resource, sale of the couple's rental property, which was necessitated by the division of the couple's resources, would reduce her income substantially; therefore, under N.J.A.C. 10:71-5.7(d) and due to the unique circumstances, the community spouse was entitled to protect the entire value of the rental property to increase her income in an attempt to reach the MMMNA and still meet the resource standard. N.S. v. DMAHS, OAL Dkt. No. HMA 4902-06, 2007 N.J. AGEN LEXIS 331, Final Decision (March 9, 2007).

Medicaid community spouse met the "exceptional circumstances" standard of proof of 42 U.S.C.A. 1396r-5 and N.J.A.C. 10:71-5.7; therefore, the community spouse's Minimum Monthly Maintenance Needs Allowance was to be recalculated and adjusted upward, beyond the standard allowances, with the inclusion of monthly adult disability

child expenses not covered by SSI, monthly bankruptcy court ordered payments, and monthly expenses of a refinance loan to prevent foreclosure. Hill v. DMAHS, OAL Dkt. No. HMA 11006-03, 2006 N.J. AGEN LEXIS 83, Initial Decision (January 12, 2006).

Community spouse was entitled to increase her community spouse resource allowance under 42 U.S.C.A. 1396r-5 and N.J.A.C. 10:71-5.7, thereby protecting additional resources and making her deceased husband, who had no income, eligible for Medicaid (adopting and modifying 2005 N.J. AGEN LEXIS 595). W.S. v. DMAHS, OAL Dkt. No. HMA 2126-05, 2005 N.J. AGEN LEXIS 1111, Final Decision (September 14, 2005).

Husband's application to recalculate his Medicaid benefit was properly denied because the husband and his wife transgressed the permissible limits of Medicaid planning by entering into a divorce from bed and board and agreeing, in a consent order without judicial fact finding, that the institutionalized husband's pension benefits would be paid to the wife as alimony. H.K. v. Division of Medical Assistance and Health Services, 379 N.J. Super. 321, 878 A.2d 16, 2005 N.J. Super. LEXIS 238 (App.Div. 2005).

Both interest and principal of community spouse's monthly annuity payments constituted income for purposes of determining minimum monthly maintenance allowance under Medically Needy Program. J.M. and E.M. v. Division of Medical Assistance and Health Services, 96 N.J.A.R.2d (DMA) 86.

Full amount of Medicaid applicant's Social Security benefits would be included as "available income" and applied to his long-term care costs, even though applicant used portion of his benefits to satisfy pre-existing alimony obligation. L.C. v. Division of Medical Assistance and Health Services, 96 N.J.A.R.2d (DMA) 73.

Exceptional circumstances resulting in significant financial distress warranted an upward adjustment in community spouse maintenance amount. M.G. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 47.

10:71-5.8 Eligibility under life care and pay-as-you-go agreements

(a) In a contractual agreement where the individual has transferred his available assets to the facility in exchange for full medical care in the institution, the institution has a legal responsibility to provide such care and Medicaid benefits are not payable for the institutional care. However, Medicaid eligibility may exist in the following circumstances (see also N.J.A.C. 10:71-5.4(a)13):

1. When it can be determined that no enforceable contract exists (for example, because the facility is financially unable to fulfill its responsibilities under the contract and all terms of the agreement are thus void), the facility has a legal obligation to refund to the individual any assets which remain from the amount assigned at the time the contract was signed. The individual may be eligible for Medicaid Only as long as all other eligibility criteria (including resources) are met.

2. When a contract is not actually rescinded and the individual retains his or her right under the terms of the contract but, where his or her contract rights for care in the facility are not fully met, Medicaid benefits may be available for those medical expenses not being met by this facility if the individual meets eligibility requirements.