STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF GRAND TRAVERSE

IN RE HAROLD GAULT,

Petitioner

File No. 06-25485-AA
HON. PHILIP E. RODGERS, JR.

/

John J. Rizzo III (P58946)
Attorney for Petitioner

Joshua S. Smith (P63349)
Assistant Attorney General
Attorney for Respondent

DECISION AND ORDER ON APPEAL

In August of 2005, Petitioner Harold Gault moved into a nursing home. In October of 2005, he applied for Medicaid benefits. The Michigan Department of Human Services ("DHS") denied Petitioner's application for benefits for the stated reason that he was not eligible because the value of his and his wife's countable assets exceeded the asset limit. The asset that put them over the limit was Mrs. Gault's shares in Gault Investments, LLC.

In September of 2005, Mrs. Gault had assigned an AIG annuity worth roughly $100,000 to Gault Investments, LLC.[1] In return she had received 100,000 shares of non-voting investment shares in Gault Investments, LLC. Gault Investments, LLC restricted the sale or transfer of the shares for a period of two years and entered into a buy-sell agreement with Mrs. Gault, guaranteeing her the right to sell her shares after the two-year restricted transfer period at a sale price equal to the purchase price, plus 4% accrued interest.

Mr. Gault appealed the decision of the DHS and an administrative hearing was held. The administrative law judge ("ALJ") found that Mrs. Gault's interest in Gault Investments,

[1] It is undisputed that the Gaults formed Gault Investments, LLC in order to make the $100,000 annuity unavailable so that Mr. Gault would qualify for Medicaid benefits.

LLC was "unavailable" because of the sale or transfer restriction, but that the "conversion" of the annuity into the shares of stock in Gault Investments, LLC was a penalizing "divestment" and that a divestment penalty period during which Mr. Gault would be ineligible for benefits should have been calculated.[2] Mr. Gault appealed the ALJ's decision to this Court.

Counsel for the parties presented their oral arguments on February 20, 2007. The Court requested supplemental briefing and reset the oral arguments for March 19, 2007. Respondent filed a supplemental brief on March 9, 2007. Having reviewed the briefs, the Court dispenses with further oral argument. MCR 2.119(E)(3). The Court will now describe its legal conclusions.

STANDARD OF REVIEW

The parties agree on the applicable standard of review.

A final agency decision is subject to court review but it must generally be upheld if it is not contrary to law, is not arbitrary, capricious, or a clear abuse of discretion, and is supported by competent, material and substantial evidence on the whole record. Const 1963, art 6, § 28; MCL 24.306(1)(d). "Substantial evidence is that which a reasonable mind would accept as adequate to support a decision, being more than a mere scintilla, but less than a preponderance of the evidence." *St. Clair Intermediate School Dist v Intermediate Ed Ass'n/Michigan Ed Ass'n*, 218 Mich App 734, 736; 555 NW2d 267 (1996). If there is sufficient evidence, the circuit court may not substitute its judgment for that of the agency, even if the court might have reached a different result. *Black v Dep't of Social Services*, 195 Mich App 27, 30; 489 NW2d 493 (1992). With regard to whether a decision is arbitrary or capricious, the Court in *Romulus v Dep't of Environmental Quality*, 260 Mich App 54, 63-64; 678 NW2d 444 (2003), stated:

> To determine whether an agency's decision is "arbitrary," the circuit court must determine if it is 'without adequate determining principle [,] . . . fixed or arrived at through an exercise of will or by caprice, without consideration or adjustment with reference to principles, circumstances, or significance, . . . decisive but unreasoned.' *St. Louis v Michigan Underground Storage Tank Financial Assurance Policy Bd*, 215 Mich App 69, 75; 544 NW2d 705 (1996), quoting *Bundo v Walled Lake*, 395 Mich 679, 703 n 17; 238 NW2d 154 (1976), quoting *United States v Carmack*, 329 US 230, 243; 67 S Ct 252; 91 L Ed 209

[2] A divestment penalty is computed by dividing the uncompensated value of the resource divested ($100,000) by the average monthly long term care costs in Michigan for the applicant's baseline date (2005 = $5,367). The penalty would preclude Mr. Gault from receiving benefits for more than eighteen (18) months.

(1946). "Capricious" has been defined as 'Apt to change suddenly; freakish; whimsical; humorsome.' *St Louis, supra* at 75; 544 NW2d 705, quoting *Bundo, supra* at 703 n 17; 238 NW2d 154, quoting *Carmack, supra* at 243; 67 S Ct 252.

THE ISSUE

Whether Conversion of Mrs. Gault's Annuity into Stock in Gault Investment, LLC was a Penalizing Divestment

The Petitioner argues that, under the applicable rules and regulations ("POMS" and "PEMS"), only available, countable assets are used to determine eligibility for Medicaid benefits and there is no divestment penalty for converting available, countable assets into unavailable, uncountable assets. Further, Petitioner contends that the POMS relied upon by the Respondent is inapplicable because it relates to the Retirement and Survivor's Insurance Program and Medicare and not to Social Security Income and Medicaid.

The Respondent relies on The Close and Family Corporations portion of the POMS RS 0201.540 of the Retirement and Survivor's Insurance Program which it argues allows agencies administering any Social Security Administration ("SSA") benefits program to disregard a corporate form when the corporation is a "sham" formed merely to secure benefits. The Respondent concludes that the conversion of Mrs. Gault's annuity to stock in such a corporation was a divestment for which a penalty period should have been calculated.

The question the Court must answer is whether the conversion of Mrs. Gault's annuity into stock in Gault Investments, LLC was a penalizing divestment.

APPLICABLE LAW

The Medicaid program of the Social Security Act ("Act") provides medical assistance to persons whose "income and resources are insufficient to meet the costs of necessary care and services." 42 USC § 1396. See *Wilder v Virginia Hospital Assn*, 496 US 498, 502; 110 S Ct 2510; 110 L Ed 2d 455 (1990). States participating in the program must provide coverage to the "categorically needy," that is, persons eligible for cash assistance under either the Supplemental Security Income for the Aged, Blind, and Disabled (SSI) program or the Aid to Families with Dependent Children (AFDC) program. Congress considers these categorically needy persons "especially deserving of public assistance" for medical expenses, *Schweiker v Gray Panthers*, 453 US 34, 37; 101 S Ct 2633, 2637; 69 L Ed 2d 460 (1981), because they

"earn [ ] less than what has been determined to be required for the basic necessities of life." *Atkins v Rivera*, 477 US 154, 157; 106 S Ct 2456, 2459; 91 L Ed 2d 131 (1986). AFDC and SSI cover only basic necessities, not medical expenses. If a categorically needy person incurs medical expenses, payment of these expenses would infringe on the amounts provided by AFDC or SSI for basic necessities. Thus, mandatory medical coverage is needed for these people. *Id.*

A participating state also may elect to provide Medicaid benefits to the "medically needy," that is, other aged, blind, and disabled people and to families with dependent children, whose income and/or resources are too high to qualify them for welfare benefits. The "medically needy" are deemed "less needy" than the "categorically needy." Under 42 USC § 1396a(a)(17), they qualify for "assistance only if their income and resources [are] insufficient 'to meet the costs of necessary medical or remedial care and services.'" *Schweiker v Hogan*, 457 US 569, 573; 102 S Ct 2597, 2601; 73 L Ed 2d 227 (1982) (quoting 79 Stat. 345, as amended by 42 USC § 1396a(a)(10)(C)); *Atkins*, 477 US at 158; 106 S Ct at 2459. Only when the medically needy "spend down" the amount by which their income exceeds the medically needy income level determined necessary for the basic necessities of life are they in the same position as the categorically needy AFDC or SSI recipients. Similarly, any further expenditure by the medically needy for medical expenses would have to come from funds reserved for basic necessities. *Id.* Thus, the state, with the assistance of federal financial participation, may aid the medically needy whose income falls below the medically needy income level.

Under 42 USC § 1396a(a)(17), a state is to take into account, "except to the extent prescribed by the Secretary [of Health and Human Services], the costs . . . incurred for medical care," and must determine eligibility under standards that are "reasonable" and "comparable for all groups." Pursuant to that section, the Secretary issued a regulation permitting States to employ a maximum spend down period of six months to compute income of the medically needy. Under § 1396a(a)(10)(C)(i)(III), a state Medicaid plan must prescribe "the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility which shall be the same methodology which would be employed under [AFDC or SSI]."

The state Medicaid plan establishes the "medically needy income level" (MNIL) standard that determines the maximum amount of income a medically needy applicant is

allowed to keep for nonmedical needs and still be eligible for Medicaid. Each participating State develops a plan containing "reasonable standards . . . for determining eligibility for and the extent of medical assistance." 42 USC § 1396a(a)(17). An individual must meet two conditions to obtain Medicaid assistance. He must satisfy eligibility standards defined in terms of income or resources and he must seek medically necessary services. See 42 USC § 1396. An individual is entitled to Medicaid if he fulfills the criteria established by the State in which he lives. State Medicaid plans must comply with requirements imposed both by the Act itself and by the Secretary of Health and Human Services (Secretary). See *id* § 1396a (1976 ed. and Supp III); *Harris v McRae*, 448 US 297; 100 S Ct 2701 (1980).

The Federal Social Security Administration Program Operation Manual System ("POMS") is a policy and procedure manual used by Health and Human Services employees to evaluate claims. *Evelyn v Schweiker*, 685 F2d 351, 352 n 5 (9th Cir1982). The POMS is a compilation of the Secretary's interpretation of statutes and regulations governing programs administered by the SSA. POMS is the authorized means for issuing official Social Security policy and operating instructions. POMS § AO 20002.001.

While the United States Supreme Court has opined that the POMS "warrants respect" when reviewing claims administered by the SSA, *Washington State Department of Social and Health Services v Keffeler*, 537 US 371, 385; 123 S Ct 1017; 154 L Ed 2d 972 (2003), the POMS does not have the force of law, *Schweiker v Hansen*, 450 US 785, 789; 101 S Ct 1468, 1471; 67 L Ed 2d 685 (1981).

The State of Michigan established a Medicaid program under the Social Welfare Act, MCL 400.1, *et seq.* The Department of Human Services ("DHS") is authorized to promulgate all rules necessary or desirable for the administration of programs under the Act. MCL 400.6(1). DHS rules must be promulgated pursuant to the Administrative Procedures Act, MCL 24.201, *et seq.*, and have the force of law. DHS policies, on the other hand, are interpretative statements that do not have the force of law. MCL 400.6(3). MCL 24.207; *Faircloth v Family Independence Agency*, 232 Mich App 391; 591 NW2d 314 (1999).

MCL § 400.24 contains direct, explicit legislative authorization for the DHS to establish eligibility and financial standards for all forms of general public relief. DHS policies flow from the DHS's statutory authority and, therefore, are exercises of permissive statutory power. *Pyke v Dep't of Social Services*, 182 Mich App 619; 453 NW2d 274 (1990), lv den; *Village of*

Wolverine Lake v State Boundary Comm, 79 Mich App 56, 59; 261 NW2d 206 (1977), lv den 402 Mich 863 (1978). DHS policies are found in the Program Eligibility Manual ("PEM") and the Program Administrative Manual ("PAM").

ANALYSIS

In the instant case, the question before this Court is whether the POMS RS 0201.540 applies to a determination of eligibility for Medicaid benefits. The Petitioner argues that it does not apply because it is contained in the subsection of the POMS that apply to Retirement and Survivor Insurance benefits. Retirement and Survivor Insurance Benefits relate to Medicare and eligibility does not depend on the value of a claimant's assets. Medicaid, on the other hand, relates to Supplemental Security Income ("SSI") and eligibility depends on the value of a claimant's assets.

The Respondent contends that the POMS, regardless of the subsection heading, applies to all benefit programs.

The POMS RS 0201.540, which is at issue here, provides as follows:

> GENERAL
>
> It is a well-established principle upheld by the courts that if a corporation is recognized as such under State law and it in fact operates a business in a bonafide manner, SSA may not disregard it despite the fact that it may have been formed with the view of securing coverage, altering the distribution of the business' income or for some other purpose related to the Social Security Act or the Internal Revenue Code. If the facts establish that a properly organized corporation exists, that it operates the business as the owner and derives income, and that a claimant receives remuneration as an officer and/or because of services for the corporation, it necessarily follows that the remuneration constitutes **wages for employment**. The fact that a corporate business consists only of renting property or making and holding other investments and that the business was previously conducted by the claimant individually or by members of his/her family, will not in itself preclude **a finding of employment**.
>
> *Close or Family Corporations.* - **Questions may arise as to employment and/or wages in a claim or earnings discrepancy** based on alleged earnings from a close or family corporation. For example, records may have been manipulated to show payment of wages in inflated amounts. Also, a business which owned real estate, securities or other holdings producing investment income may have been incorporated to obtain coverage, when, in fact, the corporation has not functioned as a business entity and is nothing more than a

> legal fiction, i.e., it has done nothing more than meet the requirements of the State for the formation of a corporation.
>
> SSA's interest is such that it cannot stop with the establishment of the corporate entity in fact or in law. Court precedent has well established SSA's right and duty to look beyond form to substance in evaluating the operations of a corporation as they affect any aspect of a claim for benefits. The following sections establish guidelines and criteria for use in identifying, developing and disposing of claims and **earnings discrepancies** involving questionable close or family corporations. [Emphasis added.]

According to the plain language of the POMS RS 0201.540, the concern it addresses is an applicant using a corporate entity to interfere with the agency's ability to determine employment and make an accurate determination of whether a claimant receives "wages for employment." In the instant case, wages for employment are not at issue. In addition, accepting the Respondent's application of the POMS RS 0201.540 is contradictory to the definitions contained in 46 USC 1396p and would render the State's PEM 405 a nullity.

An asset for Medicaid purposes is defined in 46 USC 1396p as "a resource under the Supplemental Security Income program." A "resource" under the SSI program is defined in POMS SI 01110.100 as "cash and any other personal property, as well as any real property, that an individual (or spouse, if any) owns; has the right, authority, or power to convert to cash (if not already cash); and is not legally restricted from using for his/or her support or maintenance." POMS SI 01110.115 provides: "Assets of any kind are not resources (i.e., available and countable) if the individual does not have the legal right, authority, or power to liquidate them."

PEM 405 defines "divestment" as "a transfer of a resource by a client or his spouse that: (1) is within a specific time (See "LOOK-BACK PERIOD" below), and (2) is a transfer for "LESS THAN FAIR MARKET VALUE", and (3) is **not** listed below under "TRANSFERS THAT ARE NOT DIVESTMENT." "Less than fair market value" is defined as "the compensation received in return for a resource was worth less than the fair market value of the resource." PEM 405 provides that "[c]onverting an asset from one form to another of equal value is **not** divestment even if the new asset is exempt." Thus, it is not divestment to convert countable assets into non-countable assets of equal value.

It is disingenuous for the Respondent to argue that the Legislature did not intend for people to evade the asset guidelines by using estate planning to protect their assets. Federal law allows for the purchase of annuities for no other reason than to circumvent the countable asset provisions and qualify for Medicaid long-term care benefits. Deficit Reduction Act of 2005, Public Law 109-171, § 6012. It also allows for an individual to transfer assets to a family member through a promissory note to circumvent the countable asset provisions and to qualify for Medicaid long-term benefits. *Id* at Section 6016. 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 USC Sec 1396p(c)(2)(B)(l). 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 created the trust. Sec 1396p(3)(B)(l).

In *Mertz v Houstoun,* 155 F Supp 415, 426-427 (ED Pa 2001), the United Sates District Court for the Eastern District of Pennsylvania held that resources may be placed beyond the reach of either spouse, and thus not counted for Medicaid eligibility purposes, with the purchase of an actuarially sound commercial annuity for the sole benefit of the community spouse. In *James v Richman,* Docket No. 3:05-CV-2647 (MD Pa 2006), the Court held that even the income stream from a non-assignable annuity, though liquid and having a market value, is not a countable resource for determining eligibility because federal law excludes income of the community spouse from factoring into the institutionalized spouse's Medicaid eligibility. 42 USC Sec 1396r-5(b)(1). 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 the income streams' market value in the eyes of a third party. *Mertz*, 155 F Supp at 426. As the Petitioner points out, the POMS and PEM actually provide for this type of estate planning by trusts, the purchase of US savings bonds or other mechanisms.[3]

By definition, the conversion of Mrs. Gault's annuity into stock in Gault Investments, Inc. was a "divestment" because the transfer was not "for less than fair market value." PEM 405. In fact, the value of the asset did not change - the asset merely took another form - a form

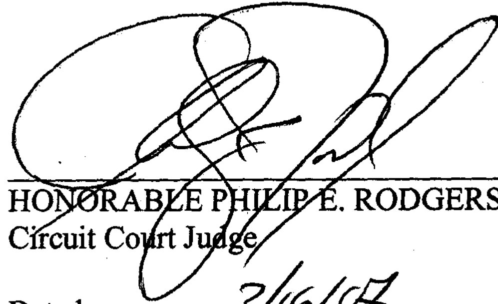
---

[3] The Petitioner was ultimately able to secure benefits by using a sole beneficiary trust.

that legally made it unavailable and uncountable. Based on the authority cited herein, not only is the value of the stock not countable, but the income stream from that investment is also not countable.

The ALJ's decision was contrary to law and must be reversed. Petitioner was entitled to Medicaid benefits without a divestment penalty.

IT IS SO ORDERED.



HONORABLE PHILIP E. RODGERS, JR.
Circuit Court Judge

Dated: 3/16/07