



STATE OF WISCONSIN

In the Matter of

(petitioner)
c/o James A. Jaeger, Attorney
2010 Eastwood Drive #301
Madison, WI 53704

DECISION

MDV-13/78679

The proposed decision of the hearing examiner dated December 4, 2006 is modified as follows and, as such, is hereby adopted as the final order of the Department.

PRELIMINARY RECITALS

Pursuant to a petition filed August 14, 2006, under Wis. Stat. § 49.45(5) and Wis. Admin. Code §HA 3.03(1), to review a decision by the Dane County Dept. of Human Services in regards to the discontinuance of the petitioner's eligibility for the Wisconsin Partnership Program (WPP), a hearing was held on September 27, 2006, at Madison, Wisconsin. At the joint request of the parties, the record was held open for 15 days for the petitioner to submit a final argument and 15 days for the county to submit a reply argument.

The issue for determination is whether the county agency correctly discontinued the petitioner's eligibility for the Wisconsin Partnership Program because she divested assets.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

(petitioner)
c/o James A. Jaeger, Attorney
2010 Eastwood Drive #301
Madison, WI 53704

Represented by:

James A. Jaeger, Attorney
Hill Glowacki Jaeger & Hughes LLC
P O Box 3006
Madison, WI 53704

Respondent:

Wisconsin Department of Health and Family Services
Division of Health Care Financing
1 West Wilson Street, Room 250
P.O. Box 309
Madison, WI 53707-0309

By: Paulette Penick, ESS I,
Dane County Dept Of Human Services
1819 Aberg Avenue
Suite D
Madison, WI 53704-6343

ADMINISTRATIVE LAW JUDGE:

Kenneth D. Duren
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES #xxxxxxxxxx) is a 76 year-old resident of Dane County. In at least July, 2006, she was certified as eligible for services under the Wisconsin Partnership Program ("WPP") and receiving these services in her home. These services were being provided by the county agency's contracted administering agency, ElderCare.
2. On August 2, 2006, the petitioner, by her attorney, mailed a letter to the county agency's change reporting section informing it that on or about June 2, 2006, the petitioner had sold her former residence realty; that on June 28, 2006, the petitioner, by her Power of Attorney (her brother, (redacted)) had entered into a written Caregiving Agreement with the petitioner's adult son, (redacted); and that in return for the lump sum payment of \$85,013.02 from the petitioner, that (redacted) had agreed to provide care for the petitioner for the rest of her life, and to provide room and board for the rest of her life. In addition the correspondence said that the petitioner's POA and (redacted) had also executed an Escrow Agreement providing that a private and commercial escrow agent had been engaged to accept the transfer of the lump sum, with instructions to disburse \$400 per month to (redacted) for the petitioner's room and board costs, and \$3,100 per month to (redacted) for the caregiving services he provides to the petitioner. See, Exhibits #1 & #2.
3. The Caregiving Agreement provides that (redacted) is to provide the petitioner with room, board, utilities including telephone service, lodging, laundry services, care, daily cleaning of her bedroom, general cleaning of his home, personal assistance connected to grooming, toileting, eating, dressing, bathing, personal hygiene, shopping, medication administration, medical transport for appointments, participate in medical planning as needed, advocacy services if she should require institutionalization; and provision of personal items and social outings should she become institutionalized, for life. In addition, if (redacted) defaults, then any balance remaining in escrow would be disbursed per the Escrow Agreement. Conversely, if the petitioner died and (redacted) was still performing, then the balance remaining goes to him immediately. See, Exhibit #1 & #8.
4. The petitioner's life expectancy at the time of execution of the Caregiving Agreement was estimated by the petitioner to be 12 years using the Life Expectancy Tables provided in the Medicaid Eligibility Handbook, at § 8.1.10., generally used in the MA Program to compute the value of life estates.
5. On August 9, 2006, the county agency issued a Negative Notice to the petitioner informing her that her MA – Partnership Waiver eligibility would be terminated on August 31, 2006, because she sold her home and divested the proceeds; and that she would remain ineligible until August 31, 2007, due to a divestment penalty period. The notice also informed her that the agency determined that the delay in reporting these events of June, 2006, meant that the agency would be finding that she was overpaid in June – August, 2006, without further elaboration.
6. On August 14, 2006, the petitioner filed an appeal with the Division of Hearings & Appeals contesting the discontinuance of her Wisconsin Partnership Program eligibility due to the divestment determination; and asserting that fair market value was received. She requested continued benefits pending the appeal, and benefits were continued pending a final decision.
7. (redacted) ceased all other employment in order to carry out his obligations under the Caregiving Agreement with the petitioner.

DISCUSSION

A single person cannot be eligible for Elderly, Blind & Disabled Medical Assistance (EBD-MA) if she has nonexempt assets exceeding \$2,000. Wis. Admin. Code § HFS 103.03(4). To prevent a person from simply giving away her assets when the specter of nursing home costs appears, the MA program has developed policies to limit eligibility in the event of such giveaways, or prohibited "divestments."

A divestment is a transfer of assets for less than fair market value. Wis. Stat. § 49.453(2)(a); Medicaid Eligibility Handbook, Appendix 4.7.2.1. A divestment or divestments made within 36 months before an application for Institutional – MA, or as here, at any time after application, may cause ineligibility for that type of MA. See, Wis. Stat. § 49.453(1)(f); Medicaid Eligibility Handbook, App. 4.7.3.

The penalty period is specified in Wis. Stat. § 49.453(3) to be the number of months determined by dividing the value of property divested by the average monthly cost of nursing facility services (\$5,339 in 2006). Medicaid Eligibility Handbook, Appendix 4.7.5. In this case, the agency calculated a disqualification period of 15 months.

A Wisconsin statute also provides as follows:

(5) CARE OR PERSONAL SERVICES. For the purposes of sub. (2), whenever a covered individual or his or her spouse, or another person acting on behalf of the covered individual or his or her spouse, transfers assets to a relative as payment for care or personal services that the relative provides to the covered individual, the covered individual or his or her spouse transfers assets for less than fair market value unless [1] the care or services directly benefit the covered individual, [2] the amount of the payment does not exceed reasonable compensation for the care or services that the relative performs and, [3] if the amount of the payment exceeds 10% of the community spouse resource allowance limit specified in s. 49.455 (6) (b) 1., the agreement to pay the relative is specified in a notarized written agreement that exists at the time that the relative performs the care or services.

Wis. Stat. §49.453.

The Medicaid Eligibility Handbook, § 4.7.8 provides the following regarding divesting by paying relatives:

4.7.8 DIVESTING BY PAYING RELATIVES.

It is divestment when an institutionalized person transfers resources to a relative in payment for care or services the relative provided to him/her. A relative is anyone related to the institutionalized person by blood, marriage, or adoption.

Count all the payments for care and services which the institutionalized person made to the relative in the last 36 months. The form of payment includes cash, property, or anything of value transferred to the relative. It is *not* divestment if all of the following conditions exist:

1. The services directly benefited the institutionalized person
2. The payment did not exceed reasonable compensation for the services provided ("reasonable compensation" is the prevailing market rate for the service at the time the service is provided)
3. If the amount of the total payment exceeds 10% of the community spouse asset share (5.10.4.2), the institutionalized person must have a written, notarized agreement with the relative. The agreement must:
 - a. Specify the service and the amount to be paid, and
 - b. Exist at the time the service is provided.If there is no community spouse, use 10% of the highest possible CSAS (community spouse asset share) in 5.10.4.2.

The Medicaid Eligibility Handbook specifically provides in determining whether fair market value was returned for an asset vis à vis the rendering of services, as follows:

3. Services which shall be assigned a valuation equal to the cost of purchase on the open market. Assume that services and accommodations provided to each other by family members or other relatives were free of charge, unless there exists a written contract (made prior to the date of transfer) for payment.

MEH, at 4.7.2.9 "Value Received".

The county agency argues the payments by petitioner to her son must therefore be considered a divestment. The county concluded that a divestment occurred because the contract was for future services. There is a basis for such a decision.

The first in a series of four relevant personal services contract divestment cases was a final decision issued by the Department's Deputy Secretary on February 20, 1997, DHA Case No. MDV-40/97114, which concluded that a front-loaded assignment of \$11,322.80 paid by a nursing home resident under contract for future supplemental personal services for the nursing home resident (receiving cares in the nursing home), with her daughter-in-law and terminable on death of the payor, was a divestment.

The second case was a final decision issued by the Department's Deputy Secretary on February 21, 2001, MDV-66/46616, which concluded that front-loaded payment of \$39,000 under a contract between nursing home resident and daughter for future supplemental personal services for the nursing home resident (receiving cares in the nursing home) was a divestment for the value of prospective portion of the services not yet received (\$29,100). In that case, room and board was not part of the contract, and the contract and services had begun years before the recipient was institutionalized.

The third decision was issued by ALJ Brian Schneider in Case MDV-40/#46647. That decision construed the impact of Wis. Stat. §49.453(5), which specifically addresses future care and personal service contracts between nursing home residents and relatives. He found that there was no divestment and stated in pertinent part:

In short, the present situation is clearly distinguished from the facts underlying the Deputy Secretary's Final Decision in MDV-40-40/97114. The SERVICES CONTRACT reviewed here appears to this fact finder to be a bona fide arms-length transaction of sufficient particularity so as to be reliable and enforceable. The former situation, in MDV-40-40/97114, was a transparent sham and artifice serving to divest assets in a hurry when the applicant in that case was precipitously institutionalized.

In that case, the institutionalized person made a front-loaded payment of \$29,946.95 under a contract between the resident (receiving cares in the nursing home) and a private managed care agency for future supplemental personal services for life. That contract was non-assignable, with no provision for refund or payment of any remainder to any beneficiary.

The fourth, and most recent, final decision issued by the Department's Deputy Secretary on September 3, 2004, DHA Case No. MDV-40/62206, concluded that a contract for front-loaded payment of \$58,750 between a nursing home resident (by her power of attorney) and a private managed care agency for future personal services between the resident and the same private managed care agency as in DHA Case No. 46647, providing personal needs care including recreation and advocacy on an "as needed basis", was a divestment.

For the benefit of both parties, I have included all of the reasoning of the Department's Deputy Secretary in the Department's final decision in Case No. 62206, which is as follows

Petitioner's attorney filed a "Brief and Memorandum in Opposition to Proposed Decision." He presented arguments that can fairly be summarized as follows: Petitioner received fair market value in the form of present and future services in return for her payment of \$58,750 under the personal services contract at issue. Utilizing present value and actuarial calculations, it is claimed that petitioner will receive \$182,500 in personal services if she lives the full term of her actuarial life expectancy. Petitioner's attorney submits that the contract price is the product of an "open market, arms-length transaction", and he analogizes it to annuities, life insurance, pensions and other like instruments. Finally, petitioner's attorney is critical of the proposed decision's use of a "reasonable purchaser" standard, arguing that the only appropriate standard is fair market value (As to this final point, the Department recognizes that "fair market value" is the appropriate test. In using the term, "reasonable purchaser", there is no intent to establish a different standard. A reasonable purchaser is simply one receiving fair market value).

The Department last dealt with the fair market value issue regarding a personal services contract in its final decision in Case # MDV-66/#46616, where the Department held that payment pursuant to the contract was for less than fair market value and therefore constituted a divestment. The contract in that case involved payments to relatives and made no use of the concept of present value. In addition to the considerations evident in the prior case, payment to non-relatives and the use of present value in the contract at issue in the instant case require further analysis.

At its most basic level, the issue is whether \$58,750 is an asset available to petitioner to be used to contribute to the cost of her care in the nursing home, thereby relieving the taxpayers of that portion of her cost of care. It is not considered available to petitioner, however, if she transferred it for fair market value.

Since retention of the cash by petitioner would inevitably result in the cash being contributed to her cost of nursing home care (cost otherwise borne by taxpayers), she is obviously and understandably motivated to transfer the cash in return for receiving anything of value. The law, however, does not permit her to simply receive something of value in return for the transfer. She is required to obtain fair market value.

Pursuant to the terms of the contract, petitioner's death at any time after execution of the contract results in retention of the entire payment by the services contractor. Petitioner's attorney has no difficulty with that result, analogizing it to annuities, life insurance policies and pensions. The Department recognizes that an annuitant, life insurance policyholder or pensioner, purchasing an annuity, policy or pension based on actuarial and present value tables, bears the risk that early death may result in some loss of benefit to the decedent. No annuity, life policy or pension, however, would be structured like the services contract in this case to permit the annuity, life insurance or pension company to retain the entire payment regardless of the date of death. If it were so structured, it would certainly not be considered a purchase for fair market value, and would, in any event, not be permitted by the regulators of those industries.

Furthermore, the value of the "as needed" contractual services is severely diminished by the full range of services required to be provided by the nursing home. Petitioner is entitled to have a plan of care developed by the nursing home. Wis. Admin. Code § HFS 132.60(8). The plan of care must include a social services component, with services provided by qualified staff. If the nursing home is unable to provide needed services, referral to an appropriate agency is required. Wis. Admin. Code § HFS 132.68. The facility is also required to have an activities program, "designed to meet the needs and interests of each resident and to be consistent with each resident's plan of care." Wis. Admin. Code § HFS 132.69. The nursing home is required to provide to each resident the opportunity to participate in outside religious, social and community groups at the resident's discretion. Wis. Admin. Code § HFS 132.31(1)(h),(o).

The contract vaguely refers to the contractor's use of its "professional expertise" to "monitor care", to "advocate for" petitioner and "to coordinate services". More specifically, the contractor claims it will provide trips on an "as needed" basis to "non-institutional life experiences", such as "religious, social, entertainment, and physical and beauty maintenance." The contract also refers to "social interaction" and assisting the petitioner with expenditures of her personal needs allowance.

In view of the nursing home's responsibility to provide social services, activities and access to outside activities, the "need" for the contractor's services will be minimal to non-existent. Finally, to the extent that these very basic services are needed at all, \$90/hour is an exorbitant rate.

The fact that petitioner in this case contracted with a non-relative would tend to favor a conclusion that she was seeking fair market value. Placing assets in the hands of family members, however, is not the only motive for disposing of assets for less than fair market

value. As noted above, faced with the prospect that the assets would be used to contribute to her cost of nursing home care, petitioner was motivated to dispose of those assets in return for receiving something of value, even if the value fell far short of fair market value.

Petitioner did not receive fair market value. For the reasons discussed herein, and the relevant rationale set forth in the final decision in Case # MDV-66/#46616, the transfer of assets constituted a divestment.

Those decisions, however, construed the impact of Wis. Stat. §49.453(5), which specifically addresses care and personal service contracts between nursing home residents and relatives. The decisions clearly expressed concern about the enforceability and reasonableness of a contract that would pay a relative for duties most relatives perform for free; and in circumstances where the payor was receiving skilled nursing facility cares that included room, board, medical cares, personal cares and facility provided recreational opportunities. This concern was then extended to commercial agencies that committed to engage in supplemental services beyond the facility cares for institutionalized persons.

In this case, the petitioner is receiving MA services through a special sub-program, the Wisconsin Partnership Program.

The Wisconsin Partnership Program (WPP) is a demonstration project authorized by the United States Department of Health & Human Services under a waiver of the Social Security Act. See, 42 U.S.C.A. §§ 1396n(a) & (b). The project is designed to save money for the federal and state governments by integrating long-term care and acute care services under one roof. In essence, the Department will pre-pay a uniform fee per person served by the WPP organization, and the organization will provide all Medicaid and Medicare covered medical services each individual is determined to need. It is also designed to maximize the ability of enrolled members to live in a setting of their own choice, to participate in community life, and to participate in making decisions regarding their own care.

The Department, operating under the aegis of a federal waiver granted under this section, must provide or arrange for all Medicaid *and* Medicare covered services required by participating recipients, i.e., “members” including nursing facility, primary, acute, and long-term care services utilizing Medicaid & Medicare certified providers. The target group for such members is the “frail elderly” and persons “under 65 years of age with disabilities”. See, Wisconsin Partnership Program Waiver, Section IV, B, effective January, 1999.

The Department performs this task by delegating the responsibility of service delivery to a private provider known as the “Partnership organization”. In Dane County, one such organization is ElderCare. See Wisconsin Partnership Program Protocol Manual, Part 1, p. 8.

The WPP organization, also known as a “Community-Based Organization” (CBO), functions like a health management plan and it is responsible for arranging and integrating all primary, acute, and long-term care services needed by an enrollee through the use of an “interdisciplinary team” comprised of a nurse practitioner, registered nurse, and social worker/social services coordinator.

The WPP is a sub-program of Medical Assistance (MA). MA (and WPP) reimburses the CBO for the costs of otherwise eligible persons who require one of several defined “levels of [nursing] care.” There are three class levels of care known (in descending order of severity of needs) as “skilled, intermediate or limited levels of care...”. Wis. Stat., §49.45(6m)(i). These levels of care are defined in the Wisconsin Administrative Code, re-stated generally, as follows.

Skilled level of nursing care is care that is furnished pursuant to a physician's order and that requires the skills of professional personnel such as a registered or licensed practical nurse. This highly demanding class level of care includes two standard types known as “Intensive Skilled Nursing” (ISN) and “Skilled Nursing Facility” (SNF). Either type of care is provided directly by, or under the supervision of, LPNs or RNs, 24 hours per day. See Wis. Adm. Code, §HFS 132.13(32). The cares are of “inherent complexity” requiring the services of such professionals to prevent deterioration of the person's

conditions or “maintain current capacities”; or simple unskilled tasks needed where there are “special medical complications”. Id.

Intermediate level of nursing care is care that requires the skill of a registered nurse for observation and recording of reactions and symptoms, and for supervision of nursing care. This class level of care includes what is known as the “Intermediate Care Facility - 1” standard. ICF-1 care means basic care consisting of physical, emotional, social, and other rehabilitative services under periodic medical supervision. The care requires the skill of a registered nurse for observation, recording reactions, and supervision. Wis. Adm. Code, §HFS 132.13(10).

Limited level of nursing care is care which can be provided safely only by or under the supervision of a person no less skilled than a licensed practical nurse who works under the direction of a registered nurse. Wis. Adm. Code, §HFS 132.13(12).

The petitioner is rated at the Intensive Skilled Nursing (ISN) level of care. See, Exhibit #4.

In this case, the petitioner transferred the bulk of the net proceeds (\$85,013.02) of the sale of her primary residence (June 2, 2006) to a private escrow agent known as Counselors Capital, under a written “Escrow Agreement” (executed on June 27, 2006). The sale price of the home was \$185,000, and it was sold to an apparently unrelated third party. After subtraction from the sale price of \$10,585.97 in Seller’s costs, \$21,200.37 to 1st mortgage holder Anchor Bank, \$55,367.45 to (redacted) as 2nd mortgage holder, and \$1,815.51 in pro-rata property taxes, the actual net proceeds of the sale transaction paid to the petitioner was \$96,007.70. See, Exhibits #9 & #10. The Escrow Agreement provided that a private and commercial escrow agent had been engaged to accept the transfer of the lump sum, with instructions to disburse \$400 per month to the petitioner’s son, (redacted), for the petitioner’s room and board costs, and \$3,100 per month to (redacted) for the caregiving services, for so long as he provides the agreed upon cares to the petitioner. The Escrow Agreement provides that if (redacted) defaults on performance, then the remaining funds shall be used for a replacement “Caregiver Agreement”, and if none, only then pass to the MA Estate Recovery Program.

Separately, the petitioner’s POA and her son, (redacted), executed a Caregiving Agreement on June 27, 2006. In said Agreement, (redacted) agreed to provide his mother with room, board, utilities including telephone service, lodging, laundry services, care, daily cleaning of her bedroom, general cleaning of his home, personal assistance connected to grooming, toileting, eating, dressing, bathing, personal hygiene, shopping, medication administration, medical transport for appointments, participate in medical planning as needed, advocacy services if she should require institutionalization; and provision of personal items and social outings should she become institutionalized, *for life*. This Agreement further provided that if (redacted) defaulted on performance, then any balance remaining in escrow would be disbursed per the Escrow Agreement. Conversely, if the petitioner died and (redacted) was still performing, then the balance remaining goes to him immediately. See, Exhibit #1 & #8.

The petitioner’s representatives first reported *most* of these events to the county agency administering the WPP eligibility on August 3, 2006. The agency asserts that it was not informed of the full sale price and the 2nd mortgage payoff to (redacted) until the actual hearing on September 29, 2006. The agency also asserts that the portion of the sale proceeds paid to (redacted) on the 11 sequential “mortgage notes” of the period of October, 1996 – September 1999, are also divested sums. However, the negative action taken by the county agency on August 9, 2006, was a determination that the petitioner divested, and the amount divested renders her ineligible for WPP for 15 months.

The petitioner’s attorney asserts that this fact pattern is not a divestment at all. Rather, the petitioner asserts that (redacted) has provided her with full fair market value in the form of his services and room & board, as outlined above, in return for the right to be paid the \$3,500 per month for each month he performs, and the balance immediately if his mother dies while still receiving his services fully performed. Attorney Jaeger asserts that assuming (redacted) is on call 24 hours per day, seven days a week and that this contract pays only \$6.45 per waking hour, that this is reasonable in light of (redacted) testimony that he made inquiries and was told that the comparable services on the open market would cost \$16.50 - \$23 per hour. See, Jaeger Brief, at p.4. (redacted) provided two rate sheets for “home helper

services” and/or “companionship and homemaking services” as comparables, at these hourly rates. See, Exhibits #13 & #14.

In addition, (redacted) testified that he had quit his job in order to devote himself to providing full-time care to his mother under this Agreement. He had formerly been a Manager with Meriter Retirement Services, as well as having prior experience in other service professions including as a police officer and an emergency medical technician. Under this Agreement, the petitioner is the only client he is providing such supplemental cares.

Attorney Jaeger also asserts that as the petitioner is 76 years old and has a life expectancy of 12 years under MA life expectancy tables (used for other purposes by MA), that the \$3,100 payments discounted at 5% per annum for 12 years would have a present value of \$335,175; thus, he asserts that the payment of \$85,000 now is a good value, and more importantly, a fair market value. See, Jaeger Brief, at p.4.

Attorney Jaeger notes that it is the intent of policymakers to encourage families to care for their elders. I disagree that the only way to encourage this is to allow individuals to divert large sums of money and shift the care costs to the taxpayer-funded Medicaid program. Additionally, the policy consideration underlying prohibiting divestments is equally or more compelling - those who can afford to pay for their medical care should so that Medicaid dollars are conserved for those who cannot. If further evidence of this policy intent was needed one only needs to review the recent federal changes made through the Deficit Reduction Act of 2005 that include closing divestment loopholes and tightening penalty periods.

Petitioner’s attorney argues that the \$85,013.02 is not a payment advanced for future services but rather a single-sum payment made for lifetime care. That is a distinction without a difference for Medicaid purposes. Whether the payment was for one unit of service – a lifetime of care – or for multiple units of future services, the bottom line is that petitioner is paying for an uncertain amount of services to be rendered at a future time. Because (redacted) receives approximately \$85,000 to potentially provide only one week or one month of services it can hardly be said that that is reasonable compensation or a fair exchange for petitioner’s money. That (redacted) quit his job to remain home with petitioner is extraneous to whether she is paying only market-rate compensation or is getting a fair deal. The appropriate focus here is on petitioner, not (redacted).

Petitioner argues that § 49.453(5) is met and therefore there is no divestment. First, as I noted above a transfer of this lump sum for an uncertain amount of future services does not allow a finding that this is reasonable compensation. Although she asserts that this could amount to mere dollars per hour over her lifetime it is equally conceivable that it could amount to hundreds per hour with an earlier death. Reasonable compensation cannot be fixed if there is a floating set of circumstances.

Second, the analysis does not stop with § 49.453(5) and the accompanying Handbook pages. The Court of Appeals, 4th District, held that even if a transfer meets one of the § 49.453 subsections it still must meet the general test under § 49.453(2). *Buettner v. WDHS*, 264 Wis. 2d 700 (Ct. App. 2003). Under sub. (2) a transfer must be made for fair market value. In concluding that petitioner’s transfer was not, I adopt the reasoning in MED-66/46616 that stated in part:

A reasonable person interested in obtaining personal care and services at a value of \$300 per month would normally purchase those services on a weekly or monthly basis. For convenience, he or she might make an advance payment for 6 months or possibly even a year. One might even envision a multi-year contract, but a reasonable purchaser would certainly insist on periodic payments rather than an up-front lump sum payment.

A \$29,100 personal services contract that has a theoretical actuarial term of 97 months, but will terminate upon death (whether that event occurs in one week or after 25 years) is not a reasonable proposition. A person motivated exclusively by the desire to obtain fair market value for the transfer would not enter into that contract. A reasonable purchaser would want assurance that he or she will receive \$300 worth of services in exchange for a payment of \$300. That purchaser would not run the risk of obtaining \$300 worth of services in exchange for a \$29,100 payment. On the other hand, time is money. If services are contemplated many years hence, a reasonable purchaser would not make an

up-front lump sum payment. The purchaser would invest those funds for his or her own benefit until the services were actually to be delivered before making payment.

* * *

In this case, petitioner is willing to risk non-receipt of care and services because the non-earned funds will go to his relatives. That is an understandable motive, but this compensation arrangement is not a reasonable one. Because the compensation is not reasonable, the \$29,100 transfer is not for fair market value and therefore constitutes a divestment.

Petitioner's attorney suggests that using actuarial life expectancy as the basis to determine adequate consideration is similar to how annuities are calculated. As with annuities, he argues that the transfer should not be rejected simply because of a lump sum payment. However, annuities are distinguishable from this purchase of services arrangement in that they are designed to deal with risk-sharing; there is no necessary risk on (redacted) part. Petitioner asserts that (redacted) risk is that petitioner will outlive her life expectancy and his services will need to continue without payment. There is nothing to insure against (redacted) ceasing services once the money runs out. Although an annuity provides prospective long-term financial security to the purchaser in exchange for bearing the risk of losing some of the purchase price in the event of an earlier death, petitioner is not guaranteed that future security although she immediately bears the risk.

Not only are the units of services that will be provided under this agreement uncertain, so are the services that will be purchased. I accept that petitioner will enjoy having her son's companionship. Whether that should be compensable with the consequence that taxpayers will then pay for petitioner's care is a fair question, but is only one facet of this analysis in any event. As in MVD-40/62206 where there was an incidental need for personal services to be rendered by an external source to a resident in a nursing home, there also is an incidental need for additional personal services to a client enrolled in WPP. By contract and the Department's operational protocols, petitioner's WPP provider is responsible for an array of health-related and community-based services such as supportive housing, home care including home health aide, personal care assistance and chore services, respite care, transportation (medical and non-medical), home delivered meals and personal emergency response systems. Family caregivers meeting established criteria may be hired and paid by WPP. See, 2007 Partnership Plan Contract and WPP Protocol Manual at <http://dhfs.wisconsin.gov/WIpartnership/ProPublications.htm>. If these services are available through WPP then some of (redacted) services would be duplicative. A reasonable person would not pay twice for the same services. If petitioner has the resources to pay (redacted) to provide her care then Medicaid-paid long term care services are unnecessary. Although (redacted) compensation is reduced if petitioner enters a care facility, we are back to the issue in MDV-40/62206 as to what need would exist for any services by (redacted) and therefore what exactly is petitioner receiving for her \$85,013.02.

For the reasons discussed, I conclude both that the arrangement does not provide only reasonable compensation for services and that it is not an exchange for fair market value. Therefore, the transfer of assets constituted a divestment.

I make no ruling on the payoff of \$55,387.45 to (redacted) for past second mortgages he may have held because the issue was not raised by petitioner in this appeal.

CONCLUSION OF LAW

That the petitioner divested \$85,013.02 when she paid it to an escrow agent in June, 2006, to fund monthly payments to her son in return for room, board, laundry, personal assistance with activities of daily living, medication set-up and administration, transportation, social and recreational activities, companionship, general homemaking and housekeeping services, and post institutionalization advocacy if needed.

NOW, THEREFORE, it is

ORDERED

That the petition is herein dismissed.

REQUEST FOR A REHEARING

This is a final fair hearing decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a rehearing. You may also ask for a rehearing if you have found new evidence which would change the decision. To ask for a new hearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875.

Send a copy of your request to the other people named as "PARTIES IN INTEREST" in the proposed decision. Your request must explain what mistake the examiner made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

Your request for a new hearing must be received no later than 20 days after the date of this decision. Late requests cannot be granted. The process for asking for a new hearing is in Wisconsin Statutes § 227.49. A copy of the statutes can be found at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed no more than 30 days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

For purposes of appeal to Circuit Court, the Respondent in this matter is the Wisconsin Department of Health and Family Services. Appeals must be served on the Office of the Secretary of that Department, either personally or by certified mail. The address of the Department is: Wisconsin Department of Health and Human Services, Office of the Secretary, 1 West Wilson Street, Room 650, P.O. Box 7850 Madison, WI 53707-7850.

The appeal must also be served on the other "PARTIES IN INTEREST" named in the proposed decision. The process for Court appeals is in Wisconsin Statutes §§ 227.52 and 227.53.

Given under my hand at the City of
Madison, Wisconsin, this 16th day of
February, 2007.

/s

Susan J. Reinardy, Deputy Secretary
Department of Health and Family Services