

1989

Virginia M. Corbitt v. Utah Department of Health, Division of Health Care Financing : Brief of Petitioner

Utah Court of Appeals

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UTAH COURT OF APPEALS
BRIEF

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IN THE COURT OF APPEALS OF

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DOCKET NO. 890674-CA THE STATE OF UTAH

VIRGINIA M. Corbitt,

Petitioner,

v.

UTAH DEPARTMENT OF HEALTH,
DIVISION OF HEALTH CARE
FINANCING,

Respondent.

Case No. 890674-CA

Category No. 14a

BRIEF OF PETITIONER

Petition for review of a decision by the Utah Department of Health, Division of Health Care Financing, dated October 20, 1989, reversing Formal Order 89-207-04 and finding petitioner ineligible for Medicaid.

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MAR 28 1990

COURT OF APPEALS

VIRGINIA M. Corbitt,)	
Petitioner,)	Case No. 890674-CA
v.)	
UTAH DEPARTMENT OF HEALTH,)	Category No. 14a
DIVISION OF HEALTH CARE)	
FINANCING,)	
Respondent.)	

Petition for review of a decision by the Utah Department of Health, Division of Health Care Financing, dated October 20, 1989, reversing Formal Order 89-207-04 and finding petitioner ineligible for Medicaid.

Attorney for Petitioner

TABLE OF CONTENTS

	Page
JURISDICTION OF THE COURT OF APPEALS	1
NATURE OF THE PROCEEDINGS	1
STATEMENT OF THE ISSUES	2
DETERMINATIVE CONSTITUTIONAL PROVISIONS, STATUTES, ORDINANCES AND RULES	2
STANDARD OF REVIEW	2
STATEMENT OF THE CASE	3
a. <u>Nature of the case</u>	3
b. <u>Course of Proceedings</u>	3
c. <u>Disposition at the Medicaid Agency</u>	4
d. <u>Relevant Facts</u>	5
SUMMARY OF THE ARGUMENT	8
ARGUMENT	9
<u>POINT I</u> THE DIRECTOR'S DECISION UPHOLDING THE DENIAL OF CORBITT'S FIRST APPLICATION FOR FAILURE TO PROVIDE VERIFICATION SHOULD BE REVERSED, SINCE IT IS BASED ON AN ERRONEOUS INTERPRETATION OR APPLICATION OF THE MEDICAID LAW	9
<u>POINT II</u> THE DECISION SHOULD BE REVERSED, SINCE THE DIRECTOR ERRED IN APPLYING THE LAW IN FINDING THAT CORBITT TRANSFERRED ASSETS IN ORDER TO QUALIFY FOR MEDICAID	15
<u>POINT III</u> THE DIRECTOR'S DECISION SHOULD BE REVERSED SINCE HE WAS SUBJECT TO DISQUALIFICATION BECAUSE OF HIS FINANCIAL INTEREST IN THE MEDICAID PROGRAM.	22
<u>CONCLUSION</u>	24

TABLE OF CONTENTS CONT'D

ADDENDUM

Utah-DSS Vol. IIIM § 565-2 (2-90)
Utah-DSS Vol. IIIM § 565-3 (11-89)
Utah-DSS Vol. IIIM § 703-5 (3-90)
Utah-DSS Vol. IIIM § 731 (7-89)
Utah Admin. Code § R455-14 (1989)

TABLE OF AUTHORITIES

CASES CITED

	Page
<u>Boyd v. Dep't. of Empl. Sec.</u> , 773 P.2d 398, 400 (Utah Ct. App. 1989)	3
<u>Buckner v. Maher</u> , 424 F.Supp. 366, 369 (D. Conn. 1976)	10
<u>Downer v. State Dept. of Human Resources</u> , 705 P.2d 144 (Nev. 1985)	20
<u>Harrison v. Comm'r</u> , 529 A.2d 188 (Conn. 1987)	19
<u>Hurley v. Industrial Comm'n.</u> , 767 P.2d 524, 527 (Utah 1988)	3
<u>King v. Smith</u> , 392 U.S. 309, 333, 88 Sup. Ct. 2128, 20 L.Ed. 2d 1118 (1968)	14
<u>Matter of King James Nursing Home</u> , 351 A.2d 363, 367 (1976).	14
<u>Myer v. Niles Township</u> , 477 F.Supp. 357, 362, (N.D. Ill. 1979).	24
<u>People in Interest of S.P.B.</u> , 651 P.2d 1213, 1217 (Colo. 1982).	19
<u>Randall v. Lukhard</u> , 709 F.2d 257 (4th Cir. 1983).	20
<u>Schweiker v. Gray Panthers</u> , 453 U.S. 34, 43, 69 L.Ed. 2d 460, 101 S. Ct. 2633 (1981).	10
<u>Smith v. Miller</u> , 665 F.2d 172, 175 (7th Cir. 1981).	14
<u>Townsend v. Swank</u> , 404 U.S. 282, 286, 92 S. Ct. 502, 30 L.Ed. 2d 448 (1971);	14
<u>Ward v. Village of Monroeville</u> , 409 U.S. 57, 93 S. Ct. 80, 34 L.Ed. 2d 267 (1972).	24

RULES AND REGULATIONS CITED

42 C.F.R. § 435.911	11
42 C.F.R. § 431.205 (1985).	22

Table of Authorities cont'd

42 C.F.R. § 431.232 (1985)	22
Utah Admin. Code § R455-14.	23
Utah-DSS Vol. IIIM § 565-2 (7-89)	16
Utah-DSS Vol. IIIM § 565-2.B (2-90)	17,n.1
Utah-DSS Vol. IIIM § 565-3 (11-89).	20
Utah-DSS Vol. IIIM § 703-5 1.A.	12
Utah-DSS Vol. IIIM § 731-1 & 2.	12,13

STATUTES CITED

42 U.S.C. § 1382b(c)(1983).	15
42 U.S.C. § 1382b(c)(2)(1983)	15
42 U.S.C. § 1396a(a)(8),(19),(34)	10,11
42 U.S.C. § 1396a(3)(1983).	22
42 U.S.C. § 1396p(c)(1983).	15
42 U.S.C. § 1396p(c)(1)(1988)	16
42 U.S.C. § 1396p(c)(2)(C)(1988).	16
Utah Code Ann. § 26-18-2.1 (1988)	10
Utah Code Ann. § 26-18-2.2 & .3	23
Utah Code Ann. § 63-46b-16.	1
Utah Code Ann. § 78-2a-3(2)(a).	1
Utah Code Ann. § 63-46b-16(4)(d) (1988)	2

VIRGINIA M. Corbitt,)	
)	
Petitioner,)	Case No. 890674-CA
)	
v.)	
)	
UTAH DEPARTMENT OF HEALTH,)	Category No. 14a
DIVISION OF HEALTH CARE)	
FINANCING,)	
)	
Respondent.)	

This is a petition for review of a formal adjudicative proceeding. Jurisdiction to hear this petition is vested in the Court of Appeals by Utah Code Ann. §§ 63-46b-16, 78-2a-3(2)(a).

Virginia M. Corbitt seeks review of a final decision of the Director of the Utah Department of Health (DOH), Division of Health Care Financing (DHCF), which affirmed in part and reversed in part a hearing officer's decision. The hearing officer found that Corbitt's first application for Medicaid was properly denied for failure to provide necessary verification of eligibility. The Director affirmed this holding. The hearing officer further found petitioner eligible for Medicaid on a second application, holding that a transfer on February 23, 1989 of certain assets was not

done in contemplation of an application for benefits under Medicaid. The hearing officer's order was reviewed by the Director of DHCF who affirmed the hearing officer as to the first ruling, but reversed the second ruling, finding that the transfer of assets violated the agency's policies and procedures, thereby making petitioner ineligible for Medicaid.

STATEMENT OF THE ISSUES

1. Whether the Director of DHCF erroneously interpreted or applied the law in finding that petitioner's first application was properly denied for a lack of verification?

2. Whether the Director of DHCF erroneously interpreted or applied the law in finding that the transfer of certain assets on February 23, 1989 was done in order to qualify for Medicaid, thereby disqualifying petitioner from receiving benefits?

3. Whether the Director of DHCF was illegally constituted as a decision-making body or was subject to disqualification because of his interest in the financial matters of the Utah Medicaid program?

DETERMINATIVE CONSTITUTIONAL PROVISIONS, STATUTES,

ORDINANCES AND RULES

42 U.S.C. § 1396a et seq.
42 U.S.C. § 1396p(2)(c)(2)
(1988)

42 C.F.R. § 435.911
Utah-DSS Vol. IIIM § 565-2
2.B. (7-89)
Utah-DSS Vol. IIIM § 565-3
2. (11-89)

STANDARD OF REVIEW

The Utah Administrative Procedures Act provides that an appellate court may grant relief if it determines that a person

seeking review has been substantially prejudiced by the agency's erroneous interpretation or application of the law. Utah Code Ann. § 63-46b-16(4)(d) (1988). The Supreme Court has held that the correction-of-error standard applies to agency rulings on issues of law and extends no deference to them. Hurley v. Industrial Comm'n., 767 P.2d 524, 527 (Utah 1988). Concerning issues involving mixed law and fact, an agency decision deserves some deference and will not be set aside unless it is unreasonable. Id. However, the deference given an agency in its area of expertise is not so expansive as to require a sanctioning of the agency's misinterpretation of its own statute and related rules. Boyd v. Dep't. of Empl. Sec., 773 P.2d 398, 400 (Utah Ct. App. 1989).

STATEMENT OF THE CASE

a. Nature of the case

This is a request for review by the Court of Appeals of a final agency decision denying Virginia Corbitt Medicaid benefits. Corbitt requested a hearing, following denial of benefits on two applications for Medicaid benefits. The hearing officer found that Corbitt's initial application had been properly denied, since she had not supplied the necessary verification. He found that the denial of Corbitt's second application was improper, since property transferred by her prior to filing for Medicaid was done for purposes other than to qualify for Medicaid. The Director of DHCF reviewed the hearing officer's decision and affirmed the denial of the first application but reversed the second finding. Corbitt seeks reversal of the Director's decision and a declaration that

she has been eligible for Medicaid since the date of her original application.

b. Course of Proceedings

Corbitt filed her first application for benefits on March 16, 1989. (Transcript of Hearing ("TH") 24) It was denied May 11, 1989 for the reason that the necessary verification to determine eligibility was not provided. (Clerk's Notation of Record ("NR") 53) Corbitt requested a hearing which was held September 12, 1989 before Hearing Officer Cornelius Hyzer. (TH 2) The day prior to the hearing, Corbitt had filed a second application for Medicaid which was denied September 12, 1989 for the reason given that Corbitt had transferred her share in property held jointly with her son, Whitney Corbitt, on February 23, 1989 at less than fair market value and for the purpose of qualifying for Medicaid. (NR 56) On September 20, 1989, the hearing officer affirmed the first denial but reversed the second, finding that Corbitt had not transferred property in order to qualify for Medicaid. (NR 28) The Director of the Medicaid agency reviewed the formal order and, in an order on review issued October 20, 1989, affirmed the first finding, but reversed the second. (NR 21) Corbitt filed her petition for writ of review on November 20, 1989. (NR 9)

c. Disposition at the Medicaid Agency

The final agency action denied Corbitt Medicaid on both of her applications. The final result of the agency's action is that she will remain ineligible for Medicaid up to 30 months from the date of transfer. (TH 51-52)

d. Relevant Facts

Virginia Corbitt is an eighty-one-year-old woman who until June 1986 resided with her son, Whitney Corbitt, at a home owned jointly with him. (TH 48). At that time, Corbitt left the family home and moved to a retirement center. (TH 48) On September 12, 1986, she deeded one-half of the home to her son by a quit claim deed. (NR 47) Corbitt remained in the retirement home until February 13, 1989 when she fell and was taken to St. Mark's Hospital. (TH 46-47) She remained in the hospital until February 23, 1989 when she was transferred to Care West Nursing Home in Salt Lake City. (TH 46)

Prior to leaving the hospital, Corbitt signed a quit claim deed conveying the other half interest in the home to her son, Whitney Corbitt. (TH 46, NR 51) She also signed a durable power of attorney, appointing her son, Whitney Corbitt, as her attorney in fact. (NR 49)

At the time Corbitt was placed at Care West Nursing Home, she was receiving Medicare benefits which paid for her hospitalization and initial nursing home stay. (NR 73) On March 16, 1989, following expiration of her Medicare eligibility, Corbitt's son applied for Medicaid benefits on behalf of his mother. (TH 24) Whitney Corbitt obtained the Medicaid application from Christine DeBlasio, a social worker at Care West. (TH 4) Certain verification was needed for approval of the application, which Whitney Corbitt attempted to obtain. (TH 18-20) The requested verification was not supplied and the application was denied on May

11, 1989. (NR 53) A hearing was requested and held on September 12, 1989 before Hearing Officer Cornelius Hyzer. (TH 2) The day before the hearing, Whitney Corbitt submitted a second application for Medicaid which was denied September 12, 1989. (NR 56) The reason given for the denial was that the applicant had transferred a share of her home in February 1989 without receiving fair market value and for the purpose of qualifying for Medicaid. (NR 56) Corbitt was advised that the sanction period for the denial would be the lesser of thirty months or the fair market value of the property transferred divided by \$1,530.00. (NR 56)

At the hearing, Whitney Corbitt appeared and testified that the verification required to complete the first application was delayed, because he had had difficulty obtaining documentation from his attorney. (TH 31) He testified that Virginia Corbitt conveyed the half interest in the home to him on February 23, 1989 on the advice of his attorney. (TH 44) He testified his mother was in the hospital at the time and that the transfer needed to be done, but was not done to hide assets in order to qualify for Medicaid. (TH 44) The transfer was done, according to Whitney Corbitt, to avoid the possibility of his mother becoming incapable of signing over the title to him. (TH 44) He testified that the previous half interest was transferred to him in 1986 on the advice of his attorney in order to protect the property during a divorce proceeding. (TH 44) He testified that in February 1989, the divorce was final and it seemed to be a good time in which to

transfer the other half, since his ex-wife no longer had a claim.
(TH 45, 56)

The social worker, Christine DeBlasio, testified that at the time Virginia Corbitt was admitted to the nursing home, it was not expected that she would remain there for a long period of time. (TH 8) She noted that petitioner's treating physician, Dr. John B. Stanchfield, had stated that to his knowledge Virginia Corbitt would be able to return to her home after a short stay at the nursing home. (NR 32, TH 9-10) DeBlasio testified that because of Virginia Corbitt's declining medical condition, including a series of small strokes, it was determined in mid-March that she would not be able to return home and that an application for Medicaid should be initiated. (TH 61-62)

A representative of the Medicaid agency who appeared at the hearing, testified that Corbitt's second application was denied on the basis of state policy contained in Vol. III § 565-2. The representative testified that it is the Medicaid agency's policy to sanction a client who transfers property on the same day as entering a nursing home. (TH 51) The agency representative testified in part:

[B]ecause of the situation, because of the medical condition at the point of the transfer with her medical condition being that way and entry into the nursing home on that same day, we were basically saying that it was a transfer to become eligible for Medicaid, so we would apply the sanctions that I have just indicated there. (TH 54)

SUMMARY OF THE ARGUMENT

Federal Medicaid regulations controlling Corbitt's case do not mandate a denial of Medicaid benefits, when verification is not completed within a 45-day period. A Medicaid agency is permitted to keep the file open indefinitely, pending completion of the application by the claimant. In this case, the Director erred in finding that Corbitt's initial application was properly denied.

The Federal statutes and regulations provide that a Medicaid applicant who seeks benefits for nursing home care may be denied eligibility for a transfer of assets, unless a satisfactory showing is made that the transfer was for purposes other than to qualify for Medicaid. In this case, the hearing officer correctly found that the transfer of assets was proper. The Director of DHCF, in reviewing the hearing officer's decision, applied an erroneous standard by concluding that an inference of ineligibility may be drawn when an applicant enters a nursing home on the same day she transfers property. The Director articulated no legitimate reasons for reversing the favorable decision. But for the improper state policy, the Director should have affirmed the hearing officer's decision finding Virginia Corbitt eligible for Medicaid.

The Director was not an impartial person for purposes of reviewing the hearing officer's decision. He had an interest in the financial affairs of the Medicaid program. Thus, he should have been disqualified from reviewing the case.

ARGUMENT

POINT I

THE DIRECTOR'S DECISION UPHOLDING THE DENIAL OF CORBITT'S FIRST APPLICATION FOR FAILURE TO PROVIDE VERIFICATION SHOULD BE REVERSED, SINCE IT IS BASED ON AN ERRONEOUS INTERPRETATION OR APPLICATION OF THE MEDICAID LAW.

The hearing officer held, and the Director of DHCF affirmed, that Corbitt was not entitled to Medicaid eligibility on the basis of her March 16, 1989 application, for the stated reason that she had not provided verification as required by state policy and procedure. Corbitt's son, Whitney Corbitt, applied for benefits on March 16, 1989 on behalf of his mother and was advised to provide certain verification by March 28, 1989. Her son was unable to obtain the necessary documentation until the time of the hearing on September 12, 1989. Certain bank records were provided to the hearing officer within five days of the hearing as requested. (NR 13-20) However, the hearing officer held the denial of the first application to be proper, because Corbitt's son failed to provide the requested verification within the time limit set by the caseworker. The caseworker testified that there was "a time period of 45 days" in which to make a decision on Corbitt's application. (TH 25) Caseworker Anita Peterson also testified that 45 days was the limit for processing an application: "There's 45 days or we have to deny." (TH 28)

The hearing officer noted that the 45 day time limit for providing verification may be extended by the agency, but concluded it was unreasonable to expect the application to be held open indefinitely pending verification. (NR 29) A review of the

Medicaid statute and regulation shows that a Medicaid agency is not required to deny Medicaid when verification is not provided within the 45-day time limit. The Director has failed to identify a sufficient legal basis for concluding that the March 16, 1989 application was properly denied.

Medicaid is a complicated federal/state health program which has been described as "among the most intricate ever drafted by Congress." Schweiker v. Gray Panthers, 453 U.S. 34, 43, 69 L.Ed. 2d 460, 101 S. Ct.2633 (1981). Since Medicaid is a joint health care effort between the federal government and participating state governments, legal determinations necessarily involve a consideration of both state and federal law, with federal law controlling under the Supremacy Clause of the federal Constitution. This interrelationship has been well summarized in the case of Buckner v. Maher, 424 F.Supp. 366, 369 (D. Conn. 1976). Implementation of a Medicaid program is authorized in the state of Utah by Utah Code Ann. § 26-18-2.1 (1988).

Neither the relevant federal statute nor the implementing regulation prescribes a strict time limit for determining Medicaid eligibility. The relevant portions of the federal Medicaid statute provide as follows:

A state plan for medical assistance must --

....

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

....

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

....

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

....

42 U.S.C. § 1396a(a)(8),(19),(34)

The relevant federal regulation governing timely determinations of eligibility is found at 42 C.F.R. § 435.911 and provides as follows:

(a) The agency must establish time standards for determining eligibility and inform the applicant of what they are. These standards may not exceed --

(1) Sixty days for applicants who apply for Medicaid on the basis of disability; and

(2) Forty-five days for all other applicants.

(b) The time standards must cover the period from the date of application to the date the agency mails notice of its decision to the applicant.

(c) The agency must determine eligibility within the standards except in unusual

circumstances, for example --

(1) When the agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action, or

(2) Where there is an administrative or other emergency beyond the agency's control.

(d) The agency must document the reasons for delay in the applicant's case record.

(e) The agency must not use the time standards --

(1) As a waiting period before determining eligibility; or

(2) As a reason for denying eligibility (because it has not determined eligibility within the time standards).

The state policy and procedure manual which applies the federal laws provides:

Eligibility Decisions

1. Deadline for Determining Eligibility

A. An eligibility decision must be made within 45 days of the date of the application. There is one exception: a decision must be made within 90 days of the date of the application if a disability determination must be made as part of the eligibility determination.

If a decision cannot be made before the deadline, document the cause of the delay in the case record. Utah-DSS Vol. IIIM § 703-5 1.A.

Verification

What Must Be Verified?

All factors of eligibility must be verified.

There is only one exception to this rule. It is called "The Prudent Person Concept". This assumes that, as a prudent person, you can use your professional judgment to decide if something can be left unverified. If you decide to accept the client's word for something instead of verifying it, document it in the case record or application form. Utah-DSS Vol. IIIM § 731-1.

Who Must Provide Verification?

It is the responsibility of the applicant or recipient to obtain acceptable verification of eligibility factors. Help the client to get the verification if the client needs help. Utah-DSS Vol. IIIM § 731-2. See Addendum

The federal law and regulations do not mandate denial of a Medicaid application when the applicant does not complete verification within a forty-five day period. Instead, the law sets out a general requirement of forty-five days, with certain exceptions. One of the exceptions contained in the federal regulation is when the applicant delays in taking a required action. In this case, the providing of additional verification was a required action which was delayed by causes beyond Corbitt's control. She relied on her son, Whitney Corbitt, to accomplish her Medicaid eligibility. He testified that because of his inability to obtain documents from his lawyer, it was not possible to complete the application within the stated time period. (TH 31) This should have been considered by the hearing officer as an extenuating circumstance which, under the federal regulation, would permit the application file to be kept open beyond the forty-five day time limit. The Medicaid agency caseworker should not have closed Corbitt's file, but should have simply noted in the file the reason for the delay. Instead, the caseworker applied an improper state policy which directed denial at the end of 45 days.

A state Medicaid agency cannot adopt a policy which contradicts federal law. It is well established in the case law that a state regulation is invalid if found to be inconsistent with

the federal statute governing the program. Townsend v. Swank, 404 U.S. 282, 286, 92 S. Ct. 502, 30 L.Ed. 2d 448 (1971); King v. Smith, 392 U.S. 309, 333, 88 S. Ct. 2128, 20 L.Ed. 2d 1118 (1968). While a state's participation in Medicaid is voluntary, once it elects to participate in the program, it must fully comply with federal statutes and regulations. Smith v. Miller, 665 F.2d 172, 175 (7th Cir. 1981). A participating state does have some discretion in establishing time limits for filing claims, but such limits have been construed as directory in nature, from which exception should be granted to avoid an injustice when the facts so demand. Matter of King James Nursing Home, 351 A.2d 363, 367 (1976).

When the facts in the case are considered in light of the above-referenced law, it should be concluded that Corbitt was improperly denied Medicaid eligibility on her first application. The hearing officer did not consider the express language of the federal regulation which permits additional time for determining eligibility when delays are caused by the applicant. Since the federal law does not require a denial of an application under these circumstances, any explicit or implicit requirements in the state regulations requiring denial are inconsistent and invalid under the Supremacy Clause. The federal regulation clearly reflects congressional intent to permit exceptions to a harsh time limit when equity and justice so require. The facts of this case demonstrate a solid basis for such an exception. Corbitt was incapable of completing her own Medicaid application. She relied

on the assistance of her son who made a good faith effort to comply with the caseworker's requirements. Since the federal law does not strictly require compliance with a forty-five-day time limit, the hearing officer should have granted more latitude and considered the date of the first application as the effective date of eligibility.

POINT II

THE DECISION SHOULD BE REVERSED, SINCE THE DIRECTOR ERRED IN APPLYING THE LAW IN FINDING THAT CORBITT TRANSFERRED ASSETS IN ORDER TO QUALIFY FOR MEDICAID.

The Medicaid statute has for some time allowed states to impose a penalty on persons who transfer assets in order to qualify for Medicaid to cover nursing home expenses. Until recently, the sanctioning of persons who made such transfers was optional. 42 U.S.C. § 1396p(c)(1983). The statute provided that states could deny assistance when a transfer was made within 24 months of application, provided they specified a procedure implementing such denial which was no more restrictive than that set forth in 42 U.S.C. § 1382b(c)(1983). The referenced section was contained in that portion of the Social Security Act governing the Supplemental Security Income (SSI) program and contained a similar penalty for transfers during a 24-month period. Additionally, the statute created a presumption that such transfers were made to establish eligibility for assistance unless the applicant furnished "convincing evidence to establish that the transaction was exclusively for some other purpose." 42 U.S.C. § 1382b(c)(2)(1983)

On July 1, 1988, the statutes referenced above were amended. The Medicaid statute was amended to require states to sanction individuals who transferred property for less than fair market value during a 30-month period prior to applying for Medicaid. 42 U.S.C. § 1396p(c)(1)(1988) Deleted from the Medicaid statute was the previous cross-reference to the SSI statute in 42 U.S.C. § 1382b(c). Instead, the Medicaid statute was revised to provide that an individual need only make a "satisfactory showing" that the transfer was made for a purpose other than to qualify for Medicaid. Specifically, the statute now reads:

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1)_ to the extent that --

....

(C) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that (i) the individual intended to dispose of the resources either at fair market value, or for other valuable consideration, or (ii) the resources were transferred exclusively for a purpose other than to qualify for medical assistance. 42 U.S.C. § 1396p(c)(2)(C)(1988)

At the time of Corbitt's hearing, the hearing officer applied state regulations which were not in strict compliance with the federal statute. Included in the record as Exhibit 4 is Section 565-2 of Vol. IIIM regarding transfers of assets on or after July 1, 1988. (NR 57) The applicable portion of that regulation provided as follows:

Do not sanction the client if the client can prove the asset was not transferred in order to become eligible for Medicaid. It is the client's responsibility to provide evidence

that a transfer was made for another purpose
AND that Medicaid was not even a minor factor
in the decision. If a reliance upon Medicaid
can be inferred, sanction the client.
(emphasis added) Utah DSS-Vol. IIIM § 565-2
(7-89)¹

Despite the state's use of a regulation which was more restrictive than required by the Medicaid statute, the hearing officer correctly found that Corbitt had established sufficient evidence to overcome the presumption that she had transferred property to her son in order to qualify for Medicaid. Although the hearing officer did not use the "satisfactory showing" standard, it is clear from his decision that he felt the resources in question were transferred for a purpose other than to qualify for Medicaid. Reviewing the hearing officer's decision in light of the correct standard cited above, it should be concluded that his decision was based on substantial evidence as articulated in his decision. Because of its relevance, the hearing officer's summary is quoted in extenso:

¹The pertinent section has since been revised to remove the offensive final sentence. The most recent version of the IIIM manual reads:

Do not sanction the client if the client can prove the asset was not transferred in order to become eligible for Medicaid. It is the client's responsibility to provide evidence that a transfer was made for another purpose AND that Medicaid was not even a minor factor in the decision. Follow the guidelines in Sec. 565-3. Utah-DSS Vol. IIIM § 565-2.B (2-90)

The guidelines referred to in section 565-3 are contained in the Addendum.

The Petitioner in this case was fully aware of her desire to transfer her assets as an inheritance to her son and had taken steps to do so in 1986. Under advice of counsel, and with a divorce pending, it was prudent to delay the transfer of the remaining equity in the property to him until the divorce was concluded. The testimony of the Petitioner's son was that there was no expectation whatsoever that she would be requiring Medicaid when she had other insurance available and it was anticipated that this would be short term stay. It was the intervening small strokes that caused the petitioner to lose her mental faculties, creating a pressing need to obtain Medicaid benefits. This all took place subsequent to the quit claim deed being signed on February 23, 1989. The law provides for a presumption that the transfer of assets was done in contemplation of application for Medicaid benefits, but the testimony of the Petitioner's son rebuts the presumption and therefore prevails. The only evidence presented at the hearing on this issue showed that the Petitioner was anticipated to have a short stay at the nursing home which would preclude any expectation of a long term stay, especially of the type of serious nature that developed in this Petitioner's medical condition. (NR 28) See Addendum

When the hearing officer's decision reached the Director of DHCF, an incorrect standard was applied in reviewing the findings.

The Director states in his decision:

In this case, the Division of Health Care Financing finds that based upon the hearing record, a reliance upon Medicaid can be inferred....Reliance upon Medicaid can be inferred when an eighty-one-year-old woman such as petitioner enters a nursing home, gives her son the power-of-attorney and quit claims her dwelling to him on the same day....However, a reasonable inference can be drawn that reliance upon Medicaid was contemplated....(emphasis added) (NR 23-24)

The Director erred in not applying the proper standard for judging whether a transfer of assets was made to qualify for Medicaid. The statute clearly requires that an applicant need only make a "satisfactory showing"; it says nothing about drawing an inference from facts established at the hearing. The hearing officer had already found that the presumption of a disqualifying transfer had been overcome. To allow the Director in reviewing the decision to draw a different inference from the facts results in the presumption being reconstituted and, in effect, makes it irrebuttable. Such a result is not condoned in the law. See People in Interest of S.P.B., 651 P.2d 1213, 1217 (Colo. 1982).

Reliance on an inference in a case of this type was rejected in Harrison v. Comm'r, 529 A.2d 188 (Conn. 1987) wherein the Connecticut Supreme Court reviewed a transfer of assets under the old statute. The Connecticut Medicaid agency had included a "foreseeability test" in its manual and provided that if an applicant had failed to retain sufficient assets to meet foreseeable needs for 24 months after the transfer, "it must be inferred" that the transfer was not made exclusively for some other purpose than to qualify for Medicaid. The court began its analysis by noting the fundamental rule that an administrative agency must act within its statutory mandate and "has no authority to modify, abridge or otherwise change the statutory provisions under which it acquires authority." Id., at 192. The court reviewed the Connecticut regulations under the old "convincing evidence"

standard of 42 U.S.C. § 1382b(c) and concluded that the department policy was inconsistent with federal and state statutes.

An overly restrictive transfer of assets rule was also reviewed and rejected in Randall v. Lukhard, 709 F.2d 257 (4th Cir. 1983). The court held that a Virginia rule requiring documentary evidence in every case showing that a claimant has other resources available at the time of transfer to cover present and expected future medical expenses was excessive. The court found it highly improbable that disabled individuals would be able to objectively demonstrate availability of other assets to avoid disqualification. The court stated:

We think that they should not be rendered ineligible if by other credible evidence, short of documentary proof, they can establish that theirs was a lawful purpose. Id., at 267

In Downer v. State Dep't of Human Resources, 705 P.2d 144 (Nev. 1985), a ninety-year-old individual who transferred property to his daughter and son-in-law prior to applying for Medicaid was held to be not disqualified. The court concluded that the Medicaid applicant could not have anticipated an application for Medicaid, because he believed his death was imminent.

Recent amendments to respondent's regulations further suggest that the "inference" language is not permissible. As noted, the offending sentence has now been removed. See supra, at 17, n.1. Second, a set of guidelines has been added for determining whether a transfer was made in order to qualify for Medicaid. Utah-DSS Vol. IIIM § 565-3 (11-89). Although the guidelines may be questionable in light of Randall v. Lukhard, supra, they do contain

two criteria which lend support to petitioner's argument. The section provides in part:

Some Factors Indicating the Transfer Was Not to Become Eligible

Here is a list of some factors which may indicate the client did not transfer assets to become eligible and did not expect Medicaid to meet his needs after the transfer. This list is not all-inclusive.

- A. The client suddenly, unexpectedly, became disabled AFTER the transfer.
- B. The client learned that he has a disabling condition AFTER the transfer. Utah-DSS Vol. IIIM § 565-3 2. (11-89)

In this case, the evidence established, and the hearing officer found, that Corbitt's incapacitating condition arose after she was admitted to the nursing home on February 23, 1989. Based on respondent's own regulations, that finding is entitled to substantial weight. The hearing officer who reviewed Corbitt's case, and who had the best opportunity to judge her credibility, concluded that the transfer of property was not made for a disqualifying purpose. When his decision was reviewed by the Director, an improper standard utilizing an inference was applied. At the time of the review, the Medicaid statute did not contain any language allowing the Director of DHCF to draw an inference from facts established at a hearing. Instead, the Director was required to determine whether a satisfactory showing had been made that the transfer was for some purpose other than to qualify for Medicaid. The Director articulated no legitimate reasons for reversing the hearing officer's decision. His reversal represents an arbitrary

act in complete disregard of the Medicaid statute. Under the principles of law governing the relationship between the state and federal participants in the Medicaid program, it was improper for the Director to apply such a standard. A review of the law and the record shows that the hearing officer applied the correct legal standard and identified substantial evidence upon which to base his decision. Therefore, the Director's decision should be reversed and the hearing officer's holding reinstated, finding Corbitt eligible for Medicaid.

POINT III

**THE DIRECTOR'S DECISION SHOULD BE REVERSED
SINCE HE WAS SUBJECT TO DISQUALIFICATION
BECAUSE OF HIS FINANCIAL INTEREST IN
THE MEDICAID PROGRAM.**

The statute establishing the Medicaid program also provides that an opportunity for a fair hearing must be provided to individuals denied medical assistance. 42 U.S.C. § 1396a(3)(1983). The statute is implemented in the federal regulations at 42 C.F.R. § 431.200 et seq.. The regulation provides that the state's hearing system must provide for:

- (1) a hearing before the agency; or
- (2) an evidentiary hearing at the local level, with the right of appeal to a state agency hearing.
42 C.F.R. § 431.205(1985)

The regulation then provides that if a local evidentiary hearing decision is adverse to an applicant or recipient, the agency must inform the individual of a right of appeal to the state agency. 42 C.F.R. § 431.232 The regulations require that a state plan

provide the necessary means for meeting the hearing requirements listed.

The state of Utah provides hearing rights in its regulations for applicants and recipients. Utah Admin. Code § R455-14 et seq.. A hearing officer is to conduct a fair hearing, but is not empowered to issue a final agency decision. Instead, at the conclusion of the formal hearing, the hearing officer is to submit a recommended decision to the executive director of DOH who will then decide whether to accept or reject it. Judicial review is then to be allowed from the executive director's decision. See Addendum.

The result of the review system established by the state of Utah DOH is that every fair hearing decision is reviewed by the Director of the Medicaid program who is also responsible for conserving the limited resources of the Medicaid program. Utah provides by statute for creation of DHCF and for the appointment of a Director by the DOH executive director. Utah Code Ann. § 26-18-2.2. Among the responsibilities of the director of DHCF is to "prepare and administer the division's budget..." Id. The statute further provides that the division "is responsible for the effective and impartial administration of this chapter in an efficient, economical manner." Utah Code Ann. § 26-18-2.3. Finally, it provides:

The division shall establish, on a statewide basis, a program to safeguard against unnecessary or inappropriate use of Medicaid services, excessive payments, and unnecessary or inappropriate hospital admissions or lengths of stay. Id.

It is well established in the law that an adjudicator of an administrative claim is disqualified if he has a pecuniary interest in the outcome. Myer v. Niles Township, 477 F.Supp. 357, 362 (N.D. Ill. 1979). The adjudicator is disqualified even if the pecuniary interest is no more than an indirect outgrowth of a desire to protect official funds. Ward v. Village of Monroeville, 409 U.S. 57, 93 S. Ct. 80, 34 L.Ed. 2d 267(1972) (A mayor responsible for village finances and whose court generated village funds was disqualified from trying traffic offenses.) In Myer, the court held that a panel of township supervisors who had the sole discretion to determine an applicant's eligibility for medical indigent benefits and who also had an interest in protecting township funds could not provide a fair hearing before an unbiased decision-maker. Myer v. Niles Township, supra, at 362.

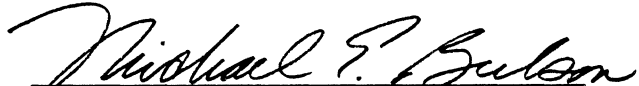
In this case, Director Betit has a direct, statutorily-mandated obligation to protect and conserve scarce Medicaid funds. Given Director Betit's pecuniary interest in protecting Medicaid funds, he could not act as an impartial agency officer in reviewing Corbitt's claim. Therefore, he should have been disqualified from reviewing the hearing officer's decision.

CONCLUSION

The Director erred in finding that Corbitt's first application was correctly denied. He further erred in reversing the hearing officer and finding a disqualifying transfer of assets. The

Director's decision should be reversed and Medicaid benefits granted from the date of the first application.

Respectfully submitted this 27th day of March, 1990.

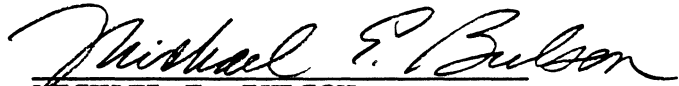

MICHAEL E. BULSON
Attorney for Petitioner

CERTIFICATE OF SERVICE

I hereby certify that on this 27th day of March, 1990, I served copies of the above BRIEF OF PETITIONER by First-class mail, postage prepaid, upon:

R. Paul Van Dam
Attorney General of Utah
State Capitol Building
Salt Lake City, Utah 84114

J. Stephen Mikita
Assistant Attorney General
120 N. 200 W.
Salt Lake City, Utah 84401


MICHAEL E. BULSON
Attorney at Law

A D D E N D U M

TRANSFER OF ASSETS - Transfers On or After July 1, 1988

565-2 • Transfers On or After July 1, 19881. When to Sanction Clients

Sanction clients who transfer assets for less than fair market value to become eligible for Medicaid. It does not matter if the client is a resident of a medical institution or approved for the Home and Community-Based Care Waiver at the time of the transfer.

2. When NOT to Sanction Clients

Do not sanction clients in these situations:

- A. Do not sanction the client if the asset was transferred more than 30 months prior to the date of the application.
- B. Do not sanction the client if the client can prove the asset was not transferred in order to become eligible for Medicaid. It is the client's responsibility to provide evidence that a transfer was made for another purpose AND that Medicaid was not even a minor factor in the decision. Follow the guidelines in Sec. 565-3.
- C. Do not sanction the client if the sanction would be an undue hardship. Follow the rules in Sec. 565-4.
- D. Do not sanction the client if the transfer fits one of the following situations. (The "5 OK Transfers")
 - (1) Transfer of a home to the spouse.
 - (2) Transfer of any asset to a spouse OR a blind or disabled son or daughter.
 - (3) Transfer of a home to a son or daughter under 21 years of age.
 - (4) Transfer of a home to a sibling who has an equity interest in the home and who has lived in the home for at least 1 year immediately preceding the client's entry into a medical institution.
 - (5) Transfer of a home to a son or a daughter who has lived in the home and cared for the client for at least 2 years prior to the individual's entry into the medical institution.

TRANSFER OF ASSETS - Transfers On or After July 1, 1988

3. Secondary Transfers After October 1, 1989

If assets have been transferred without sanction because the situation is one identified in Sec. 565-2 #2(D), sanction the client if the asset is transferred again AFTER October 1, 1989 for less than fair market value.

Sanction the individual making the first transfer. The sanction period for the individual must be based on the value of the asset that person transferred. If the person making the secondary transfer also transfers some of his own assets in addition to the assets received from the first transfer, that person may also be sanctioned.

The sanction period for either individual begins on the date of the secondary transfer.

THERE IS ONE EXCEPTION TO THIS RULE: Do not sanction anyone if the secondary transfer also fits one of the situations in Sec. 565-2.

EXAMPLE:

Mary and Bob Jones were both identified on the deed as owners of their home, which is worth \$36,000. Before entering a nursing home in June, Mary transferred her 1/2 interest in the home to her husband. Mary was not sanctioned for this transfer because Sec. 565-2 #2(D) says that a client may transfer any asset to a spouse without being sanctioned.

In October, Bob Jones signed a quit claim deed giving the house to his son for \$1.00. His son is over 21, not disabled, and had not been living in the house prior to the transfer. Bob is sanctioned for the transfer of his half of the house. Mary is sanctioned for the half of the house she gave to Bob and he transferred. The sanctions begin in August for both of them.

4. How to Sanction the Client

Clients who are sanctioned for transferring assets are not eligible for institutional care or Home and Community-Based Care. They may be eligible for regular Medicaid services. Apply the Medicaid policy in Volume IIID.

Report the client's name and PACMIS ID number to either PDU or Health Care Financing. You may do this on the phone, in writing, or by PACMIS Mailbox addressed to Jennifer P. Lee.

TRANSFER OF ASSETS - Transfers On or After July 1, 1988

5. Setting the Sanction Period

A. The period of ineligibility begins with the month in which the assets were last transferred. The client is ineligible for the LESSER of:

(1) 30 months, OR

(2) the number of months resulting from dividing the uncompensated value by the average private-pay rate for nursing homes. The uncompensated value is the difference between the equity value of the transferred asset and the amount of money received by the client for it. (Equity value is the fair market value minus any indebtedness against the asset.) See Table II for the average private-pay rate for nursing homes.

TRANSFER OF ASSETS - Transfer to Become Eligible

565-3 Transfer to Become Eligible

Do not sanction the client if the client can prove that Medicaid was not a reason for the transfer. The client must also prove that he did not expect Medicaid to meet his needs after transferring the asset.

1. Verification

It is the client's responsibility to provide all supporting documentation, such as legal documents, realtor agreements, relevant correspondence, and statements from other individuals. If the client needs help getting these, a worker may help.

If the client claims that Medicaid was not a factor in the decision to transfer the asset, ask the client to write a statement explaining:

- A. The reason for the transfer
- B. Attempts to transfer the asset for fair market value
- C. The reason for accepting less than fair market value
- D. The client's plans for providing for himself after the transfer
- E. The client's relationship to the new owner of the asset
- F. Why the client believes he received fair market value for the asset

TRANSFER OF ASSETS - Transfer to Become Eligible

2. Some Factors Indicating the Transfer Was Not to Become Eligible

Here is a list of some factors which may indicate the client did not transfer assets to become eligible and did not expect Medicaid to meet his needs after the transfer. This list is not all-inclusive.

- A. The client suddenly, unexpectedly, became disabled AFTER the transfer.
- B. The client learned that he had a disabling condition AFTER the transfer.
- C. The client unexpectedly lost other assets, worth more than the Medicaid asset limit, AFTER the transfer.
- D. The transfer was court-ordered.
- E. The assets were transferred to a religious order by a member of that order in accordance with a vow of poverty.

EXAMPLES:

Mr. Johnson applied for Medicaid in May. The previous June, he had sold assets worth \$8,000 for \$6,000. He explained that he sold the assets to pay \$4,000 in medical bills. He accepted less than fair market value because he needed the money quickly and could not wait for a better offer. When he transferred the money, his countable assets were too high for Medicaid because he also owned farmland in Nevada worth \$12,000. In January, he and his wife separated. She was given the farmland in the divorce decree. Now his assets are below the asset limit. Mr. Johnson's claim that he did not transfer the assets to become eligible should be accepted because he tried to sell the asset for fair market value AND he would have remained ineligible for Medicaid if he had not unexpectedly lost the farmland.

In February, Mrs. Mason transferred assets worth \$53,000 to her daughter in exchange for a life estate in the daughter's home. The life estate is worth \$40,000. She did it because she was elderly and no longer able to live alone. She did not want to move into her daughter's home without paying her for it in some way. DO NOT accept Mrs. Mason's claim that the transfer was not done to become eligible. Mrs. Mason knew that she was getting older and would probably need medical care in the future. The home could have been sold for fair market value and the difference between its value and the life estate value could have been used for her medical needs. Instead of reserving her assets to provide for her medical care, she impoverished herself. This is evidence of an expectation that Medicaid would take care of her medical needs.

APPLICATIONS - Eligibility Decisions

703-5 Eligibility Decisions1. Deadline for Determining Eligibility

- A. An eligibility decision must be made within 45 days of the date of the application. There is one exception: a decision must be made within 90 days of the date of the application if a disability determination must be made as part of the eligibility determination.

If a decision cannot be made before the deadline, document the cause of the delay in the case record.

- B. If unverified eligibility factors do not affect the eligibility of the entire household (For example, the client has not given proof of citizenship for one child.), the application may be approved for those members determined eligible.

The application cannot be approved if unverified eligibility factors affect the whole household. (For example, the wages of a working parent are unverified.)

2. Certification of Decision

Indicate the eligibility decision on the last page of Form 61A or Form 61FC. Record the eligibility decision on Form 727 Case Action Log.

- A. If the application is denied, note the date and the reason for the denial.
- B. If the application is approved, indicate the date and category of assistance.

3. Notification of Approval or Denial

If the application is approved or denied, notify the applicant in writing of the approval or denial, the reason for the action, the policy citation in this manual, and the Social Services office to contact for information on the income method used to determine the spenddown.

4. ALERTS and PENDS

Put an ALERT on a case when a change is expected to occur before the next review if that change will not affect eligibility.

Put a PEND on a case if a change is expected to occur before the next review if that change will affect eligibility. Also use PENDS to ensure that information or proofs are collected from the client.

VERIFICATION

731 Verification731-1 What Must Be Verified?

All factors of eligibility must be verified.

There is only one exception to this rule. It is called "The Prudent Person Concept". This assumes that, as a prudent person, you can use your professional judgement to decide if something can be left unverified. If you decide to accept the client's word for something instead of verifying it, document it in the case record or application form.

731-2 Who Must Provide Verification?

It is the responsibility of the applicant or recipient to obtain acceptable verification of eligibility factors. Help the client to get the verification if the client needs help.

731-3 What is Acceptable Verification?

Verification may be those items listed on the Verification Tables or other documents accepted by the district worker.

File copies of acceptable documents in the case record. When a narrative record is used to record verification of items for which there is no document, attach a sheet of paper in the case record. On the sheet of paper, explain how that item was verified. Sign and date the paper.

731-4 Primary Verification

The verification tables list examples of acceptable verification for each eligibility factor for the appropriate category and program.

Once an eligibility factor has been verified, no further verification is necessary unless it is an item subject to change and would be reverified at a regular time.

pliance had occurred. The written request from the provider must be submitted by him/her to:

Division of Health Care Financing
Bureau of Program Review
ATTN: PEER REVIEW
P.O. Box 16580
Salt Lake City, Utah 84116-0580

This written request will be submitted to the appropriate Professional Society requesting that their Peer Review Committee conduct a formal peer review of the Division of Health Care Financing determination.

The informal hearing requirements of Sec. 26-23-2(1) UCA, (1953) are satisfied by the professional peer review process.

If either the Division of Health Care Financing or the provider is dissatisfied with the results of the formal peer review they may request a formal hearing before the Department of Health pursuant to Sec. 23-32-2, UCA (1953) by complying with the formal hearing procedures set forth in the Division of Health Care Financing ADMINISTRATIVE HEARING PROCEDURES.

In situations of violations of compliance of professionally recognized medical standards, identified by peer review, the Division of Health Care Financing may pursue any legal sanction for recovery of overpayments.

Should Federal Financial Participation (the amount the federal government contributes to provider reimbursement) be disallowed on reimbursements made to the provider, the provider will reimburse to the State the total amount that the State paid for the services disallowed (including Federal audit, quality assurance review, or prior authorization requirements) only if the provider was at fault.

R455-14. Division of Health Care Financing Administrative Hearing Procedures for Medicaid/UMAP Applicants, Recipients and Providers

R455-14-0. Policy Statement

R455-14-1. Administrative Hearing Procedures Provide

R455-14-2. Discovery

R455-14-3. Declaratory Orders

R455-14-0. Policy Statement

It is the policy of the Division of Health Care Financing to resolve disputes at the lowest level. The following rules are not meant to foreclose the Division's preference for informal resolutions through open discussion and negotiation between the Division, and applicants, recipients and providers.

R455-14-1. Administrative Hearing Procedures Provide

1. HEARING RESPONSIBILITY

a. In accordance with Section 1902(a)(3) of the Social Security Act, 42 Code of Federal Regulations (CFR) Part 431, Subpart E, Sections 26-1-4.1 and 26-23-2 U.C.A. (1953), and 63-46b-1, et seq. U.C.A. (1987), all Title XIX (Medicaid)/Utah Medical Assistance Program (UMAP) recipients or providers (and applicants under certain circumstances) aggrieved by any action or inaction of the Department of Health (DOH), Division of Health Care Financing (DHCF), will be given an opportunity for a hearing upon written request.

b. A hearing is not required and will not be

granted to an applicant, recipient or provider if the sole issue(s) is a Federal or State law or policy requiring an automatic change in covered services adversely affecting some or all (applicants) recipients or providers (42 CFR 431.220).

c. A hearing also is not required and will not be granted to a provider for Medicaid certification surveys, plans of correction pursuant to those surveys or inspections of care, when such state agency action is required by federal statute or regulation to be conducted according to federal procedures (Section 63-46b-1(2)(l) U.C.A. (1988), 42 CFR 431, Subpart D).

(1) Any Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF) or Intermediate Care Facility/Mentally Retarded (ICF/MR) whose certification or provider agreement is denied, terminated or not renewed will be governed by the evidentiary hearing procedures set forth in 42 CFR 431.153, including appropriate cross-references to 42 CFR Part 498, with the offering of an informal reconsideration in accordance with 42 CFR 431.154 prior to the conducting of a full evidentiary hearing. All of the federal regulatory citations in this subsection are incorporated herein as if set forth in full.

(2) Any SNF, ICF or ICF/MR whose payment for new admissions is denied will be governed by the informal hearing procedures set forth in 42 CFR 442.118 and 442.119, including appropriate cross-reference to 42 CFR 489.62 as specifically concerns SNFs. All of the federal regulatory citations in this subsection are incorporated herein as if set forth in full.

2. Applicability

EXCEPT AS SPECIFIED HEREIN, THESE PROVISIONS ONLY APPLY TO TITLE XIX MEDICAID/UMAP RECIPIENTS OR PROVIDERS. These rules do not apply to initial applications for medical assistance. A Medicaid/UMAP applicant who has been denied eligibility for medical assistance through the local Office of Community Operations (OCO), Assistance Payments Administration (APA), Department of Social Services (DSS), must submit a written request for an eligibility determination hearing to: The Department of Social Services, Office of Administrative Hearings, P.O. Box 45500, Salt Lake City, Utah 84145-0500 or the applicant may deliver the written request in person to the local OCO.

3. Eligibility Hearing for both Non-Medical Assistance AND Medical Assistance

If eligibility for a non-medical assistance program(s) in addition to Medicaid/UMAP is at issue, the Medicaid/UMAP eligibility determination hearing shall be conducted by the Department of Social Services through the Office of Administrative Hearings. Requests for such hearings shall be sent to the address in Section 2, above. All such hearings shall be conducted according to DSS hearing rules. DSS shall propose a recommended decision concerning the medical assistance issue(s) only and shall submit it to the Executive Director of DOH or his/her designated representative for agency review. Thereafter the recommended decision shall be handled in accordance with Sections 63-46b-12 and 63-46b-15, U.C.A. (1987).

4. Eligibility Hearing For Medical Assistance Only

All requests for hearings to consider eligibility as to medical assistance only, shall be forwarded by DSS to DHCF. A formal hearing in accordance with the hearing procedures herein shall be conducted by DHCF.

5. Definitions

The definitions of the Utah Administrative Procedure Act (UAPA), Section 63-46b-1, et seq., U. C. A. (1987) as set forth in Section 63-46b-2 are hereby incorporated by reference. In addition:

a. "Action" means a denial of Medicaid/UMAP eligibility as regards an applicant; denial, termination, suspension, or reduction of Medicaid/UMAP covered services in the case of recipients; or, a reduction or denial of reimbursement for such services, findings of licensing survey deficiencies requiring a Plan of Correction, failure of DHCF to accept a Plan of Correction required by licensing, or other sanctions as set forth in "DHCF ADMINISTRATIVE SANCTIONS PROCEDURES AND GUIDELINES", R455-22, in the case of providers.

b. "Aggrieved Person" means any applicant, recipient or provider aggrieved by any action or inaction of DHCF.

c. "Date of Action" means the date on which a denial of eligibility for, termination, suspension or reduction of Medicaid/UMAP covered services becomes effective, in the case of applicants or recipients; or, in the case of providers the date on which:

- (1) A reduction or denial or reimbursement or sanction becomes effective;
- (2) Notice is given of licensing survey deficiencies; or
- (3) Notice is given that DHCF will not accept a plan of correction of survey deficiencies required by licensing.

d. "Division Director" means the Director of the Division of Health Care Financing of the Utah Department of Health or his/her designated and authorized representative.

e. "Executive Director" means the Executive Director of the Utah Department of Health or his/her designated and authorized representative.

f. "Formal Hearing" means a hearing before a hearing officer, conducted in accordance with UAPA.

g. "Notice" means a written statement of the action DHCF intends to take, the reasons for the intended action, the specific regulations that support (or the change in Federal or State law that requires) the action, the right to a hearing when applicable, the procedure to obtain a hearing, and an explanation of the circumstances under which Medicaid/UMAP benefits or reimbursement will be continued if a hearing is requested.

h. "Request for a Formal Hearing" means a clear expression in writing which meets the criteria of a "Request for Agency Action" as set forth by Section 63-46b-3(2)(c), U. C. A. (1987) by an aggrieved person or authorized representative.

6. Notice

a. When Notice Required

Every individual who is affected by an adverse action taken by DHCF will be given timely notice.

b. Content of Notice

A notice under this Section must contain:

- (1) A statement of the action DHCF intends to take;
- (2) The date the intended action takes effect;
- (3) The reasons for the intended action;
- (4) The specific regulations that support, or the change in Federal or State law or policy, that requires the action;
- (5) The aggrieved person's right to request a formal hearing before DHCF, when applicable, and the method by which such hearing may be obtained from DHCF;

(6) A statement that the aggrieved person may represent himself or use legal counsel, relative, friend or other spokesman at the formal hearing; and,

(7) An explanation of the circumstances under which Medicaid/UMAP coverage or reimbursement will be continued if a formal hearing is timely requested.

c. Advance Notice

DHCF will mail a notice at least ten (10) calendar days before the date of the intended action EXCEPT as noted below:

(1) DHCF may mail a notice not later than the date of action if:

- (a) DHCF has factual information confirming the death of a recipient/provider;
- (b) DHCF receives a clear written statement signed by a recipient/provider that:

1) He/she no longer wishes services or reimbursement, or

2) Gives information that requires termination or reduction of services or reimbursement and indicates that he/she understands that this must be the result of supplying that information;

(c) The recipient has been admitted to an institution where he/she is ineligible under the State Plan for further services;

(d) The recipient/provider's whereabouts are unknown and the Post Office returns DHCF mail directed to him/her indicating no forwarding address;

(e) DHCF establishes the fact that the recipient has been accepted for Medicaid/UMAP services by another local jurisdiction, State, Territory or Commonwealth;

(f) A change in the level of medical care is prescribed by the recipient's physician; or

(g) A termination, suspension or reduction of Medicaid/UMAP covered services or reimbursement is necessitated by an imminent peril to the public health, safety, or welfare.

(2) DHCF may shorten the period of advance mailed notice to five (5) days before the date of action if:

(a) DHCF has facts indicating that action should be taken because of probable fraud by the applicant/recipient/provider; and

(b) The facts have been verified, by affidavit, if possible.

7. Request for Formal Hearing and Agency Response

Formal hearings are held for "medical assistance only" issues. If an aggrieved person's request for an eligibility hearing concerns both non-medical assistance and medical assistance, he should refer to R455-14-1.A.3, above.

An aggrieved person may request a formal hearing within the following deadlines, depending upon the type of request:

a. An aggrieved UMAP or Medicaid provider may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later, by DHCF of an action or inaction.

b. An aggrieved Medicaid applicant or recipient may request a formal hearing regarding eligibility for "medical assistance only" within 90 calendar days from the date written notice is issued or mailed, whichever is later, by DHCF of an action or intended action.

c. An aggrieved UMAP applicant or recipient may request a formal hearing regarding eligibility within 90 calendar days from the date written notice is

issued or mailed, whichever is later, by DHCF of an action or intended action.

d. An aggrieved UMAP applicant or recipient may request a formal hearing regarding scope of service within 30 calendar days from the date written notice is issued or mailed, whichever is later, by DHCF of an action or intended action.

e. Failure to submit a timely request for a formal hearing will constitute a waiver of a person's formal hearing or pre-hearing rights. A request for a hearing shall be in writing, shall be dated, and shall explain the reasons for which the hearing is requested. An aggrieved person may use the hearing request form which is attached to all negative eligibility action notices, or the form which is provided in Attachment "A," which is entitled "Requests for Hearing/Agency Action." DHCF will provide copies of the form in Attachment A to all interested persons. The address for submitting a "Request for Hearing/Agency Action" for: (a) Medicaid or UMAP providers; and (b) Medicaid or UMAP scope of service hearings is as follows:

Division of Health Care Financing

Attention: Formal Hearings

P.O. Box 16580

Salt Lake City, Utah 84116-0580

The address for submitting a "Request for Hearing/Agency Action for Medicaid and UMAP applicants regarding eligibility issues is:

The Department of Social Services

Office of Administrative Hearings

P.O. Box 45500

Salt Lake City, Utah 84145-0500

f. Requests for formal hearing will be docketed and scheduled within 30 calendar days. DHCF as respondent shall schedule a hearing or begin negotiations in the matter in writing within 30 days of the date of issuance of the request for formal hearing or agency action.

8. Denial or Dismissal of Request for a Hearing

DOH or DHCF may deny or dismiss a request for a formal hearing if:

a. The aggrieved person withdraws the request in writing;

b. The aggrieved person fails to appear at a scheduled hearing without good cause; or

c. The provider fails to allow DHCF access to its records pursuant to R455-14-2 below.

9. Reinstatement/Continuation of Services

a. DHCF may reinstate services for recipients or suspend any adverse action for providers as defined in Section 5.a if an aggrieved person requests an formal hearing not more than ten (10) calendar days after the date of action.

b. DHCF must reinstate or continue services for recipients or suspend adverse actions for providers until a decision is rendered after a formal hearing if:

(1) Adverse action is taken without giving the ten (10) day advanced mailed notice to a recipient/provider in all circumstances where such advance notice is required;

(2) In those circumstances where advance notice is not required, as set forth in section 6.c.(1); the aggrieved person requests a formal hearing within ten (10) calendar days following the date the adverse action notice is mailed;

(3) DHCF determines that the action resulted from other than the application of Federal or State law or policy.

c. DHCF may proceed with its intended action if:

(1) The aggrieved person withdraws his request for either a formal hearing in writing; or,

(2) The aggrieved person prolongs the hearing process without good cause; or,

(3) A recipient's whereabouts are unknown, as indicated by the return of agency mail directed to him/her which is not forwardable.

10. Formal Hearing

a. How to Request a Formal Hearing

A request for a formal hearing must be made to the Division of Health Care Financing, 288 North 1460 West, P. O. Box 16580, Salt Lake City, Utah 84116-0580, Attention: "Formal Hearings."

b. Notice of Formal Hearing

DHCF shall notify the aggrieved person and/or his/her attorney, in writing, of the date, time and place of the hearing. Notice shall be mailed not less than ten (10) calendar days before the scheduled date of the formal hearing.

c. Form of Papers

All papers to be filed in a formal hearing shall:

(1) Be typewritten or legibly hand-written;

(2) Bear a caption clearly showing the title of the hearing;

(3) Bear the docket number, if any;

(4) Be dated and signed by the party or his/her authorized representative and shall contain his/her address and telephone number; and

(5) Consist of an original and two (2) copies filed with DHCF.

Hearings may be delayed until these requirements are met.

d. Service

(1) The party filing papers and documents shall serve them upon all parties to the formal hearing. Proof of service shall be filed with DHCF.

(2) Service shall be personally delivered or by mail, properly addressed with postage prepaid, one (1) copy to each party entitled thereto. When a party is represented by an attorney, service upon the attorney shall be deemed service upon the party or parties.

(3) Proof of service shall be by certificate, affidavit or acknowledgment.

(4) Wherever notice by DHCF is required, notification shall be effective upon the date of first class mailing to a party's residence or business address.

(5) In addition to the methods set forth in these rules, a party may be served in any manner permitted by law.

e. Intervention

As permitted by Utah Code Ann. 63-46b-10, intervention will be permitted provided the following requirements are met:

(1) Persons desiring to intervene in a formal hearing must petition for leave to intervene at least seven (7) days before the scheduled hearing, unless otherwise permitted by the hearing officer.

(2) The petition must contain a clear and concise statement of the direct and substantial interest of the person seeking leave to intervene in the hearing.

(3) Persons seeking affirmative relief shall state the basis of such relief.

(4) Other parties to the hearing must have an opportunity to support or oppose intervention.

(5) The hearing officer may grant leave to intervene subject to such reasonable conditions as he may prescribe. An intervenor may be dismissed from the hearing if it appears that he has no direct or substantial interest in the hearing.

f. Conduct of Hearing

(1) Formal hearings shall be conducted by an impartial hearing officer who is appointed by DOH. The hearing officer shall be empowered with such authority as granted by Section 63-46b-1; et seq.

U. C. A. (1987), except as may be limited by these rules. No hearing officer shall have been directly involved in the initial determination of the action in question.

(2) All formal hearings shall be conducted only after adequate written notice of the hearing has been served on all parties setting forth the time, date and place of the hearing.

(3) Testimony shall be taken under oath, or affirmation administered by the hearing officer.

(4) Each party shall have the right to:

(a) call and examine parties and witnesses;

(b) introduce exhibits;

(c) question opposing witnesses and parties on any matter relevant to the issue even though the matter was not covered in the direct examination;

(d) impeach any witness regardless of which party first called him/her to testify; and

(e) rebut the evidence against him/her.

(5) The rules of evidence as applied in civil actions in the courts of this State shall be generally followed in the hearings. Any relevant evidence may be admitted if it is the type of evidence commonly relied upon by prudent men in the conduct of their affairs.

Hearsay evidence may be used for the purpose of supplementing or explaining other evidence, but shall not be sufficient by itself to support a finding unless it would be admissible over objection in civil actions. The hearing officer shall give effect to the rules of privilege recognized by law. Irrelevant, immaterial and unduly repetitious evidence shall be excluded.

(6) The hearing officer may order the taking of interrogatories and depositions and assess the expense to the requesting party if the hearing officer deems it proper.

(7) The hearing officer may question any party or witness and may admit any evidence he believes is relevant or material.

(8) The hearing officer shall control the taking of evidence in a manner best determined to be best suited to ascertain the facts and safeguard the rights of the parties. The hearing officer shall explain the issues and the order in which evidence will be received.

(9) A party has the burden of proving, by a preponderance of the evidence whatever facts it must establish to sustain its position. A provider always has the burden of proof to show that services were, in fact, rendered as billed.

(10) The burden of proof as to a particular fact is on the party against whom a finding on that fact would be required in the absence of further evidence.

g. Ex Parte Communications

(1) Except as otherwise provided below, ex parte communications are prohibited.

(2) The hearing officer shall decline to listen to or accept any communication offered in violation of this rule and shall explain to the offeror that any communication received off the record and in violation of this rule must be made a part of the record and furnished to all parties.

(3) This rule shall NOT apply to:

(a) The disposition of ex parte matters authorized by law; or

(b) Communications concerning status of the hearing and uncontested procedural matters.

h. Continuances or Further Hearings

(1) The hearing officer may continue a formal hearing to another time or place, or order a further hearing on his/her own motion or upon the showing of good cause, at the request of any party.

(2) Where the hearing officer determines that

additional evidence is necessary for the proper determination of the case, he/she may at his/her discretion:

(a) Continue the hearing to a later date and order the party to produce additional evidence; or

(b) Close the hearing and hold the record open in order to permit the introduction of additional documentary evidence. Any evidence so submitted shall be made available to both parties and each party shall have the opportunity for rebuttal.

(3) Written notice of the time and place of a continued or further hearing shall be given in accordance with Section 10.b, except that when a continuance is ordered during a hearing and adequate oral notice is given.

i. Record

A complete record of all formal hearings shall be made. The testimony shall be electronically recorded and/or memorialized by court reporter. The recording and/or memorialization shall be transcribed if requested by a party to the hearing. The requesting party shall pay the costs of transcription and for copying costs. At the conclusion of the formal hearing, the complete record of the hearing will be maintained in a secured area and shall be considered the sole property of DHCF. DHCF or its designated agent will retain electronic recordings/memorialization of formal hearings for a period of one (1) year. Written records and documents will be retained for a period not to exceed three (3) years.

j. Proposed Decision and Final Agency Review

(1) At the conclusion of the formal hearing, the hearing officer shall take the matter under advisement and shall submit to the Executive Director of DOH a proposed decision, based on the evidence and testimony introduced at the hearing.

(2) The proposed decision shall be in writing and shall contain findings of fact and conclusions of law.

(3) The Executive Director of DOH may:

(a) adopt the proposed decision, or any portion of the decision.

(b) reject the proposed decision, or any portion thereof, and make his own independent determination based upon the record.

(c) remand the matter to the hearing officer to take additional evidence; and the hearing officer thereafter shall submit to the Executive Director of DOH a new proposed decision.

(4) Review by the Executive Director constitutes agency review and final administration action, and is subject to judicial review in accordance with the procedures set forth in Subsection 10.1.

(5) The aggrieved person or his/her representative shall be notified of the final administrative action and the aggrieved person's right to judicial review of the action.

(6) When the final administrative action is favorable to the aggrieved person, DHCF shall promptly take corrective action.

(7) Subject to provisions for safeguarding confidential information, all hearing decisions shall be kept on file for public inspection.

k. Agency Review

Reconsideration. Section 63-46b-13 Utah Code Ann. 1953, as amended, is hereby incorporated by reference.

l. Judicial Review

(1) Judicial review of a final agency action may be secured by the aggrieved party by filing a petition in the Utah Court of Appeals within thirty (30) days after issuance of the Executive Director's final administrative action. The petition shall be served

upon the Executive Director and shall state the grounds upon which review is sought. The Executive Director shall file with his/her Answer certified documents, papers, transcripts of all testimony taken in the matter, recommended findings of fact and conclusions of law of the hearing officer and the final administrative action of the Executive Director.

(2) Judicial review of final administrative action is governed by Section 63-46b-16 and Section 63-46b-1, et seq. U. C. A. (1987), and Section 78-2a-3, U. C. A. (1953).

R455-14-2. Discovery

A. DISCOVERY PROVISIONS

The Utah Rules of Civil Procedure are inapplicable to these proceedings and no formal discovery except as set forth hereinafter shall be permitted. Unless otherwise limited by order of the hearing officer, the scope of discovery in formal adjudicative proceedings shall be as follows:

1. Review of Applicant/Recipient and Provider Records

a. DHCF shall be permitted to review all records which are pertinent to the hearing which are in the custody or control of the applicant or recipient and their health care providers. DHCF shall give at least three (3) days' written notice the custodian of such document(s).

b. DHCF shall be allowed to inspect a provider's records which are pertinent to the hearing. Inspection shall be made at the provider's business office during regular working hours and after at least three (3) days written notice.

2. Review of DHCF Records and Files

a. Before the Formal Hearing

Upon prior written request, the aggrieved person or his/her representative will be permitted to examine all documents and records to be used by the State at the formal hearing, not later than three (3) days before the formal hearing. The aggrieved party may request the Medicaid Management Information System (MMIS) claim file. This will be available for review fifteen (15) calendar days after DHCF receives a written request for the information.

b. At the Formal Hearing

The aggrieved person or his/her representative will be given an opportunity to:

(1) Examine the aggrieved person's case file and all documents and records to be used by DHCF at the hearing;

(2) Bring witnesses to the hearing; and

(3) Establish all pertinent facts and circumstances.

3. Pre-hearing Procedure

a. The hearing officer may elect to hold a pre-hearing meeting for any of the following reasons:

(1) to formulate or simplify the issues;

(2) to obtain admissions of fact and documents which will avoid unnecessary proof;

(3) to arrange for the exchange of proposed exhibits or prepared expert testimony;

(4) to outline procedures to be followed at the formal hearing; or

(5) to agree to such other matters as may expedite the orderly conduct of the hearing or the settlement thereof.

Agreements reached during the conference shall be recorded or the parties may enter into a written stipulation or agree to a statement made on the record by the hearing officer.

4. Interrogatories, Depositions, and Requests for Admissions

a. The hearing officer may order the taking of

interrogatories and depositions, and set appropriate time-frames, assess sanctions for non-compliance, and assess the expense to the requesting party if the hearing officer deems it proper.

b. The hearing officer may permit the filing of Requests for Admission, set appropriate time-frames for responses, and assess sanctions for non-compliance.

5. Medical Examination

a. The hearing officer may order at DHCF expense a medical assessment in order to obtain information necessary for a fair decision. This information subject to confidentiality requirements shall be made a part of the formal hearing record.

6. Witnesses and Subpoenas

a. A party shall arrange for the presence of his witnesses at the hearing.

b. A subpoena to compel the attendance of a witness or the production of evidence may be issued by the hearing officer, upon written request by a party and a sufficient showing of need.

c. A subpoena may also be issued by the hearing officer on his own motion.

d. An application for subpoena duces tecum for the production by a witness of books, papers, correspondence, memoranda, or other records shall be made by affidavit to the hearing officer. The application must include:

(1) The name and address of the person or entity upon whom the subpoena is to be served;

(2) A description of the documents, papers, books, accounts, letters, photographs, objects, or tangible things not privileged, that which the applicant seeks;

(3) A showing of the materiality to the issue involved in the hearing; and

(4) A statement by the applicant that to the best of his knowledge the witness has such items in his possession or under his control.

e. The applicant shall arrange to have all subpoenas served which the hearing officer issues to him. A copy of the affidavit presented to the hearing officer shall be served with the subpoena.

f. Except for employees of DOH, witnesses subpoenaed for any hearing are entitled to appropriate fees and mileage. The witness shall file a written demand for the fees with the hearing officer not later than ten (10) days after the date the witness appeared at the hearing.

7. Sanction by Hearing Officer

a. The hearing officer may sanction or penalize any party that fails to obey an order entered by the hearing officer.

R455-14-3. Declaratory Orders

As required by Section 63-46b-21, U. C. A. (1987), this rule provides for procedures for requesting of DOH through DHCF for the issuance of a declaratory order determining the applicability of a statute, rule, or order to specified circumstances.

A. DEFINITIONS For purposes of these provisions:

1. "Agency" means the Division of Health Care Financing, Utah Department of Health.

2. "Applicability" means a determination of whether a statute, rule, or order should be applied, and if so, how the law as stated should be applied to specific facts and circumstances.

3. "Declaratory Ruling" means an administrative interpretation or explanation of rights, status, and or other legal relations under a specific statute, rule, or order.

4. "Order" means an agency action of particular