NOT DESIGNATED FOR PUBLICATION

STATE OF LOUISIANA

COURT OF APPEAL

FIRST CIRCUIT

NO. 2014 CA 0791

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WIDLEY DAVID

VERSUS

STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

Judgment Rendered: DEC 23 2014

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On Appeal from the
18th Judicial District Court
In and for the Parish of Pointe Coupee
State of Louisiana
No. 44,267, Div. C

The Honorable Alvin J. Batiste, Jr., Judge Presiding

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BEFORE: GUIDRY, THERIOT, AND DRAKE, JJ.

DRAKE, J.

Defendant, the Louisiana Department of Health and Hospitals ("DHH"), appeals the district court's reversal of DHH's administrative denial of Medicaid benefits to the plaintiff-appellee, Widley David. Mr. David also filed an answer to the appeal. For the reasons that follow, we reverse.

FACTS AND PROCEDURAL HISTORY

In January 2008, Mr. David entered Pointe Coupee Healthcare, a nursing facility in New Roads, Louisiana, where he remained until his death on May 17, 2012, at the age of ninety-seven.[1] Mr. David was never married and had no children. For many years, he lived with a brother who was also unmarried and childless. He lived alone after that brother died in 2003, and his closest relatives were his nephew, Ivy David, and Ivy's wife, Mary. Mr. David cared for himself, with some help from Ivy and Mary, and paid for his own healthcare until his cash resources were depleted. In November 2007, Mr. David fell and broke his hip, which led to his hospitalization, and eventually, his residence in Pointe Coupee Healthcare.

From the time Mr. David was placed in the nursing home, Ivy and Mary were his only source of assistance outside of the nursing home staff. Ivy and Mary visited him daily and brought him food and clothing. The Davids also paid for various bills on Mr. David's behalf and frequently drove him to doctor's visits in Baton Rouge. To be able to provide assistance to his uncle, Ivy quit his job, at which he earned approximately $10,000.00 per year. In the summer of 2008, Mr. David advised his attorney that he wanted to give Ivy and Mary cash payments to compensate them for their services. Mr. David issued six checks to Ivy and Mary,

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[1] The Succession of Widley David was substituted as the proper party plaintiff following Mr. David's death.

totaling $49,195.00, over a three year period, which Ivy and Mary aver were remunerative donations to recompense them for services rendered to Mr. David.[2]

On December 20, 2010, Ivy made an application for Long Term Care vendor payment benefits ("LTC benefits") under the Louisiana Medicaid Program on behalf of Mr. David. DHH instituted a routine investigation of Mr. David's eligibility status. After gathering information, DHH determined that the six cash payments Mr. David made to Ivy and Mary amounted to a transfer of resources by Mr. David for less than fair market value within a sixty month (five year) look-back period. Consequently, DHH presumed that the transfer was done with the intent to qualify for Medicaid benefits. Based upon that determination, DHH rejected Mr. David's application for LTC Medicaid benefits on April 6, 2011.[3] As a penalty, Mr. David was rendered ineligible for LTC benefits for a period of fourteen months and twenty-four days, November 1, 2010, through January 24, 2012. No appeal was taken from the April 6, 2011 ineligibility decision.

On July 12, 2011, Mr. David, through a Pointe Coupee Healthcare facility representative, requested a status change from "private pay" to "Medicaid only." A second letter was provided by DHH to Mr. David on July 18, 2011, which stated that he was ineligible for LTC benefits for the time period of July 1, 2011, through January 24, 2012, due to the six cash transfers totaling $49,195.00.[4] According to Section I-1670 of the Louisiana Medicaid Eligibility Manual ("MEM"), a copy of which was attached to DHH's July 18, 2011 letter, once the penalty period has begun to run, it continues until expiration.

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[2] We note that the checks were not part of the administrative record. The total amount transferred by the six checks Mr. David issued to Ivy and Mary was $49,195.00. One of the checks, in the amount of $10,000.00, was a check made payable to Security Plan Life Insurance Company, the premium of which was returned. Apparently, Ivy David was listed as the owner of this policy. That payment is not at issue in this appeal.

[3] We note that Mr. David was approved as a Qualified Medicare Beneficiary.

[4] We note that after the expiration of Mr. David's ineligibility period of fourteen months and twenty-four days, DHH certified Mr. David for LTC benefits beginning January 25, 2012. Mr. David received LTC benefits until his death on May 17, 2012.

Mr. David appealed the July 18, 2011 ineligibility decision with DHH's Bureau of Appeals, arguing that none of the cash payments were made for the purpose of qualifying for LTC benefits but instead were remunerative donations.[5] An administrative hearing was held on September 14, 2011, before an Administrative Law Judge ("ALJ"), who affirmed DHH's denial of Mr. David's eligibility for LTC vendor benefits, relying on DHH's previous denial of eligibility.

Mr. David filed a petition for judicial review in the district court pursuant to the provisions of the Louisiana Administrative Procedure Act, La. R.S. 49:950, *et seq*. Following a hearing, the district court signed a judgment in favor of Mr. David, reversing the decision of the ALJ and ordering DHH to reimburse Mr. David $49,195.00. In reversing the decision of the ALJ, the district court found that Mr. David had successfully rebutted the presumption that the transfer of cash resources was made to reduce assets in order to qualify for LTC benefits and that DHH had failed to refute and contradict the testimony and evidence offered by Mr. David. Mr. David now appeals from the district court's judgment.

SPECIFICATIONS OF ERROR

DHH argues that the district court erred in reversing the ALJ's ruling upholding DHH's ineligibility determination. DHH maintains that Mr. David was ineligible for LTC benefits because DHH presumes that the six cash transfers Mr. David made during the five-year period preceding his application for Medicaid benefits were done in order for him to be eligible to receive Medicaid. DHH contends that Mr. David had the opportunity to rebut the presumption that these cash transfers were made for purposes other than qualifying for Medicaid benefits, but that he failed to present satisfactory proof. DHH argues that the Medicaid

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[5] Louisiana Civil Code article 1527 states that "the rules peculiar to donation inter vivos do not apply to a donation that is made to recompense for services rendered that are susceptible of being measured in money unless at the time of the donation the value of the services is less than two-thirds of the value of the thing donated."

Eligibility policy does allow an individual to enter into a Personal Care Agreement with his caregivers to pay for the caregiving services out of his resources, but certain formalities must be satisfied for a Personal Care Agreement to be valid. Here, DHH avers the record is devoid of any substantiating documentary proof of the performance of the alleged services rendered by Ivy and Mary David.

Mr. David counters that he rebutted the presumption that the six cash transfers were made for purposes other than qualifying for LTC benefits by offering proof that the cash transfers were remunerative donations designed to compensate Ivy and Mary David for the personal services and care they were providing him. Ivy and Mary David testified as to the nature and the value of their services. At the administrative hearing on September 14, 2011, Mr. David contended that DHH offered no evidence to support its position that the cash transfers amounted to prohibited transfers for less than fair market value, and that DHH simply put forth an ineligibility calculator and argued that it was allowed to base its decision on the prior determination of ineligibility made in Mr. David's first application.

We also note that Mr. David answered the appeal of DHH. Mr. David argues that the October 16, 2013 judgment of the district court, which reversed the decision of the ALJ, was silent as to legal interest and court costs. Mr. David requests that we modify the judgment to award him the entire amount of the claim, $49,195.00, together with court costs and interest from the date of judicial demand until paid. See La. C.C.P. art. 2133.

STANDARD OF REVIEW

The Louisiana Administrative Procedure Act, at La. R.S. 49:964(G), governs the judicial review of a final decision in an agency adjudication, providing that:

> G. The court may affirm the decision of the agency or remand the case for further proceedings. The court may reverse or modify the decision

> if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:
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> (1) In violation of constitutional or statutory provisions;
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> (2) In excess of the statutory authority of the agency;
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> (3) Made upon unlawful procedure;
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> (4) Affected by other error of law;
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> (5) Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion; or
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> (6) Not supported and sustainable by a preponderance of the evidence as determined by the reviewing court. In the application of this rule, the court shall make its own determination and conclusions of fact by a preponderance of evidence based upon its own evaluation of the record reviewed in its entirety upon judicial review. In the application of the rule, where the agency has the opportunity to judge the credibility of witnesses by first-hand observation of demeanor on the witness stand and the reviewing court does not, due regard shall be given to the agency's determination of credibility issues.

Any one of the six bases listed in the statute is sufficient to modify or reverse an agency determination. *Doc's Clinic, APMC v. State ex rel. Dept. of Health and Hospitals,* 07-0480 (La. App. 1 Cir. 11/2/07), 984 So. 2d 711, 718, *writ denied,* 07-2302 (La. 2/15/08), 974 So. 2d 665. The APA further specifies that judicial review shall be conducted by the court without a jury and shall be confined to the record. La. R.S. 49:964(F).

When reviewing an administrative final decision, the district court functions as an appellate court. *Doc's Clinic,* 984 So. 2d at 718. Once a final judgment is rendered by the district court, an aggrieved party may seek review by appeal to the appropriate appellate court. La. R.S. 49:965. On review of the district court's judgment, no deference is owed by the court of appeal to the factual findings or legal conclusions of the district court, just as no deference is owed by the Louisiana Supreme Court to factual findings or legal conclusions of the court of appeal. *Carpenter v. State, Dept. of Health and Hospitals,* 05-1904 (La. App. 1 Cir. 9/20/06), 944 So. 2d 604, 608, *writ denied,* 06-2804 (La. 1/26/07), 948 So. 2d

174. Consequently, this court will conduct its own independent review of the record in accordance with the standards provided in La. R.S. 49:964(G).

This dispute may be analyzed under either La. R.S. 49:964 G(5) or (6), because when the issue on review is an administrative agency's evaluation of the evidence and application of law to facts, our review becomes somewhat intertwined. Credibility determinations of evidence are specifically considered as factual questions under La. R.S. 49:964 G(6), but the application of the facts to the law at issue is a legal conclusion subject to analysis under La. R.S. 49:964 G(5). *Wild v. State, Dept. of Health & Hospitals*, 08-1056 (La. App. 1 Cir. 12/23/08), 7 So. 3d 1, 4-5.

LAW AND DISCUSSION

The Medicaid Program authorizes federal financial participation in state medical assistance plans that provide funds to persons whose income and resources are insufficient to pay for the cost of necessary medical treatment, care, and services. 42 U.S.C. § 1396, *et seq.; Wild,* 7 So. 3d at 5. States that participate in the program are required to institute reasonable standards for eligibility determination that are consistent with the objectives of the assistance program. 42 U.S.C. § 1396a(a)(17)(A); *Wild*, 7 So. 3d at 5. These standards must consider only resources and income available to the applicant and provide a reasonable method of evaluation. 42 U.S.C. § 1396a(a)(17)(B) and (C); *Wild*, 7 So. 3d at 5. An individual is entitled to Medicaid assistance if the criteria established by the state where the individual resides are fulfilled. *Wild,* 7 So. 3d at 6.

DHH created the MEM to set forth standards for Medicaid eligibility determinations, including benefits for LTC nursing facilities in Louisiana. Eligibility for LTC benefits is specifically based on need, calculated by evaluating income and resources available to the applicant. If resources are greater than the

Supplemental Security Income resource limit, the applicant is ineligible for LTC benefits.[6] *Wild*, 7 So. 3d at 6.

MEM Sections I-1670, *et seq.* cover "Transfer of Resources for Less than Fair Market Value." Pursuant to Section I-1672, DHH must consider all transfers that occurred anytime during or after the 60-month (five year) period before the Medicaid application was filed. Transfers of resources include the sale, purchase, trade, exchange, or giving away of personal or real property. MEM I-1673. Transfers of resources for less than fair market value are presumed to be for the purpose of qualifying for Medicaid benefits, unless the individual presents convincing evidence that the transfer was exclusively for some other purpose. MEM I-1671. In all cases, applicants shall be offered the opportunity to rebut the presumption that a transfer was made to reduce resources in order to qualify for Medicaid by providing convincing evidence, which proves the transfer was done solely for a reason other than to qualify for Medicaid. MEM I-1671.

Section I-1673.2 excludes a transfer from assessment of penalties if it represents the applicant "using a resource to repay a valid debt or make a purchase." A valid debt is defined as one based on a "legally binding agreement made in good faith." MEM I-1673.3.

Section I-1673.3 further provides that:

> Relatives and family members legitimately can be paid for care they provide. However, it is presumed that services provided for free at the time were intended to be provided without compensation. Therefore, a transfer to a relative for care provided for free in the past is a transfer of assets for less than fair market value. **Tangible evidence in the form of a copy of the payback arrangement that had been agreed to in writing at the time services were provided and ensuing payment records are required to rebut this presumption.** [Emphasis added.]

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[6] The Medicaid Program is part of the federal Social Security Act. 42 U.S.C. § 1396, *et seq.* The applicable portion of Title 42 of the United States Code dealing with certain transfers of assets is found in Section 1396p. *Wild*, 7 So. 3d at 6 n.5.

Additionally, Section I-1673.10 allows for Personal Care Agreements ("PCA"), which are contracts that allow an individual to pay another person to provide personal care services. A PCA is valid only if all of the following criteria are met:

- The agreement provides for the provision of reasonable and necessary medical care or assistance which is not otherwise covered by Medicare, Medicaid, or private insurance.
- The agreement **must be in writing, and properly executed prior to the service or assistance being provided**. The agreement cannot be applied retroactively to pay for services or assistance that was provided prior to the agreement.
- The agreement must specify the type, frequency, and time to be spent providing the services or assistance.
- The agreement must provide for payment upon rendering of the services or assistance, or within thirty (30) days thereafter.
- The agreement must be supported by evidence that payments were made in accordance with the agreement.
- The caregiver cannot be the spouse or parent of the applicant/enrollee.
- The applicant/enrollee or his or her legally authorized representative has the power to modify, revoke or terminate the agreement. [Emphasis added.]

Pursuant to Section I-1673.10, a Personal Care Agreement ceases upon admission to a nursing facility for more than forty-five days.

The issue in this appeal is whether Mr. David's representatives rebutted the presumption that the six cash transfers were made to reduce his assets in order to qualify for Medicaid. Here, Mr. David made an application for LTC benefits for a nursing home facility, which was denied by DHH. That ineligibility determination was never appealed by Mr. David. Then, while the ineligibility period was still running (November 1, 2010, through January 24, 2012), Mr. David made a request for a change –from "private pay" to "Medicaid only" – which DHH denied. Thus, an application was made for Medicaid LTC benefits, that application was denied, and then a request for a change was made.

Mr. David had the opportunity to rebut the presumption at the hearing before the ALJ. Mr. David argued that the transfers were made for purposes of compensating Ivy and Mary David for providing care and assistance to him. The

ALJ considered testimony of Ivy and Mary David, as well as Mr. David's attorney, John Jewell, regarding Ivy and Mary's services rendered for the care of Mr. David.

Based on MEM I-1673.3 or I-1673.10, a payback arrangement or personal care agreement was necessary to validate this alleged arrangement; however, Mr. David did not offer any type of tangible or documentary evidence of an agreement, contract, or Personal Care Agreement to substantiate and validate his argument. The record is void of any evidence that complied with Medicaid eligibility requirements to validate the resource transfers. On appeal, Mr. David argues that a Personal Care Agreement could not have been confected in this case, since any such agreement ceases upon admission to a nursing facility for more than forty-five days. See MEM I-01673.10. We note, however, that relatives and family members can be paid for care they provide, but a copy of the payback arrangement is required to rebut the presumption. See MEM I-1673.3.

Therefore, this court disagrees with the district court that the ALJ's conclusions based on application of the law (represented by the MEM guidelines) to the facts in this matter were arbitrary and a clearly unwarranted exercise of discretion. Consequently, we find that the district court committed error in reversing the ALJ's findings and conclusions in this matter as arbitrary and a clearly unwarranted exercise of discretion.

Answer to Appeal

Mr. David argues that the judgment in this matter, signed October 16, 2013, was silent as to legal interest and court costs. Mr. David answered the appeal of DHH, arguing that he is entitled to judgment amending the award to the entire amount of the claim, $49,195.00, together with legal interest from the date of judicial demand, and all costs of all proceedings. See La. C.C.P. art. 2133. However, because we reverse the judgment of the district court, we deny the relief requested.

DECREE

For the reasons assigned, we reverse the judgment of the district court in this matter. The answer to appeal filed by Mr. David is denied. All costs of this appeal are to be borne by the plaintiff-appellee, Mr. Widley David.

JUDGMENT REVERSED; ANSWER TO APPEAL DENIED.