[Note to reader: This is a very early rough draft. It is meant as the basis for further discussion and input. This draft is expected to change substantially and be expanded significantly in the coming months. In recognition of this, I would ask that you do not share or cite it without explicit permission.]

VALUING CARE

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ABSTRACT

Much has been written in the family law literature about how the law supports, undermines, and values the care that family members provide to children and young adults. Consistent with the field's historical tendency to focus on the concerns of younger persons, the family law literature is examining how the law treats care provided to older adults is much less developed.

This study therefore seeks to understand how elder care is valued in the modern era. It does so by examining a concrete situation in which the state is called upon to declare if care provided to older adults has monetary value and, if so, what value. Specifically, it examines how state regulations, administrative law judges, and the courts assess the value of personal care contracts entered into by older adults who subsequently apply for Medicaid coverage of long-term care services. The number such contracts is skyrocketing because, in the wake of the Deficit Reduction Act of 2005, personal services contracts have become a popular Medicaid planning techniques. Using this technique, an older adult enters into a personal service contract with an adult child (or other person whom he or she wishes to benefit) to provide certain caregiving services. If the older adult pays fair market value for the services, then he or she is effectively able to give money to the care provider without incurring a Medicaid eligibility penalty that would result from an outright transfer. In many cases, state departments of social services nevertheless impose a penalty on older adults who have entered into such contracts, claiming that the payment was a "gift" or that the services rendered had no monetary value.

By determining the conditions under such state regulations require payments for elder care to be deemed gifts, and when administrative judges and the courts affirm denials of Medicaid coverage on the grounds that alleged care payments were impressible gifts, this study helps paint a picture of how elder care is valued—or is not valued—in modern America.

The study is guided by, and builds upon, a study that Hendrik Hartog published in his book Someday All This Will Be Yours *which analyzed court decisions determining whether to enforce a promise by an older adult to give land to a caregiver in return for care and/or company. Hartog used these cases to show how people in the 19th and early 20th century perceived their moral and legal responsibilities to family and the aged. Notably, he found that courts'*

willingness to enforce such promises varied significantly based on the gender of the care provider. Because such cases were rarely brought after the early 20th century, however, the study was unable to assess how such caregiving might be valued today and whether such gender discrepancies persist. This project therefore uses a very different set of cases to try to explore these questions in a modern context.

The study's early findings suggest that all three categories of legal actors examined (state regulators, administrative law judges, and state courts) attach little or no monetary value to elder care in most cases. Many states are adopting regulations that presume that that elder care delivered by family members lacks monetary value. When confronted with cases in which such presumptions might be rebutted by the facts, administrative law judges routinely hold that personal care services provided by family members—even when significant and necessary to keep an older adult out of a nursing home—were either gratuitous or simply lacked monetary value. The result is that, in the name of combatting Medicaid fraud, states are preventing older adults from entering into binding contracts to pay for their own care. They are also penalizing older adults who attempt to do so by rendering them ineligible for critically needed services.

While public distaste for Medicaid planning may partially explain these patterns, it cannot fully explain the state's willingness so profoundly devalue personal services provided to older adults. Rather, the language used both in state regulations and in case decisions suggests that these patterns reflect entrenched, gendered stereotypes about personal care work.

I. INTRODUCTION

Much has been written about how the law supports, undermines, and values the care that family members provide to children and young adults. [1] By contrast, the legal literature examining how the law treats care provided to older adults is much less developed and, consequently, how elder care is valued is far less understood.[2]

This Article seeks to help fill this gap and thereby further understandings how elder care is valued in the modern area. It does so by looking at a concrete legal situation in which the state is called upon to declare if care provided to older adults have monetary value and, if so, what value. Specifically, it examines how state regulations, administrative law judges, and federal judges assess the value of personal care contracts entered into by older adults who subsequently apply for Medicaid coverage of long-term care services. Examining the valuation of elder care through this lens provides a disturbing picture of elder care in America. It suggests that while attitudes toward care for children have evolved significantly, the valuation of family care for elders remains antiquated.

As this Article explores, the devaluation of elder care observed in the context of Medicaid eligibility determinations is not disturbing simply because it reflects a lack of appreciation of the nature of the work done by care providers. It is also disturbing because it undermines older adults' fundamental right to contract in a way that is both offensive to their civil rights and impairs their ability to engage in essential self-protective behavior at a time of intense vulnerability. If older adults are not able to enter into binding contracts with family caregivers they may be unable to meet their basic needs and may be forced into premature institutionalization. Moreover, if older adults pay for family care and that care is later determined to lack monetary value, they face the very real possibility of being denied essential long-term care services.

This Article proceeds in three primary sections. Section II provides the overview of personal services contracts and explains why older adults may wish to pay family members to

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[1] The literature shows how, historically, care provided within families was generally seen as lacking in economic value but that, over the last century, there has been a sea change in how family care for children is valued. This change has been made visible in the nation's divorce courts where changing approaches to division of property have allowed courts to publically (and at times generously) value parent's child care work. For example, the move toward equitable distribution of property upon divorce based on a partnership theory of marriage has increased the ability of women who have cared for children at the expense of paid work outside the home to be compensated for that care work. *See* Laura Rosenbury, *Two Ways to End Marriage: Death or Divorce*, UTAH L. REV. 1239 (2005). Notably, there is no parallel action to the divorce action to provide a window into how the courts view the contributions of an individual makes to the older generation.

[2] Hendrik Hartog's 2012 book S*omeday All This Will Be Yours*, provided a rare glimpse of the value courts accord to elder care by analyzing court decisions in the late 1800s and early 20th century that determined whether to enforce a promise by an older adult to give land to a caregiver in return for care or company. Hartog's work showed that whether courts saw the underlying behavior as economic in nature varied significantly based on the gender of the care provider. *See* HENDRIK HARTOG, SOMEDAY ALL THIS WILL BE YOURS (2012). Unfortunately, the types of cases he examined largely disappeared after the first half of the 20th century and thus does not indicate whether similar patterns exist today. *See* Nina A. Kohn, *The Nasty Business of Aging*, 40 LAW & SOCIAL INQUIRY 506 (2015) (discussing possibilities for investigating whether such attitudes persist and referencing this study as one approach to doing so).

provide care. Section III describes the governmental response to personal care contracts and how the government penalizes older adults who enter into personal care contracts with family caregivers. Section IV then explains why this backlash has occurred despite substantial public rhetoric in favor of family care and the benefits that accrue to the public when families care for their own.

II. OVERVIEW OF PERSONAL CARE CONTRACTS AND THEIR USE

As individuals grow older, many find it increasingly difficult to meet their own physical, psychological, and social needs. For those with significant financial resources, assisted living facilities and continuing care retirement communities can fill the need by providing a combination of housing and support services.[3] However, such arrangements are generally only available to those who have sufficient resources to privately pay for them or who have purchased adequate long-term care insurance, a product generally only affordable to those who are at least upper-middleclass.

Those who cannot afford these supportive forms of care face a challenge of how to meet their needs. They can try to make do without assistance. Alternatively, if they are or become impoverished, they can apply for Medicaid[4] to cover care in a nursing home. Neither option is likely to be attractive as few wish either to engage in self-neglect or to live in a nursing home.

A third option is to turn to family members to meet their needs. Family members are, in many cases, ideal candidates to fill the gap between what older adults' need and what they can afford to buy on the open market. Ties of loyalty and a sense of duty may lead family members to perform personal care services without pay, for lower pay, or under conditions[5] that professional care providers would reject. Indeed, the bulk of home care provided to older adults is performed by family members without pay. In fact, an estimated 80 percent of those receiving home health care rely exclusively on unpaid caregivers.[6]

While most elder care provided by families is unpaid, some is not. Elders may offer payment to encourage or reward care, or family members may demand it. In some cases, payment may reflect that fact that providing care is not a financially viable option for the care provider without a guarantee of payment.[7]

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[3] In 2013, the average monthly cost of an assisted living facility was $3,427 a month ($41,124 annually). *See* John Hancock, Inc., Long-Term Cost of Care Study (2013). [Add cite to costs CCRCs.]

[4] Medicaid is a federal-state partnership program. As such, although the program's general parameters are established at the federal level. Medicaid eligibility criteria and benefits can vary significantly from state. Unlike most developed countries, the United States does not have universal long-term care coverage and, instead, Medicaid is a means-tested program.

[5] Visiting nurse agencies often require care recipients to prove they have back-up care in the event the professional caregiver cannot make a caregiving appointment.

[6] *See* THE CAREGIVING PROJECT FOR OLDER AMERICANS, CAREGIVING IN AMERICA (c. 2006) (by contrast, only 8% rely exclusively on paid caregivers).

[7]Elders who pay their family members to provide care do so both formally and informally. [Add research indicating the extent and manner of formality]

From a public policy perspective, it is advantageous for older adults to pay family members to provide care.[8] Due to changing demographics, the ratio of older adults needing assistance with daily life to younger adults is increasing. The result is a growing gap in the need for affordable care and the availability of affordable care.[9] Paying family members to provide elder care may expand the pool of available workers, thereby increasing the likelihood that older adults will be able to obtain the care they need in community-based settings.

Paying caregivers for their work also has the potential to improve the economic and working conditions of those providing care. Serving as an informal, unpaid care worker comes at significant cost. Not only do individuals assuming this role face a lost opportunity in terms of acquiring paid work or obtaining career advancement,[10] but they lose both the occupational safety protections afforded paid care workers[11] and the retirement benefits that accompany paid work. Since women are the primary providers of elder care including family elder care, such costs accrue largely to them.[12] Thus, paying family care providers have the potential to reduce income inequality, including in retirement, [13] between the genders.

To the extent that such payment allows people to remain in the community who might otherwise need nursing home care, it also benefits taxpayers. The average cost to the Medicaid program of a month nursing home care is roughly $7,000.[14] Thus, each month during which nursing home admission is delayed represents a potentially significant savings to taxpayers.

For some older adults, paying for personal care may have an additional benefit: it preserves assets while still allowing the older adult to qualify for public assistance to pay for

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[8] Indeed, to the extent that payment for family care is debated in the public arena, the debate is over whether the state should directly pay family care providers. Increasingly, Medicaid programs do offer payment to family care givers as part of the push for community-based living and consumer directed care.

[9] *See* Richard W. Johnson et al., *Meeting the Long Term Care Needs of the Baby Boomers: How Changing Families Will Affect Paid Helpers and Institutions*, Brief, Urban Institute 27 (2007), *available at* http://www.urban.org/research/publication/meeting-long-term-care-needs-baby-boomers (estimating that "the number of older paid home care users per working-age adult will increase by about 80 percent between 2000 and 2040, while the number of older nursing home residents per working-age adult will increase by about 75 percent). *Cf.,* Daniela Kraiem, *Consumer Direction in Medicaid Long-Term Care: Autonomy, Commodification of Family Labor, and Community Resilience*, 19 AM. U. J. GENDER SOC. POL'Y & L. 671 (2011) (discussing how consumer directed care, which can allow for the hiring of family members, can increase the pool of labor available for long term care services).

[10] *See* Nicole B. Porter, *The Transformative Power of Law: Article: Synergistic Solutions: An Integrated Approach to Solving the Caregiver Conundrum for "Real" Workers*, 39 STETSON L. REV. 777 (2010) (discussing how caregivers are disadvantaged in the work force).

[11] Notably, these protections are already much weaker in the home care context than in most industries. [Cite Peggie Smith's work in this regard]

[12] *See* Kraiem, supra note 9 [Add parenthetical comment].

[13] Jennifer L. Morris, *Explaining The Elderly Feminization Of Poverty: An Analysis Of Retirement Benefits, Health Care Benefits, and Elder Care-Giving*, 21 ND J. L. ETHICS & PUB POL'Y 571 (2007) (arguing that the fact that women are the primary informal caregivers reflects gender-based social norms, and criticizing the U.S. retirement system for failing to take into account the effect these norms have one women).

[14] [Add cite]. Approximately two-thirds of nursing care expenses are paid by the public Medicaid program. [Cite] The private pay rate is substantially higher. In 2013, the average cost of a private nursing home room was just over $94,000 a year and the cost of a semi-private room was nearly $83,000 per year. *See* John Hancock, Inc., Long-Term Cost of Care Study (2013), available at http://www.sfpfinancial.com/files/16915/2013%20Cost%20of%20Care.pdf

certain forms of long-term care. Specifically, in recent years, some older adults have begun paying family members to provide care in order to preserve resources as part of "Medicaid planning." In the United States, Medicaid, which is the primary payer for nursing home care, is a means-tested program. Thus, only those with limited resources qualify. Medicaid planning typically involves engaging in behavior that reduces an individual's financial resources while preserving those resources for persons of the would-be Medicaid recipient's choosing. Potential Medicaid applicants have to be very careful, however, in how they dispose of assets. This is because, as is explained further in Section III(A), the Medicaid program penalizes applicants who have transferred resources of for less than fair market value in the five years preceding a Medicaid application.

Entering into a personal care contract can be a way to get around the prohibition on resource transfers. Instead of giving money to an adult child or other loved one—which would result in a period of ineligibility for Medicaid coverage for Medicaid's long-term care coverage unless done five years prior to a Medicaid application— an older adult enters into a contract with the person they wish to benefit in which the older adult agrees to pay that person for rendering personal care services. So long as the would-be Medicaid beneficiary receives value equivalent to what is paid for the services, the transfer should not been considered a transfer for less than fair market value.

In sum, personal care contracts can be an attractive option for older adults, especially those who are lower-middle class and middle-class, who need significant personal assistance but who neither desire nor require the services of a nursing home. By paying family members to provide care, older adults may be able to continue to reside in a community-based setting in a way that is both more affordable and safer than would otherwise be possible. In addition, such arrangements may help preserve resources for family members that would otherwise be spent on institutional care.

III. THE BACKLASH AGAINST PAYING FAMILY

The use of personal care contracts for Medicaid planning purposes has led to a stark—yet rarely discussed—counter attack by state governments concerned by this use. As this Section reveals, state regulators are increasingly adopting eligibility criteria that make it extremely difficult for individuals who have paid family caregivers to qualify for Medicaid. Administrative law judges and courts considering the cases of individuals who have been denied eligibility because they have paid family caregivers have likewise taken a very harsh approach to such payments.

A. The Regulatory Attack

As briefly discussed in Section II, the Medicaid program is the primary payer for nursing home care in the United States. Because it is a means-tested program designed to serve the poor, only those with limited resources qualify for Medicaid coverage of long-term care services. To ensure that individuals do not self-impoverish in order to qualify, the federal government imposes strict eligibility penalties on those who give money area. Specifically, under federal law, individuals are ineligible for Medicaid if they have transferred resources for less than fair market value for the purpose of establishing Medicaid eligibility within five years of applying for Medicaid.[15] All transfers for less than fair market value are then "presumed to have been made for the purpose of establishing SSI or Medicaid eligibility unless the individual (or eligible spouse) furnishes convincing evidence that the resource was transferred exclusively for some other reason."[16] A wide variety of actions and inactions are considered transfers for less than fair market value, including a transfer of income or resources made without consideration and a transfer of income or resources in exchange for something worth less than the income or resources transferred. [17]

Thus, when an individual applies for Medicaid, the state has the opportunity to scrutinize applicants' finances to determine if the person has gifted money. Transfers to family are naturally more likely to be suspect as it is to family that individuals most commonly gift property. Accordingly, when an applicant has transferred money to a family member and asserts that the money was payment for services, not a mere gift, the state has cause to determine what—if any—value those services had. When the state agrees that the transfer was in fact a payment for services of equal or greater value, there is no further issue about the transfer. Where the state finds that the payment was not a payment for services, or that the payment was above the fair market value, then the state will impose a penalty on the applicant such that the applicant will be ineligible for coverage for a period of time (the length of which depends on the amount of money deemed improperly transferred).

The consequences of the state determining that a transfer for less than fair market value has occurred are significant. The penalty period is a length of time during which the applicant is deemed ineligible for long-term care Medicaid benefits. To calculate the length of the penalty period, the dollar value of the transfer is divided by the average monthly cost of nursing home care in the applicant's geographic region. The resulting number is the number of months that the individual will be ineligible for Medicaid.[18] Thus, in a region where the average cost of a month of nursing home care is $8,500, an $85,000 transfer will result in a ten month penalty period.

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[15]20 CFR § 416.1246(a) ("An individual (or eligible spouse) who gives away or sells a nonexcluded resource for less than fair market value for the purpose of establishing SSI or Medicaid eligibility will be charged with the difference between the fair market value of the resource and the amount of compensation received. The difference is referred to as uncompensated value and is counted toward the resource limit (see § 416.1205) for a period of 24 months from the date of transfer.")

[16] 20 CFR § 416.1246(e)

[17] 20 C.F.R. § 416.1246

[18] The underlying rationale is that coverage should be denied for the length of time that the transferred assets could have covered the applicant's nursing care had they been retained by the applicant. Since the private pay rate for nursing homes typically exceeds the Medicaid regional rate, the length of the penalty period is generally longer than the length of time, however, for which the assets would actually have covered nursing home care.

This period runs from the first day of the month after the transfer, or on the first day of the month the institutionalized individual is receiving nursing facility services for which Medicaid would otherwise pay, whichever is later.

At first blush, the prohibition on transfers for less than fair market value would not seem to pose any obstacle to paying for care. After all, caregiving services have clear economic value as evidenced by the growing home care industry.[19] Not surprisingly, federal law permits caregiving services, like other types of services for which one might pay to be treated as having monetary value when calculating whether or not a Medicaid applicant has transferred resources for less than fair market value. This is true regardless of who provides those services.

The one limitation on paying for personal care services under federal law that services must have been provided "pursuant to a binding (legally enforceable) agreement in effect at the time of transfer" in order not to be considered a prohibited transfer.[20]

This federal language has been interpreted, however, by the states in ways that can make it very difficult to pay for caregiving services provided by family members without incurring a penalty.

One interpretation with this effect is that some states are declaring contracts made with family members to be something other than binding contracts. A common way to do this is to treat such agreements as lacking consideration on the basis that the services were provided for "love and affection" and that "love and consideration" is simply not adequate compensation. New Jersey is emblematic of this approach. New Jersey's applicable regulations create a specific presumption with regard to care from friends or relatives:

> In regard to transfers intended to compensate a friend or relative for care or services provided in the past, care and services provided for free at the time they were delivered shall be presumed to have been intended to be delivered without compensation. Thus, a transfer of assets to a friend or relative for the alleged purpose of compensating for care or services provided free in the past shall be presumed to have been transferred for no compensation. This presumption may be rebutted by the presentation of credible documentary evidence preexisting the delivery of the care or services indicating the type and terms of compensation. Further, the amount of compensation or the fair market value of the transferred asset shall not be greater than the prevailing rates for similar care or services in the community. That portion of compensation in excess of the prevailing rate shall be considered to be uncompensated value. [21]

Thus, caregiving by relatives is treated as not having monetary value even under circumstances care from non-relatives would be treated as having value.

Another approach is to be very demanding in the type of proof required to show that adequate consideration was paid. In many cases, these requirements are imposed not in the

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[19][Footnote industry size and literature on the professionalization of elder care]
[20] 20 CFR § 416.1246(c)
[21] New Jersey Admin. Code **10:71–4.10(6)(ii)**

state's regulations, but in administrative guidance that informs local officials making Medicaid eligibility determinations. For example, according to administrative guidance in New York, contracts are not considered as being for fair market value unless they contain certain terms,[22] and are supported by detailed documentation.[23] In addition, "No credit is allowed for services that are provided as part of the Medicaid nursing home rate."[24] Similarly, to rebut the presumption that relatives who provide assistance or services are doing so out of love and affection, Michigan requires: 1) tangible evidence payment obligation existed when care was rendered, including a written agreement with notarized dated signatures; 2) that the services were recommended in a signed writing by client's physician as necessary to prevent the transfer of the client to a residential care or nursing facility; and 3) the care provider not also be the surrogate decision-maker who signed the contract on behalf of the client.[25]

The result of such burdensome proof requirements is that applicants are unlikely to satisfy them unless they have had sophisticated legal assistance in drafting the contract.[26] The irony is that such requirements may therefore have the least effect on those who entered into a personal care contract only after an attorney advised them to do so for Medicaid planning purposes.

B. Hearing Determinations

When the responsible state agency denies a Medicaid application or assesses a period of ineligibility on the basis that payment to family caregiver was a transfer for less than fair market value, the applicant has a right to appeal that decision by requesting an administrative hearing. When an applicant exercises that appeal right, administrative law judges (ALJs) must decide whether that care the applicant was provided has monetary value and, if so, how much monetary value.

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[22] "Uncompensated Transfer – A personal service contract that does not provide for the return of any prepaid monies if the caregiver becomes unable to fulfill his/her duties under the contract, or if the A/R dies before his/her calculated life expectancy, must be treated as a transfer of assets for less than fair market value. If there are no such legally enforceable provisions, there is no guarantee that FMV will be received for the prepaid monies. If a personal service contract stipulates that services will be delivered on an "as needed" basis, a determination cannot be made that FMV will be received in the form of services provided through the contract. A transfer of assets penalty must be calculated for an otherwise eligible individual." GIS 07 MA/019, available at http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/07ma019.pdf

[23] "In order to assess the value of these furnished services, the district must be provided with credible documentation (e.g., a log with the dates and hours of services already provided). Any amount subtracted (i.e., the credit for caregiver services actually provided) must be commensurate with a reasonable wage scale, based on fair market value for the actual job performed and the qualifications of the caregiver. If credible documentation is not provided, no credit is deducted when calculating the uncompensated transfer amount. For assistance in evaluating job duties and pay rates, districts may refer to the U.S. Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook. . . . If a district determines that a reasonable pay rate for a particular job/service is less than the amount spelled out in the contract, the district should use the lesser amount in calculating the amount of compensation received for the transfer." GIS 07 MA/019, available at http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/07ma019.pdf

[24] GIS 07 MA/019, available at http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/07ma019.pdf

[25] [Add reference. ALJs are citing PEM 405 and *BEM 405)*]

[26] *Accord* RICK L. LAW & KERRY PECK, ALZHEIMER'S AND THE LAW: COUNSELING CLIENTS WITH DEMENTIA AND THEIR FAMILIES (2014) (explaining how to draft personal care contracts that are likely to satisfy the requirements of the Medicaid program and how to amass the necessary accompanying documentation).

To understand how ALJs make these determinations, it is necessary to review their decisions. Two factors complicate this ostensibly simply process. First, ALJ decisions are highly fact-specific, often unsystematic, and—due to privacy concerns—made available only in a form that excised key demographic information. Second, not only is there no comprehensive reporting system for such decisions, but most states do not even make the decisions publically available. Those that do, moreover, often only make a small, presumably unrepresentative, subset of opinions available.

In order to understand how ALJs view the value of elder care services in the context of Medicaid eligibility decisions despite these limitations, I systematically looked for all publically available fair hearing decisions.[27] I found four states that make all fair hearing decisions available online. From these, I found 44 fair hearing decisions considering whether a personal care services were a transfer for less than fair market value. Of these, the majority (28) fully upheld the state's determination that there had been a transfer for less than fair market value in the value that the state had determined. A substantial minority of the remainder found that at least a portion of value alleged to have been a valid transfer to pay for care was a transfer for less than fair market value, but that the state had not correctly assessed the value of that transfer. Finally, one found that payments were not in fact for care at all, and another found there was insufficient information to reach a determination and ruled that further process was in order. Notably, not a single hearing decision found that all payments made for personal care services were for fair market value.

Notably, the rates of affirmation decisions versus recalculation decisions varied significantly from state to state. In Ohio, 18 out of 20 decisions were affirmed. In New York, by contrast, 10 out of 16 decisions were that recalculation is in order. This difference appears to be at least partially attributable to the different regulatory standards employed in the two states. [Note to reader: this section will be substantially expanded in the next draft.]

That said, it would be incorrect to assume that the patterns in ALJ decision making witnessed can be fully explained by the regulatory requirements. ALJs considering appeals of determinations appear to be doing more than simply giving effect to the limitations placed on them by state regulations. They appear to be consistently construing those regulations in an exacting manner that is highly unfavorable to family caregivers.

One way ALJs do so is to require contract terms not required by the underlying regulations. For example, several Michigan determinations found that a contract for personal care services lacked monetary value because it stated that services were to be provided "as needed" and thus were only "possible;"[28] in doing, these decisions effectively created a new rule that was not actually present in the underlying regulations or administrative guidance.[29] Similarly, New Jersey ALJs have deemed services as lacking all value where contracts are not transferable, although such a reading is not required by statute.[30] Likewise, many ALJ decisions

[27] [Explain the failure of states to make these critical documents available.]
[28] [Add cite to decisions]
[29] [Add cites to relevant regulations and guidance]
[30] New Jersey: HMA1036-08:

affirm state agency determinations on the grounds that the applicant provided "inadequate" documentation" even though the level of documentation to be provided was not specified in the underlying regulations.

A key pattern in ALJ decisions is that ALJs frequently find care provided to older adults to be worth substantially less than what it could be bought for on the market. For example, a 2013 New Jersey fair hearing decision considered whether a woman had made a transfer for less than fair market value by paying her daughter-in-law and grandson for care.[31] The woman had paid her daughter-in-law (a dental hygienist) and her grandson (an emergency medical technician who also lived with her) $25 per hour to assist her with such tasks as shopping, showing, laundry, meal planning and preparation, medication administration, washing and combing her hair, cleaning her dentures, laundry, and paying bills upon the advice of her lawyer, who had told her that $25 a hour was a reasonable rate for such services. In reviewing her transitions, the state Medicaid office valued the services received at $10.80 per hour on the grounds that this was the Department of Labor rate for unlicensed caregivers; the state did not bother to investigate private market value. The woman and her family subsequently acknowledged that home health aides in her region are generally paid $20 per hour, which was undisputed. The ALJ nevertheless held that the state's calculation was proper (i.e., that the services were worth only $10.80/hour) and therefore found that there had been an improper transfer in the amount of $39,760.

Having determined that ALJs are, in many cases, going out of their way to discretion to find in favor of the state, the question is why. Are there certain factors that are leading ALJs to view personal care contracts in a negative light? Since past empirical and theoretical research on caregiving suggests that caregiver gender plays a critical role in whether or not care is seen as having monetary value, my initial hypothesis was that ALJs would be more likely to find that personal care services lacked monetary value,[32] or had minimal monetary value, when those care services were performed by a women, and even more so when they were performed for another woman. I initially planned to try to get at this question by coding the cases for both caregiver and care recipient gender. However, virtually all care recipients were female. Likewise, virtually all hearing decisions involved at least one female caregiver. When males were performing the role of caregiver, they were almost always doing so alongside a mother, wife, or sister. Thus, neither the gender of the caregiver nor of the care recipient can be shown to have a clear impact on hearing outcomes. It is, of course, possible that these gender patterns are the result of state officials being more sympathetic to male care givers or male care recipients and denying their applications at a lower rate. However, there is currently no mechanism for determining whether or not this is the case.

I then began coding decisions for (1) gendered language; and (2) language about familial expectations. In so doing, I found a significant use of both gendered language and language about role expectations. Due to the complexity of the cases, however, it was not possible to show a clear causal link. Thus, it appears that gender and familial role expectations appear to be salient to administrative law judges and "on their mind" as they consider these cases. But it cannot be said that this thinking leads to differential treatment between appellants. [Note to

[31] New Jersey: HMA09604-13

[32] [Cite Hartog, feminist literature on caregiving, and other caregiving literature.]

reader: I am still in the middle of this process so conclusions are preliminary; I am hoping to expand the number of cases examined to get an even deeper read on what is going on.]

C. Court Decisions

There have been relatively few court decisions considering whether personal care contracts have economic value. Of the handful of cases that exist,[33] a few have found economic

[33] *See* Swartz v. N.Y.S. Dept. of Health, 946 N.Y.S. 2d 698 (N.Y. App. Div. 2012) (holding that a transfer for less than fair market value occurred when daughter was paid for caring for her parents during nighttime hours because daughter did not contemporaneous document the services provided each night, and that a payment for less than fair market value was made when father paid daughter at a rate equivalent to what he would have paid a local healthcare agency to the extent that this amount was greater than the mean hour wage for a home care worker in the state according to Bureau of Labor statistics); Forman v. Director of Office of Medicaid, 944 N.E.2d 1081 (Mass. Ct. App. 2011) (in a case in which a mother transferred a lump sum of $20,000 to her daughter in return for a personal services contract under which the daughter was to provide a myriad of services for as long as they were appropriate, finding that the entire payment was a transfer for less than fair market value on the grounds that the contract had no ascertainable fair market value because its value was uncertain; in doing so, the court emphasized that the daughter had provided services to the mother prior to the contract for free, although it recognized that she had not done so to the same extent prior to the contract); Joyner v. N.C. Dept. of Health and Human Servs., 715 S.E.2d 498 (N.C. Ct. App. 2011) (finding that a personal care contract in which a mother paid her son a lump sum for anticipated future services was a transfer for less than fair market value because anticipatory lump sum payments can likely never be said represent fair market value payment for services; also remanding the case for consideration of whether a care provider son had successfully rebutted the presumption that a payment for services rendered in the past had been performed "in obedience to a moral obligation and without expectation of compensation"); Austin v. Indiana Family and Social Serv. Admin., 947 N.E.2d 979 (Ind. Ct. App. 2011) (finding that the full value aunt's transfer of $35,000 to her nephew and his wife pursuant to a "life services agreement" was a transfer for less than fair market value; in so doing, expressing concern that the agreement did not provide for a return of funds should the aunt not live to her full life expectancy, finding that most of the services to be provided were duplicative of those provided by the aunt's nursing home, and that the nephew and niece's visits to the aunt had no market value because they appeared to fall "within the realm of 'love and affection'"); Gauthier v. Director of Office of Medicaid, 956 N.E.2d 1236 (Mass. App. Ct. 2011) (in a case in which a mother paid her son and daughter-in-law, a registered nurse, $182,000 for room and board and services, finding that the entire value of the payment should not be considered a transfer for less than fair market value because the care providers had designed and built a handicapped-accessible area in their house for the mother's use in which she resided for approximately 22 months and, therefore, remanding the case to the Office of Medicaid board of hearings); E.S. v. Div. of Medicaid Assistance and Health Serv., 990 A.2d 701 (N.J. Super. Ct. 2010) (finding that a life care contract entered into for $55,550 between a daughter and her mother after the mother had moved to a nursing home had no monetary value despite the fact that it was calculated based on the motehr's life expectancy, a set number of hours of week per week, and an hourly rate based on market knowledge; the court reasoned that this was because the agreement had "no value on the open market" because the care recipient was prohibited in transferring her rights under the contract to another party"); Dambach v. Dept. of Social Serv., 313 S.W.3d 188 (Miss. Ct. App. 2010) (finding that payments made pursuant to a verbal agreement between mother and daughter entered that the mother would use whatever money she had to pay her daughter to provide room, board, and personal care were made in return for "fair and valuable consideration"); E.S. v. Division of Med. Asst. & Health Servs., 412 N.J. Super. 340 (2010) Brewton v. State Dept. of Health and Hospitals, 956 So.2d 15 (La. App. 2007) (finding that a couple did not make a transfer for less than fair market value when they transferred approximately $159,000 to a nephew, niece, and the niece's husband pursuant to a personal services contract, reasoning that although the couple were in a nursing home for much of the time during which services were performed many services were not duplicative of those provided by institutions) ; Carpenter v. State Dept. of Health and Hospitals, 944 So.2d 604 (La. App. Ct. 2006) (finding that a mother had entered into a written personal services contract with her daughter 15 years prior to nursing home placement and that the nearly $30,000 transferred pursuant to that agreement was not a transfer for less than fair market value).

value contrary to the state's position.[34] For example, in *Damach v. Dept. of Social Services*, a mother and daughter entered into a verbal agreement that the mother would use whatever money she had to pay her daughter to provide room, board, and personal care because she preferred to live with her daughter than move to a nursing home.[35] The daughter initially charged the mother $75 per day to do so, and later reduced this to $50 a day, amounts which she reported on her federal income tax return as income in exchange for care.[36] The Missouri Court of Appeals hearing the case determined that these payments were intended and were made in return for "fair and valuable consideration."[37]

Most, however, have taken the approach generally observed in ALJ opinions: treating the care provided as lacking economic value. In some cases, the courts have made it clear that this is because the type of services provided were those that the care provider should be expected to perform without compensation because of the care provider's position within the family. For example, in the 2006 case *Barnett v. Department of Health & Human Services*, a Maine court considered a case in which an adult daughter was paid for:

> paying bills; filing paperwork; shopping for supplies, medications, clothing, and holiday presents; and taking [her mother] to her appointments with her doctor, dentist, and lawyer. And during visits to her mother at a NH, assisting with meals, brushing her teeth, giving her manicures, trimming her hair, cleaning her hands and face, and bringing her sister for a visit . . ..[38]

The court refused to find these services had any monetary value – declaring them simply "the services that any daughter would provide for her ailing mother without charge."[39] Likewise, in *Austin v. Indiana Family and Social Serv. Admin*., the Indiana Court of Appeals refused to find that visits by a nephew and his wife to an institutionalized aunt had any market value because they appeared to the Court to fall "within the realm of 'love and affection'".[40]

Another common approach taken by courts is to treat personal care service contracts as lacking monetary value where the payment in the form of a lump sum payment for future services. Such future services are treated as too uncertain as to have an ascertainable fair market value. This approach is ironic in that there is a clear parallel to such anticipatory contracts in the elder care marketplace: the continuing care retirement community (CCRC). CCRCs commonly require entrants to pay a large lump sum fee in return for future services despite the fact that the duration of those services is uncertain; should the individual die shortly after paying the fee, typically it is retained by the CCRC. In many cases, the lump sum payments being offered to family members could be said to be the poor-man's version of the CCRC contract: older adults

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[34] *See* Dambach v. Dept. of Social Serv., 313 S.W.3d 188 (Miss. Ct. App. 2010) (Brewton v. State Dept. of Health and Hospitals, 956 So.2d 15 (La. App. 2007); Carpenter v. State Dept. of Health and Hospitals, 944 So.2d 604 (La. App. Ct. 2006).
[35] *See* Dambach v. Dept. of Social Serv., 313 S.W.3d 188, 192 (Miss. Ct. App. 2010).
[36] *Id.*
[37] *Id.*
[38] Estate of Ethel Barnett v. Department of Health and & Human Services, 2006 WL 1668138 (2006).
[39] *Id.*
[40] Austin, *supra* note [] at [jumpcite]

who could not afford the large fees typically associated with CCRCs get a similar right to "life time" services for a lower price.

Yet another approach is for courts to treat personal service contracts as having no monetary value because they contain terms which, according to the courts, render the agreements essentially worthless. For example, in *E.S. v. Div. of Medicaid Assistance and Health Serv.*, a New Jersey court ruled that a personal services contract entered into between a mother and a daughter had "no value on the open market" because the care recipient was prohibited in transferring her rights under the contract to another party".[41] In another case, *Austin v. Indiana Family and Social Serv. Admin*., the court found a "life services agreement" suspect because it did not provide for a return of funds should the aunt not live to her full life expectancy. What is perhaps most notable about this approach is that contracts with these same terms would generally be fully permissible and enforceable if entered into with non-relative care provider. Indeed, were contracts with professional service providers such as assisted living facilities and CCRCs held to such standards, it seems probable that they would be routinely found unenforceable, potentially forcing a substantial change in industry practice.

In short, court decisions considering the market value of personal service contracts typically find these contracts lack monetary value. In so doing, they frequently point to the familial relationship between care provider and care recipient, the personal nature of the care, and the lack of certainty as to care needs as key factors for their findings. Yet these three factors that are at the core of the experience of family care and in many cases appear to be what motivates older adults to desire family care in the first place.

IV. LESSONS FROM THE BACKLASH AGAINST PERSONAL CARE CONTRACTS

As described in the preceding Section, older adults who have entered into personal care contracts have been heavily penalized for doing so by being denied essential long-term care services. This Section seeks to explain this reaction and how it has occurred despite both policymakers and advocates calls for greater calls for greater support for family caregivers.[42]

A. Opposition to Medicaid Planning

At first blush, it is appealing to simply attribute the backlash against personal care contracts to the strong sentiment against Medicaid planning. Public and governmental distaste for Medicaid planning is palpable.[43] Medicaid planning has been criticized as unethical and as a form of elder abuse. Congress even went so far as to attempt to criminalize Medicaid planning.[44]

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[41] [Add jumpcite]

[42] [Add information about the debate over family care and family care supports]

[43] [Add cites to representative critiques]

[44] In 1996, Congress passed a statute criminalizing certain forms of Medicaid planning. *See* 42 U.S.C. § 1396p(c) [verify cite]. The Act, nicknamed the "Granny Goes to Jail Act" was soon repealed, and instead Congress attempted to bar attorneys from counseling clients about Medicaid planning. *See* 42 U.S.C. § 1320a-7b(a). [verify cite] In response, Attorney General Janet Reno then announced she would not enforce the Act because it violated the first Amendment. The U.S. District Court for the northern District of New York subsequently enjoined the federal court from enforcing the Act. *See* New York State Bar Assoc. v. Reno, 999 F. SUPP. 710 (N.D.N.Y. 1998).

Governmental distaste for Medicaid planning can partially explain the reaction against personal care contracts. The state regulations that signal out personal care contracts were certainly a response to the rise in the use of personal care contracts as a Medicaid planning strategy after the passage of the Deficit Reduction Act of 2005 which severely curtailed the utility of many then-existing Medicaid planning strategies.[45] Lawyers working in the field of elder law increasing advised would-be Medicaid beneficiaries to enter into a personal services contract with an individual whom he or she wishes to benefit. Because would-be beneficiaries were receiving something of clear value in return, surely payments pursuant to such a contract could transfer resources without incurring a transfer penalty. Indeed, the strategy was appealing in part because it felt less like a sneaky game (as had so many previous strategies) more like a legitimate approach to meeting care needs.[46] Moreover, the approach also has the collateral benefit of allowing resources to be passed to an heir without probate or gift tax,[47] although not without income tax.[48]

Nevertheless, the problem with simply attributing the backlash to anti-Medicaid planning sentiment is that this explanation is that it is highly incomplete. State regulations defining when a payment to a family member is to be treated as lacking in fair market value are rarely targeted to those situations in which the payment would be motivated by Medicaid planning concerns. Rather, in many cases, the regulations appear to have the opposite effect. For example, in states like Michigan which only permit the payments without penalty where there has been a complex, formal contract entered into by the care recipient and care provider, the conditions are actually more likely to be met when the contract was motivated by Medicaid planning concerns because it is only the involvement of a sophisticated elder law specialist that the terms are likely to be satisfied.[49]

Similarly, a review of the ALJ decisions considering the effect of payments to family caregivers reveals that in many cases ALJs are finding that services provided lacked monetary value even when there is no finding—and in some cases, no allegation—that the payment was motivated in whole or in part by a desire to qualify for Medicaid coverage.[50]

In short, distain for Medicaid planning cannot fully explain the extent of the backlash against payments to family members, nor can it explain the form that the backlash has taken. Other factors appear to be playing a significant role.

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[45] As revised by the Deficit Reduction Act of 2005, the rules create a five-year look-back period for all transfers for less than fair market value ("FMV") and changing the date of onset of the penalty period for such transfers. As such, many Medicaid planning techniques that were used prior to 2005 are no longer effective.

[46] Anecdotally, in teaching law students about Medicaid planning strategies, the author has observed students (even those troubled by Medicaid planning in general) to be very receptive of the use of personal care contracts as Medicaid planning technique.

[47] It also allows it to pass without estate tax (although this is rarely a concern for those engaging in Medicaid planning given the high exemption levels—$5,250,000 in 2013).

[48] Richard L. Kaplan, *Federal Tax Policy And Family-Provided Care For Older Adults*, 25 VA. TAX REV. (2005) (discussing the income tax implications of such arrangements).

[49] *See supra* note 24 and accompanying text.

[50] *See*, *e.g.*, J.W. v. Division of Medical Assistance & Health Services and Hunterdon County Board of Social Services, Hearing No. HMA4558-14 (NJ August 12, 2014) (finding that the services could not be valued because of insufficient documentation).

B. Historical Bias Against Care Work

A review of the regulatory response, hearing decisions, and court cases considering the effect of personal care contracts on Medicaid eligibility strongly suggests that the backlash reflects, in a quite significant way, a continuation of historical biases against, and stereotypes about, care work.

Historically, care provided within families was generally seen as lacking in economic value. Care work has been associated with the feminine and private sphere. A sphere which is seen as operating largely outside of the monetary system despite the fact that the family is a vital economic unit.[51]

While most of the writing on the value placed on care work has focused on care for children, Hendrik Hartog's 2012 book *Someday All This Will Be Yours*, provided a rare glimpse into the valuation of elder care work. Specifically, Hartog examined the value courts accorded to elder care by analyzing court decisions in the late 1800s and early 20th century that determined whether to enforce a promise by an older adult to give land to a caregiver in return for care or company. Hartog's work showed that whether courts saw the underlying behavior as economic in nature varied significantly based on the gender of the care provider.[52]

What these Medicaid eligibility cases suggest, however, is that the attitudes Hartog observed remain powerful and that historical attitudes about care work as a non-economic form of labor persist. For example, a number of hearing decisions and at least one court[53] have found that a personal services contract has no value if the right to care is limited to the particular care recipient and cannot be sold to another. Thus, the intimate, highly personal nature of the care relationship is what makes in non-monetary. Likewise, as discussed in Section III, the explicit language used in some of the decisions as well as the prominence of language referencing familial roles and status also suggests that determinations may be shaped by historical biases about care work and care providers.

That persistence of this type of bias in ALJ decisions and court opinions decisions suggests just how powerful these attitudes remain in the United States. It is perhaps more understandable that regulators are dismissive of personal care contracts due to heightened vigilance about curbing Medicaid planning, and that when trying to limit their use regulators do so in a way that that draws upon available stereotypes about care work. That such stereotyped attitudes persist even when individual ALJs and judges are confronted with actual people, and people who have in many case indisputably been devoted care providers, suggests they are very deeply entrenched.

Indeed, these cases may suggest that the biases against care work has actually expanded. Although the number of cases involving male care providers was too small to reach any conclusions with confidence, it appears that ALJs tend to treat all care providers as generally

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[51] [Cite to Alicia Kelly's work]

[52] [Cite examples from Hartog's study, possibly in the body of the text]

[53] *See* E.S. v. Div. of Medicaid Assistance and Health Serv., 990 A.2d 701 (N.J. Super. Ct. 2010).

engaging in none monetary labor. Thus, to the extent that there have been advances in terms of gender equality it may have not been to the benefit of women, but rather at the expense of men. On the other hand, it is possible that one reason that so few male providers are implicated in the fair hearing decisions studied is that state agencies are less likely to deem the care they provide to be lacking in value, thus avoiding the need to file an administrative appeal.

C. Zombie Law

In addition to showing the persistence of historical attitudes towards care work, the backlash against family care payments also reflects a view of elder care in which the older adult is not an active participant. While the disputes over Medicaid eligibility are in the name of the older adult, the key players are the care provider and the state. Rarely, is the older adult directly a participant in the process. Most commonly, the care provider, in the dual role of attorney-in-fact and care provider, represents the older adult in his or her own words.

The absence of the older adult may explain why the concepts used in assessing the monetary value of personal care are taken not from modern contract law (as one would expect if examining whether or one individual can enforce a bargain against another individual) but from the law of trusts and estates (examining the effect of promises of one who is no longer a legal actor).

This is, however, highly problematic as contract doctrine tends to be far more protective of individual autonomy than trusts and estates doctrine. Most notably for the questions posed in this Article, the notion that contracts between intimates cannot be enforced because they are presumed to be made out of love and affection has been largely excised from contract law. By contrast, it remains alive and well in the testamentary context. [Note to reader: this argument will be expanded upon at length in future drafts.]

Thus, the law is increasingly treating Medicaid applicants as if they are already dead, with the effect that their fundamental right to contract is being eroded just when they most need it.

V. CONCLUSION

Quietly and without fanfare, states are adopting rules that treat elder care as lacking monetary value, thereby prevent older adults from entering into binding contracts to pay for their own care. These approaches represent a return to a rejected, gendered view of care work, and they significantly handicap the middle income older adults' ability to engage in self-protective behavior during a stage in their life when they face intense vulnerability.