PHILIP D. MURPHY
Governor

TAHESHA L. WAY
Lt. Governor

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712

SARAH ADELMAN
Commissioner

JENNIFER LANGER JACOBS
Assistant Commissioner

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
AND HEALTH SERVICES

C.T.,	:	
PETITIONER,	:	**ADMINISTRATIVE ACTION**
v.	:	**FINAL AGENCY DECISION**
DIVISION OF MEDICAL ASSISTANCE	:	**OAL DKT. NO. HMA 04165-2023**
AND HEALTH SERVICE AND	:	
MORRIS COUNTY OFFICE OF	:	
TEMPORARY ASSISTANCE,	:	
RESPONDENT.	:	

As Assistant Commissioner for the Division of Medical Assistance and Health Services, I have reviewed the record in this case, including the Initial Decision and the Office of Administrative Law (OAL) case file. Exceptions were filed by the Petitioner on February 28, 2024. Procedurally, the time period for the Agency Head to render a Final Agency Decision is May 23, 2023, in accordance with an Order of Extension.

This matter arises from the imposition of a transfer penalty on Petitioner's receipt of Medicaid benefits. By letter dated May 2, 2020, Morris County Office of Temporary Assistance (Morris County) found Petitioner otherwise eligible for Medicaid, but imposed a 237 day[1] period of ineligibility on their receipt of benefits as a result of transfers totaling $91,460 for less than fair market value during the look-back period. ID at 2.

[1] In the Initial Decision the penalty is initially stated as seventy-seven days. This is a

In determining Medicaid eligibility for someone seeking institutionalized benefits, federal law mandates that Medicaid impose a five-year look-back period to determine if the applicant has made any transfers of assets for less than fair market value. 42 U.S.C. 1396p(c)(1)(B)(i). If a transfer of asset occurs, a penalty is calculated wherein no payment may be made for nursing facility care. 42 U.S.C. 1396p(c)(1)(E)(I); see also N.J.A.C. 10:71-4.7.10(m). "A transfer penalty is the delay in Medicaid eligibility triggered by the disposal of financial resources at less than fair market value during the look-back period." E.S. v. Div. of Med. Assist. & Health Servs., 412 N.J. Super. 340, 344 (App. Div. 2010). "[T]ransfers of assets or income are closely scrutinized to determine if they were made for the sole purpose of Medicaid qualification." Ibid. Congress's imposition of a penalty for the disposal of assets for less than fair market value during or after the look-back period is "intended to maximize the resources for Medicaid for those truly in need." Ibid. The federal law was amended in 2006 to require states impose penalties based on the number of days and prohibited excluding any partial days assessed. See 42 U.S.C. 1396p(c)(1)(E)(iv)(providing a "[s]tate shall not round down, or otherwise disregard any fractional period of ineligibility"). As such, Congress made it clear that all penalties, including minimal transfers resulting in a few days of ineligibility, must be imposed.

A transfer made during the look-back period raises a rebuttable presumption that the resource was transferred for the purpose of establishing Medicaid eligibility. N.J.A.C. 10:71-4.10(j)(1); H.K. v. State of New Jersey, Dep't of Human Servs., Div. of Med. Assistance and Health Servs., 184 N.J. 367, 380 (2005). The applicant "may rebut the presumption that assets were transferred to establish Medicaid eligibility by presenting convincing evidence that the assets were transferred exclusively (that is, solely) for some other purpose." N.J.A.C. 10:71-4.10(j). The burden of proof in rebutting this presumption

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typo which is corrected throughout the rest of the Initial Decision.

is on the applicant. Ibid. The regulations also provide that "if the applicant had some other purpose for transferring the asset, but establishing Medicaid eligibility appears to have been a factor in his or her decision to transfer, the presumption shall not be considered successfully rebutted." N.J.A.C. 10:71-4.10(i)2.

The Initial Decision affirmed the imposition of the transfer penalty, finding that Petitioner's representatives failed to provide any testimony from a source with direct information concerning the transfers at issue to rebut the presumption that the assets were transferred to establish Medicaid eligibility. Based upon my review of the record, I hereby REVERSE the findings and conclusions of the Administrative Law Judge (ALJ) and REMAND the matter for additional proceedings in accordance with this decision.

The transfers at issue were made to several individuals whose identities and addresses cannot be located. ID at 3. The Petitioner contends that these were not genuine transfers and went to unidentified third parties who defrauded the Petitioner. Morris County contends that they are still obligated to assume the money was used for personal purposes and impose a penalty because there was no closure to the criminal investigation. Ibid.

In the Initial Decision, the ALJ found that while the Petitioner made a good faith effort to rebut the presumption by providing the Police Incident Report, (P-1), and Investigation Reports, (P2-P3), no witnesses were called that could explain and discuss the suspicious transactions resulting in $91,460 in unexplained withdrawals from Petitioner's accounts. ID at 6. Further finding, there was no live testimony from someone involved either in handling Petitioner's finances, and/or local authorities or a representative from the skilled nursing facility where Petitioner resided. Ibid. The ALJ also found that while the documentation provided by the Petitioner indicates that the Petitioner filed a report of fraud it is not conclusive on its own that a fraud took place and

it does not rise to "convincing evidence that the assets were transferred exclusively" for a purpose other than qualifying for Medicaid. Ibid.

In the filed exceptions, Petitioner's counsel argues that there was no reason to require testimony because the Petitioner provided a written police report. The Incident Report accounted for approximately $40,000 of the $91,460 transferred in this case and states that Officer K.H. responded to a report of theft by J.M. a representative of Brookside Senior Citizens Apartments. (P1) J.M. advised the officer that large withdrawals from the Petitioner's account were noticed during a monthly financial audit. When questioned, the Petitioner claimed that they were contacted numerous times about winning a $5,000,000.00 prize and that they had to transfer money to claim. Ibid. The report states that J.M. advised Officer K.H. that the Petitioner mailed over 11 checks equaling about $40,000.00. Ibid. According to the Incident Report, Officer K.H. "advised" the Petitioner to not send any more money, and "informed" them that they did not win a prize and that the money was being transferred fraudulently. Ibid. Officer K.H. concluded the Incident Report by stating that they were forwarding a copy of the Incident Report to the investigative division for further review. Ibid. The Incident Report is dated September 23, 2021 and indicates that that the transfer at issue were made during a sixteen-month time period, going back to May 2020. Ibid. The language of the Incident Report is clear that the report itself is not a conclusion that the transfers at issue in this case were transferred based on fraud. In fact, Officer Hawthorne states in the report that the report is being sent to the investigation division for further review. Furthermore, the Incident Report is based on a report of transfers totaling about $40,000.00. However, the transfers at issue in this case total $91,460.00.

The submitted incident report memorialized a report of fraud and is not clear evidence that fraud or a scam did in fact take place. Nor is the incident report, on its own

clear, evidence that the funds at issue were transferred exclusively for a purpose other than qualifying for Medicaid. However, there may be stronger evidence available the Petitioner could provide that could potentially demonstrate that the transfers at issue in this matter were fraudulent and stemmed from a scam. Consequently, I am REMANDING the matter to give Petitioner the opportunity to provide credible documentary evidence, including but not limited to bank records related to fraud reports, internal fraud investigation reports, and attempts to cancel checks. The Petitioner should also provide live testimony, including but not limited to witnesses who were involved in handling the Petitioner's finances, local law enforcement authorities involved in the investigation, or a representative from the skilled nursing facility in which the Petitioner resided. The Petitioner should also address why the alleged fraudulent transfers at issue in this case were only reported sixteen months after the first transfer was made.

THEREFORE, it is on this 22nd day of May 2024,

ORDERED:

That the Initial Decision is hereby REVERSED and REMANDED in accordance with this decision.

Gregory Woods OBO JLJ

Jennifer Langer Jacobs, Assistant Commissioner
Division of Medical Assistance and Health Services