State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION

OAL DKT. NOs. HMA 00900-24 and
HMA 02330-24
AGENCY DKT. NO. 0710571157
(CONSOLIDATED)

L.B.,

Petitioners,

v.

ESSEX COUNTY DIVISION OF FAMILY ASSISTANCE & BENEFITS,

Respondent.

L.B. petitioner appearing pro se

Rebecca Smith, Family Services Worker, for respondent under N.J.A.C. 1: -1-5.4(a)(3)

Record Closed: April 17, 2024 Decided: April 26, 2024

BEFORE **NANCI G. STOKES,** ALJ:

STATEMENT OF THE CASE

The Essex County Division of Family Assistance and Benefits (Essex) denied the petitioner's July 2023 renewal for Medicaid's Managed Long-Term Services and Supports (MLTSS) program because the petitioner failed to timely provide all requested verifications, despite Hudson's reconsideration of materials the petitioner later supplied. Should the denial stand? Yes. An applicant must supply timely verifications to establish

their Medicaid eligibility. N.J.A.C. 10:72-2.3(a).

PROCEDURAL HISTORY

Essex issued two denials to L.B. concerning her July 2023 Medicaid renewal, determining that she failed to supply necessary eligibility verifications: one on October 17, 2023, and a second on December 5, 2023.

On November 15, 2023, petitioner appealed the October 17, 2023, termination.

On December 20, 2023, petitioner appealed the December 5, 2023, denial.

The Division of Medical Assistance and Health Services (DMAHS) transmitted the case regarding the December 5, 2023, denial to the Office of Administrative Law (OAL), where it was filed on January 23, 2024, as a contested case under the Administrative Procedure Act, N.J.S.A. 52:14B-1 to-15, and the act establishing the OAL, N.J.S.A. 52:14F-1 to-13, for a hearing under the Uniform Administrative Procedure Rules, N.J.A.C. 1:1-1.1 to -21.6. The OAL docketed that transmittal as HMA 00900-24.

On March 18, 2024, the OAL scheduled the case before me on April 4, 2024. At that time, both parties needed to submit additional materials. I rescheduled the case for a hearing on April 17, 2024.

However, DMAHS transmitted the case regarding the October 17, 2023, termination to the Office of Administrative Law (OAL), where it was filed on February 21, 2024, as a contested case under the Administrative Procedure Act, N.J.S.A. 52:14B-1 to-15, and the act establishing the OAL, N.J.S.A. 52:14F-1 to-13, for a hearing under the Uniform Administrative Procedure Rules, N.J.A.C. 1:1-1.1 to -21.6. The OAL docketed that transmittal as HMA 02330-24. On April 15, 2024, the OAL scheduled that case for a hearing before another administrative law judge (ALJ) on May 1, 2024.

As both cases involved the same Medicaid renewal, the same parties, and interrelated issues, I consolidated the cases with the parties' consent at the start of the

hearing on April 17, 2024. Thus, this decision memorializes the consolidation absent a separate order to facilitate consistency and a timely hearing in both cases. See N.J.A.C. 1:1-14.6 (providing an ALJ with broad authority to conduct cases, including rulings or actions needed for expeditious and fair conduct of proceedings); N.J.A.C. 1:1-17.3 (standards for consolidation).

Essex provided additional materials on April 4, 2024. Petitioner supplied multiple documents on April 11, 2024, and April 16, 2024.[1]

On April 17, 2024, I conducted the consolidated hearing and closed the record.

FINDINGS OF FACT

Based on the testimony the parties provided, and my assessment of its credibility, together with the documents that the parties submitted, and my assessment of their sufficiency, I **FIND** the following as **FACT**:

On July 10, 2023, Essex sent petitioner a Medicaid renewal packet requesting L.B., like all beneficiaries, to supply income information by August 8, 2023, including recent bank statements for all accounts. (P-5.) L.B. was seventy-four years old and received $1,568 monthly in Social Security retirement benefits. (R-1.)

Indeed, Essex explained that it must verify all sources of income and resources under the Medicaid program to assess financial eligibility. See Medication Communication No. 22-04; N.J.A.C. 10:72-2.3.

However, Essex did not receive the requested income information sought in the renewal letter by August 8, 2023. Thus, on September 25, 2023, Essex sent a Notice for Verification seeking bank statements from three banks, Citibank, TD, and Chase, and an MCU credit union by October 9, 2023.

[1] The petitioner tried to provide materials by email on April 4, 2024, but the OAL could not open the items and requested that the petitioner resubmit the documents in a different format.

On October 12, 2023, Essex received some banking documentation but was still missing statements from Citibank. Essex first denied petitioner's application on October 17, 2023, terminating her case on October 31, 2023, having not received all requested banking documentation. That letter is state-generated and does not specify the verifications missing. Still, the denial advises petitioner to supply the missing materials for consideration or file a new application if unable to provide the materials within ninety days of the termination date.

Since Essex received some documentation it sought, the assigned family service worker, Rebecca Smith, reviewed the items L.B. sent. Based on her review, Essex sent a second Notice of Verification on October 18, 2023, seeking the missing Citibank statements and a letter of explanation concerning multiple monthly cash and Zelle deposits into L.B.'s Chase account due November 1, 2023. Specifically, Smith printed the letter and placed the letter for posting in the mailroom, as with all other Essex mailings.

Thus, Essex provided the petitioner with additional information and an opportunity to supply the missing information despite the October 17, 2023, termination. Essex asserts it can reconsider a verification denial once, and then it must deny the case if materials remain missing. However, the petitioner maintains that she did not receive the October 18, 2023, letter. Yet, the petitioner supplied the missing Citibank statements after the October 18, 2023, letter.

Essex also made multiple attempts to reach petitioner and her daughter by telephone. Essex documents phone contacts with clients, their attempts to contact clients, and actions taken in the WeCare portal (WeCare). WeCare also allows an applicant or others to contact Essex about a case. WeCare includes multiple entries for this case. F.N. also tried to reach a caseworker on several occasions. L.B. did not designate her daughter as an authorized representative (DAR), but L.B. allowed F.N. to assist her with her Medicaid application and these appeals.

Notably, on October 25, 2023, F.N. called about the October 17, 2023, denial. On October 26, 2023, a supervisor documented leaving a voicemail message for L.B.'s daughter explaining what information was missing: the Citibank statements and letter of explanation for Zelle and cash deposits in L.B.'s Chase account. On November 27,

2023, Essex received the Citibank statements but no letter of explanation. Another caseworker tried to reach L.B. by phone on November 30, 2023, to no avail.

Upon reconsideration of December 5, 2023, Essex again denied L.B.'s Medicaid case. Undeniably, Essex received no letter of explanation regarding the cash and Zelle deposits necessary to determine L.B.'s financial eligibility before December 5, 2023,

On December 26, 2023, WeCare reflects that a female supervisor spoke with the client, L.B. According to the WeCare note documenting that call, L.B. told the administrator that she would send the letter of explanation. L.B. remembers speaking with a woman from Essex but recalls no details of the call, including the date or substance of the call. F.N. called on December 26, 2023, maintaining that her mother supplied all requested statements. (R-1 and P-4.)

Still, Essex received no letter of explanation before L.B.'s appeals or within ninety days of the October 31, 2023, termination date. Instead, on April 15, 2024, the petitioner first presented a letter of explanation for the deposits drafted by her daughter, N.F. (P-7.) Petitioner asserts that Essex should have sent a second letter about the Chase account explanation or done more to alert her about what was missing. Although the petitioner denies receiving the October 18, 2023, letter, I do not **FIND** it credible that she and her daughter were unaware of the need to explain the Zelle or cash deposits, even if they were unclear about what to explain. Instead, Essex tried several times to advise L.B. and F.N. what was still missing and documented those attempts in the normal course of business. Thus, I **FIND** that a preponderance of the evidence demonstrates that the petitioner was aware of the need for further verification.

Notably, the April 15, 2024, letter was not part of the materials reviewed or received by Essex when processing the case, and Essex maintains that it must be part of a new application. Indeed, petitioner acknowledges that she presented the letter for a new application, if necessary. Thus, I give no weight to this document as to the propriety of Essex's earlier actions in these cases, and it is not evidence I consider. Similarly, N.F. supplied current bank statements, which have no bearing on this decision for the same reason but would be part of Essex's review of a new application. (P-6.)

LEGAL ANALYSIS AND CONCLUSION

Congress created the Medicaid program under Title XIX of the Social Security Act. 42 U.S.C. §§1396 to 1396w. The federal government funds the program that the states administer. Once the state joins the program, it must comply with the Medicaid statute and federal regulations. Harris v. McRae, 448 U.S. 297, 300 (1980). New Jersey participates in Medicaid through the New Jersey Medical Assistance and Health Services Act (Act). N.J.S.A. 30:4D-1 to -19.5.

The Commissioner of the Department of Human Services (DHS) promulgated regulations implementing New Jersey's Medicaid programs to explain each program's scope and procedures, including income and resource eligibility standards. See, e.g., N.J.A.C. 10:71-1.1 to -9.5 (Medicaid Only); N.J.A.C. 10:72-1.1 to -9.8 (Special Medicaid Programs); E.S. v. Div. of Med. Assistance and Health Servs., 412 N.J. Super. 340, 347 (App. Div. 2010).

The Act established the Division of Medical and Health Services (DMAHS) within the DHS to perform the administrative functions concerning Medicaid program participation. Bergen Pines County Hosp. v. New Jersey Dep't of Human Serv., 96 N.J. 456, 465 (1984); see also N.J.S.A. 30:4D-4, -5.

County welfare agencies (CWA), such as Essex, assist [DMAHS] in processing applications for Medicaid and determining whether applicants have met the income and resource eligibility standards." Cleary v. Waldman, 959 F. Supp. 222, 229 (D.N.J.1997), aff'd, 167 F.3d 801 (3d Cir.), cert. denied, 528 U.S. 870 (1999). Significantly, an applicant bears the burden of establishing eligibility for Medicaid benefits. D.M. v. Monmouth Cnty. Bd. of Soc. Servs., HMA 6394-06, Initial Decision (April 24, 2007), adopted, Dir. (June 11, 2007), http://njlaw.rutgers.edu/collections/oal/.

N.J.A.C. 10:72-2.3(a) requires Essex to verify all eligibility factors. Under N.J.A.C. 10:72-4.4, Essex determines income eligibility under the Aged, Blind, and Disabled (ABD) program using the income eligibility standards within N.J.A.C. 10:71-5.1 to -5.9, with certain exceptions. Similarly, Essex's resource eligibility determination

follows resource standards at N.J.A.C. 10:71-4.1 to -4.11 according to N.J.A.C. 10:72-4.5.

Under N.J.A.C. 10:71-5.1(b), income is "receipt, by the individual, of any property or service which he or she can apply, either directly or by sale or conversion to meet his or her basic needs for food or shelter." The CWA must consider all income, whether cash or in-kind in determining eligibility, unless such income is exempt under the provisions of N.J.A.C. 10:71-5.3. Ibid. Generally, income in kind is any support or maintenance in kind from a person other than a responsible relative for the applicant's housing, utilities, food, or basic needs. See N.J.A.C. 10:71-5.4(a)12. All income unless specifically excluded is includable in the determination of countable income. N.J.A.C. 10:71-5.4(a).

The Medicaid regulations also explain that the valuation of resources held in accounts is "its equity value." N.J.A.C. 10:71-4.1(d). The CWA considers liquid and non-liquid resources in determining eligibility unless such resources are excluded under the provisions of N.J.A.C. 10:71-4.4(b). Thus, the CWA often needs information from the applicant to verify financial eligibility and determine if any exclusions may apply.

Notably, an applicant is the primary source of information and must cooperate with the agency in securing evidence to corroborate their statements. N.J.A.C. 10:72-1.4(a)2, N.J.A.C. 10:72-2.3. Further, a CWA must seek verification of questionable information provided by an applicant. N.J.A.C. 10:72-2.3(c).

Under Medicaid Communication No. 22-04, updating Medicaid Communication No. 10-09, and 42 CFR 435.952 (c)(2), if a verification results in a discrepancy, insufficient information, or an error, the CWA will send a Request for Information (RFI) letter. The RFI letter will allow the applicant fourteen days to respond. See Medicaid Communication No. 22-04. If the CWA receives no response, it will deny the application for failure to provide information under 42 CFR 435.952 (c)(2). The CWA may send an additional RFI letter if the applicant's response to the first RFI prompts the need for further outreach, as Essex did here. Here, I **CONCLUDE** that Essex, as a courtesy, reviewed the late materials it received but could not confirm L.B.'s eligibility without an

explanation of the deposits, which it requested. Indeed, despite several attempts to address the letter of explanation with petitioner and her daughter, Essex did not receive one until these appeals.

Still, the regulations governing Medicaid recognize that there may be "exceptional cases" when an applicant cannot produce the required information timely. See e.g., N.J.A.C. 10:71-2.3(c) (permitting an extension of time to issue an eligibility determination when the applicant did not produce information due to exceptional "[c]ircumstances wholly beyond the control of both the applicant and the [CWA]"). Yet, at best, an extension is permissible, not required. Ibid.; S. D. v. Division of Med. Assistance & Health Servs. and Bergen County Bd. of Social Services, 2013 N.J. Super. Unpub. LEXIS 393 (February 22, 2013); see also J.D. v. Div. of Med. Assistance & Health Serv., No. HMA 3564-14, Initial Decision (June 26, 2104) http://njlaw.rutgers.edu/collections/oal/, adopted, Dir. (July 29, 2014) https://www.state.nj.us/humanservices/providers/rulefees/decisions/dmahs2014.html, (finding that a guardian's difficulty in obtaining requested documents because of non-cooperation from the applicant's family and financial institutions did not constitute extraordinary circumstances).

Here, L.B. requests that Essex excuse her from timely supplying the explanation she later provided well beyond processing timeframes because she was unaware of Essex's need for further verifications. However, I found that L.B. was aware that she needed to explain the deposits into the Chase account. Thus, I **CONCLUDE** that exceptional circumstances are not present to excuse L.B.'s earlier failure and that she must supply a new application. See, e.g. Chalmers v. Shalala, 23 F.3d 752 (1994) (holding that while many applicants seeking public assistance often have limited abilities in the application process due to disabilities, this does not alone excuse or diminish their responsibilities over resources).

Therefore, I **CONCLUDE** that L.B.'s failure to provide verifications for her Medicaid redetermination made her ineligible and that L.B.'s appeal should be **DISMISSED.**

ORDER

Given my findings of fact and conclusions of law, I **ORDER** that L.B. is ineligible for Medicaid because she failed to supply necessary verifications and that her appeal is hereby **DISMISSED**.

I **FILE** this initial decision with the **ASSISTANT COMMISSIONER OF THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES**. This recommended decision is deemed adopted as the final agency decision under 42 U.S.C. § 1396a(e)(14)(A) and N.J.S.A. 52:14B-10(f). The **ASSISTANT COMMISSIONER OF THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES** cannot reject or modify this decision.

If you disagree with this decision, you have the right to seek judicial review under New Jersey Court Rule 2:2-3 by the Appellate Division, Superior Court of New Jersey, Richard J. Hughes Complex, PO Box 006, Trenton, New Jersey 08625. A request for judicial review must be made within 45 days from the date you receive this decision. If you have any questions about an appeal to the Appellate Division, you may call (609) 815-2950.

April 26, 2024

DATE

NANCI G. STOKES, ALJ

Date Record Closed: April 26, 2024

Date Filed with Agency: April 26, 2024

Date Sent to Parties: April 26, 2024

ljb

APPENDIX

WITNESSES

For Petitioner:

L.B.

F.N.

For Respondents:

Rebecca Smith, FSW

EXHIBITS

For Petitioner:

P-1 Email dated April 11, 2024, with MCU statements

P-2 Email dated April 11, 2024, with Chase statements

P-3a Email dated April 11, 2024, with Citibank statements

P-3b Email dated April 11, 2024, with additional Citibank statements

P-4 Screenshots of WeCare

P-5 Email dated April 11, 2024, with attachments

P-6 Email dated April 15, 2024, with current bank statements

P-7 April 15, 2024, letter

For Respondent:

R-1 Fair Hearing packet

R-2 Denial letters and RFIs