State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION
OAL DKT. NO. HMA 11466-24
AGENCY DKT. NO. N/A

S.L.,

Petitioner,

v.

GLOUCESTER COUNTY
DIVISION OF SOCIAL SERVICES,

Respondent.

S.L., petitioner, pro se

Nicole Harris, Fair Hearing Liaison, appearing for respondent pursuant to N.J.A.C. 1:1-5.4(a)(3)

Record Closed: September 27, 2024 Decided: October 10, 2024

BEFORE **TAMA B. HUGHES**, ALJ:

STATEMENT OF THE CASE

S.L. ("S.L." or "petitioner") appeals the denial of Medicaid eligibility by the Gloucester County Division of Social Services ("respondent" or "County") for failure to provide documentation.

PROCEDURAL HISTORY

By letter dated July 8, 2024, petitioner's application for Medicaid Only was denied. Petitioner timely appealed, and the Division of Medical Assistance and Health Services transmitted the matter to the Office of Administrative Law on August 20, 2024. N.J.S.A. 52:14B-1 to -15; N.J.S.A. 52:14F-1 to -13. The matter was heard on September 27, 2024, at which time the record closed.

FACTUAL DISCUSSION AND FINDINGS

Paul Watkins (Watkins), a Human Services Specialist III in the Medicaid Unit, testified on behalf of the County. Petitioner filed a Medicaid Application (Application) for Medicaid Only on February 15, 2024. (R-1 at 2–21.) Petitioner identified one bank account on the Application. (R-1 at 9.) The Application was denied on February 26, 2024, for being over the income limit. (R-1 at 22–23.) Petitioner appealed the determination, and on the hearing date, the County rescinded its action to reevaluate the household composition and Application.

As part of the re-evaluation review, on June 14, 2024, a request for information (RFI) was sent to the petitioner. (R-1 at 36.) The RFI sought financial information related to seven bank accounts that had come up on the Active Verification System (AVS)—a system that the County uses to look up financial information on clients—for the time period of November 1, 2023, to February 1, 2024, and additional information regarding petitioner's minor child.[1] All documentation was required to be submitted by June 28, 2024.

On or about June 27, 2024, petitioner provided the County with the financial documentation that was requested, with the exception of the account information related to the JP Morgan Chase Bank account ending #7138 and the PNC Bank account ending

[1] Information to the following accounts was requested: JP Morgan Chase Bank account ending #7138; JP Morgan Chase Bank account ending #1669; PNC Bank account ending #9464; PNC Bank account ending 9472; PNC Bank account ending 9499; PNC Bank account ending 1972; PNC Bank account ending 1999; PNC Bank account ending #2019.

#9464 accounts. (R-1 at 37–86.) For those accounts, petitioner failed to provide the requested documentation reflecting the balance in the accounts as of February 1, 2024.

By letter dated July 8, 2024, petitioner was notified that his Application was denied for failure to provide the required documentation. (R-1 at 87–89.)

On cross-examination, Watkins was questioned about the termination of petitioner's health benefits. According to Watkins, petitioner was the recipient of benefits under the Affordable Care Act, which had been terminated. The Application that he filed with their office was for Medicaid Only. When asked why the County did not inform him that documentation was missing, Watkins indicated that petitioner was put on notice of what documentation was required. It was the applicant's responsibility to provide it. N.J.A.C. 10:71-2.2(c)(5) mandates that the agency notify an applicant as expeditiously as possible as to their eligibility. It does not require the County to notify an applicant if their required documentation is deficient.

S.L. testified on his own behalf. According to S.L., this is the second hearing on this Application. In the first hearing, the County made an error in calculating the household size by not including their minor child as part of the household. The County also recommended that he refile, which he did. That application was also denied and is pending appeal. It appears that in the second application, the County again failed to include his minor child in the household composition.

The County asked for copies of his bank statements, which he provided. He personally asked them if everything was in order, and they said everything was okay, only to be told later in the denial letter that some of the documentation was missing. He has always done his best to cooperate and provide the necessary documentation.

He is currently undergoing treatment for cancer, which has run into complications. He is undergoing chemotherapy and other treatments, which makes it critical to have continued health care coverage. Denying his coverage based on administrative issues has put his access to essential medical care at risk. Given these circumstances, he respectfully asks that the health care coverage be reconsidered. He would like Medicaid

to allow him to submit the missing paperwork and evaluate his application using the correct household size. Additionally, if there are further issues, such as missing paperwork, he would ask that the County notify him directly and give him a chance to file them before a denial determination is made.

Regardless of how the error occurred, notice should have been given to him to cure the issue. He is looking for a fair and accurate assessment based on the correct household size and available resources. His medical needs make it imperative that this matter be resolved as expeditiously as possible.

On cross examination, S.L. acknowledged that the County must look at household size, income and resources in determining eligibility for Medicaid programs such as the one he applied to. He was unaware that the resource limit for the program that he applied to was $6,000.

He did not have proof that he sent all of the documents relating to the PNC account ending #9464 or the JP Morgan Chase Bank account ending #7138. He sent everything by mail and requested a return receipt. He could not say for certain that the documents in question were in the packet of information he sent to the County.

I found both witnesses' testimony to be both candid and credible. After hearing the testimony presented and upon review of the documentation submitted into evidence, I **FIND** the following as **FACT**:

1. On February 15, 2024, S.L. filed an Application for Medicaid Only. Petitioner identified only one bank account — J.P. Morgan Chase Bank account ending #7138 on the Application.

2. The Application was denied on February 26, 2024, for being over income. The determination was appealed, and the matter was transmitted to the OAL for a hearing. On the hearing date, the County rescinded its action to re-evaluate the household composition and financial qualification.

3. On June 14, 2024, petitioner was sent an RFI returnable on June 28, 2024. The RFI requested banking statements for the period of November 1, 2023, to February 1, 2024, from multiple financial institutions. See footnote 1.

4. On June 28, 2024, petitioner submitted documentation from all the requested institutions. However, documentation was missing for account balances for February 1, 2024, from the JP Morgan Chase Bank account ending #7138 and the PNC Bank account ending #9464. The documentation that was provided reflected that the client's resources were over the monthly resource limit of $2,000.

5. On July 2, 2024, a denial notification was sent to petitioner denying his application for failure to provide the appropriate documentation.

6. It is the responsibility of the County to ensure that the applicant is financially eligible to receive Medicaid Only benefits.

7. As part of the documents presented for the hearing, petitioner provided copies of the financial documents that he had provided to the County. The required documentation for the J.P. Morgan Chase Bank account ending #7138 for February 2024 was in the packet; however, the account information for the PNC Bank account ending #9464 was not.

LEGAL DISCUSSION

The Medicaid program is a cooperative federal-state venture, established by Title XIX of the Social Security Act. 42 U.S.C.A. §§1396, et seq. It "'is designed to provide medical assistance to persons whose income and resources are insufficient to meet the costs of necessary care and services.'" L.M. v. Div. of Med. Assistance and Health Servs., 140 N.J. 480, 484 (1995) (quoting Atkins v. Rivera, 477 U.S. 154, 156, 106 S. Ct. 2456, 2458, 91 L. Ed. 2d 131, 137 (1986)); See Mistrick v. Div. of Med. Assistance and Health Servs., 154 N.J. 158, 165 (1998).

Eligibility for Medicaid is governed by regulations adopted in accordance with the authority granted to the DMAHS and the Commissioner of the Department of Human Services. N.J.S.A. 30:4D-7. The DMAHS and Commissioner are required to establish a policy and procedures for the Medicaid application process and shall supervise the operation of, and compliance with, the policy and procedures. N.J.A.C. 10:71-2.2(b).

Medicaid applicants must satisfy certain income and resource eligibility standards. N.J.A.C. 10:71-4.1 to -4.11; N.J.A.C. 10:71-5.1 to -5.9. As part of the application process, an applicant must "[a]ssist the CWA [county welfare agency] in securing evidence that corroborates his or her statements," including information about the applicant's income and resources." N.J.A.C. 10:71-2.2(e)(2). In this regard, "[d]ocumentary sources of evidence present factual information recorded at some previous date by a disinterested party," including "certificates, legal papers, insurance policies, licenses, bills, receipts, notices of RSDI benefits, and so forth." N.J.A.C. 10:71-3.1(b)(1). Importantly, "[e]ligibility must be established in relation to each legal requirement to provide a valid basis for granting or denying medical assistance." N.J.A.C. 10:71-3.1(a).

An applicant whose Medicaid application is denied by a CWA for failure to provide verification of eligibility in accordance with N.J.A.C. 10:71-2.2(e)(2) may request a fair hearing before the OAL to challenge the agency's decision. N.J.A.C. 10:49-10.3(b). In such appeals, the main issue is whether the applicant timely provided the agency with sufficient documentation to determine their financial eligibility for Medicaid. However, a review of administrative decisions shows that in cases in which an applicant made a good-faith effort to cooperate with the CWA's document requests but ultimately failed to do so due to "exceptional circumstances," such failure may be excused, and the CWA may be ordered to give the applicant more time to provide verifications.

However, in the absence of "exceptional circumstances," a denial for failure to provide verifications will be upheld even if the applicant or his representative cooperated with the CWA during the application period, especially when the CWA extended the application period. Thus, in J.B. v. Cape May Cnty. Bd. Of Soc. Servs., HMA 06942-14, Initial Decision (August 22, 2014), adopted, Dir. (September 9, 2014), www.njlaw.rutgers.educ/collections/oal>, the ALJ affirmed the denial of petitioner's

application because the CWA had given her attorneys almost six months to provide all of the necessary documents, but in response to each of the agency's numerous notices, the attorneys inexcusably managed to provide only some of the requested documents. In J.D. v. Div. of Med. Assistance & Health Serv., HMA 03564-14, Initial Decision (June 26, 2014), www.njlaw.rutgers.edu/collections/oal>, adopted, Dir. (July 29, 2014), www.state.nj.us/humanservices/providers/rulefees/decisions, the ALJ found that a public guardian's difficulty in obtaining requested documents due to a lack of cooperation from petitioner's family and financial institutions did not constitute extraordinary circumstances in light of the fact that the CWA had provided the public guardian an additional two months to obtain the necessary documents, and the agency had still not received all of the outstanding information.

In the instant matter, petitioner contends that he submitted all of the necessary documentation. If documentation was missing, the County should have contacted him, and he would have provided it. Additionally, the County has in both his applications, the instant one and the second application that he filed, failed to properly consider his household composition and financial eligibility. Given his current medical situation and his ongoing cooperation in providing the County with the necessary documentation, he believes that the matter should be remanded for further consideration with the documentation that he provided on the hearing date.

Respondent contends that notice was provided to the petitioner, which outlined the exact documentation that was needed and when the documentation was required to be submitted. In order to assess qualification for Medicaid benefits, all sources of income and resources must be reviewed. In the absence of credible verification of all eligibility factors, eligibility for the Medicaid program may not be established. N.J.A.C. 10:72-2.3(e).

As part of the application process, both the applicant and the respondent have responsibilities related to the application process. The respondent exercises direct responsibility in the application process to:

1. Inform the applicants about the purpose and eligibility requirements for Medicaid Only, inform them of their rights and responsibilities under its provisions and inform applicants of their right to a fair hearing;

2. Receive applications;

3. Assist the applicants in exploring their eligibility for assistance;

4. Make known to the applicants the appropriate resources and services both within the agency and the community, and, if necessary, assist in their use;

5. Assure the prompt and accurate submission of eligibility data to the Medicaid status files for eligible persons and prompt notification to ineligible persons of the reason(s) for their ineligibility.

[N.J.A.C. 10:71-2.2(c).]

As a participant in the application process, a petitioner is required to:

1. Complete, with assistance from the CWA if needed, any forms required by the CWA as a part of the application process;

2. Assist the CWA in securing evidence that corroborates his or her statements;

3. Report promptly any change affecting his or her circumstances.

[N.J.A.C. 10:71-2.2(e).]

Here, no exceptional circumstances were presented by the petitioner to explain why the documentation was missing. It appears that contrary to petitioner's assertion, two key pieces of financial information were missing from the financial documentation

submitted as part of the Application. Notably, even the documentation submitted by the petitioner for the Fair Hearing was missing the PNC documentation.

The missing documentation does not appear to be intentional on the petitioner's part—rather an unintentional oversight. Unfortunately, however, the result of the omission remains the same. The onus is on the petitioner to ensure that all relevant documentation requested by the respondent is provided. As unfair as that may seem, it is not the respondent's responsibility to reach out to each and every applicant to remind them to provide the necessary or missing documentation to process their application. That is the responsibility of the applicant. The petitioner was told what documentation was required and when it was due. Unfortunately, what was provided was not completely responsive to RFI.

For all of the foregoing reasons, I conclude that respondent's denial of petitioner's February 15, 2024, Medicaid application for failure to provide documentation was reasonable and proper and should be **AFFIRMED**.

ORDER

It is **ORDERED** that respondent's denial of S.C.'s February 15, 2024, Medicaid application for failure to provide the required documentation to process the application is **AFFIRMED,** and petitioner's appeals are **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 forty-five 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.

October 10, 2024
DATE

TAMA B. HUGHES, ALJ

Date Received at Agency:

Date Mailed to Parties:

TBH/cb

APPENDIX

WITNESSES

For petitioner:

S.L.

For respondent:

Paul Watkins, Human Services Specialist III

EXHIBITS

For petitioner:

P-1 (52 pages)

For respondent:

R-1 Fair Hearing Packet (113 pages)