State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION

T.R.,

Petitioner,

v.

ESSEX COUNTY DIVISION OF FAMILY ASSISTANCE AND BENEFITS,

Respondent.

OAL DKT. NO. HMA 03411-24
AGENCY DKT. NO. N/A

T.R.,

Petitioner,

v.

ESSEX COUNTY DIVISION OF FAMILY ASSISTANCE AND BENEFITS,

Respondent.

OAL DKT. NO. HMA 04016-24
AGENCY DKT.NO. N/A

T.R.,

Petitioner,

v.

ESSEX COUNTY DIVISION OF FAMILY ASSISTANCE AND BENEFITS,

Respondent.

OAL DKT. NO. HMA 04515-24
AGENCY DKT.NO. N/A

Yale S. Hauptman, Esq., for petitioner (Hauptman & Hauptman, PC, attorneys)

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

Record Closed: October 29, 2024 Decided: November 15, 2024

BEFORE **MATTHEW G. MILLER,** ALJ:

STATEMENT OF THE CASE

Generally, petitioner, T.R. appeals the termination of her Medicaid benefits effective on or about November 30, 2023 by the Essex County Division of Family Assistance and Benefits ("Respondent" or "Agency") for failure to provide information in violation of N.J.A.C. 10:71-2.3.

The Agency argued very simply that the petitioner has still not provided the requested information and has suggested that petitioner reapply for benefits.

Petitioner argues that T.R.'s benefits should never have been terminated, that all requested information had been supplied in timely manner and that it was only because of incompetence and miscommunication on behalf of respondent that these appeals were required.

PROCEDURAL HISTORY

The procedural history of this case is...complicated. At its most basic, however, T.R. filed three separate appeals based upon the same redetermination denial as follows:

In T.R. v. Essex County Division of Family Assistance & Benefits OAL DKT. NO. HMA 03411-24, petitioner requested a fair hearing and the matter was transmitted to the Office of Administrative Law (OAL) on March 14, 2024 for hearing as a contested case.

In T.R. v. Essex County Division of Family Assistance & Benefits, OAL DKT. NO. HMA 04016-24, petitioner requested a fair hearing and the matter was transmitted to the OAL on March 26, 2024 for hearing as a contested case.

In T.R. v. Essex County Division of Family Assistance & Benefits, OAL DKT. NO. HMA 04515-24, petitioner requested a fair hearing and the matter was transmitted to the OAL on April 4, 2024 for hearing as a contested case.

Those matters were consolidated by Order dated September 30, 2024. (C-1.)

During the proceeding, the parties agreed that this decision could be made based upon their written submissions. Given the confusing nature of the files, the record was held open until October 29, 2024 for additional submissions and to confirm that all relevant documentation had been received.

TIMELINE, FACTUAL DISCUSSION AND FINDINGS

The following **FACTS** are not in dispute, and I therefore **FIND** the following as **FACTS**:

1. In September, 2023, petitioner, T.R. (DOB: 6/30/32), who suffers from dementia, was sent a renewal package for NJ Family Care/Medicaid ("Medicaid"). The package was sent to her at her assisted living facility. (R-1.)

2. That renewal package was not sent to T.R.'s attorney, who had filed the original Medicaid application or to T.R.'s daughters, who had power of attorney.

3. On November 16, 2023, petitioner was sent a letter terminating her Medicaid benefits effective December 31, 2023 due to her alleged failure to timely return the renewal package. The letter included this paragraph:

> If you would like to return the renewal form we sent you earlier or provide the missing information, we can still see if you qualify for NJ FamilyCare/Medicaid. If we do not receive the information within 90 days from the Coverage End Date above and you still want health care

> coverage, you will have to re-apply. Please note that even if you qualify at that time, you could have a gap in your coverage. (R-1.)

3. On January 12, 2024, T.R., through her attorney, appealed the termination, noting:

> Redetermination notice was mailed to recipient who is mentally incapacitated. Redetermination package was received by Essex County on Dec. 26, 2023. (R-2.)

4. The package referenced by T.R.'s attorney on January 12, 2024 was dated December 22, 2023 and included the following items:

   a. Chase Bank checking statement (Account 3898) for November 11, 2023 through December 8, 2023.

   b. Chase Bank checking statements (Account 1758 – QIT) for December 13, 2022 through December 12, 2023.

   c. 2024 Social Security Income Letter.

   d. Advice that the home where T.R. was residing does "not maintain a PNA for (her)" would be forthcoming. (R-2.)

5. In reply to that December 22, 2023 submission from T.R., on January 10, 2024, respondent forwarded another denial letter to T.R., claiming that she was both over income and over resource. (P-1.)

6. Petitioner formally appealed that denial on February 23, 2024, simply advising that Medicaid had been wrongfully denied. (C-2.)

7. However, that January 10, 2024 denial letter was immediately followed by a January 11, 2024 Notice of Verification, with respondent requesting the following from T.R.'s attorney;

   a. Chase Bank checking statements (Account 3898) from November 1, 2022 to December 31, 2023.

b. Pension Award Letter with gross monthly amount of pension.

c. Annuity Award Letter with gross monthly amount of annuity.

d. Life insurance policy from Transamerica with face and cash values.

e. Life insurance policy from Empower with face and cash values.

The application was deemed to be "pending". (P-6.)

8. In reply to the January 11, 2024 Notice of Verification, T.R.'s attorney emailed a letter dated January 17, 2024, which included the following:

a. A copy of the January 11, 2024 letter.

b. Chase Bank checking statements from November 1, 2022 through December 31, 2023.

c. Requested Transamerica information.

d. Requested Empower information.

The letter also noted that the pension information had been supplied with the original application and has been unchanged since 2020. It was also noted that the annuity information was also included in the original Medicaid application and the monthly payout amount had also remained unchanged. It also confirmed that Transamerica was the pension provider for T.R. and that Empower was the annuity provider and that no life insurance policies exist. The monthly payments into Account #3898 simply reflect the pension and annuity. (P-7.)

9. Then on February 27, 2024, respondent noted that it had "reconsidered" the application. While T.R. was now noted to be both income and resource eligible, she was denied again, this time for failing to provide information in a timely manner. (P-3.)

10. This denial was formally appealed on March 5, 2024. (C-2.)

ISSUE

The Agency has taken the position that per N.J.A.C. 10:71-2.3 et seq., petitioner failed to provide the requested financial information so as to enable it to make an informed decision as to T.R.'s Medicaid eligibility. Therefore, its multiple denials were appropriate.

Petitioner argues that it has proven that it timely supplied all the materials requested and that respondent's handling of the file was both piecemeal and disorganized, which has caused an already difficult process to have become a practical impossibility to successfully navigate even for parties who are clearly and obviously eligible for benefits.

LEGAL ANALYSIS AND CONCLUSION

Perhaps the most concise description of the Medicaid program and how it works in New Jersey is as follows:

> Medicaid is a program created by federal law, but implemented at the state level, which provides coverage for medical care to individuals who cannot afford to obtain it on their own. See 42 U.S.C § 1396, et seq. The program is designed to provide benefits to persons "whose income and resources are insufficient to meet the cost of necessary medical services." 42 U.S.C. § 1396-1. State participation is voluntary; however, states that participate in the Medicaid program must comply with the federal statutory and regulatory framework governing Medicaid. Sabree v. Richman, 367 F.3d 180, 182 (3d Cir. 2004). New Jersey has authorized participation in the Medicaid program through its Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1, et seq. The state's Medicaid program is administered by the DMAHS...
>
> Galletta v. Velez, 2014 U.S. Dist. LEXIS 75248 at 17 (D.N.J. June 3, 2014).

The role of counties in the administration of Medicaid cases is as follows:

> Local county welfare agencies evaluate Medicaid eligibility. N.J.S.A. 30:4D-7a; N.J.A.C. 10:71-1.5, 2.2(c). An applicant must establish "eligibility . . . 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. "The CWA exercises direct responsibility in the application process to . . . [a]ssist the applicants in exploring their eligibility for assistance." N.J.A.C. 10:71-2.2(c)(3). Similarly, an applicant shall "[a]ssist the CWA in securing evidence that corroborates his or her statements." N.J.A.C. 10:71-2.2(e)(2). The CWA "review[s] . . . the application for completeness, consistency, and reasonableness." N.J.A.C. 10:71-2.9.
>
> "[T]o be financially eligible [for benefits], the applicant must meet both income and resource standards." Brown, 448 N.J. Super. at 257 (citing N.J.A.C. 10:71-3.15). Specifically, "[t]he regulations governing an individual's eligibility for Medicaid reimbursement of nursing home costs provide that in order for an individual to participate in the Medicaid Only Program, the value of that individual's resources may not exceed $2,000." H.K. v. State, 184 N.J. 367, 380, 877 A.2d 1218 (2005) (footnote omitted) (citing N.J.A.C. 10:71-4.5(c)). To determine eligibility, the agency evaluates the available assets both of the "institutionalized spouse" and the "community spouse" during a five-year "look back" period. N.J.A.C. 10:71-4.8; N.J.A.C. 10:71-4.10(b)(9); see also 42 U.S.C. § 1396r-5(c)(1)(A).
>
> N.S. v. Division of Med. Assistance & Health Servs., 2019 N.J. Super. Unpub. LEXIS 1499 (App. Div. July 3, 2019).

There is no question that it is the duty of the Agency to "verify the existence or nonexistence" of the applicant's assets per N.J.A.C. 10:71-4.2(b)(3):

> The CWA shall verify the existence or nonexistence of any cash, savings or checking accounts, time or demand deposits, stocks, bonds, notes receivable or any other financial instrument or interest. Verification shall be accomplished through contact with financial institutions, such as banks, credit unions, brokerage firms and savings and loan associations. Minimally, the CWA shall contact those financial institutions in close proximity to the residence of the applicant or the applicant's relatives and those institutions which currently provide or previously provided services to the

> applicant. N.J.A.C. 10:71-4.2 (c). Documentation of verification: Any verification which occurs in connection with the determination or evaluation of resources shall be fully documented in the case record.

The duties of the agency are also delineated in N.J.A.C. 10:71-2.2(d) and the applicant is also obliged 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; and
> 3. Report promptly any change affecting his or her circumstances.
>
> [N.J.A.C. 10:71-2.2(e)]

As noted in Galletta:

> When seeking an eligibility decision, applicants must provide the county agencies with documentation and evidence related to their resources.
>
> Id. at 18.

The regulations governing Medicaid recognize that there may be times when an applicant is unable to produce required information. See e.g., N.J.A.C. 10:71-2.3(c) (permitting an extension of time to issue an eligibility determination when information has not been produced due to "[c]ircumstances wholly beyond the control of both the applicant and the county welfare agency.").

This extension policy was outlined in Medicaid Communication No. 22-04 (May 3, 2022), which reads in relevant part:

> It should be understood that exceptional circumstances may arise in determining eligibility. Therefore, if the applicant/beneficiary requests additional time to provide information and continues to cooperate in good faith with the Agency, a reasonable extension of the time limit may be

> permitted. These exceptional circumstances shall be documented in the Worker Portal. **If an applicant/beneficiary fails to provide the requested information, fails to respond to the EDA while under a good faith extension, or fails to respond to EDA outreach, a denial/termination letter with the applicable citation must be sent.**
>
> • For denial letters when the individual failed to provide requested information (new applicants only) no further documentation will be accepted by the Agency and the individual will be provided with information to reapply. Verifications from the previous application shall be utilized in the new application where appropriate.
>
> • **For terminated beneficiaries who failed to provide information, reconsideration is required if the information is returned within 90-days of the termination date.** A new application may not be requested. A new eligibility outcome letter with the updated decision must be issued at that time

(Exhibit C-4.) (emphasis added)

In analyzing the facts and procedural machinations of these consolidated cases, it honestly never made much sense. Instead of a viable, defensible denial, it appears that this case fell victim to bureaucratic red tape, a lack of intra-agency coordination/communication and an overwhelming agency workload.

Bluntly, this case should never have been denied, but at the very least when respondent found that T.R. was both resource and income eligible on February 27, 2024, that should have been the end of the story. (P-3.) The denial at that point is very hard to understand.

This is particularly true since respondent never addressed the documentation that T.R.'s attorney inarguably supplied throughout the course of the renewal process. Instead, the constant mantra was that T.R. should reapply, since it appears that she would be eligible for benefits. The problem is, however, that by any objective measure, she has always been eligible for benefits and there has never been a need for her to reapply.

It is clear that the Transamerica and Empower information was supplied and clarified by counsel in his January 17, 2024 letter, which was emailed just six days after the January 11, 2024 request for verification.

In addition to that pension and annuity information (which was uncontestedly unchanged from T.R.'s initial application in 2020/2021), the requested banking information was also supplied. In reviewing the statements that had been provided to respondent, I had only a single question. On December 11, 2023, there was a $2,000.00 transfer into T.R.'s Qualified Investment Trust (QIT) account (#1758) from another account (#2656). While that transaction was never questioned by respondent, it is undisputed that this payment was made by T.R.'s daughters from their personal account and was meant to be a payment to counsel. Once that error was realized, just two days later on December 13, 2023, a $2,000.00 check was cut to counsel.[1]

The statement reads as follows;

(Chase **1758**)
11/11/23 – 12/13/23

11/11/23 – Beginning Balance -	$ 101.80
11/13/23 – Transfer from 3898 (SSA) -	$2,129.00
11/16/23 – Payment (nursing home) -	($2,129.00)
12/11/23 – Transfer from 3898 (SSA) -	$2,129.00
12/11/23 – Transfer from 2656 -	$2,000.00
12/13/23 – Check to Hauptmann -	$2,000.00

Having reviewed the sequence of events, the specific demands made by respondent and the prompt, compliant replies by T.R.'s attorney, I cannot understand why this case remained denied subsequent to receipt of the January 17, 2024 submission. Even addressing the one issue that raised my eyebrow concerning the mid-month $2,000.00 QIT transaction, the evidence is overwhelming and I specifically **FIND** that:

1. Once T.R. was apprised of the existence of a renewal packet, she (through counsel), immediately and timely responded to same.

[1] The banking, pension and annuity information is comprehensively explained in petitioner's July 8, 2024 and July 25, 2024 submissions. (P-12 and P-13.)

2. The completed redetermination packet was received by respondent on December 26, 2023.

3. T.R. fully and completely complied with respondent's RFV letter of January 11, 2024 with counsel's letter of January 17, 2024.

4. Respondent had literally all of the information that it had requested and with which it required to determine T.R.'s continued Medicaid eligibility by no later than January 17, 2024.

5. Respondent's February 27, 2024 decision to terminate T.R.'s Medicaid is wholly unsupported in the record.

6. Petitioner has proven by clear and convincing evidence that respondent's decision to maintain its decision to terminate T.R.'s Medicaid benefits was arbitrary, capricious and unreasonable.

This is not the standard "extension" case. Rather, T.R.'s case started off with an almost understandable bobble (a letter to a dementia patient in an assisted living facility), which was rather swiftly corrected by counsel. It is here where things went off the rails. Frankly, no extension was necessary. Counsel supplied literally the exact information requested by respondent well within the ninety-days of the December 31, 2023 termination date specified in the November 16, 2023 letter. In fact, respondent had the information five days before the termination date itself.

The January 10, 2024 letter was perhaps understandable given the holidays, but once the January 11, 2024 RFV letter was sent and responded to, this case should have ended. The fact that it has lasted this long is unacceptable. I **CONCLUDE** that T.R. clearly complied with all relevant aspects of the Administrative Code and Medicaid Communication 22-04 and in no legitimate way can respondent's interpretation of either the code provision on the factual scenario presented in this case be said to be reasonable. Blecker v. State, 323 N.J. Super 434, 442 (App. Div. 1999).

Given the totality of the circumstances and as noted above, I **FIND** that respondent's decision to terminate petitioner's Medicaid benefits was arbitrary, capricious and unreasonable and be and is hereby **REVERSED**.

I further **FIND** that given the evidence supplied by the parties (all of which was in respondent's possession in a timely manner), there is no need for T.R.'s renewal application to be reconsidered, but rather I **ORDER** that it be hereby deemed **APPROVED** and I further **ORDER** that her benefits be continued without interruption as if the termination had never occurred and that any and all back benefits potentially due to petitioner and/or her providers be remitted as soon as practically possible.

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.

November 15, 2024
DATE

MATTHEW G. MILLER, ALJ

Date Filed with Agency: November 15, 2024

Date Sent to Parties: November 15, 2024

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APPENDIX

EXHIBITS

Court:

C-1 Consolidation Order (September 30, 2024)

C-2 Appeal (February 23, 2024)

C-3 Appeal (March 5, 2024)

C-4 Medicaid Communication No. 22-04 (May 3, 2022)

For Petitioner:

P-1 Medicaid Termination Letter #2 (January 10, 2024)

P-2 Medicaid Eligibility Worksheet (January 10, 2024)

P-3 Medicaid Termination Letter #3 (February 27, 2024)

P-4 Medicaid Termination Letter #1 (November 16, 2023)

P-5 Cover letter form T.R. attorney (December 22, 2023)

P-6 Notice of Verification Letter from respondent (January 11, 2024)

P-7 Letter from T.R. attorney (January 17, 2024)

P-8 Chase Bank Statement (Account 3898) (November 9, 2023 – December 8, 2023)

P-9 Chase Bank Statement (Account 1758 - QIT) (November 11, 2023 – December 12, 2023)

P-10 Chase Bank Statement (Account 2656) (November 28, 2023 – December 27, 2023)

P-11 Check 167 from Account 1758 (December 13, 2023)

P-12 July 8, 2024 submission

P-13 July 25, 2024 submission

P-14 September 17, 2024 submission

For Respondent:

R-1 Medicaid Termination Letter #1 (November 16, 2023)
R-2 Appeal (January 12, 2024)
R-3 Fair Hearing Summary Report
R-4 Medicaid Eligibility Report (July 8, 2024)