State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION

OAL DKT. NO. HMA 10518-24

M.F.,

Petitioner,

v.

ESSEX COUNTY BOARD OF SOCIAL SERVICES,

Respondent.

Donald A. Dennison, III, Esq., for petitioner (Mandelbaum Barrett P.C., attorneys)

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

Record Closed: April 9, 2025 Decided: May 1, 2025

BEFORE **DANIEL J. BROWN**, ALJ:

STATEMENT OF THE CASE

The respondent (Essex) denied the petitioner's February 2024 application for Managed Long-Term Services and Supports (MLTSS) program because the petitioner failed to timely provide the information sought by an RFI in a timely manner. 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

On May 3, 2024, Essex issued a denial to M.F. concerning her July 2023 Medicaid application, determining that she failed to respond to a request for information dated March 15, 2024.

On May 21, 2024, the petitioner appealed the denial issued on May 3, 2024.

The Division of Medical Assistance and Health Services (DMAHS) transmitted the case regarding the May 3, 2024, denial to the Office of Administrative Law (OAL), where it was filed on July 26, 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 case was first scheduled before me on January 14, 2025. I held additional telephone conferences on February 3, 2025, February 20, 2025, March 6, 2025, and March 11, 2025, to discuss hearing availability dates, the nature of the proceeding, the issues to be resolved, and any unique evidentiary problems. I also permitted additional time for discovery. On March 11, 2025, I scheduled the case for a hearing on April 9, 2025.

On April 9, 2029, I conducted the hearing and closed the record.

FINDINGS OF FACT

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

On February 29, 2024, the petitioner applied for Medicaid benefits. The application included a form selecting a Designated Authorized Representative (DAR). The DAR selection form is a published form included with the Medicaid application to authorize a third party to represent the applicant. In this case, the DAR selection form documented that petitioner's counsel was the DAR selected for the petitioner. The form provides, in pertinent part, that the selection of a DAR doesn't relieve the petitioner of their responsibility to participate in the NJ Family Care eligibility process, including providing information and documents. The form is signed by the petitioner's Power of Attorney (POA). By letter dated March 15, 2024, Essex mailed a Request for Information (RFI) letter that listed the address of the petitioner's nursing home as the recipient address. The RFI sought a copy of the petitioner's pension award letter, a copy of the New York Life contract verifying face and cash values; a copy of the petitioner's naturalization certificate; a copy of the petitioner's passport; a copy of the petitioner's AARP Insurance contract; copies of the petitioner's two closed CD accounts and copies of statements for the petitioner's Capital One bank account. The RFI required the items to be provided by March 29, 2024. I **FIND** the items listed in the RFI were not provided to Essex by the specified date and in fact the information needed by Essex to process the application was provided well after the date allowed for by the RFI.

By letter dated May 3, 2024, Essex mailed a denial to the petitioner using the address to the petitioner's nursing home as the recipient address on the letter. The stated reason for the denial is the petitioner's failure to provide the material sought by the RFI. Essex's case worker testified that the address on the RFI and the denial were generated automatically and the case worker mailed copies of the RFI and the denial to the petitioner and the DAR. Additionally, the case worker testified that he did not preserve the envelopes that he addressed to the DAR and to the petitioner for the mailings. On May 20, 2024, a Medicaid specialist employed by the petitioner's nursing home reached out to Essex to determine the status of the petitioner's Medicaid application and was advised of the denial and the reasons for it. The DAR asserted that he was advised of the denial by the Medicaid specialist and requested for a fair hearing on the petitioner's behalf. Additionally, the DAR asserted that he did not receive a copy of the RFI until June 2024. The DAR asserted that the information needed by Essex to

evaluate the petitioner's Medicaid application was provided after the timeframe allotted for in the RFI because he did not receive the RFI until well after that time. Further, I **FIND** that Essex's case worker did not testify credibly about mailing copies of the denial to the petitioner and the DAR, and I give no weight to this testimony. I make this finding because the testimony is directly contradicted by the RFI and the denial which contains only the petitioner's address as the recipient address. I **FIND** that the RFI and the denial were mailed only to the petitioner at the nursing home where she resided and not to the DAR.

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 received, "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. Here, I **CONCLUDE** that Essex properly issued an RFI.

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 the DAR asserts that Essex should excuse the petitioner from supplying the information necessary to process the application well beyond processing timeframe because the DAR was unaware of Essex's need for further information. However, the fact that the RFI was sent to the petitioner and not the DAR does not alleviate the petitioner's obligation to respond to the RFI. Thus, I **CONCLUDE** that exceptional circumstances are not present to excuse the petitioner's failure to respond to the RFI. 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 the petitioner's failure to respond in a timely manner to the RFI for her Medicaid application made her ineligible for benefits and that the petitioner's appeal should be **DISMISSED.**

ORDER

Given my findings of fact and conclusions of law, I **ORDER** that M.F. 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.

May 1, 2025
DATE

Daniel J. Brown
DANIEL J. BROWN, ALJ

Date Record Closed: May 1, 2025

Date Filed with Agency: May 1, 2025

Date Sent to Parties: May 1, 2025

dr

APPENDIX

Witnesses

For Petitioner:

Frank Sarpong

For Respondent:

Deneen McNeil

Exhibits

For Petitioner:

- P-1 Designation of Authorized Representative Form
- P-2 Email from WeCare and Email from Axg Solutions
- P-3 Request for Fair Hearing
- P-4 Denial and Explanation of Eligibility Benefits
- P-5 Request for Information

For Respondent:

- R-1 Fair Hearing Summary Report
- R-2 Not In Evidence
- R-3 SOLQ Response Screen
- R-4 Not in Evidence
- R-5 Capital One Bank Records