State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION
OAL DKT. NO. HMA 14662-24

M.M.,

Petitioner,

v.

ESSEX COUNTY BOARD OF SOCIAL SERVICES,

Respondent.

Moishe Hersh Designated Authorized Representative (DAR) on behalf of petitioner

Michelle Coleman, Fair Hearing Liaison for respondent

Record Closed: March 27, 2025 Decided: April 17, 2025

BEFORE **ERNEST M. BONGIOVANNI**, ALJ:

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

Petitioner, M.M. (petitioner/M.M.), appeals the effective April 9, 2024 denial of Medicaid Coverage for M.M.. by the respondent Union County Division of Social Service (respondent/Agency). The Division of Medical Assistance and Health Services transmitted this matter to the Office of Administrative Law (OAL), where it was filed on September 2, 2024 as a contested case. N.J.S.A. 52:14B-1 to –15; N.J.S.A. 52:14F-1 to –13. The hearing was first scheduled for a hearing on March 13, 2025 and was

requested to be adjourned to March 19 and then adjourned to March 27, 2025 when the hearing took place, and the record then closed.

BACKGROUND

M.M. through his DAR Moshe Hirsch applied for NJ Family Care Aged Blind Disabled program benefits on January 31, 2024. On April 9, 2024, M.M. was denied benefits for "failure to provide requested information required to determine eligibility in a timely manner." The parties stipulated that only two items were arguably left outstanding at the time of the denial. One was a PNA and Qualified Income Trust which Hirsch testified was submitted on March 13, 2024, and Coleman couldn't argue otherwise as that is a "different department" from hers. Thus the only possible compliance issue of M.M. was whether she provided a reasonable explanation for an apparent drop (about $7,000) in an "account" between January 2021 and February 2021. More specifically, the issues presented are whether the DAR was reasonable in asking from the Medicaid Family Service worker for an explanation of what she meant in stating in a request for Additional Information (RFI) that the DAR produce a letter "stating the reason why client's account decreased from $10,216.54 [in "1/21"] to $2,548.04 2/2021." (P-3). Because I find there was no such "account" showing a reduction, as described by Respondent's RFI and that the petitioner's DAR was diligent in seeking information which if properly answered he could have provided the information requested in a timely fashion, I find the April 9, 2024 denial should be set aside,

FACTUAL DISCUSSION

None of the following facts were contested and I **FIND** the following to be the **FACTS** on this case:

M.M. is a resident of Future Care Consultants, Brooklyn NY. A Guardianship for her as an Incapacitated person was established with Letters of Guardianship granted on

December 21, 2020 by Order entered in the Passaic County NJ Surrogates Court. Mr. Hirsch, as M.M.'s DAR submitted the Medicaid the application. At that time, he apparently only had records relating to one Bank of America Account that was listed on the February 28 2024 RFI as an account ending with 8226. He asked for an clarification of this RFI statement. Accordingly on April 3, 2024, Mr. Hirsch wrote to the Adult Medicaid Office asking for clarification, thusly: "In the RFI you asked about a $10,216.54 balance on 01/2021 and $2,548.05 on February 2021 I do not see this in the statements. Please clarify where you see this'" (P-6). The email noted he had already asked once for this clarification, and it was established during the hearing that he also called about it. No clarification whatsoever was attempted or offered by the Medicaid Office, and six days later they wrote to deny the application.

To make matters worse, on April 21, 2024, M.M. again applied to the program. On June 12, 2024 he received an almost identical denial referencing the Cliebt's bank account dropped from $10,216.54 for 01/21 to $2,548,04 in 02/2021 and again sought an explanation. On July1, 2024 he was once again denied for the same reason "failure to provided requested information..."

On July 28, 2024, Mr. Hirsch wrote to Adult Medicaid and he referred to conversations with Mr. Andrew Jackson from that office and Ms. Coleman. After a long conversation, "we figured out there were two Bank of America Accounts which he was unaware of, one ending in 4569 and another in 4572. After a lot of work in getting all those statements, he made a thorough review and again he could no "account" that had an account balance of "$10, 216.54 in 01/2021 and to $2,548.04 on 02/21." He sent complete copies of those statements from accounts 4569 and 4572 which showed no such numbers. He also included a PNC statement previously enclosed.

At the hearing, and for the first time, it would appear, Ms. Coleman testified that the drop in one month actually was the sum totals of the drop in <u>three separate accounts</u>, not a drop in "an account".

The problem was due to her advising Mr. Hirsch from what she knew not by the induvial accounts but by the "Asset Verification System" results that created in its "summary section" the "total of all accounts listed below (emphasis supplied.). Thus when you added THREE accounts monthly totals they equaled in those two months the amounts referred to in the RFI. That's what Ms. Coleman was referring to in the RFI, Unfortunately she never in any told or even hinted to Mr. Hirsch this information.

It would be unjust to claim that a DAR for an infirm 82-year-old, could have figured out what in the world he was supposed to explain when Medicaid was saying explain this discrepancy "of an account" when they actually meant it was the combined total of three accounts balances they were concerned about.

Even if Medicaid was mistaken by its reliance on the Asset Verification System results that system, according to the exhibit provided by Ms. Coleman that System also gave individual monthly balances for three separate accounts, and her exhibit shows one Bank of America account with a January 2021 balance of $7,608.13, another Bank of America account with a January 2021 balance of $2605.41 and a PNC account January 2021 balance of $3.00 Those three accounts **totaled** the amount ($10,216.54) dropped from account dropped from $10,216.54 in 01/21 she was inquiring of but each of the RFIs stated that "clients **bank account** dropped from $10,216.54 in 01/21 to $2,548.04." (emphasis added) [1].

Mr. Hirsch was honest and correct in inquiring that he could find so such record of any account. All Medicaid had to do was clarify the situation was tell Mr. Hirsch "we are referring to the combined monthly total balances of these three accounts." As noted in the testimony, in the later application, they accepted whatever explanation was given for the one month drop in the three accounts and thus approved the application byt with an effective date of June 2024

[1] Similarly, if you totaled the three accounts balances for 02/21 they equaled the drop to $2,548.04

However, such a decision is a hollow remedy. The RFIs given to M.M.'s representatives were inaccurate, confusing, and easily clarified if any effort was made to do so. Mr. Hisrch correctly and reasonably asked for that clarification more than once and certainly did so in writing on April 3, 2024, six days before the first denial of benefits.

LEGAL ANALYSIS AND CONCLUSION

Although it is not controlling as not on all fours with the facts and issue presented here, , I.L. v. N.J. Dep't of Human Servs. Div. of Med. Assistance and Servs, 389 NJ. Super 354 (App. Div. 2006) carries persuasive reasoning, in this case, for determining the date of eligibility as the date of filing the application for benefits. In I.L. the court held the resources in dispute were inaccessible to the incapacitated applicant and therefore "excludable." The Court added, however, that the Agency could not in that case *ignore its own responsibilities* once the request for determination of eligibility had been made. As stated by the Court: "When [petitioner's] relatives failed to move for authority to access the policies in 2002, while the second application was before the Board, and no one else with authority to do so moved either to access the policies or to have a guardian appointed for I.L.'s person and property, **the Board at the very least could have acted on the application** in a timely fashion, putting the nursing home on notice of the need to act." Id at 365-366. (emphasis supplied.

Similarly here, the test must be the reasonableness of both the applicant's actions and the Agency's response to it. It would be unjust and unreasonable to uphold a denial of benefits when that denial was entirely the fault of the agency in issuing a confusing and completely inaccurate RFI (more than once) but especially given the reasonableness in the Applicant's repeated requests for a clarification, one which was so easily in the agency's grasp.

The Agency's sole reason for denial was the applicant's failure to explain "facts" which simply did not exist. It would be an injustice and not at all in keeping with

practices the Agency should enforce by denying benefits for applicants being forced to explain nonexistent "facts" based on circumstances which the Agency created by referring to a concern in an account when they were, without telling the applicant, referring to a discrepancy concerning the combined totals of all accounts. Under the circumstances the only correct and just result is to overturn the April 9, 2024 denial. Further I can see no fair alternative to basing benefits on the date of the first application for benefits January 31, 2024 along with the three-month retroactive period or prior medical expenses award. I therefore **CONCLUDE** the April 9, 2024 denial (and any subsequent denial based on it) must be and is **REVERSED**

ORDER

Based upon the foregoing, the April 9, 2024 denial by the agency of petitioner's eligibility for Medicaid is **REVERSED** and eligibility for benefits as of January 31, 2024, should be granted to petitioner

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 17, 2025

Ernest M. Bongiovanni

DATE

ERNEST M. BONGIOVANNI ALJ

Date Received at Agency: 4/17/25

Date Mailed to Parties: 4/7/25

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APPENDIX

LIST OF WITNESSES

For Petitioner

Moshe Hirsch

For Respondent

Michelle Coleman HSS3 Specialist

LIST OF EXHIBITS IN EVIDENCE

For Petitioner

P-1 Designation for Authorized Representative for Medicaid

P-2 Surrogate's Guardianship Order for M.M., an "incapacitated person."

P-3 February 28, 2024 RFI from NJFAMILYCARE to M.M

P-4 June 12, 2024 RFI from NJFAMILYCARE to M.M. regarding her second application for benefits

P-5 Statements showing balances of accounts known to M.M.'s DAR

P-6 April 3, 2024 request for clarification of the RFI advising he sees no balances as stated in the RFI regarding M.M.'s "bank account"

P-7

For Respondent

R-1 Asset Verification System Results showing cumulative totals of monthly balances and individual account monthly balances