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APPROVAL OF THE APPELLATE DIVISION

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-0790-14T3

M.K.,

Petitioner-Appellant,

v.

DIVISION OF MEDICAL ASSISTANCE
AND HEALTH SERVICES AND BURLINGTON
COUNTY BOARD OF SOCIAL SERVICES,

Respondents-Respondents.

Argued February 1, 2016 - Decided May 13, 2016

Before Judges Lihotz and Nugent.

On appeal from Department of Human Services, Division of Medical Assistance and Health Services.

Carl Ahrens Price argued the cause for appellant (Price & Price, LLC, attorneys; Mr. Price, of counsel and on the brief).

Jennifer Simons, Deputy Attorney General, argued the cause for respondent Division of Medical Assistance and Health Services (John J. Hoffman, Acting Attorney General, attorney; Melissa H. Raksa, Assistant Attorney General, of counsel; Ms. Simons, on the brief).

PER CURIAM

Petitioner M.K., a Medicaid recipient, appeals the final decision of respondent the Division of Medical Assistance and

Health Services (the Division), which imposed a period of ineligibility for benefits because she transferred ownership of her home to her daughter, J.K., for less than fair-market value within sixty months of entering a nursing home facility (the look-back period). M.K. challenges the determination, arguing J.K. satisfied the "caregiver child" exception to application of the look-back period, which is set forth in N.J.A.C. 10:71-4.10(d)(4). We affirm.

M.K. applied to the Burlington County Board of Social Services (the Board) for Nursing Home Old Aged Disabled Medicaid benefits on January 30, 2012. M.K.'s application was denied and, following her appeal, the matter was transferred to the Office of Administrative Law as a contested case for a hearing before an administrative law judge (ALJ).

These facts are undisputed and taken from the agency record, conducted over the two-day hearing. The Board, M.K., J.K., and her sister testified. Both parties introduced various documents.

James Suszynski, a Medicaid Supervisor for the Board, testified regarding the Board's review of M.K.'s application for

benefits.[1] M.K. disclosed she transferred her home to J.K. She attached a letter from J.K. delineating the level of care she provided M.K. prior to her transfer to a nursing home and a letter from her treating physician stating her physical conditions had "compromised [M.K.'s] ability to care for herself and increased her dependence upon [J.K.] for activities of daily living." Following review, the Board concluded the information was insufficient to demonstrate M.K. needed an "institutional level of care based on her medical needs," which was provided by J.K., so as to delay M.K.'s transfer to an institutional facility. Also, the application failed to show M.K. resided with J.K. during the two-year period immediately prior to her transfer to a nursing home. The Board concluded the transfer of M.K.'s residence was a gift to J.K., which did not qualify for the caregiver child exception. Accordingly, M.K. was deemed ineligible for benefits from January 1, 2012 to February 2, 2014. The Board informed M.K. it would consider supplemental submissions to rebut the determination. Apparently, further submissions were not found persuasive.

J.K. began living in her mother's home in 1987. At that time M.K. was independent. Beginning in November 2002 until

[1] The record contains references to the multi-page document, which was introduced into evidence; however, it is not included in the record.

August 2003, M.K. underwent three spinal fusion surgeries, after which she ceased driving and commenced using a walker. At that time, J.K. began assisting M.K. in her daily care, such as dressing, bathing, ascending steps, and making meals. In May 2004, M.K. suffered a stroke, complicated by sensory loss, including blindness in one eye. M.K. was also afflicted by Parkinson's disease, which impeded her ambulation, affected her balance, caused auditory and visual hallucinations, and created anxiety, paranoid thinking, depression and dementia. Finally, M.K. had a torn rotator cuff, limiting the use of her arm. These conditions required J.K.'s level of assistance to increase and from that point, M.K. never was "independent." In addition to shopping for M.K.'s food, medications, clothing and other errands, J.K. performed all house cleaning, transportation and attended to M.K.'s financial affairs. J.K. also provided daily help because M.K., for the most part, did not leave the home and needed assistance with dressing, toileting, hygiene, bathing, preparing meals (although she did not need assistance with eating), ascending or descending steps, walking, and transportation to and attendance at quarterly doctor and specialty physician visits. In 2007, M.K. employed a home health aide to attend to her, first for two hours daily then from 8 a.m. to noon each weekday. Thereafter, she was alone

until 5:30 p.m., when J.K. returned from work. J.K. testified M.K. "was not capable of taking care of herself physically" and was dependent.

On September 30, 2010, M.K.'s treating physician provided his written recommendation for nursing home placement. She moved to the Masonic Home of New Jersey, a skilled nursing care facility. M.K. was unhappy with this arrangement and on October 14, 2010, left the facility to reside with her son.[2] For five months, he and his wife assumed responsibility for M.K.'s care, except J.K. continued to obtain her medications and occasionally transported her to doctor's appointments.

On January 24, 2011, M.K. executed a deed to transfer her residence to J.K. M.K. had difficulties living in her son's home; she suffered multiple falls. After one fall, she was admitted to Cooper Hospital on March 1, 2011. Thereafter, on March 4, 2011, she returned to the Masonic Home and resided there until her death on August 31, 2012.

The ALJ retired prior to issuing a recommendation. A different ALJ reviewed the record including the parties' final submissions, and denied Medicaid. The Division reversed and ordered a remand for presentation of additional evidence on

[2] The Board noted M.K. was discharged home, which M.K. disputed, insisting she elected to leave.

specifically enumerated issues, which was conducted on April 3, 2014.[3] The remand hearing was to concentrate on the level of care necessary prior to M.K.'s institutionalization and the circumstances of M.K.'s departure from the facility in October 2010. On behalf of M.K., her treating physician appeared by telephone and introduced his treatment notes.[4] J.K. also testified.

M.K.'s physician, who was board certified in family medicine, recounted M.K.'s health problems dating back to 2002, following lower lumbar back surgeries for nerve compression. In 2004, M.K. was diagnosed with Parkinson's disease with resultant braids kinesia or muscle freezing, and she suffered a cerebellar stroke, resulting in blindness in one eye. He noted M.K. used a wheelchair when he saw her in his office because of nerve damage and weakness in her legs. Further, he related the range of motion task limitations she experienced while dressing, bathing, and combing her hair, caused by a 2008 inoperable rotator cuff tear. In his medical opinion, beginning in 2008, he did not think M.K.'s "debility and her deterioration had reached a point where . . . [her] weakness and frailty, and frequent falls, and

[3] The record does not include the referenced May 30, 2013 remand.

[4] These documents are not included in the record.

inability to care for herself really could have been adequately cared for at . . . home," making her "an appropriate person to be placed in . . . an extended care facility or nursing home."

The doctor acknowledged he never had contact with M.K.'s son and was unfamiliar with the care he provided during her stay in his home. Also, he noted during the time M.K. lived with her son she had only one medical visit, on February 7, 2011, after a fall.

J.K. was recalled. She detailed her daily-care routine for M.K. from the time she awoke at 6:15 a.m. until bedtime at 9 p.m. She also recounted the tasks undertaken for her benefit. Finally, she testified as to the difficulties M.K. experienced while living in her brother's home.

The ALJ's initial determination found J.K. provided M.K. with "care exceeding normal person support activities . . . necessary to [M.K.]'s health and safety," which allowed her to remain in her home. However, the ALJ rejected the argument that M.K. needed an institutional level of care as of September 2010, noting M.K. could be alone for approximately five hours per day, which suggested "some ability to move about her house without assistance and . . . not necessarily in need of an institutional level of care in September 2010." As of March 2011, the ALJ agreed M.K.'s circumstances had changed and she found M.K. was

in full need of a nursing level of care. However, she found J.K. was not M.K.'s caregiver for a full two years prior to that date because of the intervening period of care provided by M.K.'s son and his wife. Further, M.K.'s assets paid for the aide, which permitted her to remain in her home. Consequently, the ALJ concluded M.K.'s transfer of her home to J.K. "was a transfer at less than fair market value and not subject to the caregiver exemption," triggering imposition of a penalty period and resulting in the denial of benefits.

M.K. filed exceptions and the Division issued its final agency decision on August 25, 2014. The Division adopted the ALJ's findings and conclusions, stating M.K. failed to meet her burden to demonstrate for the two-year period prior to institutionalization, J.K. provided such care at a level preventing institutionalization. M.K. appeals from that final agency decision.

We begin by examining well-recognized principles concerning judicial review of administrative agency decisions. "Appellate courts have 'a limited role' in the review of such decisions." In re Stallworth, 208 N.J. 182, 194 (2011) (quoting Henry v. Rahway State Prison, 81 N.J. 571, 579 (1980)). We intervene only "in those rare circumstances in which an agency action is clearly inconsistent with its statutory mission or other state

policy." In re Musick, 143 N.J. 206, 216 (1996). Moreover, we are bound to defer to an agency decision unless we conclude it is "arbitrary, capricious or unreasonable, or [] not supported by substantial credible evidence in the record as a whole." Stallworth, supra, 208 N.J. at 194 (alteration in original) (quoting Henry, supra, 81 N.J. at 579-80). "Deference to an agency decision is particularly appropriate where interpretation of the [a]gency's own regulation is in issue." R.S. v. Div. of Med. Assistance & Health Servs., 434 N.J. Super. 250, 261 (App. Div. 2014) (quoting I.L. v. N.J. Dep't of Human Servs., Div. of Med. Assistance & Health Servs., 389 N.J. Super. 354, 364 (App. Div. 2006)). "A reviewing court 'may not substitute its own judgment for the agency's, even though the court might have reached a different result.'" Stallworth, supra, 208 N.J. at 194 (quoting In re Carter, 191 N.J. 474, 483 (2007)). Nevertheless, if following our review of the record, we conclude the agency's finding is clearly mistaken, the final decision is not entitled to our deference. See H.K. v. Dep't of Human Servs., 184 N.J. 367, 386 (2005).

Finally, "we are not bound by the agency's legal opinions." A.B. v. Div. of Med. Assistance & Health Servs., 407 N.J. Super. 330, 340 (App. Div.) (quoting Levine v. State, Dep't of Transp., 338 N.J. Super. 28, 32 (App. Div. 2001)), certif. denied, 200

N.J. 210 (2009). "Statutory and regulatory construction is a purely legal issue subject to de novo review." Ibid.

New Jersey has codified the federal Medicaid guidelines. Accordingly, principles underlying the establishment of Medicaid benefits are also necessary to give context to the agency's action.

> The Medicaid program, enacted in 1965 as Title XIX of the Social Security Act, "is designed to provide medical assistance to persons whose income and resources are insufficient to meet the costs of necessary care and services." Atkins v. Rivera, 477 U.S. 154, 156, 106 S. Ct. 2456, 2458, 91 L. Ed. 2d 131, 137 (1986). The program is a cooperative federal-state endeavor in which the federal government provides "financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." Harris v. McRae, 448 U.S. 297, 301, 100 S. Ct. 2671, 2680, 65 L. Ed. 2d 784, 794 (1980). "In return, participating States are to comply with requirements imposed by the [program] and by the Secretary of Health and Human Services." Atkins, supra, 477 U.S. at 157, 106 S. Ct. at 2458, 91 L. Ed. 2d at 137. Each state must develop a plan that includes "reasonable standards . . . for determining eligibility for and the extent of medical assistance . . . [that is] consistent with the objectives" of the Medicaid program. 42 U.S.C.A. § 1396a(a)(17)(A). An applicant is entitled to Medicaid benefits "if he [or she] fulfills the criteria established by the State in which he lives." Schweiker v. Gray Panthers, 453 U.S. 34, 36-37, 101 S. Ct. 2633, 2636, 69 L. Ed. 2d 460, 465 (1981). By enacting the New Jersey Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 to -19.1, New Jersey has elected to

> participate in the Medicaid program. The Department of Human Services is the agency responsible for administering the Medicaid program in New Jersey. See N.J.S.A. 30:4D-3c.
>
> [L.M. v. Div. of Med. Assist. & Health Servs., 140 N.J. 480, 484-85 (1995).]

As authorized by the Legislature, N.J.S.A. 30:4D-7, regulations governing Medicaid eligibility were adopted by the Commissioner of the Department of Human Services authorizing the Division to administer the State's Medicaid program. N.J.S.A. 30:4D-5; N.J.A.C. 10:49-1.1(a). Accordingly, the Division is responsible for protecting the interests of the New Jersey Medicaid Program and its beneficiaries. N.J.A.C. 10:49-11.1(b).

M.K. applied for institutional level Medicaid benefits while she was residing in a nursing home. The Division grants such benefits pursuant to the Medicaid Only program, N.J.A.C. 10:71-1.1 to -9.5. Among the eligibility requirements, an individual seeking these benefits must have limited financial eligibility. See N.J.A.C. 10:71-1.2(a). "All includable income and resources must fall below certain limits in order for an applicant to be deemed eligible for Medicaid benefits." E.S. v. Div. of Med. Assistance & Health Servs., 412 N.J. Super. 340, 347 (App. Div. 2010) (citing 42 U.S.C.A. § 1396a(a)(10)(A)). 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., supra, 184 N.J. at 380 (footnote omitted) (citing N.J.A.C. 10:71-4.5(c)).

The local welfare agency, in the county where the applicant resides, evaluates whether the applicant meets the eligibility requirements. N.J.S.A. 30:4D-7a; N.J.A.C. 10:71-1.5, -2.2(c). Thus, the county boards act for the Division as a "gatekeeper to prevent individuals from using Medicaid to avoid payment of their fair share for long-term care." W.T. v. Div. of Med. Assistance & Health Servs., 391 N.J. Super. 25, 37 (App. Div. 2007).

The facts here show M.K. was receiving institutional level services prior to seeking Medicaid benefits. Once she utilized her assets, she sought continued care paid by Medicaid. The regulations deem an applicant ineligible for Medicaid nursing home benefits if the individual "has disposed of assets at less than fair market value at any time during or after the 60-month period immediately before . . . the date the individual applies for Medicaid as an institutionalized individual," which we identify as the look-back period. N.J.A.C. 10:71-4.10(a)(2);

see also N.J.A.C. 10:71-4.10(b)(9)(ii).[5] If an applicant transferred assets during the look-back period, "the fair market value of the asset shall be ascertained." N.J.A.C. 10:71-4.10(c)(1).

Moreover, the transfer of an asset for less than fair market value "during the look-back period raises a rebuttable presumption that the [asset] was transferred for the purpose of establishing Medicaid eligibility." H.K., supra, 184 N.J. at 380 (citing N.J.A.C. 10:71-4.10(j)); see also 42 U.S.C.A. § 1396p(c)(1). The burden of rebutting the presumption rests on the applicant. N.J.A.C. 10:71-4.10(j).

If it is determined that the applicant transferred an asset for less than fair market value during the look-back period to become eligible for Medicaid institutional services, the applicant will be subject to a period of Medicaid ineligibility to be imposed once he or she is otherwise eligible for Medicaid benefits. N.J.S.A. 30:4D-3(i)(15)(b); N.J.A.C. 10:71-4.10(c)(4). The period of ineligibility begins on the later of

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[5] "Fair market value" is a defined term meaning "an estimate of the value of an asset, based on generally available market information, if sold at the prevailing price at the time it was actually transferred. Value shall be based on the criteria for evaluating assets as found in N.J.A.C. 10:71-4.1(d)." N.J.A.C. 10:71-4.10(b)(6). N.J.A.C. 10:71-4.1(d) defines "value" as "the price that the resource can reasonably be expected to sell for on the open market in the particular geographic area minus any encumbrances (that is, its equity value)."

the first day of the month during or after which the individual transferred the assets for less than fair market value, or the date on which he or she is eligible for medical assistance and would be receiving institutional level services but for the penalty period. 42 U.S.C.A. § 1396p(c)(1)(D)(ii).

M.K.'s appeal implicates the exception to the look-back period, found in N.J.A.C. 10:71-4.10(d)(4), which adopts 42 U.S.C.A. 1396p(c)(2)(A)(iv). The regulation provides:

> an individual shall not be ineligible for an institutional level of care because of the transfer of his or her equity interest in . . . the individual's principal place of residence and the title to the home was transferred to:
>
> . . . .
>
> 4. A son or daughter of the institutionalized individual . . . who was residing in the individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual and who has provided care to such individual which permitted the individual to reside at home rather than in an institution or facility.
>
> i. The care provided by the individual's son or daughter for the purposes of this subchapter shall have exceeded normal personal support activities (for example, routine transportation and shopping). The individual's physical or mental condition shall have been such as to require special attention and care. The care provided by the son or daughter shall have been essential to the health and safety of the individual and shall have consisted of

> activities such as, but not limited to, supervision of medication, monitoring of nutritional status, and insuring the safety of the individual.
>
> [N.J.A.C. 10:71-4.10(d)(4).]

M.K.'s challenge focuses on the ALJ's finding that she "was not necessarily in need of an institutional level of care in September 2010." She argues the standards applied were "too stringent," in light of the regulatory language. Although we agree this record provides sufficient evidence of the type of special attention and care provided by J.K. essential to M.K.'s health and safety, which met N.J.A.C. 10:71-4.10(d), we nevertheless cannot ignore the remaining requirement set forth also requiring services be provided "for a period of at least two years immediately before the date the individual becomes an institutionalized individual." N.J.A.C. 10:71-4.10(d)(4) (emphasis added).

M.K. was institutionalized on March 4, 2011. The two years immediately prior to that date include a period of approximately five months when J.K. provided no care for M.K., who resided with her son. "Medicaid is an intensely regulated program," H.K., supra, 184 N.J. at 380, and its requirements are strictly enforced. We conclude this record cannot support J.K.'s satisfaction of the mandated two-year time period for care, based on the five-month hiatus M.K. lived elsewhere.

M.K. urges her date of eligibility commenced in September 2010, when she first entered the Masonic Home. She maintains her evidence more than adequately shows J.K. provided the required level of care from September 2008 to September 2010, enabling her to remain in her home. We are not persuaded for two reasons.

First, the record is muddled on whether the level of care provided by J.K. in September 2010 was also provided from September 2008. For example, M.K. commenced assistance with a home health aide sometime in 2007, but engaged help for only two hours per day. We are not informed when the level of assistance increased to five hours per day. J.K.'s testimony also was not specific as to the dates she provided the various levels of assistance. During the remand hearing, J.K. discussed her level of care from January 2009, but did not add specifics as to the months prior to that date.

Second, the institutional records state M.K. was discharged from the Masonic Home in October 2010. As identified by the Division in its final decision, one issue to be explained on remand was the circumstances surrounding M.K.'s departure from the nursing facility after only a one-month stay; however, this was not done. Certainly, M.K. was not released to a different institution or a hospital; she chose to move to her son's home.

No evidence suggests the move was intended as temporary or for a limited purpose. We also cannot agree the period was short and should be ignored, particularly since M.K.'s initial nursing home stay was less than one month. Consequently, we reject the contention that denial of the caregiver child exception for failure to fulfill the two-year time period immediately before institutionalization was arbitrary or capricious.

We have no doubt J.K. extended love and care to her mother that added to M.K.'s comfort, welfare and happiness during those years when she was living in her own home, despite significant medical challenges. But receipt of Medicaid benefits is not automatic. Understanding the State's need to conserve limited financial resources to assure monies are paid to those who meet the circumscribed eligibility requirements, we will not merely assume the criteria was satisfied. Rather, proof must be forthcoming specifically establishing each requirement of the exception to obtain its application.

Affirmed.

I hereby certify that the foregoing is a true copy of the original on file in my office.

CLERK OF THE APPELLATE DIVISION