SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-1265-09T3

I.M.,

Petitioner-Appellant,

v.

DIVISION OF MEDICAL ASSISTANCE
AND HEALTH SERVICES and WARREN
COUNTY BOARD OF SOCIAL SERVICES,

Respondents-Respondents.

Argued May 10, 2011 – Decided June 3, 2011

Before Judges Parrillo and Yannotti.

On appeal from the Division of Medical Assistance and Health Services.

Joshua M. Spielberg argued the cause for appellant (Legal Services of New Jersey, attorneys; Mr. Spielberg, on the briefs).

Vicki A. Mangiaracina, Deputy Attorney General, argued the cause for respondent Division of Medical Assistance and Health Services (Paula T. Dow, Attorney General, attorney; Melissa H. Raksa, Assistant Attorney General, of counsel; Ms. Mangiaracina, on the brief).

Respondent Warren County Board of Social Services has not filed a brief.

PER CURIAM

Appellant I.M. appeals from the September 24, 2009 final agency decision of the Division of Medical Assistance and Health Services (DMAHS) reversing the initial decision of the Administrative Law Judge (ALJ) and terminating appellant's Medicaid benefits unless she returns certain funds to the New Jersey Division of Developmental Disabilities (DDD) that she received on behalf of her mentally disabled grandson. For the reasons that follow, we reverse.

The essential facts are not in dispute. I.M. is a seventy-nine-year-old woman and sole caregiver for her twenty-one-year-old grandson, J.M., who is mentally disabled. She has been his primary caregiver since he was three years old. I.M.'s sole source of income is Social Security survivor benefits in the amount of $1468 per month. She has received benefits under the Medicaid Only program since 2005. J.M.'s sole sources of income are Social Security and Supplemental Security (SSI) disability benefits in the total amount of $705 per month, for which I.M. is designated as representative payee. J.M. is also a Medicaid recipient and a client of the DDD, a division within the New Jersey Department of Human Services.

In December 2007, DDD sent I.M. a grant of $2000 to be used to purchase items and services for the benefit of J.M. She

spent $500 for J.M.'s special needs and, in February 2008, deposited the remainder into a new PNC Bank account ($1480 balance after $20 deduction for check printing fee), which she intended for use at a later date for J.M.'s needs. I.M. opened that account as a POD or "payable on death" account in the name of "I.M. POD to J.M."

During a standard recertification process, the Warren County Board of Social Services (WCBSS), which administers on a local basis the Medicaid Only program for which appellant had qualified, became aware of this new PNC account. When queried, I.M. explained that the funds came from DDD and belonged to J.M. However, DMAHS — the statewide administrator of the Medicaid program — considered the $1480 to be I.M.'s countable resource, which, when combined with her other PNC account, exceeded the Medicaid resource limit of $2000. Consequently, in accordance with N.J.A.C. 10:71-4.5(c), DMAHS sent I.M. a benefits termination notice, dated January 21, 2009 and effective March 1, 2009.

I.M. requested a fair hearing and the matter was transferred to the Office of Administrative Law (OAL). In the meantime, on June 11, 2009, I.M., with the assistance of counsel from Legal Services of New Jersey, deposited the $1480 in a new

PNC Bank account in J.M.'s name and social security number, with I.M. designated as the representative payee.

At the OAL hearing, Carol Gross, a representative of WCBSS, testified that in February 2009, Lani Hoever, J.M.'s case manager at DDD, advised her that I.M. was to use the DDD money for the benefit of J.M. and return any unused portion to DDD. However, Gross also admitted that she received a letter from Hoever in May 2009 stating that I.M. could continue to hold the $1480 as long as she uses it exclusively for J.M.'s benefit. Despite the apparent contradiction, Gross never called Hoever for clarification. However, Mary Giorlando, Hoever's supervisor at DDD, submitted a sworn statement that I.M. has been an "exemplary caretaker" to her grandson and confirmed that DDD approved of I.M. holding the $1480 in a bank account as long as the funds are used for J.M.'s benefit.

After the close of evidence, the ALJ issued an Initial Decision, concluding that the new PNC account "is not a countable resource that would cause [I.M.] to forfeit her Medicaid eligibility" and that "the remainder of the DDD grant is not owned by [I.M.] and is not legally accessible to her because she serves only in a representative capacity for her disabled grandson." Accordingly, since I.M. was below the

$2000 resource eligibility limit, the ALJ concluded that the termination of her Medicaid benefits was improper.

Following the filing of exceptions to the ALJ's Initial Decision, DMAHS concluded otherwise, namely that, as presently titled, the PNC bank account at issue is an available resource and, as such, I.M. would only be able to maintain her Medicaid eligibility if she returned to DDD the $1480 held in that account for J.M.'s benefit.

This appeal follows[1] in which appellant maintains that DMAHS erred in considering funds that I.M. holds as representative payee for her disabled grandson as countable resources in determining her eligibility for Medicaid benefits. We agree.

Although we are deferential to an administrative agency's "expertise and superior knowledge of a particular field[,]" Greenwood v. State Police Training Ctr., 127 N.J. 500, 513 (1992), we nevertheless must independently determine on review "whether the agency's action violates express or implied legislative policies" and "whether in applying legislative policies to the facts, the agency clearly erred in reaching a conclusion that could not reasonably have been made on a showing of the relevant factors." Mazza v. Bd. of Trs., 143 N.J. 22, 25

[1] On November 23, 2009, DMAHS stayed its final agency decision pending appeal.

(1995) (citing Campbell v. Dep't of Civil Serv., 39 N.J. 556, 562 (1963)). Here, we are satisfied that the final decision of DMAHS is arbitrary and unreasonable in its application of express legislative policy to the undisputed facts of this matter.

Some background is in order. Established in 1965 as Title XIX of the Social Security Act, Medicaid is a cooperative federal-state program "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. N.J. Div. of Med. Assistance & Health Servs., 140 N.J. 480, 484 (1995). See 42 U.S.C.A. § 1396a et seq. Participation in Medicaid by the states is optional, but once a state chooses to participate, it must adopt a plan that complies with all requirements of the federal Medicaid Act and regulations adopted by the Secretary of Health and Human Services. Mistrick v. Div. of Med. Assistance & Health Servs., 154 N.J. 158, 165-66 (1998); Estate of G.E. v. Div. of Med. Assistance & Health Servs., 271 N.J. Super. 229, 232 (App. Div. 1994).

New Jersey elected to participate in the Medicaid program by enacting the New Jersey Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 to -42. As a result, New Jersey is obligated to provide medical assistance to the "categorically

needy," which includes persons eligible to receive benefits under Aid to Families with Dependent Children (AFDC), 42 U.S.C.A. §§ 601-617, or Supplemental Security Income for the Aged, Blind, and Disabled (SSI) under Title XVI of the Social Security Act, 42 U.S.C.A. §§ 1381-1383d. See 42 U.S.C.A. § 1396a(a)(10)(A)(i); N.J.A.C. 10:69-1.1 to -12.10. The categorically needy are "persons whom Congress considered especially deserving of public assistance because of family circumstances, age, or disability." L.M., supra, 140 N.J. at 485.

In addition, New Jersey elected in 1985 to provide assistance to the "medically needy," an optional class of beneficiaries under federal Medicaid law, 42 U.S.C.A. § 1396a(a)(10)(A)(ii), through its Medically Needy program. See N.J.S.A. 30:4D-3i(8); N.J.A.C. 10:70-1.1 to -7.3. The medically needy are persons "who meet the nonfinancial eligibility requirements for cash assistance under AFDC or SSI, but whose income or resources exceed the financial eligibility standards of those programs." L.M., supra, 140 N.J. at 487. Finally, New Jersey provides benefits to those applicants, such as I.M., considered "optionally categorically needy" under its "Medicaid Only" program, which is governed by N.J.A.C. 10:71-1.1 to -9.5. Medicaid Only beneficiaries receive only Medicaid benefits, not

cash payments available under Title XVI of the Social Security Act to the aged, blind and disabled. N.J.A.C. 10:71-1.1.

The Department of Human Services (DHS), through DMAHS, is designated the exclusive state agency responsible for implementing and administering the Medicaid program in New Jersey. N.J.S.A. 30:4D-3c. Applications for Medicaid benefits are submitted to the county boards of social services, such as, here, the WCBSS. N.J.A.C. 10:71-1.5. The county boards are responsible for receiving and reviewing applications, making annual re-determinations of a beneficiary's continuing eligibility for benefits, and recommending approval, denial, continuation, or termination of benefits. N.J.A.C. 10.71-2.2, -2.12, and -8.1.

Each state participating in the Medicaid program must adopt "'reasonable standards . . . for determining eligibility for and the extent of medical assistance . . . [that are] consistent with the objectives of the Medicaid program.'" L.M., supra, 140 N.J. at 484 (quoting 42 U.S.C.A. § 1396a(a)(17)(A)). In New Jersey, eligibility for medical assistance is governed by the regulations adopted by the Commissioner of the DHS, N.J.S.A. 30:4D-7a, as set forth in N.J.A.C. 10:71-1.1 to -9.5.

Generally, only those applicants with income and non-exempt resources below specified levels may qualify for Medicaid

benefits. To be eligible for the Medicaid Only program, an individual's countable resources may not exceed $2000.[2] N.J.A.C. 10:71-4.5(c). Resources are defined as:

> any real or personal property which is owned by the applicant (or by those persons whose resources are deemed available to him/her, as described in N.J.A.C. 10:71-4.6) and which could be converted to cash to be used for his/her support and maintenance.
>
> [N.J.A.C. 10:71-4.1(b).]

Accordingly, two conditions must be met for a resource to be counted toward the $2000 limit. First, it must be owned by the applicant, and second, it must be available to him or her. A resource is considered "available" to an individual when:

> 1. The person has the right, authority, or power to liquidate real or personal property, or his or her share of it;
>
> 2. Resources have been deemed available to the applicant [under N.J.A.C. 10:71-4.6]; or
>
> 3. Resources arising from a third-party claim or action are considered available from the date of receipt by the applicant/beneficiaries, his or her legal representative or other individual acting on his or her legal behalf . . .
>
> [N.J.A.C. 10:71-4.1(c).]

[2] Unless specifically excluded under N.J.A.C. 10:71-4.4(b), both liquid and non-liquid resources are considered in the determination of eligibility. N.J.A.C. 10:71-4.1(b).

In our view, resources not owned by an individual cannot be "available" to him absent some express or implied authority. Consequently, the requirement of "availability" as set forth in 42 U.S.C.A. § 1396a(a)(17)(B) and N.J.A.C. 10:71-4.1(c), implicates a legal, not simply a physical, ability to access the resource.

We, therefore, agree with the ALJ that "availability" under the Medicaid regulations incorporates a legal rather than physical sense of possession. Relying on N.J.A.C. 10:71-4.1(c), the ALJ concluded:

> I concur with petitioner that this segregated account is not a countable resource that would cause her to forfeit her Medicaid eligibility. Subsection (1) above focuses on legal authority and right while subsection (3) makes it clear that it is the beneficiary or a representative-held fund who owns the resource, if at all. While it would be preferable for petitioner to obtain a legal order of guardianship of her grandson and its concomitant protections and oversight, the plain fact is that petitioner cannot afford to undertake the process and DDD has a six-year backlog.

We agree.

Here, it is undisputed that DDD gave the funds to I.M. as J.M.'s representative and caretaker under the express condition that the money only be used for J.M.'s benefit. I.M. spent a portion of these funds on J.M., as instructed, and placed the remainder in a new, separate bank account bearing J.M.'s name

for future use. As certified by DDD supervisor Mary Giorlando, DDD, based on its long-standing relationship with I.M., is satisfied that she has spent, and will continue to spend, the cash subsidy according to the conditions under which it was granted, and that DDD approves of I.M. holding the remaining $1480 in a bank account as long as the funds are used for J.M.'s benefit. Most tellingly, there is no proof that I.M. ever converted any of the funds in issue for her own use or benefit. On the contrary, by placing DDD's grant money in a new bank account titled in J.M.'s name and social security number with I.M. listed only as representative payee[3], I.M. has fairly established that she holds these funds in trust for her disabled grandson and that they are not available for her personal use. Thus, while I.M. may have physical access to J.M.'s funds, she holds them as his fiduciary, restricted in their use by the very terms of the DDD grant, as well as of the bank account in which they are held.

Reversed.

[3] "Representative payee" is a designation under the Social Security Act which establishes that the recipient of the funds in question is to use them only for the use and benefit of the SSI beneficiary and must account for all benefits received. 20 C.F.R. § 416.635. A representative payee who misuses benefits is liable to the beneficiary. 20 C.F.R. § 416.641.