RECORD IMPOUNDED

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APPROVAL OF THE APPELLATE DIVISION

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-2352-13T2

C.W.,

Petitioner-Appellant,

v.

DIVISION OF MEDICAL ASSISTANCE
AND HEALTH SERVICES and UNION
COUNTY DIVISION OF SOCIAL SERVICES,

Respondents-Respondents.

Argued May 18, 2015 – Decided August 31, 2015

Before Judges St. John and Rothstadt.

On appeal from the Division of Medical Assistance and Health Services, Docket No. HMA-3903-2013.

Harold L. Grodberg argued the cause for appellant (The Grodberg Law Firm, LLC, attorneys; Mr. Grodberg, on the briefs).

Kay Rabinowich Ehrenkrantz, 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; Molly Moynihan, Deputy Attorney General, on the brief).

Respondent Union County Division of Social Services has not filed a brief.

PER CURIAM

Appellant C.W. appeals from the December 4, 2013 final agency decision of the Division of Medical Assistance and Health Services (DMAHS), which reversed the initial decision of an Administrative Law Judge (ALJ) holding the Union County Division of Social Services (UCDSS) erred in downwardly adjusting C.W.'s Medicaid ineligibility penalty previously assessed for transferring assets for less than fair market value in violation of N.J.A.C. 10:71-4.10(a). For the reasons that follow, we affirm.

I.

The record discloses the following facts and procedural history. C.W., a ninety-year-old widow, began residing in a nursing home in 2007. On or before March 1, 2008, C.W. gifted $539,352.25 in cash and her home, valued at $324,582.86, to her three children. On March 11, 2008, she applied for Medicaid benefits with UCDSS. On account of the $863,935.11 in gifts to her children, C.W. was denied benefits for a period of ten years, four months and thirteen days. She did not appeal UCDSS' denial of benefits or the length of the penalty period.

Prior to May 26, 2010, the children returned $234,600 in cash to C.W., who paid that amount to the nursing home. C.W.'s home was returned to her on August 22, 2008, and subsequently

sold on July 19, 2010, with net sale proceeds of $252,272.79. These proceeds were deposited into a savings account in the names of two of her children.[1] Contemporaneously, the children entered into a written agreement that, each month, money from the account would be deposited into an account in C.W.'s name to pay for the nursing home.[2] The agreement further provided the $252,272.79 was not the property of the children, and that C.W. would have unlimited access to the funds. Should C.W. die before the total sum was spent on her care, the remaining amount was to be distributed through her will.

On January 29, 2013, C.W. reapplied for Medicaid benefits. UCDSS denied the application, referencing her prior 2008 application, which was denied, and stating C.W. had "transferred resources for less than fair market value and ha[d] also gifted resources for the purpose of qualifying for Medicaid." UCDSS also noted not all of the resources C.W. previously gifted to her children were returned. C.W. requested a fair hearing to challenge the denial, and the matter was referred to the Office of Administrative Law (OAL) for a hearing before an ALJ.

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[1] The same two children had previously been named agents-in-fact to C.W. by virtue of C.W. executing a general durable power of attorney.

[2] C.W. has subsequently attempted to construe the agreement as creating a family trust.

C.W. also engaged in discussions with UCDSS regarding her reapplication, following which UCDSS informed C.W. she would be subject to a penalty period of six years, four months and fifteen days, based upon an adjusted amount of uncompensated transfers of $557,025.04. In arriving at this amount, UCDSS relied upon the $304,752.25 in cash C.W.'s children never returned and the proceeds of $252,272.79 from the sale of the home. UCDSS' notice provided the adjusted penalty period would run from the date of C.W.'s original penalty, February 1, 2008, through June 15, 2014.

The matter proceeded before the ALJ, who converted it to a summary proceeding. C.W. argued before the ALJ that the family agreement entered into by her children should be treated as a trust-like vehicle containing her assets. UCDSS asserted these proceeds were not C.W.'s resources, but uncompensated-for transfers, since they were deposited into a bank account in the children's names over which C.W. exercised no control. The ALJ issued her initial decision in favor of C.W., concluding the proceeds from the home's sale were C.W.'s assets because the parties stipulated as much and they were used solely to pay her nursing-home expenses. The ALJ therefore recommended UCDSS further downwardly adjust its penalty period to reflect only the unreturned cash totaling $304,752.25.

UCDSS filed exceptions to the initial decision and the matter went before the DMAHS Director. The Director rejected the ALJ's recommendation, and held the original penalty of ten years, four months and thirteen days remained in effect. In so holding, the Director first concluded that Medicaid regulations do not provide for the "reopening" of an existing penalty period through the submission of a later application. Second, she noted 42 U.S.C.A. § 1396p(c)(2)(C) foreclosed any reduction of a Medicaid penalty period where not all of the previously-transferred assets were returned to the applicant. Lastly, the Director determined any attempt to alter C.W.'s penalty period "r[an] afoul of general principles of repose." C.W. also had the opportunity to request a fair hearing to challenge UCDSS' initial determination of her penalty in 2008 and did not. As such, the Director concluded DMAHS was entitled to continued enforcement of the original penalty period.

This appeal ensued.

II.

Our review of an agency decision is limited. R.S. v. Div. of Med. Assistance & Health Servs., 434 N.J. Super. 250, 260-61 (App. Div. 2014). "An administrative agency's decision will be upheld 'unless there is a clear showing that it is arbitrary, capricious, or unreasonable, or that it lacks fair support in

the record.'" Id. at 261 (quoting Russo v. Bd. of Trs., Police & Firemen's Ret. Sys., 206 N.J. 14, 25 (2011)). In determining whether agency action is arbitrary, capricious or unreasonable, our role is restricted to three inquiries:

> "(1) whether the agency action violates the enabling act's express or implied legislative policies; (2) whether there is substantial evidence in the record to support the findings upon which the agency based application of the legislative policies; and (3) whether, in applying the legislative policies to the facts, the agency clearly erred by reaching a conclusion that could not reasonably have been made upon a showing of the relevant factors."
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> [Ibid. (quoting H.K. v. Div. of Med. Assistance & Health Servs., 379 N.J. Super. 321, 327 (App. Div.), certif. denied, 185 N.J. 393 (2005)).]

"'Deference to an agency decision is particularly appropriate where the interpretation of the [a]gency's own regulation is in issue.'" Ibid. (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)). "Nevertheless, '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.

Medicaid is a federally-created, state-implemented program that provides "'medical assistance to the poor at the expense of the public.'" Estate of DeMartino v. Div. of Med. Assistance & Health Servs., 373 N.J. Super. 210, 217 (App. Div. 2004) (quoting Mistrick v. Div. of Med. Assistance & Health Servs., 154 N.J. 158, 165 (1998)), certif. denied, 182 N.J. 425 (2005); see also 42 U.S.C.A. § 1396-1. Although a state is not required to participate, once it has been accepted into the Medicaid program, it must comply with the Medicaid statutes and federal regulations. See Harris v. McRae, 448 U.S. 297, 301, 100 S. Ct. 2671, 2680, 65 L. Ed. 2d 784, 794 (1980); United Hosps. Med. Ctr. v. State, 349 N.J. Super. 1, 4 (App. Div. 2002); see also 42 U.S.C.A. § 1396a(a), (b). The state must adopt "'reasonable standards . . . for determining eligibility for and the extent of medical assistance . . . [that are] consistent with the objectives' of the Medicaid program," Mistick, supra, 154 N.J. at 166 (first and second alterations in original) (quoting L.M. v. Div. of Med. Assistance & Health Servs., 140 N.J. 480, 484 (1995)), and "provide for taking into account only such income and resources as are . . . available to the applicant." N.M. v. Div. of Med. Assistance & Health Servs., 405 N.J. Super. 353,

359 (App. Div.) (internal quotation marks omitted), certif. denied, 199 N.J. 517 (2009); see also 42 U.S.C.A. § 1396a(a)(17)(A)-(B).

New Jersey participates in the federal Medicaid program pursuant to the New Jersey Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 to -19.5. Eligibility for Medicaid in New Jersey is governed by regulations adopted in accordance with the authority granted by N.J.S.A. 30:4D-7 to the Commissioner of the Department of Human Services (DHS). DMAHS is the agency within the DHS that administers the Medicaid program. N.J.S.A. 30:4D-5, -7; N.J.A.C. 10:49-1.1. Accordingly, DMAHS is responsible for protecting the interests of the New Jersey Medicaid Program and its beneficiaries.

In this case, C.W. applied for institutional level Medicaid benefits while she was residing in a nursing home. DMAHS provides such benefits pursuant to the Medicaid Only program, N.J.A.C. 10:71-1.1 to -9.5. Among other eligibility requirements, an individual seeking such benefits must have financial eligibility as determined by the regulations and procedures. See N.J.A.C. 10:71-1.2(a). The local county welfare agencies evaluate eligibility. N.J.S.A. 30:4D-7a; N.J.A.C. 10:71-1.5, -2.2(c). Through those county agencies, DMAHS serves 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).

An individual who is already receiving institutional level services but who is not yet eligible for Medicaid benefits, such as C.W., shall be deemed ineligible for those benefits if the individual "has disposed of assets at less than fair market value at any time during the 60-month period immediately before . . . the date the individual applies for Medicaid as an institutionalized individual" (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).[3] "Fair market value" is defined as "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).[4] If the applicant transferred assets during the look-back period,

[3] On February 8, 2006, the Deficit Reduction Act of 2005 enlarged the look-back period from thirty-six months to sixty months. Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006); see also 42 U.S.C.A. § 1396p(c)(1)(B)(i).

[4] 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 fair market value of the asset shall be ascertained and fully documented. N.J.A.C. 10:71-4.10(c).

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. v. State, 184 N.J. 367, 380 (2005) (citing N.J.A.C. 10:71-4.10(j)); see also 42 U.S.C.A. § 1396p(c)(1).[5] The burden of rebutting the presumption rests on the applicant, who must present "convincing evidence that the assets were transferred exclusively (that is, solely) for some other purpose," as well as credible documentary evidence of the fair market value of the transferred assets. N.J.A.C. 10:71-4.10(j). The presumption "shall be considered successfully rebutted only if the applicant demonstrates that the asset was transferred exclusively for some other purpose." N.J.A.C. 10:71-4.10(l)(1). "If the applicant had some other purpose for transferring the asset, but establishing Medicaid eligibility appears to have been a factor in his or her decision to transfer, the presumption shall not be considered successfully rebutted." N.J.A.C. 10:71-4.10(l)(2).

[5] "In determining whether or not an asset was transferred for fair-market value, only tangible compensation, with intrinsic value shall be considered." N.J.A.C. 10:71-4.10(b)(6)(i).

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, determined in accordance with 42 U.S.C.A. § 1396p(c)(1)(E), "shall be the number of months equal to the total, cumulative uncompensated value of all assets transferred by the individual, on or after the look-back date, divided by the average monthly cost of nursing home services in the State of New Jersey." N.J.A.C. 10:71-4.10(m)(1).

The period of ineligibility begins on the later of 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). An institutionalized individual who is ineligible for payment for long-term care services because an asset transfer precluded her from eligibility "shall be entitled to ancillary services if otherwise eligible." N.J.A.C. 10:71-4.10(m).

Applying the above standards, we discern no reason to disturb DMAHS' decision, as it is amply supported by the record. C.W. argues the Director's overturning both UCDSS' and the ALJ's partial reduction in her penalty was "absurd" and failed to properly interpret and apply Medicaid Communications Nos. 10-02 and 10-06. Put simply, this argument cannot withstand even the most forgiving scrutiny. DMAHS issued Medicaid Communication No. 10-02 on May 26, 2010, which provided no adjustments to an applicant's penalty period can be made absent a "satisfactory showing" of compliance with 42 U.S.C.A. § 1396p(c)(2)(C)'s requirements that:

> (i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, (ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or (iii) all assets transferred for less than fair market value have been returned to the individual.

On July 19, 2010, DMAHS issued Medicaid Communication No. 10-06, with the purpose of clarifying its treatment of returned assets under § 1396p(c)(2)(C). The clarification stated:

> The above [federal statute] is applicable to transfers for less than fair market value and adjustments to the penalty period cannot be made absent the return of all assets. A partial return of assets may have resulted in a reduced penalty period for Medicaid applications filed prior to May 26, 2010, where assets were partially returned prior to May 26, 2010.

The reductions in C.W.'s penalty period at issue resulted from her second application for Medicaid benefits, dated January 29, 2013. Therefore, on its face, No. 10-06's limited provision for a reduced penalty period following a partial return of assets previously transferred during the look-back period is not applicable. C.W.'s proposed interpretation of the regulations distorts the fundamental facts at the heart of this case: she applied for benefits in 2008, was denied, had a penalty imposed for improperly transferring assets during the look-back period and elected not to challenge that determination. C.W. points to no regulation or other authority, nor are we able to locate any, supporting the proposition she should be able to relitigate a previously-adjudicated and finalized penalty through a subsequent and wholly independent reapplication.

We are satisfied there is sufficient credible evidence in the record supporting DMAHS' decision and the decision was not arbitrary, capricious or unreasonable. See R.S., supra, 434 N.J. Super. at 261. As such, we agree with the Director that UCDSS' and the ALJ's reductions to C.W.'s penalty lacked any legal support and were therefore improper.[6] We hold the initial

[6] In light of our holding, we need not address the question of whether the Director erred in concluding the family agreement (continued)

penalty period of ten years, four months and thirteen days remains in force.

Affirmed.

(continued)
entered into by C.W.'s children did not result in a trust-like vehicle for the protection of C.W.'s assets.