State of New Jersey

OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION

OAL DKT. NO. HMA 3127-15

AGENCY DKT. NO. N/A

R.P.,

Petitioner,

v.

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

Respondents.

Jane M. Fearn-Zimmer, Esq., for petitioner (Rothkoff Law Group, attorneys)

Shelby Neiss, Esq., participant status for Hammonton Center for Rehabilitation (Schwartz, Sladkus, Reich, Greenberg & Atlas, LLP attorneys)

Elizabeth D'Ancona, Esq., for respondent, Atlantic County Board of Social Services (James F. Ferguson, County Counsel)

Division of Medical Assistance and Health Services, respondent, appearing without a representative, pursuant to N.J.A.C. 1:1-5.6(a)

Record Closed: January 11, 2016 Decided: January 15, 2016

BEFORE **W. TODD MILLER**, ALJ:

STATEMENT OF THE CASE

On October 20, 2014, the Atlantic County Medicaid Long-Term Care Unit (CWA) notified petitioner that his application for Medicaid eligibility was denied. The CWA concluded that petitioner failed to provide the requisite documentation necessary to make an eligibility determination (C-1; R-1:14). Petitioner asserts that the circumstances were beyond his control and that he was entitled to more time to make submissions. 42 C.F.R. § 435.911; N.J.A.C. 10:71-2.3(c). Alternatively, petitioner asserts that the CWA was asking for information that does not exist and, that it could have made a determination. And finally, the Hammonton Center for Rehabilitation (HCR) has provided petitioner with long-term care services since October 2013 and is owed $264,146 as of December 2015 (C-4). Petitioner is entitled to a substantive decision on the merits of his Medicaid application rather than a procedure rejection or denial. For the reasons discussed below, the determination of the CWA is **REVERSED.**

PROCEDURAL HISTORY

The petitioner requested a fair hearing and the matter was filed at the Office of Administrative Law (OAL) on March 3, 2015, to be heard as a contested case pursuant to N.J.S.A. 52:14B-1 to 15 and 14F-1 to 13. The matter was heard on June 22, 2015. Post-hearing submissions were received thereafter and the record closed on January 11, 2016.

STATEMENT OF FACTS

On or about September 27, 2013, R.P. was admitted for skilled nursing care at the Hammonton Center for Rehabilitation and Healthcare. R.P. was not clinically determined to be incapacitated but was diagnosed with dementia and lacked the capacity and the ability to assist with the three successive Medicaid applications. On November 19, 2013, petitioner applied for Medicaid. The first Medicaid application was

denied on June 4, 2014 (204 days after the application was filed) for failure to supply the CWA with information needed to make a determination (CWA-Exhibit A). Petitioner requested a fair hearing in that matter and initial decision reflects:

> Barbara Paugh, Assistant Administrative Supervisor with the Atlantic County Department of Human Services, testified on behalf of the agency. Ms. Paugh indicated that when the application was filed on November 19, 2013, an initial needs list was given to JFZ (R-1, page 9). An updated needs list was sent to JFZ on December 4, 2013, requesting information be provided by December 19, 2013 (R-1, pages 11-12). Several extensions were granted to allow JFZ additional time to obtain the documents requested. From December 2013 through May 2014 several letters were exchanged between the agency and JFZ either asking for additional information or supplying documentation. On May 20, 2014, six months after the application was originally filed, the agency sent a notification to JFZ requesting more information and establishing a deadline of June 4, 2014, for submission of the documents requested (R-1, pages 33-64).
>
> JFZ submitted additional information to the agency by letter dated June 3, 2014, that the agency received on June 6, 2014. JFZ again requested an additional extension to obtain certain documents that she was unable to obtain before the June 4, 2014 deadline (R-1, pages 65-68). The application was denied on June 10, 2014, and notification was sent to JFZ indicating this action was taken due to her "Failure to provide information needed to make a determination" (R-1, pages 71-73). The notice did not specify what information was needed to make a determination.
>
> Ms. Paugh stated that three items that had previously been requested remained outstanding on the June 4, 2014 deadline. First, the agency requested verification of activity for a Bank of America account owned by petitioner (R-1, page 39). On June 3, 2014, JFZ provided verification for transactions on the Bank of America statement for December 2013 as requested on May 20, 2014. Questions raised in the May 20, 2014 correspondence regarding other activity on the Bank of America account, however, including questions regarding five checks drawn on the account on January 11, 2012, remained unanswered on June 4, 2014. Next, the agency requested information concerning an account owned by petitioner with Great West Life and Annuity Insurance Company (Great West). The agency requested verification of whether this account was an

> annuity or a life insurance policy (R-1, page 48). This requirement was acknowledged by JFZ in her letter to the agency dated June 3, 2014, and she requested additional time to get that information because Great West was a third party and required time to gather the information requested (R-1, page 67).
>
> Initial Decision, HMA 7818-14 (decided November 25, 2014); [emphasis added]; Affm'd Dir. of DMAHS January 20, 2015.
>
> (R-1:2-11).

On July 17, 2014, petitioner filed a second Medicaid application. The second application was denied on October 20, 2014 (ninety three days), (C-1; R-1:14). The CWA stated "This action has been taken because: Failure to provide documenation required to make a determination. Specifically, a listing of 1099's from the IRS for the years 2009-2013, as well as bank statements on any and all accounts discovered through those 1099's. This includes Wachovia Securities that earned over $46,000 in interest in 2009." (C-1; R-1:14).

It is the Ocotber 20, 2014, denial that is presently before this tribunal. A third application was filed on April 8, 2015, but not before this ALJ.

At the fair hearing, the the CWA supported the denial as follows:

> The first application for Medicaid Only benefits for [R.P.] was made on November 19, 2013 by his attorney, Jane Fearn-Zimmer, Esq. (JFZ).
>
> 2. The application was denied on 6/10/14.
>
> 3. JFZ requested a Fair Hearing. This Fair Hearing was held on October 7, 2014. The record was closed on November 7, 2014, Initial Decsion (11/25/2014) and Final Agency decision (1/20/2015) upheld the denial. [Pages 1-12]
>
> 4. While waiting for the Fair Hearing to take place,JFZ made another application for Medicaid for [R.P.] on July 17, 2014. [Page 13] This application was denied on 10/20/2014. [Page14]
>
> 5. Outstanding at time of denial were:

a. A listing of 1099's from the IRS for the years 2009-2013, with bank stamements for any accounts discovered through those 1099's.

b. Wachovia Securities statements for account which earned over $46,000.00 in interest in 2009.

6. Page 15 shows request for the above information dated 9/8/2014 with a deadline of 10/18/2014.

7. Petitioner filed another application 4/8/15. Items 5a and 5b are still outstanding.

8. Pettioner supplied statements for a Wachovia Securities account (attempting to fulfill 5b), however this was not the correct account, as it closed in 2008 so it could not have possibly earned interest in 2009.

(R-1)

Jane M. Fearn-Zimmer, Esq., counsel for petitioner submitted a certification stating the following:

1. I am a Senior Associate Attorney with the Rothkoff Law Group, counsel for petitioner, R.P. I make this certification on behalf of R.P. in the Medicaid Fair Hearing held on June 22, 2015.

2. R.P. was admitted to Hammonton on September 27, 2013 following an unexpected and rapid decline of mental capacity, which occurred over a period of approximately five (5) months.

3. I am informed and believe that though R.P. has not been adjudicated to be an incapacitated person, he probably lacks capacity and the ability to assist and participate in the Medicaid application process, due to his dementia diagnosis.

4. R.P. originally made an application for Medicaid benefits on November 19, 2013, seeking September 1, 2013 eligibility.

5. R.P.'s original application was denied by notice dated June 14, 2014 based upon a failure to provide information.

6. The information Medicaid sought, for which the original application was denied, has since been provided.

7. R.P. filed a second Medicaid application on July 17, 2014.

8. On September 18, 2014, the Atlantic County Division of Social Services issued a pending notice requesting documentation regarding a Wachovia Securities account which was later determined to have been closed in 2008, which was prior to the beginning of the five year Medicaid look back period.

9. Specifically, in the September 18, 2014 letter, the Atlantic County Division of Social Services acknowledged that it was requesting:

> More detailed information about these accounts, please have the IRS provide a listing of all 1099's received for the years 2009 through 2013. These reports from the IRS will actually show account numbers which will prove quite beneficial in ascertaining the correct information. I would suggest that as soon as you receive the information from the IRS you start requesting the statements, as appropriate, from the banks. Please do not wait for me to request them, as I am letting you know now that I will need statements from any accounts which we do not currently have in our possession.
>
> Regarding account ending in 5357 with Wachovia, there were 3 deposits about which Angelika requested documentation which have yet to be addressed. As far as I can see, the deposit slips and images have not yet been supplied. They occurred 7/31/2009, 8/20/2009 (2 deposits) and were in the amounts of $7,500 and $2,288.00 and $11,049.04, respectively. Please provide the deposit slips with check images.
>
> The deadline for the required information will be one month from today, October 18, 2014.

A true and correct copy of the letter is affixed as Exhibit "A."

10. By letter dated September 30, 2014, I sent respondent copies of the deposit slips for the three transactions requested by the respondent, i.e., the two deposits on July 31, 2009 and August 20, 2009 in the amounts of $7,500 and $2,288 and the $11,049.04 deposit. A true and correct copy of the letter is affixed as Exhibit "B."

11. On that same date, I sent a form IRS 8821 to Michele Jennings, the attorney in fact for R.P.

12. On October 6, 2014, I telephoned Michele Jennings to follow up on the IRS 8821 form, which I still needed her to sign and the missing deposit slips. She said that she will return the signed form to me the next day by dropping the form off at my office on October 7, 2014.

13. On October 8, 2014, I wrote to Wells Fargo Advisors, LLC, and requested the missing 1099. See Exhibit C.

14. On October 10, 2015, I spoke with Thomas Costa, CPA, the former accountant for R.P. who prepared his 2009 federal income tax return. Mr. Costa stated that he did not have any copies of his former client's 1099's. I reminded him that I was still waiting for Michele Jennings to return the signed IRS 8821 form to me and I asked him to please contact her directly to remind her to do this.

15. On October 14, 2014, I had still not yet received any IRS 8821 from Michele Jennings. I telephoned her twice and left message for her at her work and on her cellular mobile line.

16. On October 16, 2014, I still had not received any IRS 8821 form from Michele Jennings. received or the missing deposit slips. I telephoned Michele Jennings and she said that she would go to the bank to obtain the deposit slips.

17. On October 17, 2014, Michele Jennings came to my Cherry Hill office and advised that she had ordered the 1099's from Wells Fargo and from the Bank of America. In order to obtain a 1099 from Wells Fargo for the Wachovia Securities account, she was required to complete an Associated Person form.

18. On October 17, 2014, I provided the requested statements for R.P.'s Bank of America account with copies of cancelled checks, and I requested in the cover letter **additional time** to provide the 1099's from Bank of America and Wells Fargo Bank, and additional statements that had been requested from Wells Fargo and Wachovia accounts.

19. **Three days later**, Medicaid issued the October 20, 2014 denial, which is the subject of this Fair Hearing. The October 20, 2014 notice, R.P.'s second Medicaid application was denied for: "Failure to provide documentation required to make a determination. Specifically a listing of 1099's from the IRS for the years 2009 – 2013, as well as bank statements on any and all accounts discovered through those 1099's. This includes a Wachovia Securities account that earned over $46,000 in interest in 2009."

20. On October 31, 2014, I spoke by telephone with Wells Fargo Customer Service to follow up on my letter of October 8, 2014, requesting the 1099. Michele Jennings was also on the call. The bank refused to assist us, stating that they were unable to locate the completed Associated Person form which Michele Jennings had previously provided to them.

21. On November 5, 2014, I spoke by telephone with Wells Fargo Customer Service but was unable to reach Michele Jennings by telephone and could not proceed further with the conference call.

22. On November 7, 2014, I travelled to the Cherry Hill branch of Wells Fargo Bank and met with Tammy Loomis at that branch. Ms. Loomis verified that there was no further documentation in their system regarding the three deposits in after searching the Wells Fargo databases. She subsequently verified the above

information with her colleague, April. She then telephoned the Customer Support Escalation hotline and confirmed that there were no offsets to any of these cash deposits, and there were no closed accounts, no checks or groups of checks which matched the deposits. She advised me that the Escalation Team will provide a letter verifying this; per Wells Fargo policies and the letter will be provided in approximately one week.

23. Wells Fargo/Wachovia did not respond to the request for copies of the records of the deposits of $7,900 on July 31, 2009, $11,049.04 and $2,288 on August 20, 2009 until November 18, 2015, when it responded that all the deposits in question were cash deposits and no additional information about these deposits was located. See Exhibit D.

24. Wells Fargo/Wachovia did not respond to the request for a copy of the 1099 for the 2009 taxable year until November 21, 2014, when it sent a facsimile indicating that the account in question was closed in 2008. By inference, there was no 1099 generated for this account for the 2009 taxable year for R.P. See Exhibit E.

25. At that time, Petitioner was advised that that the last 1099 was issued in 2008, and that the associated account was closed in that year.

26. There was never a 1099 issued by Wells Fargo/Wachovia Securities for the 2009 taxable year. Therefore, the County Welfare Agency's request for petitioner's 1099 transcript for 2009 was completely irrelevant, and all available information had already been provided.

27. Petitioner was finally able to obtain confirmation from the accountant who prepared the erroneous tax return, that the report of $46,732 on petitioner's 2009 tax return was an error on his part.

28. In the interim, R.P. filed a new application with the County Welfare Agency on or about April 8, 2015.

29. On April 17, 2015, nine (9) days after that application, the County Welfare Agency issued a notice that they could not complete the processing of the third application within the requisite forty-five (45) days, and that it would be held in pending status. See Exhibit F.

30. On April 30, 2015, respondent's attorney sent an e-mail to me, which stated:
    I am wondering if you are considering withdrawing this fair hearing, because you may have filed it before we had the first hearing. If I remember correctly, you may just have been denied around the time of the first fair hearing. Since this is the same issue (likely to go the same way?) and you have a reap pending, just let me know if you are going to proceed with this hearing or withdraw.
    See Exhibit G.

31. On the evening of Sunday, June 21, 2015, I ordered the 2009 tax return transcripts from the Internal Revenue Service. I was subsequently advised by the Internal Revenue Service that no tax return transcripts were available for the period in question.

32. On July 20, 2015, I wrote a follow up letter to the IRS, requesting the tax account transcripts for the 2009 and 2010 taxable years. See Exhibit H.

33. On July 28, 2015, I served a subpoena on Wells Fargo in attempt to locate any copies of checks corresponding to the cash deposits in question. See Exhibit I.

34. On August 7, 2015, I received the letter from Wells Fargo advising that there are no documents responsive to the request for check copies. See Exhibit J.

35. On August 19, 2015, I received the RAIVS Third Party Reject Notification from the IRS. See Exhibit K.

36. Thomas Costa, CPA signed a certification advising that R.P. did not receive any taxable income from Wachovia Securities for the 2009 taxable year and he did

not receive any 1099's from this financial institution for R.P. for the 2009 taxable year and that the report of $46,732 in income in 2009 from a Wachovia Securities account was an error.

37. The bottom line is that the County Welfare Office is persisting in denying Medicaid eligibility to R.P. based on my alleged failure provide any 1099 for R.P. for the Wachovia Securities account for the 2009 taxable year.

38. This prejudices R.P., who will lose months of retroactive coverage if the denial of his Medicaid application is left to stand.

CONCLUSIONS

Medicaid is a cooperative federal and state program established by Title XIX of the Social Security Act for the purpose of furnishing medical assistance to qualified aged, blind or disabled persons and families with dependent children. 42 U.S.C.A. §§ 1396 to 1396u; N.J.S.A. 30:4D-1, -2. It "is 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. Division of Medical Assistance & Health Services, 140 N.J. 480, 484 (1995) (citations omitted). Medicaid is intended to be a funding of last resort for those in need. N.J.S.A. 30:4D-2.

As a participating state in the Medicaid program, New Jersey must ensure that its medical assistance plan complies with federal Medicaid law. Wilder v. Virginia Hospital Ass'n, 496 U.S. 498, 501 (1990); Bethpage Lutheran Service, Inc. v. Weicker, 965 F.2d 1239, 1240 (2d Cir. 1992); Caldwell v. Blum, 621 F.2d 491, 494 (2d Cir. 1980). The Fourteenth Amendment prohibits states from depriving a person of life, liberty, or property without due process of law. Here petitioner has a protectable "property interest" in his Medicaid benefits under the Fourteenth Amendment. Goldberg v. Kelly, 397 U.S. 254, 262 (1970).

The processing of Medicaid applications involves shared responsibility. The burden does not rest exclusively with the applicant. N.J.A.C. 10:71-2.2 sets forth

responsibilities for both the CWA and the applicant, during the application process. Specifically, N.J.A.C. 10:71-2.2(e) states "as a participant in the application process, an applicant shall:

1. Complete, **with the assistance from the CWA if needed**, any forms required by the CWA as a part of the application process;

2. **Assist the CWA in securing evidence that corroborates his or her statements**; and

3. Report promptly any change affecting his or her circumstances.

[Emphasis added].

N.J.A.C. 10:71-4.1(d) instructs the CWA to verify the value of resources:

> 3. Verification of value: The CWA shall verify the equity value of resources through appropriate and credible sources. Additionally, the CWA shall evaluate the applicant's past circumstances and present living standards in order to ascertain the existence of resources that may not have been reported. If the applicant's resource statements are questionable, or there is reason to believe the identification of resources is incomplete, **the CWA shall verify the applicant's resource statements through one or more third parties.**
>
> i. Responsibility of applicant: If the **third-party contact** is required in accordance with the provisions above, the applicant shall cooperate fully with the verification process. If necessary, the applicant shall provide written **authorization allowing the CWA to secure the appropriate information**.

As indicated in Goldberg v Kelly, supra, Medicaid is a taxpayer funded insurance program (i.e. protectable property interest) intended to assist qualified disabled individuals when they are most vulnerable due to age related or unexpected onset of disabilities. Pursuant to 28 C.F.R. §35.130 (b)(7) "A public entity **shall make** reasonable modifications in policies, practices, or procedures when the modifications

are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." In the instant matter, petitioner is indisputably a disabled individual that is entitled to an accommodation when applying for a public benefit, which has been deemed a property interest. In Ability Ctr. of Greater Toledo v. Lumpkin, 808 F. Supp. 2d 1003, 1023 (U.S.D.C. Ohio 2011) the Court discussed the accommodations for the disabled in the context of applying for public benefits:

> A plaintiff need not allege either disparate treatment or disparate impact to state a reasonable accommodation claim. See, e.g., Henrietta D. v. Bloomberg, 331 F.3d 261, 276-77 (2d Cir. 2003).
>
> Title II "**requires that public entities make reasonable accommodations for disabled individuals so as not to deprive them of meaningful access to the benefits of the services such entities provide**." Ability Ctr. of Greater Toledo v. City of Sandusky, 385 F.3d. 901, 907 (6th Cir. 2004); see also Tennessee v. Lane, 541 U.S. 509, 531, 124 S. Ct. 1978, 158 L. Ed. 2d 820 (2004) (recognizing that "**failure to accommodate persons with disabilities will often have the same practical effect as outright exclusion**[.]"). As the Supreme Court held in Alexander v. Choate, 469 U.S. 287, 301, 105 S. Ct. 712, 83 L. Ed. 2d 661 (1985), "an otherwise qualified handicapped individual must be provided with meaningful access to the benefit that the grantee offers."
>
> When necessary to avoid discrimination on the basis of disability, **a public entity shall, pursuant to 28 CFR § 35.130(b)(7), make reasonable modifications in policies, practices, or procedures.** The entity need not make the accommodation, however, if it either "imposes undue financial and administrative burdens on a grantee, or requires a fundamental alteration in the nature of [the] program." Sandison v. Michigan High Sch. Athletic Ass'n, 64 F.3d 1026, 1034 (6th Cir. 1995) (quoting School Bd. of Nassau County v. Arline, 480 U.S. 273, 287 n.17, 107 S. Ct. 1123, 94 L. Ed. 2d 307 (1987)).

Here, the agency issued its decision in accordance with N.J.A.C. 10:71-2.3(a). The regulation states, in pertinent part:

> The maximum period of time **normally essential to process an application** for the aged is 45 days; for the disabled or blind, 90 days.
>
> [Emphasis added].

The regulation discusses the **"normal time"** it should take **"the CWA"** to "process an application." It does not take the applicant any time to process the application – as it is obviously not the job of the applicant. This regulation is a job performance regulation imposing job standards on the agency personal to meet certain consumer protection ideals for the aged, blind, and disabled. Finally, the regulation is unfairly vague in that it generalizes by stating how much time is "normally" required for the CWA to process application. "Normal" based upon what? A healthy competent applicant with very few financial transactions? Or a very sick individual who has thousands of transactions and hired Medicaid planners that set up trust and other planning devices? Again, the regulation merely sets standard for the CWA as to what is "normal" processing time. Nowhere does it permit the agency to turn the regulation on its head and deny a Medicaid client a remedy when their application is anything but "normal." In fact cutting the application process short because of the CWA time limits is expressly forbidden by 42 C.F.R. § 435.912(g) (**agency must not use the time standards as a reason for denying eligibility because it has not determined eligibility within the time standards**), (discussed, infra).

Here, the CWA waited ninety-three days for the second application and denied petitioner's request on the basis of failing to provide information (C-1; R-1:14). (The CWA waited 204 days in the first application, presumably relying on the language found in N.J.A.C. 10:71-2.3(a) that allows for more time. The submission process appears to be very discretionary and highly arbitrary to this petitioner.

Indeed N.J.A.C. 10:71-2.3(a) is tempered by N.J.A.C. 10:71-2.3(c). This regulation states, in pertinent part:

> (c) It is recognized that there **will be exceptional cases where the proper processing of an application cannot be completed within the 45/90-day period**. Where substantially reliable

> evidence of eligibility is still lacking at the end of the designated period, **the application may be continued in pending status**. In each such case, the **CWA shall be prepared to demonstrate** that the delay resulted from one of the following:
>
> (1). **Circumstances wholly within the applicant's control**;
>
> (2). A determination to **afford the applicant, whose proof of eligibility has been inconclusive, a further opportunity to develop additional evidence of eligibility before final action** on his or her application;
>
> (3). An administrative or other emergency that could not reasonably have been avoided; or
>
> (4). **Circumstances wholly outside the control of both the applicant and CWA**.
>
> See also; 42 C.F.R. § 435.912 (formerly 42 C.F.R. § 435.911)

Federal law found at 42 C.F.R. § 435.912 entitled "Timely determination of eligibility" contains **agency only** guidelines and has distinct exceptions to the 45/90 deadline. The exceptions protect the disabled Medicaid applicant from premature rejection of their application, due to their disability or other hardships. It states:

> (a) For purposes of this section--
>
> (1) "Timeliness standards" refer to the maximum period of time in which every applicant is entitled to a determination of eligibility, **subject to the exceptions in paragraph (e) of this section.**
>
> (2) "Performance standards" are overall standards for determining eligibility in an efficient and timely manner across a pool of applicants, and include standards for accuracy and consumer satisfaction, but do not include standards for an individual applicant's determination of eligibility.
>
> (b) Consistent with guidance issued by the Secretary, the agency must establish in its State plan timeliness and performance standards for, promptly and without undue delay--
>
> (1) Determining eligibility for Medicaid for individuals who submit applications to the single State agency or its

designee.

(2) Determining potential eligibility for, and transferring individuals' electronic accounts to, other insurance affordability programs pursuant to § 435.1200(e) of this part.

(3) Determining eligibility for Medicaid for individuals whose accounts are transferred from other insurance affordability programs, including at initial application as well as at a regularly-scheduled renewal or due to a change in circumstances.

(c) (1) The timeliness and performance standards adopted by the agency under paragraph (b) of this section must cover the period from the date of application or transfer from another insurance affordability program to the date the agency notifies the applicant of its decision or the date the agency transfers the individual to another insurance affordability program in accordance with § 435.1200(e) of this part, and must comply with the requirements of paragraph (c)(2) of this section, subject to additional guidance issued by the Secretary to promote accountability and consistency of high quality consumer experience among States and between insurance affordability programs.

(2) Timeliness and performance standards included in the State plan must account for--

(i) The capabilities and cost of generally available systems and technologies;

(ii) The general availability of electronic data matching and ease of connections to electronic sources of authoritative information to determine and verify eligibility;

(iii) The demonstrated performance and timeliness experience of State Medicaid, CHIP and other insurance affordability programs, as reflected in data reported to the Secretary or otherwise available; and

(iv) The needs of applicants, including applicant preferences for mode of application (such as through an internet Web site, telephone, mail, in-person, or other commonly available electronic means), as well as the relative complexity of adjudicating the eligibility determination based on household, income or other relevant information.

(3) Except as provided in paragraph (e) of this section, the determination of eligibility for any applicant may not exceed--

> (i) **Ninety days for applicants who apply for Medicaid on the basis of disability**; and
>
> (ii) Forty-five days for all other applicants.
>
> (d) The **agency must** inform applicants of the timeliness standards adopted in accordance with this section.
>
> (e) The **agency must** determine eligibility within the standards **except in unusual circumstances**, for example--
>
> (1) When the **agency cannot** reach a decision because the applicant or an examining physician delays or fails to take a required action, or
>
> (2) When there is an administrative or other emergency **beyond the agency's control**.
>
> (f) The **agency must** document the reasons for delay in the applicant's case record.
>
> (g) The **agency must not** use the time standards--
>
> (1) As a waiting period before determining eligibility; or
>
> (2) **As a reason for denying eligibility (because it has not determined eligibility within the time standards)**.

Note - that the majority of the provisions place a burden upon the CWA to protect the applicant from agency delay and not the agency from client delay. Based upon language found in 42 C.F.R. § 435.912 it is abundantly obvious that this regulation was promulgated to protect Medicaid applicants from bureaucratic delay. Indeed, the time limits only apply to the CWA. They are relaxed or suspended if the applicant is having justifiable difficulty producing records.

In New Jersey both N.J.A.C. 10:71-2.3(a) and N.J.A.C. 10:71-2.3(c), which were promulgated in response to the federal regulations, are likewise intended to protect Medicaid applicants from bureaucratic delay. This is demonstrably obvious because the Medicaid applicant is hardly mentioned in the regulations, in the context of time limits. Only the CWA is confined by the time restraints. The pertinent state and federal regulations speak only to the burden upon the CWA to take action within 45/90 day time

period. These regulations prevent the CWAs from "foot dragging" or delaying to the detriment of the Medicaid client who are generally pressed for time and in need of relief due to unexpected illness.

Conversely, the regulations do not place any time restriction limitation upon a mentally impaired applicant who is woefully lost as to their financial resources. In fact, the regulations include protective provisions directing the CWA that disabled applicants are entitled to more time, if matters are outside the control of the CWA N.J.A.C. 10:71-2.3(c)1, or financial information is unavailable and in the possession of third parties. N.J.A.C. 10:71-2.3(c)4; N.J.A.C. 10:71-2.3(e)(1). (supra)

The look-back period increased on February 8, 2006, from thirty-six months to sixty-months pursuant to Deficit Reduction Act[1] of 2005. This substantially increased the burden on Medicaid applicants and the CWA as sixty months of transactions must be reviewed.

Here, petitioner rapidly declined over a period of five months and unexpectedly ended up in a long-term care facility. There was no lead-time for petitioner to arrange five years of financial affairs. When Medicaid applicants are mentally incapable of assisting in their pursuit of Medicaid coverage, the regulations clearly protect them from being penalized; due to their inability to submit in-depth analysis of five years' worth financial transactions for items; such as stock transactions and thousands of ordinary banking transactions; particularly when third parties banks, brokerage firms, IRS and accountants protect these transactions from fraud, improper disclosure, or cyber intrusion.

This is not a case where the petitioner failed to make the required submissions or cooperate with the CWA. (Certification of Zimmer; C1-3). The record in this case reflects that petitioner made substantial document submissions to the CWA (September 14, 2014 (C-1); August 11, 2015 (C-2); August 29, 2015 (C-3). The same seems to

[1] Section 6011(a) of the Deficit Reduction Act (DRA); P.L. 109-171, amends section 1917(c)(1)(B)(i) of the Social Security Act (the Act). The amendment provides that for any transfer of assets made on or after the date of enactment of the DRA (February 8, 2006), the look-back period is 60 months.

have occurred in the first application. Third parties such as Bank of America, Great Western Insurance, IRS, attorneys and accountants would not turn over information, as anyone would have desired.

There are very few tools to force the hand of third parties. Compelling third parties responses cannot occur unless court intervention is initiated (e.g. subpoena power). And the OAL rules only permit a subpoena to issue for production of records to be produced at the OAL hearing. An OAL subpoena cannot be used as a discovery technique on a non-party. N.J.A.C. 1:1-11.1(d). Therefore the petitioner is left without an efficient means to gather third party records. Thus the petitioner's failure to produce records within the 45/90-day timeframe is a precarious situation. The CWA, with its sway as a government authority, and with the consent of the applicant, would in certain instances, likely garner a more timely response from third parties.

In the present case the submissions reflect that this case took on the features of complex litigation, rather than one resembling a "normal" application. Petitioner's initial application and subsequent submissions included five years' worth of financial information. The CWA responded with very detailed discovery type demands after petitioner made its good faith submission. Each submission triggered more questions from the CWA (e.g. applicant produces five years of bank statements – CWA request copies of checks and bank deposits slips along with a narrative about the deposit or payment, albeit from a client with dementia). And this is the second application filed by petitioner. The CWA already had extensive discovery from the first case/application. Here, the CWA, in good faith, continually shifted the burden back to petitioner to produce more and more detailed proofs each time bank statements or institutional information was submitted. The questions and answer cycle gets deeper and more arduous each time, with the probing inquires going well beyond what the regulations anticipate to be "normal" or "routine". N.J.A.C. 10:71-2.3(a). I **CONCLUDE** this application was not routine or normal.

The CWA's follow-up questions were appropriate and same is not faulted for their inquiries. Rather, it is entirely unrealistic in a case such as the present, that five years' worth of financial transactions can be produced, and analyzed followed by more

requests and analysis all within 45/90 days, particularly when the source of information is mentally impaired or incapacitated person.

Case-in-point, the CWA requested the following just in the second Medicaid application:

CWA's July 27, 2015 Demand

Part 1
PLEASE PROVIDE THE DOCUMENTS MARKED BELOW
BANK STATEMENTS:
RECENT COPY OF PENSION STUB OR CHECK
LIFE INSURANCE POLICIES (FACE AND CASH VALUE)
CURRRENT HEALTH INSURANCE BILL
BURIAL AND IRREVOCABLE INFORMATION
DEED TO PROPERTY LOCATED AT:
MOST RECENT PROPERTY TAX BILL
LEASE OR MORTGAGE BILL
SPOUSE'S INCOME
PELASE REFER TO ATTATCHED LETTER OF NEEDS
OTHER Please see attatched.

Attached

I have reviewed the documentnation you provided and found that most of the requested items are still missing as of today: See highlighted items on the letter written to you by my supervisor, Barbara Paugh, on 9/18/14. Provide those items.
Note that the Wells Fargo account (ending in 7137) you provided was closed 1 2008 and is not in our look back. The accounts in question were open in 2009.
BOA ending in 1151
Provide updated bank statements from 9/7/14 to most recent or closing. Include all check images if applicable)
Please provide check images #109, #101, #102.
Provide following deposit tickets (make sure to include corresponding deposit documentation): $1,816 on 11/19/09, $22,916.80 on 10/13/09, $7,277.68 on 10/7/09, $71,231.64 on 12/15/09.

Wells Fargo Sav ending in 2727:
The last statement I have on file shows a balance of $673.72 on 4/15/11

Provide updated to closing.
Provide deposit ticket and corresponding deposit documenation: $7,900 on 7/3/09,
$2,288 on 8/20/09, $11,049.00 on 8/20/09.
Following payments were made out of account ending in 5357 to and American Express Credit Card. Provide the cards account number as well as the account holder's name and of course the payments must match the card.
$18,291.43 on 5/29/09, #2 2,800 on 6/27/09, $5993.96 on 3/11/09, $2,711.78 on 2/17/09, $3,927.20 on 1/6/09, $7,423.30 on 1/4/09, $6,718 on 12/16/09, $10,084.76 on 12/4/08, $5000 on 12/4/08.
Wells Fargo account 1010201113840:
Last statement on file shows a balance of $30,0082 on 2/23/09.

Provide updated bank statements to closing. Include all withdrawal/deposit dcoumentaion to verify where the money was deposited (if applicable).
Great West policy #93617601: Document what kind of investment this was. If it was a Life Insurance Policy provide the surrender documentation.
If is is an annuity provide the look back from 11/19/08 to most recent or closing.
Condo lease for condo in Mexico: Provide a notorized translation
Best benefits: If cancelled provide a cancellation verification
Aetna & Bravo: Provide current monthly health premium bills (C-3).

CWA's Setpember 18, 2014 Demand

I have personally reviwed the application for [R.P.] ahd have found that there are some items whaich are stilll required in order to make a determination of eligibilty for Medicaid.

I note that in the 2009 tax return that an account with Wachovia Securities earned a substantial amount of interest (over $46,000.00). To date, there has not been any

> information provided regarding an account with Wachovia Securities. We will need this information. In addition, a Wachovia bank account earned interest in excess of $40,000.00. While we do not have statements from a Wachovia Account, it does not appear to be the same account as the statements show minimul interest accruing in the account you have provided. In order to get more deatiled information about these accounts, please have the IRS provide a listing of all 1099's received for the years 2009 through 2013. These reports from the IRS will actually show account numbers which will prove quite beneficial in ascertaining the correct inromation. I would suggest that as soon as you receive the infomation form the IRS you start requesting the statements, as appropiate from the banks. Please do not wait for me to request them, as I am letting you know now that I will need statements from any accounts which we currently do not have in our possession.
>
> Regarding the account ending in 5357 with Wachovia, there were 3 deposits which Angelika requested documenation which have yet to be addressed. As far as I can see, the deposit slips and images have not yest been supplied. They occurred on 7/31/2009, 8/20/2009 (2 depostis) were in the amounts of $7,500 and $2,288.00 and $11,049.04, respectfully. <u>Please provide deposit slips with check images.</u>
>
> Finally, the bank statements provided for Bank of America from December 2013 through June 2014 did not contain the check images. <u>Please supply those images .</u> (C-1).

The history reflects that each time the petitioner submitted pertinent information, the CWA responded with requests for more details from third parties, including copies of cancelled checks, copies of deposit slips that resulted in demands served upon the IRS, banks, brokerage firms, accountants, and attorneys. And the CWA placed the burden directly upon the applicant even though the regulations state that the CWA can also request permission from the applicant to communicate directly with third parties. <u>N.J.A.C.</u> 10:71-4.1(3). This was no easy task as delineated in the Certification of Zimmer.

Based upon the plain text and regulatory history, I **CONCLUDE** the aforementioned regulations were primarily intended to protect Medicaid applicants from "bureaucratic delay", not applicant inability (See Footnote 2). The regulations place pressure on the CWA to process applications swiftly for the sick and disabled. They also are intended to put pressure CWA to help the applicants get information from third parties. N.J.A.C. 10:71-2.2(e); N.J.A.C. 10:71-4.1. The regulatory scheme was not intended to put pressure on, or to inadvertently penalize applicants. The CWA cannot reject applications filed by mentally compromised applicants under the 45/90 day rule, when the applicants are acting in good faith, but are still having trouble assembling hundreds of corroborative papers for transactions being reviewed by the CWA. Here, the CWA turned the 45/90 day regulation against the applicant thereby cutting off his eligibility determination for procedural reasons, even though the regulation is silent as to the burden of production placed upon the applicant under this rule or regulation.

The CWA has turned a clearly worded consumer protection regulation into consumer rejection regulation. Nowhere does either N.J.A.C. 10:71-2.3(a) or N.J.A.C. 10:71-2.3(c) state that the applicant shall do anything in any particularized timeframe. N.J.A.C. 10:71-2.3 is titled policy and procedure on "prompt disposition." Section (a) discusses the CWAs "processing time." Section (c) again discusses prompt processing by the CWA. And section (c) excuses the CWA from prompt processing if the circumstances are beyond or outside the control the CWA. If the circumstances are wholly within the control of the applicant – the CWA is excused from the 45/90 day processing time limit. If the client's submissions are inconclusive the applicant is to be given more time and the CWA is excused from the 45/90 day processing time limit. If the circumstances are wholly outside of the control of the CWA and the applicant – the CWA is excused from the 45/90 day processing time limit. Finally, and most importantly, **agency must not use the time standards imposed upon them to as a reason for denying eligibility** 42 C.F.R. § 435.912(g).

The Medicaid 45/90 time limit regulation is slightly analogous to a zoning board application. If a zoning board fails to make a decision within 120 days of the submission, it results in a favorable decision for the applicant. N.J.S.A. 10:55D-76c. This protects the property owner from "foot dragging" and "bureaucratic delay" by the

municipal agency. However, zoning boards are insulated from the automatic approval statute if the application was never complete. The zoning board must first certify that application is complete before the 120-day limitation period starts to run. N.J.S.A. 40:55D-10.3. The same rational applies to the present Medicaid matter. The Medicaid applicant makes its submission and if the application is deficient, the 45/90 day time limit is not triggered because there is really no completed application pending before the CWA. The applicant has not triggered the time clock, which is what the 45/90 day regulation infers.

Here, the CWA continuously requested volumes of information post-submission. The applicant cannot, pre-submission, anticipate each and every item that the CWA will request after the initial application is filed. Hence, the case takes on a complex sequence of discovery requests that burdens the application process and delays the decision. As a result, the CWA triggers the 45/90 day limitation, not based upon the applicant's submission, but based upon the CWA's quest for explicit details regarding remote transactions that a mentally disabled applicant cannot recall. This triggers arduous excursions into institutional record keeping which is protected by ironclad confidentially policies or laws. The point being, that it is the CWA that is driving the inquisitions into financial matters and it is the Medicaid applicant that is being penalized as a result due to the back and forth between the applicant and the agency. All along the CWA can make its own direct and independent inquiries with third parties and leave the applicant out of the process. N.J.A.C. 10:71-4.1(3); N.J.A.C. 10:71-2.2(e).

As stated in Ability Ctr. of Greater Toledo v. Lumpkin, supra, disability law requires that public entities make reasonable accommodations for disabled individuals so as not to effectively deprive them of meaningful access to the benefits or services provided by same. And public agencies indeed have a duty to offer reasonable modifications to their policies, practices, and procedures under the Fourteenth Amendment for disabled individuals so they are not effectively or unintentionally denying access to the vital programs which have in fact funded by the applicants. Simply put, there is nothing contained the regulations, or regulatory history, that authorizes a government agency to use a consumer protection regulation as a sword (i.e. prematurely cut off consideration) against disabled applicants.

I **CONCLUDE** that petitioner, a disabled person, meets the exceptional circumstances set forth in N.J.A.C. 10:71-2.3(c); 42 C.F.R. § 435.912. The legislative history and reported cases demonstrate that the timeliness regulation was specific to the CWA, and it was intended[2] for the benefit of Medicaid applicants to ensure the CWA does not delay processing their applications. The regulation was not intended to be a tool to administratively or procedurally dismiss applications for disabled applicants, 42 C.F.R. § 435.912(e) and (g). Petitioner, as a disabled individual, is to be afforded procedural due process and policy accommodations 28 C.F.R. § 35.130 (b)(7); Ability Ctr. of Greater Toledo v. Lumpkin, supra. The failure to accommodate petitioner, a disabled person, with more time to locate documents in his possession or in the possession of third parties, "will . . . have the same practical effect as outright exclusion." Id. I **CONCLUDE** that the procedural denial of petitioner's Medicaid application (ninety three days) was a violation of 28 C.F.R. § 35.130 (b)(7); 42 C.F.R. § 435.912(e) and (g); N.J.A.C. 10:71-2.3(c)(1), (2) and (4). The decision was arbitrary and capricious since the first application was granted over two-hundred days. There is no discernable basis between ninety-three days and two-hundred and four days.

---

[2] See, comments found at 77 FR 17144 entitled **"**Timeliness Standards" (§ 435.912*)*

Comment: A number of commenters requested additional **information regarding timeliness and performance standards that will assure a seamless consumer experience, minimize administrative burdens, and otherwise ensure compliance with various provisions of this final rule.** We also received comments requesting additional information with respect to the data reporting requirements for States to ensure adequate oversight of the administration of the program.

Response: We recognize the need to provide parameters within which performance will be measured and to outline the areas where data and other information will need to be provided to monitor compliance with this final rule. We have revised current regulations at § 435.911 (redesignated at § 435.912) to provide additional guidance on the timeliness standards for making eligibility determinations. We are soliciting additional comment and issuing as interim final § 435.912.

Under the current regulations, States **are directed to establish standards not to exceed 90 days in the case of individuals applying for Medicaid on the basis of disability and 45 days for all other applicants**. The revised regulation at § 435.912 distinguishes between performance and timeliness standards, and States are directed to establish both. Under § 435.912(a), "timeliness standards" refer to the **maximum period of time in which every applicant is entitled to a determination of eligibility**, subject to the exceptions in § 435.912(e); "performance standards" are overall standards for determining eligibility in an efficient and timely manner across a pool of applicants, and include standards for accuracy and consumer satisfaction, but do not include standards for an individual applicant's determination of eligibility.

Procedural dismissal of cases involving protected rights of the disabled should be avoided, if possible. Yancsek v. Hull Corp. 204 N.J. Super. 429 (App. Div. 1985). Petitioner is entitled to a decision on the merits his Medicaid application since it is a program that petitioner helped fund over his lifetime. There is considerable prejudice to the petitioner and the long-term care facility while there is no comparable or measureable prejudice to the CWA. Over $250,000 in care was provided to petitioner by the long-term care facility that could or will, go unreimbursed. This is fundamentally unfair because it's based upon a technical or procedural denial of assistance rather than from a meritorious consideration of the application. The procedural denial is extraordinarily harmfully to the long-term care facilities and its residents. There is no "free lunch" and these costs will certainly being apportioned in other ways. As a matter of policy and fact, the CWA's action does not protect the client/consumer as envisioned by the 45/90-day regulation.

ORDER

Based upon the foregoing, the determination of the CWA denying petitioner's request for Medicaid eligibility, for failing to provide documentation, is **REVERSED**. Petitioner's initial Medicaid application dated July 17, 2014, is returned to the CWA for continued discovery, processing and analysis. The CWA and petitioner shall jointly and cooperatively work on acquiring the necessary documents from third parties. Petitioner shall not be penalized for any inaction by third parties. A decision on the merits of the second application must issue, unless petitioner fails to cooperate, without good cause.

I hereby **FILE** my initial decision with the **DIRECTOR OF THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES** for consideration.

This recommended decision may be adopted, modified or rejected by the **DIRECTOR OF THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES**, the designee of the Commissioner of the Department of Human Services, who by law is authorized to make a final decision in this matter. If the Director of the Division of Medical Assistance and Health Services does not adopt, modify or reject this decision within forty-five days and unless such time limit is otherwise extended, this

recommended decision shall become a final decision in accordance with N.J.S.A. 52:14B-10.

Within thirteen days from the date on which this recommended decision was mailed to the parties, any party may file written exceptions with the **DIRECTOR OF THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, Mail Code #3, PO Box 712, Trenton, New Jersey 08625-0712**, marked "Attention: Exceptions." A copy of any exceptions must be sent to the judge and to the other parties.

January 14, 2016

DATE

W. TODD MILLER, ALJ

Date Received at Agency: January 14, 2016

Date Mailed to Parties:

/jb

WITNESSES

For Petitioner:

Jane M. Fearn-Zimmer

For Respondent:

Barbara Paugh

BRIEFS AND EXHIBITS

For Petitioner:

Letter dated June 19, 2015

Letter dated November 2, 2015

Letter dated November 5, 2015

Letter dated November 16, 2015

For Respondent:

R-1 CWA Submission (18 pages)

Participant:

Letter dated June 19, 2015

Letter dated November 5, 2015

By the ALJ:

C-1 CWA submission dated September 18, 2014

C-2 Petitioner’s submission to the CWA dated August 11, 2015

C-3 Petitioner’s submission to the CWA dated August 26, 2015

C-4 Hammonton Center for Rehabilitation invoice through December 31, 2015