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SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-3041-16T1

R.P.,

Petitioner-Appellant,

v.

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

Respondents-Respondents.

Argued April 30, 2018 – Decided May 25, 2018

Before Judges Accurso and Vernoia.

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

John P. Pendergast argued the cause for appellant (SB2 Inc., attorneys; John Pendergast, on the briefs).

Jacqueline R. D'Alessandro, Deputy Attorney General, argued the cause for respondents (Gurbir S. Grewal, Attorney General, attorney; Melissa H. Raksa, Assistant Attorney General, of counsel; T. Nicole Williams-Parks, on the brief).

PER CURIAM

R.P. appeals from a final decision of the Director of the Division of Medical Assistance and Health Services (DMAHS) finding her ineligible for Medicaid benefits because she failed to timely provide requested verifications permitting the Camden County Board of Social Services (CCBSS) to make an eligibility determination. We vacate the decision and remand for further proceedings.

I.

In a letter dated May 2, 2016, CCBSS denied R.P.'s application for Medicaid benefits because she failed to timely provide verifications CCBSS asserts it requested. R.P. appealed the denial to DMAHS, which referred the matter to the Office of Administrative Law for a hearing. The evidence at the hearing before an Administrative Law Judge (ALJ) showed the following.

On January 7, 2016, R.P.'s step-daughter V.S. met with CCBSS representative Cynthia L. Repsher, completed a Medicaid application on R.P.'s behalf, and delivered the application to Repsher.[1] The application showed R.P. owned a residence, and had

[1] R.P. was hospitalized when V.S. submitted the Medicaid application. On appeal, R.P.'s counsel argues R.P. was incapacitated and suffering from dementia at that time. We observe, however, that the day following submission of the application, R.P. executed a power of attorney designating V.S. as her representative to make all decisions concerning R.P.'s medical care in the event R.P. "become[s] incapable of making decisions for [her]self." The two witnesses attesting to R.P.'s execution of the power of attorney did not perceive R.P. as

a bank account with a balance of $5641.49 as of December 7, 2015, and a pending claim for proceeds from a life insurance policy for her late husband. The application, which V.S. signed as R.P.'s authorized agent, expressly advised that "an individual is only permitted to retain $2,000 or $4,000 in applicable program resources in order to be eligible" for Medicaid benefits.

When V.S. submitted the application, Repsher asked V.S. to supply additional information. V.S. testified she was advised R.P. was "over resourced" and may have assets whose value exceeded the $2,000 limit for Medicaid eligibility. V.S. acknowledged she was told to spend R.P.'s bank account down to less than $2,000,[2] and was requested to provide CCBSS with R.P.'s birth certificate, the deed to R.P.'s home, and information concerning R.P.'s husband's life insurance policy and proceeds. V.S. testified Repsher did not give her a letter requesting information or verifications CCBSS needed to determine R.P.'s eligibility.

At the hearing, DMAHS presented the testimony of William Gensel, the Supervisor of CCBSS's Medical Outpatient Unit. Gensel testified the Unit takes Medicaid applications from patients in

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incapacitated or suffering from dementia; they witnessed R.P.'s signature and represented that R.P. "appear[ed] to be of sound mind."

[2] V.S. provided a bank statement showing the balance in the account. V.S. held the account jointly with R.P.

health care facilities. Gensel did not have any direct involvement in his Unit's receipt or processing of R.P.'s application, but testified concerning the documents in the Unit's file and explained the Unit's practices in accepting Medicaid applications.

Gensel testified the Unit's practice was to review a Medicaid application upon receipt, and provide the applicant with a "pending notice" listing any additional information required to complete an eligibility determination. According to Gensel, CCBSS's file showed a pending notice was prepared by Repsher on January 7, 2016, the day V.S. submitted R.P.'s application. Gensel explained that because the pending notice was addressed to V.S. but did not include an address, he expected the notice was given directly to V.S. when she submitted the application.

The January 7, 2016 pending notice requested verification of R.P.'s Medicare Card, proof of health insurance, information concerning her husband's life insurance policy and the use of any life insurance proceeds, the fair market value of R.P.'s home, and the January and February 2016 statements from R.P.'s bank accounts. The pending notice stated that if the requested verifications were not provided by February 21, 2016, the Medicaid application "[would] be denied on" February 21, 2016. V.S. never supplied the verifications requested in the pending notice.

Gensel further testified CCBSS's file showed a February 22, 2016 pending notice addressed to V.S. The notice sought the same information requested in the January 7, 2016 notice, and stated the decision on R.P.'s eligibility would remain pending until March 7, 2016. Gensel explained the letter's inclusion of V.S.'s home address indicated that, in accordance with CCBSS's practice, it was mailed to her. He acknowledged the letter included an incorrect zip code for V.S.'s address, but noted the CCBSS file did not show the letter had been returned. V.S. testified she never received the February 22, 2016 notice, and the verifications requested in the notice were not provided prior to the March 7, 2016 deadline.

On May 2, 2016, CCBSS denied R.P.'s Medicaid application based on her failure to timely provide the requested verifications. In a letter addressed to V.S., CCBSS explained the verifications were required to determine R.P.'s eligibility, and V.S. failed to assist by not providing requested necessary documentation. See N.J.A.C. 10:71-2.2(e)(2). The denial letter included the same incorrect zip code that was on the February 22, 2016 pending notice, but V.S. testified she received the denial letter at her home.

The ALJ who conducted the hearing, at which only Gensel and V.S. testified, issued a written decision. The ALJ noted Gensel's

testimony that the initial January 7, 2016 pending notice "would have been handed to" the applicant when the application was submitted.[3] Although V.S. denied receiving the January 7, 2016 pending notice, the ALJ found V.S. "acknowledged" receipt of the "the initial request for verification." The ALJ found as a matter of fact that the February 22, 2016 pending notice was sent with the wrong zip code due to "an error [of] the agency," and that V.S. "did not receive" the notice.

The ALJ concluded CCBSS "requested a clear and succinct verification of [R.P.'s] resources" from V.S., and it "was never provided." The only factual finding supporting the conclusion, however, is the ALJ's erroneous determination, which is contradicted by the evidence, that V.S. acknowledged receipt of the original January 7, 2016 request for verification. Based on that finding, the ALJ determined R.P. "failed to comply with N.J.A.C. 10:71-2.2(d)(2) by not verifying or explaining the resource information for the [January 7, 2016] Medicaid

[3] The ALJ incorrectly stated that Gensel testified the notice "would have been handed to R.P." There was no testimony R.P. was involved in the submission of the application, and it is undisputed V.S. submitted the application on R.P.'s behalf.

application . . . ," and recommended affirmance of CCBSS's denial of Medicaid benefits.[4]

In DMAHS's final agency decision, the Director adopted the ALJ's findings and determined "[t]here is no dispute that [R.P., through her step-daughter V.S.] received CCBSS'[s] first request" for verification on January 7, 2016, when CCBSS "handed" it to V.S. The Director ignored that, contrary to the ALJ's finding and his own, V.S. denied receipt of the notice and, therefore, whether CCBSS delivered the notice to V.S. was a disputed factual issue.

The Director further found the February 22, 2016 notice was sent to the wrong zip code, did not make any findings as to whether V.S. received it, and did not reject the ALJ's finding that V.S. never received the notice. The Director concluded R.P. failed to provide the requested verifications prior to the May 2, 2016 denial

[4] It is difficult to discern the ALJ's findings concerning V.S.'s credibility. The ALJ's finding V.S. "testified in a manner that lent to her credibility" suggests he found V.S.'s testimony credible. The ALJ begins the following sentence with the word "[h]owever," suggesting that although V.S. "testified in a manner that lent to her credibility," the ALJ rejected V.S.'s testimony, or at least some part of it, as not credible. The incongruity of the ALJ's findings is further demonstrated by the fact that if he found V.S. a credible witness, he would have accepted her testimony she was never given the January 7, 2016 pending notice. Instead, he found she acknowledged receipt of that notice, which the record shows is not the case. In sum, the ALJ's credibility and factual findings cannot be logically reconciled and in certain instances are unsupported, and unsupportable, by the evidentiary record.

of benefits, adopted the ALJ's findings and recommendation, and affirmed CCBSS's denial of R.P.'s Medicaid application.

R.P. appealed, and presents the following arguments for our consideration:

> POINT I
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> R.P. was incapacitated during the Medicaid application process, thus her resources were required to be excluded pursuant to N.J.A.C. 10:71-4.4 [].
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> POINT II
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> V.S. did not receive the pending notices Camden County was required to send prior to denying R.P.'s Medicaid application in violation of Medicaid Communication No. 10-09 [].
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> POINT III
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> Respondent should have reviewed all the information regarding R.P.'s Medicaid application on its merits [].

II.

Our role in reviewing the decision of an administrative agency is limited. In re Stallworth, 208 N.J. 182, 194 (2011). We accord a strong presumption of reasonableness to an agency's exercise of its statutorily delegated responsibility, City of Newark v. Nat. Res. Council, 82 N.J. 530, 539 (1980), and defer to its fact finding, Utley v. Bd. of Review, 194 N.J. 534, 551 (2008). We will not upset the determination of an administrative agency absent

a showing "that it was arbitrary, capricious or unreasonable, that it lacked fair support in the evidence, or that it violated legislative policies." Parascandolo v. Dep't of Labor, Bd. of Review, 435 N.J. Super. 617, 631 (App. Div. 2014) (quoting Campbell v. Dep't of Civil Serv., 39 N.J. 556, 562 (1963)).

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. In New Jersey, eligibility for Medicaid is determined by the Commissioner of the Department of Human Services. See N.J.S.A. 30:4D-7. DMAHS is the agency within the Department of Human Services that administers the Medicaid program, N.J.S.A. 30:4D-5; N.J.A.C. 10:49-1.1(a), and is responsible for safeguarding the interests of the New Jersey Medicaid program and its beneficiaries, N.J.A.C. 10:49-11.1(b).

A County Welfare Agency, such as CCBSS, evaluates Medicaid eligibility. N.J.S.A. 30:4D-7a; N.J.A.C. 10:71.2.2(a); N.J.A.C. 10:71-3.15. Eligibility must be established based on the legal requirements of the program. N.J.A.C. 10:71-3.15. A County Welfare Agency is required to verify the equity value of resources through appropriate and credible sources. If an applicant's resource statements are questionable or the identification of resources is incomplete, "the [County Welfare Agency] shall verify

the applicant's resource statements through one or more third parties." N.J.A.C. 10:71-4.1(d)(3).

County Welfare Agencies review Medicaid applications "for completeness, consistency, and reasonableness." N.J.A.C. 10:71-2.9. Applicants must provide verifications that are identified, and "[a]ssist the [County Welfare Agency] in securing evidence that corroborates his or her statements." N.J.A.C. 10:71-2.2(e)(2).

Here, the Director's decision affirming CCBSS's denial of R.P.'s application is based on a finding that it was undisputed V.S. received CCBSS's January 7, 2016 pending notice. As noted, however, the record shows otherwise. V.S. denied receiving the notice, and Gensel testified only that he expected the notice had been given to V.S. Thus, whether V.S. received the January 7, 2016 pending notice is a disputed factual issue that neither the ALJ nor the Director decided due to their erroneous and unsupported finding that V.S.'s receipt of the notice was undisputed. Because the final agency decision is based on a factual determination that finds no support in the record, we are constrained to vacate the decision and remand for further proceedings. The Director shall decide whether V.S. received the initial pending notice on January 7, 2016, consider that fact and all of the other evidence,

determine whether CCBSS correctly denied R.P.'s application[5] and make the findings required by N.J.S.A. 52:14B-10(c). See In re Stallworth, 208 N.J. at 194 (finding an agency's action is arbitrary, capricious or unreasonable when the record does not contain substantial evidence supporting a finding upon which the agency's decision is based).

We also consider the ALJ's factual finding that V.S. did not receive the February 22, 2016 pending notice due to DMAHS's error in addressing the notice to an incorrect zip code.[6] The Director adopted the ALJ's factual findings, but did not address the effect, if any, of DMAHS's failure to deliver the February 22, 2016 notice to V.S.

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[5] We leave in the Director's discretion whether a remand to the ALJ is necessary for the development of an additional evidentiary record or further findings of fact.

[6] The ALJ found as a matter of fact that V.S. did not receive the February 22, 2017 notice. The finding is supported by the evidence showing the incorrect zip code on the notice and V.S.'s testimony she did not receive the second notice. "In rejecting or modifying any findings of fact, the agency head shall state with particularity the reasons for rejecting the findings and shall make new or modified findings supported by sufficient, competent, and credible evidence in the record." A.M.S. ex rel. A.D.S. v. Bd. of Educ. of City of Margate, 409 N.J. Super. 149, 159 (App. Div. 2009) (emphasis added); see also N.J.S.A. 52:14B-10(c). The Director did not state with particularity that he rejected the ALJ's finding V.S. did not receive the February 22, 2016 notice, and otherwise stated he adopted the ALJ's findings. We therefore infer the Director also concluded V.S. did not receive the second notice.

DMAHS's Medicaid Communication No. 10-09 (Nov. 24, 2010) requires that during the initial face-to-face meeting between County Welfare Agency representatives and Medicaid applicants, the agency representative must provide the applicant with a "checklist/missing information letter to the applicant or their representative highlighting verifications and supporting documentation which are required to process the Medicaid application." Medicaid Communication No. 10-09.

Where the requested information is not supplied within the timeframe provided in the initial notice, the County Welfare Agency "must" send the applicant or their representative "an additional request for information" detailing "what documentation is still needed in order to determine eligibility." Ibid. The second request must advise "that if the information is not received within the specified time period from the receipt of the request, the case will be denied." Ibid. On remand, the Director shall consider the requirements of Medicaid Communication No. 10-09, and decide what effect, if any, CCBSS's failure to deliver the second notice to V.S. has on the validity of CCBSS's denial of R.P.'s Medicaid application.

We reject R.P.'s claim that CCBSS was obligated to obtain the requested verifications on its own. The controlling regulations do not require that either CCBSS or DMAHS obtain all application

information on their own. <u>See</u> 42 C.F.R. § 435.948(a). The regulation requires that the state Medicaid agency obtain limited information only "to the extent the agency determines such information is useful to verifying the financial eligibility of an individual." <u>Ibid.</u>

There is no regulation precluding a state Medicaid agency from obtaining information directly from the applicant. <u>See</u> 42 C.F.R. § 435.952(c). In New Jersey, the law requires the applicant to provide such information and verifications to the relevant agency. N.J.A.C. 10:71-2.2(e); N.J.A.C. 10:71-3.1(b). As a participant in the process, R.P. was required to assist CCBSS in securing evidence that corroborated the information submitted in support of her application. N.J.A.C. 10:71-2.2(e)(2). We reject R.P.'s contentions to the contrary.

We are also not persuaded by R.P.'s contention that the ALJ and the Director erred by failing to consider evidence which she produced for the first time following the May 2, 2016 denial of benefits, and which she contends showed she was eligible for benefits. CCBSS is permitted to deny applications when the applicant fails to timely provide verifications. <u>See</u> N.J.A.C. 10:71-2.2(e), -2.9, -3.1(b). CCBSS denied the application because R.P. did not timely supply the verifications as required by the pending notices. The issue before the ALJ and the Director was

whether R.P. timely provided the requested information, and not whether R.P. was otherwise entitled to benefits. Thus, verifications submitted following CCBSS's denial were irrelevant to the issue before the ALJ and the Director.

R.P.'s remaining arguments are without merit sufficient to warrant discussion in a written opinion. R. 2:11-3(e)(1)(E).

Vacated and remanded for further proceedings consistent with this opinion. We do not retain jurisdiction.

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

CLERK OF THE APPELLATE DIVISION