State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION
OAL DKT. NO. HMA 14843-19
AGENCY DKT. NO. N/A
REMAND
OAL DKT. NO. HMA 11312-2018
AGENCY DKT. NO. N/A
OAL DKT. NO. HMA 03024-19
AGENCY DKT. NO. N/A
CONSOLIDATED

H.H.,

Petitioner,

v.

MONMOUTH COUNTY DIVISION OF SOCIAL SERVICES,

Respondent.

Nicole C. Tomlin, Esq., appearing for petitioner (Hanlon, Niemann and Wright, P.C., attorneys)

Susan Pansky, Fair Hearing Liaison, for respondent, pursuant to N.J.A.C. 1:1-5.4(a)(3)

Record Closed: March 16, 2020 Decided: April 20, 2020

BEFORE: **JUDITH LIEBERMAN**, ALJ

STATEMENT OF THE CASE

Petitioner, H.H., appealed the denial of her application for Medicaid benefits and subsequent approval and imposition of a transfer penalty by the respondent, Monmouth County Division of Social Services (Division). The Division initially denied petitioner's application because she had income in excess of her reasonable medical expenses. After a hearing before the OAL, the denial was reversed because petitioner's monthly facility and other medical expenses exceeded her total monthly income. The Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), reversed the Initial Decision and remanded the matter to the OAL for a hearing during which petitioner was to present evidence of her room and board expenses, as distinguished from her medical expenses.

PROCEDURAL HISTORY

On July 23, 2019, the Division notified petitioner that it denied her Medicaid application. Petitioner filed a timely appeal and DMAHS transmitted this matter to the Office of Administrative Law (OAL), where it was filed on August 6, 2018, as a contested case. N.J.S.A. 52:14B-1 to-15; N.J.S.A. 52:14F-1 to-13. On November 20, 2018, the petitioner filed a motion for summary decision. The record for the motion closed on January 14, 2019, and an Order denying the motion was issued on February 13, 2019.

Petitioner reapplied for Medicaid benefits on November 8, 2018. On February 8, 2019, the Division notified petitioner she was subject to a 191-day transfer penalty and was eligible for Medicaid-Managed Long Term Care Services and Supports (MLTSS) effective May 11, 2019. The petitioner filed a timely appeal of this decision and DMAHS transmitted the matter to the OAL, where it was filed on March 4, 2019, as a contested case. N.J.S.A. 52:14B-1 to-15; N.J.S.A. 52:14F-1 to-13.

The two matters were consolidated, with the consent of the parties, on March 6, 2019. A hearing was conducted on March 11, 2019, and May 17, 2019. The record remained open for the parties to submit briefs. Briefs were received on June 10, 2019, and June 11, 2019, and the record closed on June 11, 2019. An extension of time to file

the initial decision was authorized. An Initial Decision granting petitioner's appeal and reversing the Division's determination was issued on July 23, 2019. On October 18, 2019, DHAMS issued a Final Decision in which it reversed and remanded the matter for a new hearing.

A second hearing was conducted February 6, 2020, and the record remained open for the parties to submit briefs. All briefs were received by March 16, 2020, and the record closed that day. An extension of time to file the initial decision, due to the closure of State government offices, was authorized.

FACTUAL DISCUSSION AND FINDINGS

The following facts were either undisputed or found after testimony and the presentation of evidence during the first hearing in this matter. I, thus, **FIND** the following **FACTS**:

1. Petitioner[1] applied for MLTSS on May 1, 2018. R-1. The petitioner resided at B. Assisted Living Facility ("Facility") when the application was submitted to the Division. Ibid.

2. The petitioner's gross monthly income, from Social Security, was $1,734. Ibid. $134 was deducted from this income each month to pay for Medicaid Part B. P-4, 8.

3. On May 4, 2018, the petitioner purchased a Medicaid compliant annuity with $34,200 of her funds. The annuity paid the petitioner five equal, monthly payments of $6,841.29 from June 2018, through October 2018. The annuity was non-transferrable, non-assignable, could not be surrendered or commuted, was irrevocable and immediate and had no cash or loan value. The State of New Jersey was the primary beneficiary upon the petitioner's death. P-3, 5.

[1] The application was completed by petitioner's daughter, H.A., who was designated to serve as the petitioner's attorney in fact. P-11. Petitioner died on November 12, 2019.

4. On May 1, 2018, the petitioner established a Medicaid-compliant Qualified Income Trust (QIT). P-11. She deposited the monthly income from the annuity into the QIT. P-5.

5. On May 26, 2018, the petitioner transferred $66,000, which was subject to a transfer penalty.

6. The Division determined the petitioner was clinically eligible for MLTSS effective February 26, 2018.

7. On July 23, 2018, the Division denied the petitioner's May 1, 2018, Medicaid application. The denial notice included the following language:

> This action was taken because: Due to excess income, [H.H.'s] monthly gross income ($8,575.29) exceeds the private pay rate for a semi-private room at $187.00 per day ($5,797.00 per month). (Medicaid only pays for a semi-private room).
>
> Please be advised: In order to maintain Medicaid eligibility, the Medicaid recipient's combined resources (example: bank accounts, PNA, cash surrender value or life insurance, etc.) cannot exceed $2,000.00 for the Medicaid Only program, as of the first moment of the first day of each month.
>
> . . .
>
> These actions are required by the following regulations: 42 USC §1396-1 and N.J.S.A. 30:4D-2.[2]

[2] These sections provide, in pertinent part:

> For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services[.]
> 42 USCS 1396-1 (emphasis added).
>
> It is the intent of the Legislature to make statutory provision which will enable the State of New Jersey to provide medical assistance, insofar as practicable, on behalf of persons whose resources are determined to be inadequate to enable them to secure quality medical care at their own expense[.]
> N.J.S.A. 30:4D-2 (emphasis added).

R-2.

8. The petitioner, through H.A., filed a second Medicaid application on November 8, 2018. R-5. Her monthly income was $1,734, from Social Security. Ibid.

9. On February 8, 2019, the Division issued a second notice in which it advised the petitioner was subject to a 191-day transfer penalty. She was eligible for ancillary services only from November 1, 2018, through May 10, 2019, and for MLTSS effective May 11, 2019. R-6, 7.

10. The petitioner resided in a studio room at the Facility. She paid the Facility $187 per day for her room, $58 per day for additional care required to assist her with her activities of daily living, and $39 per day for administration of medication. P-6. This totaled $8,520 per month in months with thirty days and $8,844 per month in months with thirty-one days.

11. Between June 1, 2018, and October 31, 2018, the petitioner's medical expenses, in addition to the Facility costs and $134 that was deducted from her monthly Social Security income, were:

    - $272.25 for health insurance monthly premium
    - $78.92 for prescriptions (average)[3]

    P-8, 9, 10.

12. The petitioner requested the least expensive room available at the Facility at the time she moved to the Facility.

13. The petitioner's monthly income, from June 2018, through October 2018, was insufficient to pay her monthly Facility costs and other medical expenses.

[3] The petitioner's medical expenses for each month were enumerated at P-10. The Division did not contest these figures.

14. Between June 2018, and October 2018, the Facility used subsequent months' payments, made by or on behalf of the petitioner, to pay prior months' outstanding balances.

15. The petitioner did not receive annuity income after October 2018.

16. After October 2018, the Facility was unable to satisfy the petitioner's prior months' outstanding balances with her subsequent months' income.

17. The Facility's ledgers and invoices recorded the services provided to petitioner and petitioner's payments for those services, as follows:

Suite 245/Manalapan or Suite 202/Manalapan	$187/day
Service Level 3	$58/day
Medication Administration – Deluxe	$39/day
Tier 1 Charge	$0

PP[4]-6.

Testimony

For petitioner:

Maggie Widner, Facility Business Manager, explained that "service level 3" referred to the fee charged for the provision of assistance to the petitioner with her activities of daily living ("ADL charges"). This included transporting, bathing and feeding her. She explained that all residents received "Level I" nursing services, which involved the provision of twenty-four hour nursing services. Petitioner required additional

[4] "PP" and "RR" refer to documents presented during the remand hearing by the petitioner and respondent, respectively.

assistance, which caused her to be charged the additional "level 3" fee. "Medication administration – deluxe" referred to the provision of medication to petitioner. All other services provided to petitioner were included in the room and board charge, which was $187 per day. This charge, which was also referred to as the "daily rate", included all of the services the Facility was required to provide for the residents.

Widner referred to a letter from the Corporate Manager of Business Office Operations for the Facility. The letter, which she received January 17, 2020, enumerated the services that were included in the daily rate. They included but were not limited to housing, electricity, heat, cable television, meals, housekeeping, social interaction and activities, transportation to doctors and other appointments within twenty miles, twenty-four hour nursing services, and laundry services. Widner explained that the services provided in exchange for the daily rate were not enumerated in any greater detail and there was no legal requirement for the Facility to present its bills in any other way. Petitioner paid for these services; Medicaid did not pay for them.

Referring to a "Resident Ledger Report" for May 2018 through December 2018, Widner explained that, on December 31, 2018, the Facility charged petitioner the "daily rate" of $187 for thirty-one days.[5] The total charge for the month was $5,797. PP-6 at 4. This charge included all the services enumerated by the Corporate Manager. PP-17.

The following charge on the Resident Ledger Report was for "service level 3," which was for the additional assistance petitioner required. This assistance was provided in addition to the basic services that were provided to all residents and which were included in the basic room and board (daily rate) charge. On December 31, 2018, petitioner was charged $58 per day, for thirty-one days, for the additional assistance. The total was $1,798 for the month. PP-6 at 4.

The next charge was for "medication administration – deluxe." This was required because petitioner received more than six medications. On December 31, 2018, she was

[5] The charge was identified on the Resident Ledger Report as "Suite 245/Manalapan" or "Suite 202/Manalapan." PP-6. Petitioner resided in rooms numbered 245 and 202. Those were studio rooms, the style of which was referred to as "Manalapan." PP-17.

charged $39 per day for thirty-one days for this service. The total charge was $1,209. PP-6 at 4.

For respondent:

M.D. Islam, Human Services Specialist 3, explained that, pursuant to the Final Decision issued by DMAHS, non-medical expenses must be excluded from the calculation of petitioner's medical expenses. Petitioner's monthly medical expenses were as follows:

- Service Level 3 $1,798
- Medication administration $1,209
- Medicare Part B premium $134
- Health Insurance premium $272.25
- Average medication administration costs $57.27

Together, these expenses constituted petitioner's total monthly medical expenses. This amount, $3,470.52, was lower than her monthly income. Petitioner was, therefore, ineligible for Medicaid until her income fell below the cost of her medical expenses. Islam noted that Medicaid never pays for the room and board charges incurred by a resident of an assisted living facility.

Additional Factual Findings

After having the opportunity to review the evidence and consider the testimony, I **FIND** the following additional **FACTS**. Petitioner documented the following monthly medical expenses:

- Health insurance premium $272.25
- Prescriptions (average) $78.92[6]

[6] The monthly expenditures for health insurance and prescriptions between June 1, 2018, and October 31, 2018, $272.25 and $78.92, respectively, were included in the findings of fact in the first Initial Decision.

- Medicare Part B premium $134
- Service level 3 $1,798
- Medication administration – deluxe $1,209

These figures totaled $3,492.17 per month.[7] This is less than petitioner's total monthly income from June 2018, through October 2018, which was $1,734 from Social Security and $6,841.29 from her annuity.

I also **FIND** that the "daily rate" charge included the fees associated with multiple non-medical services, including but not limited to utilities, cable television and social interaction. Petitioner did not offer specific, detailed evidence concerning which portion of this charge was used to pay for medical expenses. Petitioner identified neither the precise medical-related services that were included within the daily rate charge nor the cost of those services.

Parties' Arguments

Petitioner contends she should have been permitted to use the funds in her QIT – which she properly established -- to pay for the room and board (daily rate) charges. The funds in her QIT should not have been counted when her Medicaid eligibility was determined. Petitioner acknowledges that she was responsible for paying for her room and board prior to Medicaid approval, as well as after approval, and contends there is no legal authority prohibiting her from using her QIT funds to pay for this. She contends that if she is not permitted to use her QIT funds to pay for all of her assisted living costs, she and many other similarly situated individuals will be forced to move to skilled nursing facilities. She argues this is contrary to the Legislature's goal of helping individuals remain in the community rather than in a nursing home.

Respondent contends that petitioner did not adequately demonstrate the services she received. It argues further that petitioner did not receive the service described as

[7] The costs listed here for service level 3 and medication administration - deluxe are for months with thirty-one days. The amounts would be reduced by $58 and $39, respectively, in months with thirty days.

"twenty-four hour nursing services – Level 1 assessment of ADLs," which is included in the room and board charge. It contends that service is available to all residents, including those who do not need much assistance, while petitioner paid for a higher level of care. It thus concludes the level 1 component of the room and board costs should be excluded from any calculation of petitioner's medical expenses.

LEGAL ANALYSIS AND CONCLUSIONS

The Initial Decision addressed the Division's determination that petitioner was ineligible for Medicaid because she had excess income during the months she deposited her annuity income into her QIT. It based its determination on a finding that petitioner selected a private room and that she would have been able to fully pay for her care had she selected a less expensive semi-private room. I concluded the governing regulations do not require use of the semi-private room rate when calculating eligibility for MLTSS. Instead, the regulations require examination of whether the petitioner's total income exceeded her total medical costs, including the private pay costs associated with her nursing home care and other medical expenses. I concluded petitioner was eligible for MLTSS effective June 2018, "[b]ecause the petitioner's facility and other medical expenses exceeded her total monthly income, which was comprised of her Social Security and annuity income, which was properly deposited in an [Qualified Investment Trust] beginning June 2018[.]" Initial Decision at 15.

On October 18, 2019, DMAHS issued a Final Decision that reversed the Initial Decision in part and remanded the matter to the OAL. DMAHS agreed that there must be an examination of petitioner's total medical costs and a determination whether her total income exceeded those costs. Final Decision at 2. It noted, however, that room and board is not considered a medical expense when the applicant resides in an assisted living facility. The matter was thus remanded for a hearing during which petitioner was to "provide evidence of her room and board expenses" because Medicaid may not pay housing costs for assisted living facilities.[8]

[8] DMAHS referred to New Jersey FamilyCare Comprehensive Waiver, https://www.nj.gov/humanservices/dmahs/home/NJ_1115_Demonstration_Comprehensive_Waiver_9-9-11.pdf and https://www.state.nj.us/humanservices/doas/forms/PR-2_inst.pdf. Ibid. The latter authority

In support of the remand, DMAHS cited to G.T. v. DMAHS and Gloucester County Board of Social Services, OAL DKT. No. HMA 7855-15, Final Decision December 19, 2012. In G.T., the cost of the shelter portion of an assisted living fee had not been established during a hearing before the administrative law judge. In remanding the matter to the OAL, the Director wrote, "[s]helter costs would include rent, mortgage and taxes. The bill from [the assisted living facility] states that the bill is for room and board, which indicates it includes the cost of food at a minimum. The record below did not delineate what portion of the monthly fee was for the spouse's shelter. Assisted living rates include services such as housekeeping, laundry, day program, transportation, and assistance with dressing, bathing or medications. These are not shelter costs[.]" Final Decision at 2. On remand, G.T. presented evidence concerning the facility's costs for its insurance, real estate taxes, leasehold expenses, maintenance and utilities. Initial Decision at 6. The ALJ found, and the Director agreed, that these costs constituted petitioner's shelter costs. Id. at 9, Final Decision at 3.

Here, petitioner did not present proofs concerning the full extent of her medical expenses. Although the room and board fee provided for services the Director previously identified as other than shelter costs, e.g., housekeeping, laundry, transportation and assistance with dressing, bathing and medications, petitioner did not produce complete evidence concerning the actual medical services for which she paid. While she asserted that the cost of level 1 care was included in her basic room and board fee and that the level 3 charge was an additional medical expense, she did not offer testimony or other evidence concerning the difference between level 1 and level 3 care. She also did not provide evidence concerning the actual cost of the level 1 care. The remaining evidence largely related to a lump sum that included the cost of admittedly non-medical services.[9]

advises that MLTSS participants living in assisted living facilities are responsible for paying for their room and board. Instructions for Completing the Patient Pay Liability Worksheet PR-2 at 1.

[9] During oral argument, counsel for petitioner conceded that some of the costs that were included in the room and board fee, such as utilities, were not medical expenses. It should also be noted that, although respondent claimed that the daily rate did not include a charge for medical services because petitioner paid a separate service level 3 charge, there is no evidence in the record to support this conclusion.

Petitioner argues that this is not the crucial issue to be resolved. Instead, she contends she may deposit any amount of income in a QIT and that the income must not be considered when evaluating her financial eligibility for Medicaid. She also contends that there is no legal authority supporting the agency's determination that her monthly income must be measured against her monthly medical expenses. She concludes that the agency's determination would necessarily render everyone who lived in assisted living and funded a QIT to be ineligible for Medicaid.

Notwithstanding petitioner's legal and policy arguments, the purpose of the hearing on remand was set forth in the Remand Order. Petitioner was "to provide evidence of her room and board expenses." Pursuant to the rules governing administrative proceedings, I am limited by this directive.[10]

Petitioner has not produced adequate evidence, through either testimony or documents, to fully distinguish her room and board expenses from her medical expenses. Without this evidence, I am unable to make a factual finding concerning all of these costs. I am mindful that petitioner is limited, at least to some extent, to the information made available to her by the Facility. Nonetheless, given the mandate of the Remand Order and the absence of sufficient evidence concerning the charges and expenditures at issue, I must **CONCLUDE** that petitioner did not meet her burden in this remanded matter. I further **CONCLUDE** that, based upon the evidence that is in the record, petitioner's monthly income exceeded her documented medical expenses.

[10] N.J.A.C. 1:1-18.7 provides, "(a) An agency head may enter an order remanding a contested case to the Office of Administrative Law for further action on issues or arguments not previously raised or incompletely considered. The order of remand shall specifically state the reason and necessity for the remand and the issues or arguments to be considered. The remand order shall be attached to a N.J.A.C. 1:1-8.2 transmittal form and returned to the Clerk of the Office of Administrative Law along with the case record. (b) The judge shall hear the remanded matter and render an initial decision." See also In Re Kallen, 92 N.J. 14 (1983).

ORDER

Based upon the foregoing, I **ORDER** the decision of the Monmouth County Division of Social Services denying Medicaid benefits effective June 2018, is **AFFIRMED** and the petitioner's appeal is **DENIED.**

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 seven 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.

April 20, 2020
DATE

JUDITH LIEBERMAN, ALJ

Date Received at Agency: April 20, 2020

Date Mailed to Parties:

JL/vj

APPENDIX

List of Witnesses

For petitioner:

Margaret Widner

For respondent:

M.D. Islam, Supervisor

List of Exhibits

For petitioner:

P-1 Bank Statement, June 1, 2018

P-2 QIT

P-3 Annuity

P-4(a) – (e) Bank statements reflecting monthly deposits of Social Security payments

P-5(a) – (e) QIT statements reflecting monthly deposits of annuity payments

P-6(a) – (e) Monthly Facility invoices

P-7(a) – (e) Facility payments

P-8 Medical expenditures

P-9 Medication invoices

P-10 Summary of income and expenses

P-11 Power of Attorney, December 19, 2012

P-12 July 23, 2018, Medicaid denial notice

P-13 Medicaid Communication 14-15, December 19, 2014

P-14 Excerpts, State Medicaid Manual

P-15 Facility admission agreement

P-16 42 USC 1396(p)

PP-6(a) - (e) Resident Ledger Reports, Invoices

PP-17 Letter from Corporate Manager of Business Office Operations.

For respondent:

R-1 May 1, 2018, Medicaid application
R-2 July 23, 2018, denial notice
R-3 Email correspondence, billing records
R-4 OAL DKT. NO. HMA 18569-16
R-5 November 8, 2018, application
R-6 January 2, 2019, transfer penalty notice
R-7 February 8, 2019, eligibility notice
R-8 summary of income and expenses

RR-1 Summary
RR-2 Medical expense and income chart
RR-3 Resident Ledger Report
RR-4 Resident Ledger Report
RR-5 Resident Ledger Report
RR-6 Resident Ledger Report