ORIGINAL ALJ DECISION DATED 7/29/2019

State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION
OAL DKT. NO. HMA 11312-2018
AGENCY DKT. NO. N/A

H.H.,

Petitioner,

v.

MONMOUTH COUNTY DIVISION OF SOCIAL SERVICES,

Respondent.

OAL DKT. NO. HMA 03024-19
AGENCY DKT. NO. N/A
CONSOLIDATED

Fredrick P. Niemann, 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: June 11, 2019 Decided: July 23, 2019

BEFORE: **JUDITH LIEBERMAN**, ALJ

STATEMENT OF THE CASE

Petitioner, H.H., appeals the denial of her application for Medicaid benefits by the respondent, Monmouth County Division of Social Services (Division), because she had excess income.

PROCEDURAL HISTORY

Petitioner was notified of the Division's determination by way of a July 23, 2018, notice. The petitioner filed a timely appeal and the Division of Medical Assistance and Health Services (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.

The petitioner reapplied for Medicaid benefits on November 8, 2018. On February 8, 2019, the Division notified the petitioner she was subject to a 191-day transfer penalty and was eligible for 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. The record closed on June 11, 2019. An extension of time to file the initial decision was authorized.

FACTUAL DISCUSSION AND FINDINGS

The following is not disputed. I, therefore, **FIND**, the following **FACTS**:

1. The petitioner[1] applied for Medicaid-Managed Long Term Care Services and Supports (MLTSS) on May 1, 2018. R-1. The petitioner resided at B. Assisted

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

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.

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]
> 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 that 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 $29 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

[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).

expenses, in addition to the Facility costs and $134 that was deducted from her monthly Social Security income, were:

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

P-8, 9.

Testimony

For the petitioner:

H.A., the petitioner's daughter and attorney in fact, testified that the petitioner moved to the Facility after it was determined she could not reside at home. The petitioner had previously fallen while at home and been admitted to an inpatient rehabilitation facility. She moved to the Facility after she was discharged from the rehabilitation facility. As the petitioner was previously the victim of a financial fraud, H.A. was compelled to request that the petitioner be assigned to the smallest and least expensive room at the Facility. She was told the studio room was the smallest and least expensive room then available. The studio was 331 square feet and accommodated a single bed and one chair. H.A. understood that the semi-private rooms were able to accommodate larger beds.

Diane Fanok, paralegal to petitioner's counsel, testified concerning the application process. It was her understanding, based upon her review of the petitioner's finances, that her income was insufficient to pay the Facility bill each month. She suspected the Facility used subsequent payments made by the petitioner to satisfy outstanding debts from prior months.

[3] The petitioner's medical expenses for each month are enumerated at P-10. The Division did not contest these figures. The Division advised it "accepts . . . P-10 which accurately summarizes all the income and medical expenses." Respondent's brief at 2. In its post-hearing brief, the Division conceded that it should have "considered" the petitioner's medical expenses when it evaluated her application. Respondent's brief at 1.

For the respondent:

Margaret Widner was the business office manager for the Facility for eighteen years. J-1. Pursuant to the Facility's billing practice, payments received by the Facility were applied to the oldest outstanding balance. Thus, a payment would not always be applied to the current month's bill. Id. at ¶4.

Widner testified concerning the petitioner's monthly bills and how she paid them. In June 2018, the Facility's total charge for services provided to the petitioner was $8,520. Three payments were made to pay the June 2018, bill:

- $6,841.29 from petitioner's QIT
- $1,327.75 from petitioner's bank account
- $350.96 from H.A.

  Ibid.

  In July 2018, the total Facility charge was $8,804, for which three payments were made to the Facility:

- $6,841.29 from petitioner's QIT
- $1,327.75 from petitioner's bank account
- $674.96 from H.A.

  Id. at ¶5.

In August 2018, and October 2018, the total charge was $8,804. Both months, the petitioner paid a total of $8,166.04, by way of two checks. Id. at ¶¶6,8. In September, the total charge was $8,520. The petitioner paid a total of $8,166.04, by way of two checks. Id. at ¶7. The payments for these three months were drawn from the petitioner's QIT and bank account. Ibid.

Pursuant to the Facility's billing practice, the Facility applied each payment it received to the then-oldest outstanding invoice Id. at ¶9. Widner testified that the

petitioner had a balance remaining each month, starting in June 2018. Payments made during subsequent months were applied to the outstanding balances. Each successive month's payments was sufficient to cover the prior months' debts until the petitioner's Social Security income was her only available source for payments.

M.D. Islam, Assistant Supervisor of the Division's Medicaid Unit, testified that Medicaid does not permit recipients to reside in studio rooms, and instead requires semi-private rooms, pursuant to the regulation that addresses "reasonable medical expenses." Accordingly, the Division will deny an application when the applicant has sufficient funds to pay a facility's costs, using the semi-private room rate. He cited to an instruction issued by DMAHS, which he did not produce because it was an internal communication. He concluded that, had the petitioner resided in a semi-private room at the Facility, she would have had sufficient funds to pay the Facility each month, given her monthly Social Security income and monthly annuity payment that was deposited in her QIT. Thus, the Division denied her May 2018, Medicaid application.

On cross-examination, Islam acknowledged that the petitioner did not have sufficient funds to pay her Facility bills. Had a family member not paid a portion of some of her bills, the Facility would not have been fully paid in June and July. He agreed that a chart prepared by petitioner's counsel, which listed her income and her financial obligations, including unreimbursed medical expenses, was accurate. P-10. The chart showed that the petitioner did not have sufficient funds in the months of June, July, August, September and October 2018. Ibid. In reaching his determination that the petitioner was ineligible for Medicaid, Islam relied upon the Facility's billing statements, which showed a zero balance for some of these months.

Nonetheless, Islam maintained the petitioner was ineligible for Medicaid because she did not reside in a semi-private room. Pursuant to regulation, a recipient may not reside in a "luxurious studio." Because Medicaid does not cover people who choose to spend too much, and the petitioner opted for a more expensive room, she was necessarily ineligible for Medicaid prior to November 2018.[4] Islam acknowledged that the governing regulation does not explicitly address semi-private rooms. Rather, it addresses

[4] The petitioner would then be subject to a transfer penalty.

"reasonable medical expenses."

Additional Factual Findings

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

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

3. 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.

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

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

LEGAL ANALYSIS AND CONCLUSION

The Division contends the petitioner was ineligible for Medicaid on June 1, 2018, and was not eligible until November 1, 2018, because she had sufficient funds to pay the cost of her care. It maintains that the petitioner would have been able to fully pay the Facility and her other medical bills had she resided in a semi-private room at the Facility. It argues the fundamental principal of Medicaid is that it is intended to provide benefits to only those qualified persons "whose income and resources are insufficient to meet the cost of necessary medical services." Respondent's brief at 1. The Division contends this principal alone is a sufficient basis for its June 2018, denial of petitioner's application.

The petitioner argues that her annuity income was properly placed into a QIT and should not have been counted when the Division evaluated her monthly income. She also argues that the fact that she resided in a studio room rather than a semi-private room is not controlling. As her monthly Social Security income and annuity income were insufficient to pay her medical expenses, including but not limited to the bills associated with the care she received from the Facility, she was eligible for Medicaid.

Medicaid Eligibility

Medicaid is a federal program under Title XIX of the Social Security Act, 42 U.S.C.A. §§ 1396 to 1396w-5. The program is funded by the federal government and administered by the states, including New Jersey. A.K. v. Div. of Med. Assistance & Health Servs., 350 N.J. Super. 175 (App. Div. 2002). New Jersey participates in Medicaid through the New Jersey Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 to -19.5. Consistent with the recognized policy that Medicaid is designed for needy individuals, the New Jersey Legislature has directed that Medicaid benefits "shall be last resource benefits notwithstanding any provisions contained in contracts, wills, agreements or other instruments." N.J.S.A. 30:4D-2. See also L.M. v. Div. of Med. Assistance and Health Servs., 140 N.J. 480, 484 (1995) (quoting Atkins v. Rivera, 477 U.S. 154, 156, 106 S. Ct. 2456, 2458, 91 L. Ed. 2d 131, 137 (1986)) (Medicaid "'is designed to provide medical assistance to persons whose income and resources are insufficient to meet the costs of necessary care and services'"); Mistrick v. Div. of Med. Assistance and Health Servs., 154 N.J. 158, 165 (1998).

An applicant must thus meet resource and income eligibility standards before he may qualify for the Medicaid program. See N.J.A.C. 10:71-4.1 to -5.9. Income eligibility is based on an examination of "all earned and unearned income which has or will be received during the month for which application is made, beginning with the first day of such month." N.J.A.C. 10:71-5.2(b)1. "All income, whether in cash or in-kind, shall be considered in the determination of eligibility, unless such income is specifically exempt under the provisions of N.J.A.C. 10:71-5.3." N.J.A.C. 10:71-5.1.

In addition, to prevent "individuals with sufficient assets to pay for their own medical care [from] qualify[ing] for Medicaid," anyone who transfers assets for less than fair market value within sixty months of his Medicaid application will be subject to a penalty period that will delay his receipt of Medicaid long-term care services even if he is otherwise financially and clinically eligible. N.M. v. Div. of Med. Assistance & Health Servs., 405 N.J. Super. 353, 362 (App.Div.2009); 42 U.S.C. § 1396p(c); N.J.A.C. 10:71-4.10. The penalty period "begin[s] the later of (1) the first day of the month in which assets have been transferred; (2) the first day of the month after which assets have been transferred or (3) the date the individual becomes eligible and would be receiving institutional level of services but for the penalty period." I.L. v. Div. of Med. Assistance & Health Servs., HMA 1465-14, Final Decision (November 6, 2014) (citing 42 U.S.C. § 1396p(c)(1)(d)(i)) <https://njlaw.rutgers.edu/collections/oal>.

Notwithstanding the transfer penalty provision, an applicant may purchase an annuity with his assets and use the resultant income stream to pay for his nursing home care. A Medicaid-compliant annuity must name New Jersey "as the primary beneficiary for an amount equal to any medical assistance paid on behalf of the individual," and be irrevocable and nonassignable, actuarially sound, and provide for equal payments over its term, with no balloon or deferral payments. 42 U.S.C. § 1396p(c)(1)(F); 42 U.S.C. § 1396p(c)(1)(G). The income stream from the annuity may be deposited into a Qualified Income Trust (QIT) to facilitate Medicaid eligibility.

DMAHS addressed QITs in Medicaid Communication No. 14-15, dated December 19, 2014, which provided in part:

> QITs are Trust documents tied to a special bank account. The primary function of a QIT is to disregard an individual's income above 300% of the Federal Benefit Rate (FBR). In order for this income to be disregarded, it MUST be deposited monthly into the QIT bank account.

Such income is "not counted in determining an individual's eligibility for Medicaid . . . without those funds adversely affecting the individual's eligibility for Medicaid." Medicaid Manual (Transmittal 64) at 3259.7(C)2. DMAHS further explained:

> As of December 1, 2014, New Jersey ceased covering nursing home services under the Medically Needy program and those applicants, who needed institutional level of care in a nursing facility, an [assisted living] facility or home and had income in excess of [the applicable limit] were required to place the excess income in a Qualified Income Trust (QIT), also known as a Miller Trust, to obtain Medicaid benefits. See 42 U.S.C. § 1396p(d)(4)(B). By placing the excess income in a QIT, [the State] is able to exclude that amount from the income limit.
>
> [A.D. v. Div. of Med. Assistance & Health Servs., 2016 N.J. AGEN LEXIS 1145 (Sept. 12, 2016), *2, n. 2.]

Accordingly, when an applicant has income in excess of the Medicaid eligibility limit, he must establish and fund the QIT in the month the applicant wished Medicaid benefits to commence. See e.g., J.G. v. DMAHS and Camden County Board of Soc. Services., HMA 14423-15, Final Decision (May 12, 2016), http://njlaw.rutgers.edu/collections/aol/; G.S. v. DMAHS and Hudson County Board of Soc. Servs., HMA 20755-16, Final Decision (July 6, 2016), http://njlaw.rutgers.edu/collections/aol/.

In F.M. v. DMAHS and Gloucester County Division of Social Services, OAL Dkt. No. HMA10515-18, Adopted, Final Decision (March 26, 2019)[5], the Director observed, "Medicaid annuities are now used to convert resources to an income stream to pay for nursing home care while subject to penalty." In that case, the petitioner funded a QIT with an annuity that paid her $10,109.44 per month. Id. at p. 2. She also had monthly Social Security and pension income of $2,235. Ibid. The Director explained that, "[w]ith a total monthly income of $12,345.43, Petitioner is seeking to have her income pay privately for her nursing home care while she is subject to a penalty due to [an improper] transfer of $40,000." Ibid. The Director further noted that, "Petitioner's facility charges her $400 a day for a semi-private room," that "[s]he also incurs costs associated with her Medicare premium, Medicare supplemental plan and prescription drugs," and that "[t]hese total expenses put her at a deficit each month." Ibid. Thus, the Director held that, "[d]ue to the unique facts of associated with this case . . . Petitioner's total income is barely

[5] This decision is not yet publicly available.

under the private pay costs associated with her nursing home care and other medical expenses," such that "[h]er income of $12,345.43 is not a barrier to Petitioner's eligibility determination." Id. at p. 4. However, the Director cautioned that "[i]t is clear that if her only medical expense was her nursing home costs, she would have sufficient income to pay and would not be eligible." Ibid (citing A.D. v. DMAHS and Camden County Board of Social Services, OAL DKT No. 2068-16 (Final Decision, September 12, 2016), 2016 N.J. AGEN LEXIS 1145).

The Director addressed similar facts in A.D. v. DMAHS and Camden County Board of Social Services, OAL DKT. NO. 2068-16 (Final Decision, September 12, 2016), 2016 N.J. AGEN LEXIS 1145. The petitioner used $78,000 of her assets to buy a nine-month annuity that generated a $8,673.90 monthly income stream, which was placed in a QIT and used to pay her nursing home bills. The petitioner also gifted $51,000 to her daughter. Id. at *1-2. The Director noted that "[b]y converting the $78,000 into an income stream, Petitioner is seeking [to] accelerate her eligibility date so as to start the transfer penalty for the $51,000 transferred to her daughter." Id. at *2. However, "[w]ith monthly income of $10,438,80[6], Petitioner had ample income to pay for her nursing home care. The record from the nursing home shows the largest monthly charge while she was receiving the annuity income was $9,920." Ibid. Thus, "[p]etitioner's income was sufficient to meet those costs and she was not eligible for Medicaid." Ibid. The Director explained that QITs are appropriately used in situations in which "individuals in nursing homes ha[ve] incomes that [are] 'too low to enable them to pay their own nursing home costs, but too high to qualify for Medicaid benefits.'" Id. at *2 (quoting Miller v. Ibarra, 746 F. Supp. 19 (1990)). However, the Director concluded, "[t]hat is simply not the case here, Petitioner's purchase of the annuity assured her that she had income in excess of the private nursing home rate." Id. at *2. Thus, the Director observed, "[t]he problem in this case is that Petitioner's income exceeds the private pay cost of her medical care." Ibid.

Here, the petitioner established a Medicaid-complaint QIT, into which she deposited the proceeds derived from a Medicaid-compliant annuity. Her remaining income was less than the maximum permitted for Medicaid eligibility. Nonetheless, the

[6] Petitioner's annuity income plus her Social Security income.

Division contends that the petitioner's "reasonable medical expenses" should be calculated by using the semi-private room rate, not the rate she actually paid. There is an absence of federal or state regulations providing that a Medicaid applicant who established an income annuity-funded QIT to privately pay for his stay in an assisted living facility while he served a transfer-of-assets penalty would be income-ineligible if his monthly income exceeds the semi-private room rate of her facility. The above-referenced, recent administrative decisions, F.M. and A.D., were not conditioned upon the petitioners having resided in semi-private rooms. Rather, the Director concluded that, so long as a Medicaid applicant's monthly income does not exceed the sum of his monthly "private pay costs" – whether for a private or a semi-private room – and his "other medical expenses," then he is income-eligible for Medicaid and the transfer-of-assets penalty starts the month in which he became income-eligible.[7] Thus, the fact that the petitioner resided in a studio room, rather than a semi-private room, is not controlling here.[8]

The Division further contends the petitioner was ineligible for Medicaid between June 2018, and October 2018, because the Facility's records "show[ed] zero balance due." Brief at 4. However, Widner testified that the petitioner did not have sufficient funds to pay her monthly bills and that subsequent months' payments were used to satisfy the prior months' unpaid bills, resulting in statements that reflected no outstanding balance. Islam conceded this. Nonetheless, in further support of this argument, the Division refers to B.K. v. DMAHS and Monmouth County Division of Social Services, OAL DKT. No. 18569-16 (Final Decision, June 5, 2017) http://njlaw.rutgers.edu/collections/oal/final/hma18569-16_1.pdf, in which the Medicaid applicant was contractually obligated to self-pay her nursing facility expenses for two years. The contract, which the petitioner signed on her own behalf, provided that the nursing facility would not accept Medicaid during that two-year period. Thus, as the Administrative Law Judge noted, "payment cannot be made to this facility by Medicaid because the facility will not accept Medicaid medical-assistance payments until the

[7] Assuming the applicant met all other Medicaid-eligibility requirements.

[8] It should be noted that the cost of the semi-private room in F.D. was $400 per day and the petitioner here requested and received the least expensive room available at the time of her admission. It should also be noted that the Division presented no evidence to support its assertion that the petitioner's residence was "luxurious."

petitioner has been a resident for two years, as set forth in the contract. The result is that this application for Medicaid benefits is premature, and was properly denied." Initial Decision at 8. The Initial and Final Decisions also noted that the petitioner, who had transferred all of her assets and was subject to a transfer penalty, "either had access to the transferred resources, or a third party will be using them, to satisfy her two-year contractual obligation to the facility, particularly as no other guarantor is noted in the contract as having accepted the obligation to pay the facility." Final Decision at 3. Contrary to the Division's argument, B.K. is not analogous to the present matter. Here, there is no evidence that the Facility would not accept Medicaid payments on behalf of the petitioner.[9] Also, as discussed further below, the petitioner did not have access to additional funds. Her assets were properly placed in a QIT and any additional payments made on her behalf were made directly to the Facility.

The Division suggests that payments made by the petitioner's daughter should be "taken into account by the State in determining whether the individual applying for medical assistance is, in fact, in need of such assistance." Ibid. (citing Normal v. St. Clair, 610 F.2d 1228 (5th Cir. 1980). In Norman, the Second Circuit addressed "deeming" of spouses' income when assessing Medicaid applications. The above-referenced citation was taken from the Congressional Record, in which "Congress made it clear that states could not extend [financial] responsibility beyond the spouse to children and other relatives." 610 F.2d at 1236. The court did not address the issue presented here. Moreover, the Division did not address the application of N.J.A.C. 10:71-5.3(a)3, which excludes "[t]hird-party payments for medical care or services, including room and board furnished during medical confinement" from a Medicaid applicant's countable income. Here, the petitioner's daughter made two payments directly to the Facility. These third-party payments were not made to the petitioner and, thus, did not constitute countable income that could be considered available to the petitioner.

Accordingly, for the reasons stated above, I **CONCLUDE** the governing regulations do not require use of the semi-private room rate when calculating the petitioner's eligibility for MLTSS. Rather, the regulations require examination of whether the petitioner's total

[9] There is not a contractual restriction on receipt of Medicaid payments, as in B.K. The Division's contention that there was "no one to pay" because the petitioner paid her bills is, as discussed above, incorrect.

income exceeded her total medical costs, including the "private pay costs associated with her nursing home care and other medical expenses" such as Medicare and prescription drug costs. Because 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 a QIT beginning June 2018, I **CONCLUDE** the petitioner was eligible for MLTSS effective of June 2018.

ORDER

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

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.

July 23, 2019
DATE

JUDITH LIEBERMAN, ALJ

Date Received at Agency: July 23, 2019

Date Mailed to Parties:

JL/vj

APPENDIX

List of Witnesses

For petitioner:

H.A.

Diane Fanok

For respondent:

M.D. Islam, Supervisor

Margaret Widner

List of Exhibits

Joint:

J-1 Widner Affidavit, with 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)

P-17 Medicaid Transfer or Asset Rules, sections 6011, 6016

P-18 Petitioner's request for production of documents and September 13, 2018, correspondence

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