SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-0403-16T4

E.T.,

Petitioner-Appellant,

v.

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES,

Respondent-Respondent,

and

HUDSON COUNTY BOARD OF SOCIAL SERVICES,

Respondent.

Submitted October 4, 2017 – Decided November 20, 2017

Before Judges Koblitz and Manahan.

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

SB2, Inc., attorneys for appellant (John Pendergast, on the briefs).

Christopher S. Porrino, Attorney General, attorney for respondent (Melissa H. Raksa, Assistant Attorney General, of counsel;

Stephen Slocum, Deputy Attorney General, on the brief).

PER CURIAM

Petitioner E.T. appeals the August 12, 2016 final agency decision of the Director of the Division of Medical Assistance and Health Services (Director), denying Medicaid benefits for failure to provide necessary verifications. We affirm.

We briefly recite the underlying facts and procedural history relevant to our decision. E.T. became a nursing facility resident in 2012. Shortly thereafter, Sam Stern was appointed as E.T.'s authorized representative and attorney—in-fact.[1]

On August 6, 2015, Future Care Consultants (Future Care), on behalf of E.T., first filed application for Medicaid benefits to the county welfare agency (CWA), Hudson County Board of Social Services (HCBSS). On August 18, 2015, Future Care received correspondence from HCBSS requesting additional necessary verifications excluded from E.T.'s application, giving a deadline of September 29. The requested verifications included E.T.'s bank records and a billing and payment history from the nursing facility.

[1] Sam Stern is owner of Future Care Consultants, the financial agent for multiple nursing facilities in New Jersey, including E.T.'s facility.

Upon further review of the application, HCBSS discovered two additional bank accounts that required verification. By notice dated September 3, 2015, HCBSS requested the additional verifications from Future Care, however, the due date specified on the notice was incorrectly deemed September 14, rather than September 29. On multiple occasions thereafter, HCBSS notified Future Care by telephone regarding the due date error on the September 3 notice, and to confirm the verifications were due by September 29. Future Care did not remark about their non-receipt of the September 3 notice, nor awareness of the due date error reflected on the notice. Subsequently, by facsimile, Future Care provided the missing verifications requested within the August 18 notice, but neglected to include the additionally requested verifications from the September 3 notice.

On September 17, Future Care submitted another application for Medicaid benefits on behalf of E.T. assuming incorrectly that the first application had been denied. Since HCBSS did not consider the original application as denied, it processed the September 17 submission as part of the August 6 application.[2]

[2] In the ALJ's decision, the judge found the September 17 submission by HCBSS to be a "second application." The Director concluded that this finding was erroneous and that this submission was part of the first application of August 6.

The following day, Stern emailed HCBSS stating, "We were told about but never [rec]eived a second pending letter with an earlier due date than the first letter." In response, HCBSS confirmed that the September 3 notice was sent and an explanation of the incorrect due date was given to a Future Care representative. Notwithstanding, the required verifications regarding the additional bank accounts requested by HCBSS were not provided.

On October 13, 2015, two weeks after the September 29 due date, HCBSS denied E.T.'s first Medicaid application for failing to provide the necessary verifications requested in the September 3 notice. Future Care appealed, and the matter was scheduled for an administrative hearing before an administrative law judge (ALJ).[3]

The appeal hearing was held on May 4, 2016. Testimony was presented by both parties. On June 27, 2016, the ALJ issued an initial decision reversing the HCBSS's denial and granting E.T. Medicaid benefits effective September 17, 2015. In reaching the decision, the ALJ concluded, "[E.T.] failed to provide verification of resources in a timely manner for the first application [August 6], but timely provided documentation for the

[3] While the hearing was pending, Future Care filed another separate application for Medicaid benefits on E.T.'s behalf, which was approved.

second application of September 17, 2015." The ALJ further concluded that, "Future Care provided the required verification documentations in a timely manner for the September 17, 2015 application and should be granted eligibility effective that date."

On August 12, 2016, the Director issued a final agency decision, which adopted the ALJ's finding that E.T. did not timely provide the requested verifications with regard to the August 6 application, and the application for Medicaid was properly denied for failure to provide necessary verification. However, the Director reversed the ALJ's findings and conclusions regarding the September 17 application, finding a lack of support in the record that an application was submitted on that date or that any notice was transmitted to the OAL.[4] This appeal followed.

I.

As a threshold matter, an appellate court will not reverse the decision of an administrative agency unless it is "arbitrary, capricious or unreasonable or it is not supported by substantial credible evidence in the record as a whole." Henry v. Rahway

[4] Additionally, according to the Director's final decision, consistent with the petitioner's brief, the second Medicaid application was filed in November 2015. As such, the Director held that "any findings or conclusions regarding the timeliness of petitioner's submissions in connection with subsequent Medicaid applications are not currently before the court."

State Prison, 81 N.J. 571, 579-80 (1980) (citing Campbell v. Dep't of Civil Serv., 39 N.J. 556, 562 (1963)). In cases where an agency head reviews the fact-findings of an ALJ, a reviewing court must uphold the agency head's findings even if they are contrary to those of the ALJ, if supported by substantial evidence. In re Suspension of License of Silberman, 169 N.J. Super. 243, 255-56 (App. Div. 1979), aff'd, 84 N.J. 303, 418 (1980); S.D. v. Div. of Med. Assistance and Health Servs., 349 N.J. Super. 480, 483-84 (App. Div. 2002).

New Jersey participates in the federal Medicaid program pursuant to the New Jersey Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 to -19.5. Eligibility for Medicaid in New Jersey is governed by regulations adopted in accordance with the authority granted by N.J.S.A. 30:4D-7 to the Commissioner of the Department of Human Services. The Division of Medical Assistance and Health Services (DMAHS) is the agency with the Department of Human Services that administers the Medicaid program. N.J.S.A. 30:4D-5, -7; N.J.A.C. 10:49-1.1. Accordingly, DMAHS is charged with the responsibility for safeguarding the interests of the New Jersey Medicaid program and its beneficiaries. N.J.A.C. 10:49-11.1(b). DMAHS is required to manage the state's Medicaid program in a fiscally responsible manner. See Dougherty v. Dep't of Human Servs., Div. of Med. Assistance & Health Servs., 91 N.J. 1, 4-5

(1982); Estate of DeMartino v. Div. of Med. Assistance & Health Servs., 373 N.J. Super. 210, 217-19 (App. Div. 2004).

The local CWA 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. The CWA must verify the equity value of resources through appropriate and credible sources. If the applicant's resource statements are questionable or the identification of resources is incomplete, "the CWA shall verify the applicant's resource statements through one or more third parties." N.J.A.C. 10:71-4.1(d)(3).

"The process of establishing eligibility involves review of the application for completeness, consistency, and reasonableness." N.J.A.C. 10:71-2.9. Applicants must provide the CWA with verifications, which are identified for the applicant. The applicant must "[a]ssist the CWA in securing evidence that corroborates his or her statements." N.J.A.C. 10:71-2.2(e)(2). The applicant's statements in the application are evidence and must substantiate the application with corroborative information from pertinent sources. N.J.A.C. 10:71-3.1(b).

The CWA must timely process the application. See 42 U.S.C.A. § 1396(a)(3); 42 C.F.R. § 435.911; N.J.A.C. 10:71-2.3. It must send each applicant written notice of the agency's decision on his

or her application and if eligibility is denied, the reasons for the denial and right to request a fair hearing. See 42 C.F.R. § 435.913; N.J.A.C. 10:71-8.3. The CWA should deny applications when the applicant fails to timely provide verifications. See N.J.A.C. 10:71-2.2(e), -2.9, -3.1(b).

Here, E.T. argues the Director's final decision is plainly unreasonable due to its failure to recognize the September 17 application as separate from the August 6 application. We disagree. Stern acknowledged during the hearing before the ALJ that HCBSS accepted the September 17 application as part of the August 6 application. Furthermore, although the ALJ found the September 17 application to be separate, it was stipulated by the parties that only the August 6 application was before the ALJ.

Given the deference we accord the Director's findings and having determined that they are supported by sufficient credible evidence in the record, we conclude the decision was neither arbitrary nor unreasonable. As such, we discern no basis to disturb the decision.

II.

E.T. further contends that HCBSS violated Medicaid Communication No. 10-09. Medicaid Communication No. 10-09 states:

> If additional verifications are needed and the applicant or their representative does not respond to the worker's request after a

> time period, as specified by the Agency, an additional request for information must be sent informing the applicant of what documentation is still needed in order to determine their eligibility. This letter will also inform the applicant or their representative that if the information is not received within the specified time period form the receipt of the request, the case will be denied.
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> . . . .
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> If the applicant or their representative continues to fail to provide the requested information, or fails to act within the spirit of cooperation, a denial letter with applicable New Jersey Administrative Code citations must be sent to the applicant. After the denial letter is sent, no further documentation will be accepted by the Agency. The applicant or their representative will be informed that a new application must be submitted; however, verifications from the previous application shall be utilized in the new application where applicable. Every application must have a disposition regarding eligibility within these new timeframes, except when documented exceptional circumstances arise.

Although Stern claimed that Future Care did not receive the September 3 notice, he did not dispute that HCBSS sent the notice to the correct address. A properly addressed letter which is not returned is deemed received. See First Resolution Inv. Corp. v. Seker, 171 N.J. 502, 506 (2002) (citing Morristown Mem'l Hosp. v. Caldwell, 340 N.J. Super. 562, 564 (App. Div. 2001)).

The record supports that multiple attempts were made by HCBSS to notify Future Care regarding the missing verifications. Saliently, Stern testified that he was aware of the September 3 notice when he corresponded with HCBSS.

Although the ALJ found as fact that E.T. did not receive the notice, the Director is not bound by the ALJ's fact-finding and may adopt, modify, or reject the ALJ's decision. N.J.A.C. 1:1-18.3. Here, the Director modified the ALJ's decision because sufficient credible evidence found within the record demonstrated that the September 3 notice was sent to E.T. It was not arbitrary, capricious, or unreasonable for the Director to reject the ALJ's finding that the September 3 notice was sent to Future Care. Again, we discern no basis to disturb the decision on this score.

III.

Finally, E.T. argues that the court should award Medicaid benefits due to the failure of HCBSS to comply with the duty to assist with E.T.'s Medicaid application. Contrary to E.T.'s argument, controlling regulations do not require the state Medicaid agency to obtain all application information on its own. See 42 C.F.R. § 435.948(a). The regulation directs the state Medicaid agency to obtain limited information only "to the extent the agency determines such information is useful to verifying the financial eligibility of an individual." Ibid.

There is no regulation that requires agencies to obtain information about a Medicaid applicant's bank records from an electronic service. See 42 C.F.R. § 435.952(c). Furthermore, there is no regulation that precludes the state Medicaid agency from obtaining such information directly from the Medicaid applicant. Ibid. In New Jersey, the law requires the Medicaid 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 application process, an applicant shall assist the county welfare agency in securing evidence that corroborates his or her statements. N.J.A.C. 10:71-2.2(e)(2).

Here, HCBSS requested specific verifications from E.T. on September 3. Future Care was aware of the notice and the information requested by HCBSS before the September 29 deadline. However, the requested verifications were not provided, and there was no request for additional time in order to comply. Since E.T. both failed to provide the requested verification and failed to satisfy the requirements imposed on Medicaid applicants by N.J.A.C. 10:71-2.2(e) and N.J.A.C. 10:71-3.1(b), the denial of E.T.'s August 6 Medicaid application was grounded in the applicable regulations and was not arbitrary, capricious, or unreasonable.

Finally, E.T. argues that the decision approving his November Medicaid application should have been retroactive to August 6.

This argument is without merit as in contravention of applicable law. Although E.T.'s November application was granted, it was after the requirements imposed by the Administrative Code for determining eligibility were satisfied. As the Director held, and we agree, E.T. did not satisfy those requirements in his August 6 application and his eligibility for the benefits as of that date was not established.

We conclude E.T.'s remaining arguments, not specifically addressed herein, lack sufficient merit to warrant discussion in a written opinion. R. 2:11-3(e)(1)(E).

Affirmed.