SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-2147-16T3

J.H.,

Petitioner-Appellant,

v.

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES,

Respondent-Respondent,

and

OCEAN COUNTY BOARD OF SOCIAL SERVICES,

Respondent.

Submitted February 6, 2018 – Decided February 21, 2018

Before Judges Carroll and Leone.

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

SB2 Inc., attorneys for appellant (Ada Sachter Gallicchio, on the briefs).

Gurbir S. Grewal, Attorney General, attorney for respondent (Melissa H. Raksa, Assistant Attorney General, of counsel; Lauren S. Kirk, Deputy Attorney General, on the brief).

PER CURIAM

J.H. appeals the November 23, 2016 final agency decision of the Division of Medical Assistance and Health Services (DMAHS) that denied her application for Medicaid benefits. We affirm.

J.H. submitted an application for Medicaid benefits to the Ocean County Board of Social Services (OCBSS) on February 22, 2016. That same day, OCBSS provided a letter to J.H. requesting documentation and verification required to determine her eligibility.

On February 26, 2016, OCBSS sent J.H. a notice requesting the following information: (1) verification of a $159.83 payment to Allstate and the policy's cash surrender value if it was a life insurance policy; (2) current statements for a Wells Fargo checking account, and verification for twenty-one designated payments and cash withdrawals totaling more than $14,000 during the period between February 8, 2012, and November 30, 2015; (3) the listing agreement for J.H.'s home; (4) information regarding the purpose of a separate $334.75 payment; and (5) "[a]ny and all pertinent verifications of all resources solely or jointly owned (bank accounts, C.D.'s, stocks, bonds, money markets, 401K's, IRA's, annuities, trusts, cash surrender value of life insurance policies, etc.) opened or closed in the last [five] years prior to application in addition to the accounts listed above." The

notice advised J.H. of the name and phone number of the OCBSS representative J.H. could call "if [she] ha[d] any questions regarding this matter." Finally, the notice instructed J.H. her application could be denied if she failed to furnish the requested information by March 7, 2016.

On March 7, 2016, OCBSS sent J.H. another notice advising that her application could be denied if she failed to supply the information by March 21, 2016. On March 21, 2016, OCBSS sent J.H. a "final notice," again requesting information concerning bank accounts and insurance policies. J.H. was instructed to supply the information by April 4, 2016, or OCBSS "may take action to deny" her application. As with the prior notices, OCBSS provided J.H. with the name and phone number of its representative to call if she had any questions. On April 13, 2016, J.H.'s application for Medicaid was denied for non-compliance with the February 26, March 7, and March 21, 2016 notices.

At J.H.'s request, a hearing was conducted concerning the denial of her application. On September 30, 2016, an Administrative Law Judge (ALJ) issued an Initial Decision affirming the denial of Medicaid benefits to J.H. In his written opinion, the ALJ determined:

> The issue in this case is whether [OCBSS] appropriately denied [J.H.'s] application when she did not provide the requested

> information by April 4, 2016. 42 C.F.R. § 435.912(c)(3) and N.J.A.C. 10:71-2.3(a) provide that the agency has forty-five days to render a decision on eligibility for an applicant who is not applying on the basis of disability. In the present case, [OCBSS] advised [J.H.] a number of documents and explanations were requested. There is no dispute that those documents were not received on time and one [was received] after the application had been denied. In addition, some of the verifications were not provided at all because there were no records produced regarding the commingled bank account.

The ALJ also rejected J.H.'s argument that OCBSS should have assisted her in securing the requested information. The ALJ found J.H. never requested assistance and that at all times OCBSS dealt only with J.H.'s authorized representative at Future Care Consultants.

On administrative appeal to the DMAHS, the Director reviewed the record, including the ALJ's Initial Decision, and adopted the findings and conclusions of the ALJ in their entirety. The Director concluded "[t]he credible evidence in the record demonstrates that [J.H.] failed to provide the needed information prior to the April 13, 2016 denial of benefits. Without this information, OCBSS was unable to complete its eligibility determination and the denial was appropriate."

On appeal, J.H. contends DMAHS's final decision was arbitrary and capricious. Specifically, she argues: (1) the ALJ was biased

against her; (2) the ALJ failed to provide an analysis as part of his decision; (3) OCBSS violated her due process rights by failing to provide adequate notice of the denial; and (4) OCBSS failed to offer her the necessary assistance with her Medicaid application.

We review an agency's decision for the limited purpose of determining whether its action was arbitrary, capricious or unreasonable. "An administrative agency's decision will be upheld 'unless there is a clear showing that it is arbitrary, capricious, or unreasonable, or that it lacks fair support in the record.'" R.S. v. Div of Med. Assistance and Health Servs., 434 N.J. Super. 250, 261 (App. Div. 2014) (quoting Russo v. Bd. of Trs., Police & Firemen's Ret. Sys., 206 N.J. 14, 25 (2011)). "The burden of demonstrating that the agency's action was arbitrary, capricious or unreasonable rests upon the [party] challenging the administrative action." E.S. v. Div. of Med. Assistance & Health Servs., 412 N.J. Super. 340, 349 (App. Div. 2010) (alteration in original) (quoting In re Arenas, 385 N.J. Super. 440, 443-44 (App. Div. 2006)).

"Medicaid is a federally-created, state-implemented program that provides 'medical assistance to the poor at the expense of the public.'" Matter of Estate of Brown, 448 N.J. Super. 252, 256 (App Div.) (quoting Estate of DeMartino v. Div. of Med. Assistance & Health Servs., 373 N.J. Super. 210, 217 (App. Div. 2004); 42

U.S.C.A. § 1396-1), certif. denied, 230 N.J. 393 (2017). To receive federal funding, the State must comply with all the federal statutes and regulations. Harris v. McRae, 448 U.S. 297 (1980).

In New Jersey, the Medicaid program is administered by DMAHS pursuant to the New Jersey Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 to -19.5. "In order to be financially eligible, the applicant must meet both income and resource standards." Brown, 448 N.J. Super. at 257 (citing N.J.A.C. 10:71-3.15). The county welfare boards evaluate eligibility. Through those county agencies, DMAHS serves as a "gatekeeper to prevent individuals from using Medicaid to avoid payment of their fair share for long-term care." W.T. v. Div. of Med. Assistance & Health Servs., 391 N.J. Super. 25, 37 (App. Div. 2007) (citing N.J.S.A. 30:4D-1 to -19.1).

DMAHS's regulations establish "policy and procedures for the application process." N.J.A.C. 10:71-2.2(b). The county welfare boards exercise "direct responsibility in the application process to . . . [r]eceive applications." N.J.A.C. 10:71-2.2(c). They also "[a]ssure the prompt and accurate submission of eligibility data." N.J.A.C. 10:71-2.2(c)(5). The regulations establish time frames to process an application, with the "date of effective disposition" being the "effective date of the application" where the application has been approved. N.J.A.C. 10:71-2.3(b)(1).

Under both federal and New Jersey law, except in unusual or exceptional circumstances, Medicaid eligibility determinations must be made within forty-five days. 42 C.F.R. § 435.912(c)(3)(ii); N.J.A.C. 10:71-2.3(a). Examples of exceptional cases where the forty-five day period can be enlarged include:

> 1. Circumstances wholly within the applicant's control; [or]
>
> 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[.]
>
> [N.J.A.C. 10:71-2.3(c)(1)-(2).]

Here, DMAHS's final agency decision was not arbitrary, capricious or unreasonable. J.H. does not dispute that: her application for Medicaid was filed on February 22, 2016; she was given four opportunities to provide the information necessary to determine her eligibility for benefits; she did not timely submit all the required information; and she never requested additional time. When the verifying information was not timely provided, DMAHS properly denied the application. DMAHS was correct to deny an application that did not have the information necessary to verify eligibility because Medicaid is intended to be a resource of last resort and is reserved for those who have a financial or

medical need for assistance. See N.E. v. Div. of Med. Assistance & Health Servs., 399 N.J. Super. 566, 572 (App. Div. 2008).

J.H. has failed to demonstrate any unusual or exceptional circumstances that would warrant a continuation of her eligibility determination beyond the normal forty-five day deadline. Moreover, contrary to J.H.'s argument, the notice of denial was adequate because it stated it was for non-compliance, it identified the contact letters to which plaintiff failed to respond, and the letters detailed the information requested. While J.H. complains OCBSS failed to assist her in obtaining the information necessary to complete her Medicaid application, the record is devoid of any indication that either J.H. or her authorized representative ever sought such assistance.

After carefully reviewing the record and the applicable legal principles, we conclude that J.H.'s further arguments are without sufficient merit to warrant discussion in a written opinion, Rule 2:11-3(e)(1)(E), and that the agency's decision is supported by sufficient credible evidence in the record. R. 2:11-3(e)(1)(D).

Affirmed.