SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-0825-21

S.G.,

Petitioner-Appellant,

v.

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, and ATLANTIC COUNTY DEPARTMENT OF FAMILY AND COMMUNITY DEVELOPMENT,

Respondent-Respondents.

Submitted January 24, 2023 – Decided April 28, 2023

Before Judges Susswein and Fisher.

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

Michael Heinemann, attorney for appellant.

Matthew J. Platkin, Attorney General, attorney for respondent Division of Medical Assistance and Health

Services (Melissa H. Raksa, of counsel; Kathleen E. Horton, Deputy Attorney General, of counsel).

James F. Ferguson, County Counsel, attorney for Atlantic County Department of Family and Community Development, join in the brief of respondent Division of Medical Assistance and Health Services.

PER CURIAM

Petitioner Estate of S.G.[1] appeals from a final agency decision denying S.G.'s application for Medicaid benefits for failure to provide information requested by the county welfare agency (CWA)—the Atlantic County Department of Family and Community Development. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) adopted the initial decision of an administrative law judge (ALJ), finding that S.G.'s designated authorized representative (DAR)[2] had been given ample time to submit the requested verifications and failed to make a

[1] S.G. passed away during these proceedings. Accordingly, her estate is the petitioner for purposes of this appeal.

[2] Medicaid applicants can "designate an individual or organization to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications with the agency." 42 C.F.R. § 435.923(a)(1). The regulations further provide that an authorized representative "[i]s responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation, . . . to the same extent as the individual he or she represents." 42 C.F.R. § 435.923(d).

detailed request for an extension showing exceptional circumstances that prevented her from complying with the CWA's deadline. After carefully reviewing the record in view of the governing legal principles, we affirm.

I.

On September 27, 2019, S.G. filed an application for Medicaid benefits. On October 1, 2019, the CWA sent a letter to the DAR requesting information and documents needed to verify S.G.'s eligibility for benefits, including details of certain deposits, copies of checks, and copies of bank statements from multiple accounts.

On October 11, 2019, the DAR requested an extension. The CWA granted an extension until November 1, 2019. On October 31, 2019, the DAR asked for a second extension without having provided any of the requested verifications. The CWA granted the extension. On November 6, 2019, the DAR submitted only some of the requested verifications.

On November 7, 2019, the CWA sent the DAR a second letter, requesting additional bank statements for specified accounts and renewing the request for the items from the October 1, 2019 letter that had not been provided. On November 11, 2019, the DAR submitted some of the requested documentation and advised that she was trying to obtain the remaining documentation.

On November 22, 2019, the CWA sent a third request for the documentation detailed in previous letters that had still not been provided. Between November 26 and December 2, 2019, the DAR provided copies of checks and bank statements for only two of the specified accounts. On December 3, 2019, the CWA sent a fourth letter, requesting the missing verifications, including deposit slips that had been requested in the first letter. The letter warned that if the documentation was not provided in ten days, the application would be denied on December 17, 2019.

On December 12, 2019, the DAR submitted information concerning a single deposit but made no mention of the other outstanding verifications. In an email dated December 13, 2019, the DAR asked for an extension on the due date. On December 19, 2019, the CWA sent a fifth letter renewing its request for outstanding verifications, extending the time for the DAR to submit documentation for an additional ten days, and advising that the application would be denied on January 8, 2020 if the documentation was not received.

On December 23, 2019, the CWA sent a sixth letter, listing outstanding verifications and requesting additional documentation across four different bank accounts, including the withdrawal slip for a $6,000 withdrawal on February 6,

2019, a current statement of an $845 transfer on July 5, 2019, and the withdrawal slip or current statement for a $9,999 withdrawal on April 9, 2018.

On January 6, 2020, the CWA sent a seventh and final request asking for the missing verifications listed in the December 23, 2019 letter. The seventh letter informed the DAR that the application would be denied on January 28, 2020 if she did not provide the requested documentation in ten days. The letter further advised that once a denial letter was sent, no further documentation would be accepted.

Although the DAR communicated with the CWA during the ten-day period, she neither requested an extension of time nor provided the outstanding verifications. On January 18, 2020—after the ten-day period elapsed but before the denial letter date—the DAR submitted fourteen pieces of documentation. Immediately prior to the application's denial, there were three outstanding requests, including the withdrawal slip for the $6,000 withdrawal, the current bank statement for the $845 transfer, and the withdrawal slip or current bank statement for the $9,999 withdrawal. On January 21, 2020, the DAR submitted documentation for the $6,000 withdrawal and asked the CWA to "please hold the case." The remaining verifications were not provided by the January 28, 2020 deadline.

On January 31, 2020, S.G.'s application for benefits was denied for failure to provide verifications necessary to determine eligibility. On February 7, 2020, S.G. requested a fair hearing,[3] and the matter was transmitted to the Office of Administrative Law (OAL). The hearing was delayed due to S.G.'s death, and was finally convened on April 27, 2021.

On June 29, 2021, the ALJ issued an initial decision finding that the CWA reasonably denied S.G.'s application. The ALJ explained that pursuant to N.J.A.C. 10:71-2.3, the maximum time period to process an application is ninety days unless the CWA finds an exceptional reason to extend the time limit. The ALJ noted that there were no unique circumstances justifying an extension in this matter.

On September 24, 2021, the DMAHS's Assistant Commissioner issued a final agency decision adopting the ALJ's initial decision. DMAHS noted there

[3] Under applicable state and federal regulations, if an applicant is denied Medicaid benefits, the "applicant . . . [is] to be afforded the opportunity for a fair hearing in the manner established by the policies and procedures set forth in N.J.A.C. 10:49-10 and 10:69-6." N.J.A.C. 10:71-8.4(a); 42 C.F.R. § 431.220. Applicants have the right to fair hearings when "their claims . . . are denied or are not acted upon with reasonable promptness." N.J.A.C. 10:49-10.3(b); 42 C.F.R. § 431.220(a)(1). Requests for fair hearings must be submitted to the DMAHS in writing within twenty days of the denial, reduction, or partial denial of Medicaid benefits. N.J.A.C. 10:49-10.3(b)(1) and (3); 42 C.F.R. § 431.221(d).

were numerous missing verifications needed to finalize the application, including items first requested in the CWA's October 1, 2019 letter.

S.G.'s estate raises the following contentions for our consideration:

> POINT I
>
> [THE CWA] SHOULD HAVE GRANTED AN ADDITIONAL EXTENSION DUE TO ITS FAILURE TO REQUEST THE SUBJECT VERIFICATIONS UNTIL ITS SIXTH REQUEST LETTER.
>
> POINT II
>
> [THE CWA]'S FAILURE TO GRANT AN ADDITIONAL EXTENSION WAS ARBITRARY, CAPRICIOUS, AND UNREASONABLE.

II.

We begin by addressing our standard of review and general governing legal principles. This court's review of a DMAHS determination is limited. C.L. v. Div. of Med. Assistance & Health Servs., 473 N.J. Super. 591, 597 (App. Div. 2022) (citing Barone v. Dep't of Hum. Servs., Div. of Med. Assistance & Health Servs., 210 N.J. Super. 276, 285 (App. Div. 1986)). "It is settled that [a]n administrative agency's interpretation of statutes and regulations within its implementing and enforcing responsibility is ordinarily entitled to our deference." Ibid. (alteration in original) (quoting Wnuck v. Div. of Motor Vehicles, 337 N.J. Super. 52, 56 (App. Div. 2001)).

"Where [an] action of an administrative agency is challenged, a presumption of reasonableness attaches to the action of an administrative agency[,] and the party who challenges the validity of that action has the burden of showing that it was arbitrary, unreasonable or capricious." Id. at 597–98 (alterations in original) (quoting Barone, 210 N.J. Super. at 285). "Delegation of authority to an administrative agency is construed liberally when the agency is concerned with the protection of the health and welfare of the public." Id. at 598 (quoting Barone, 210 N.J. Super. at 285). Thus, our task is limited to deciding:

> (1) whether the agency's decision offends the State or Federal Constitution; (2) whether the agency's action violates express or implied legislative policies; (3) whether the record contains substantial evidence to support the findings on which the agency based its action; and (4) whether in applying the legislative policies to the facts, the agency clearly erred in reaching a conclusion that could not reasonably have been made on a showing of the relevant factors.
>
> [Ibid. (quoting A.B. v. Div. of Med. Assistance & Health Servs., 407 N.J. Super. 330, 339 (App. Div. 2009)).]

Medicaid is a federally created, state-implemented program designed to ensure that people who cannot afford necessary medical care are able to obtain it. 42 U.S.C. § 1396(a). New Jersey participates in the Medicaid program

through the New Jersey Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 to -19.5. DMAHS is responsible for administering the Medicaid program in our State. Through its regulations, DMAHS establishes "policy and procedures for the application process and supervise[s] the operation of and compliance with the policy and procedures so established." N.J.A.C. 10:71-2.2(b).

Local CWAs, however, receive applications and determine Medicaid eligibility. N.J.A.C. 10:71-2.2(c) and -3.15(a). As explained in N.J.A.C. 10:71-2.9, "[t]he process of establishing eligibility involves a review of the application for completeness, consistency, and reasonableness." CWAs must verify an applicant's resources through credible sources, which includes evaluation of the applicant's past circumstances and present living standards in order to ascertain whether resources have not been reported. N.J.A.C. 10:71-4.1. Importantly for the purposes of this appeal, N.J.A.C. 10:71-2.2(e) requires the applicant to "[a]ssist the CWA is securing evidence that corroborates his or her statements." N.J.A.C. 10:71-3.1(b) also requires the applicant to substantiate his application with corroborative evidence from pertinent sources.

Medicaid regulations require than an application for benefits must be processed within forty-five days for the aged and ninety days for applicants who

are disabled or blind. N.J.A.C. 10:71-2.3(a). After the passing of the forty-five or ninety day period, the CWA must find an exceptional reason for the delay in order to extend the application time limit. N.J.A.C. 10:71-2.3(c). Thus, if an applicant fails to timely provide verification, absent extensions, the CWA will deny an application.

S.G.'s estate does not dispute that verifications requested by the CWA were not provided. The record reflects that the DAR was given ample time either to submit the requested verifications or request an extension of the deadline set by the CWA's final letter. The CWA was under no obligation to grant an additional extension without a showing of any exceptional circumstances.

We add the DAR testified that she worked for a professional consulting company and that her job "was to apply for Medicaid on behalf of the patients." We are therefore not dealing with a disabled applicant who was physically unable to compile and forward the necessary bank records. In these circumstances, DMAHS's final decision was not arbitrary, capricious, or unreasonable as to justify appellate intervention. To the extent we have not specifically addressed them, any additional arguments raised by petitioner lack sufficient merit to warrant discussion. R. 2:11-3(e)(1)(E).

Affirmed.

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

CLERK OF THE APPELLATE DIVISION