SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-3010-21

K.O.,

Petitioner-Appellant,

v.

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, and MORRIS COUNTY OFFICE OF TEMPORARY ASSISTANCE,

Respondents-Respondents.

———————————————————

Submitted September 12, 2023 – Decided September 26, 2023

Before Judges Smith and Perez Friscia.

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

The Murray Firm, LLC, attorneys for appellant (Robert J. Murray, on the briefs).

Matthew J. Platkin, Attorney General, attorney for respondent Division of Medical Assistance and Health Services (Melissa H. Raksa, Assistant Attorney

General, of counsel; Francis X. Baker, Deputy Attorney General, on the brief).

John A. Napolitano, Morris County Counsel, attorney for respondent Morris County Office of Temporary Assistance (William G. Johnson, Special Morris County Counsel, on the statement in lieu of brief).

PER CURIAM

K.O.[1] appeals from the August 6, 2021 final agency decision of the Assistant Commissioner of the Division of Medical Assistance and Health Services (DMAHS), which affirmed the Morris County Office of Temporary Assistance's (OTA) denial of K.O.'s Medicaid benefits, and reversed the Administrative Law Judge's (ALJ) initial decision vacating that denial. After a review of the record and applicable law, we reverse and remand to provide K.O. the opportunity to complete the Medicaid benefits application process.

I.

On February 26, 2021, K.O.'s attorney filed an application on her behalf with the OTA for Medicaid benefits. K.O. was a resident of an assisted living community in Morris Plains. On March 9, 2021, the OTA, in furtherance of K.O.'s Medicaid application, requested by letter that K.O. provide the following

[1] We use initials to preserve the confidentiality of these proceedings. R. 1:38-3(c)(9).

eligibility verification documents: (1) Medicaid card; (2) Social Security Administration (SSA) award letter; (3) U.S. Department of Housing and Urban Development (HUD) statement; (4) spouse's death certificate; (5) facility personal need allowance (PNA); (6) clarification as to whether retroactive Medicaid benefits were sought; and (7) a letter from the facility stating the date of admission. The OTA letter stated "[f]ailure to provide the requested information and documentation within [forty-five] calendar days from the date of this letter may result in denial of [the] application." On March 11, 2021, K.O.'s counsel, who handled the matter throughout the application process, submitted to the OTA: her Medicare card; a 2021 SSA "benefit verification letter" with her healthcare benefit deduction; a closing statement in connection with the sale of real property in Ridge, N.Y.; her spouse's death certificate; and a letter from the assisted living facility regarding her admittance.

On April 25, 2021, the OTA requested by letter that K.O. provide the following additional documentation within ten days: (1) Citibank account records from February 1, 2016 to February 1, 2021 for account xx10; (2) a copy of the entire HUD statement; (3) PNA statements from account origination; (4) verification as to whether K.O. had any additional health or prescription

insurances and copies of insurance cards; (5) health and prescription insurance statements; and (6) insurance premiums with proof of payment.

On May 5, 2021, K.O. submitted: bank statements for Citibank account xx10 from origination in October 2017 to February 2021; a complete HUD statement; a United Health Care Supplement Part C insurance card with the specified monthly premium costs; and that there was no PNA account at the assisted living facility. K.O.'s counsel also emailed, "Please let me know if you need anything additional on this matter." Approximately one month later, on June 4, 2021, K.O.'s counsel again emailed the OTA, "Could you please provide [the] status of this Medicaid application?"

On June 6, 2021, the OTA sent a third letter notice for additional documents and provided ten days for the submission of the following: (1) Citibank account records from February 1, 2016 to February 1, 2021 for account xx58; (2) detailed deposit explanations for five Citibank transactions for account xx10; (3) an accounting of four bill payments paid to separate individuals; (4) a complete current copy of the United States Department of Veterans Affairs (VA) award letter; (5) a detailed explanation regarding a $3,000 withdrawal from account xx10; (6) a copy of Part C and D Medicare supplemental insurance cards; (7) the last will and testament for K.O.'s deceased spouse; and (8)

disclosure of any additional financial resources or property belonging to her late spouse, such as investment accounts, IRA, 401K, stocks, bonds, life insurance policies, car, etc. The letter also stated, "Please be advised that any unexplained checks/withdrawals or transfers of resources may result in a penalty period of ineligibility."

On June 11, 2021, K.O. submitted to the OTA the following: a June 4, 2018 letter explanation of VA death pension benefits; copies of checks for three of the five transactions requested; representation from K.O.'s counsel that K.O.'s former spouse "did have a will, however, the family no longer [had] a copy"; and the resubmission of K.O.'s United Healthcare Supplement Part C card. Relevantly, on the same day, K.O.'s counsel again inquired as to any deficiency and requested, "Please let me know if you need any additional documents."

On July 7, 2021, K.O.'s counsel again inquired by email, "Could you please provide an update on this application?" The OTA responded the same day by email that "[t]he application was submitted for denial due to lack of documentation." K.O.'s counsel immediately responded, "Could you please advise what documentation was missing? I provided everything requested in the 6/6/2021 letter." A brief email exchange occurred between the parties, and the OTA claimed deficiencies with the submission of verification of a will, VA

benefits, Citibank account xx10 transactions, and Part D card. K.O.'s counsel responded and referenced the June 11 submissions of VA benefit information, Part C card, and the representation that K.O. did not have a copy of the will. The email further advised there was no account ending in xx85. The OTA provided no response and requested no further clarification or verification. On August 6, 2021, the OTA formally denied K.O.'s application for Medicaid benefits. Ten days later, K.O. requested a fairness hearing through the DMAHS, which was granted.

The parties waived testimony and submitted the matter on the papers before the ALJ. On January 24, 2022, the ALJ, in a written initial decision, reversed the OTA's denial of K.O.'s Medicaid benefits. The ALJ found: (1) K.O. provided timely responses to the first, second, and third document requests; (2) K.O. provided fully responsive answers to the OTA's first and second requests; (3) K.O. submitted all the documents in her possession that pertained to the OTA's third request and acted in good faith when responding to same; and (4) between June 11, 2021 and August 6, 2021, the OTA failed to communicate to K.O. that her third response was insufficient or that additional documentation was required. The ALJ recommended the DMAHS: vacate the denial of benefits; reinstate K.O.'s Medicaid application; require the OTA provide a

"written explanation of the inadequacies and list what alternative documents would be acceptable to [the] OTA if the requested documents cannot be located or produced"; and provide K.O. two weeks to respond to any requests made by the OTA.

On January 26, 2022, the OTA filed exceptions to the ALJ's decision with the DMAHS. On April 22, 2022, the Assistant Commissioner of the DMAHS issued a final agency decision, which rejected the ALJ's recommended reversal, and upheld the OTA's denial of Medicaid benefits finding K.O. had failed to provide the requested verification documentation for an eligibility determination under N.J.A.C. 10:71-2.2(e). The Assistant Commissioner specifically found K.O. failed to provide: additional details as to ownership and use of the Citibank account number xx58; documentation for two missing Citibank account xx10 transactions, including cancelled checks and deposit slips from her daughter's account; the Part D supplemental insurance card or proof that K.O. attempted to secure the cards not in her possession; demonstration of "attempts to obtain a copy of the will" to address entitlement to "an elective share";[2] and a more current VA benefits letter to address whether K.O. qualified for any additional

[2] An elective share, under N.J.S.A. 3B:8-1 to 11 is the equivalent of one-third of the deceased spouse's augmented estate, subject to the limitations and conditions set forth by statute.

benefits. The Assistant Commissioner noted K.O. did not request an extension to supplement the submissions. However, the Assistant Commissioner did not address K.O.'s counsel's timely requests to be informed of any deficiencies to provide any missing documentation.

On appeal, K.O. contends her application for Medicaid benefits was wrongly denied, as she: timely responded to each verification request with the information available to her; attested the Citibank account was a debit card and not a bank account; attested Citibank was unable to provide information about the two deposits from her xx10 account; provided the OTA caseworker all available VA information prior to the OTA's denial; provided relevant financial information on insurance, thus there was no need for the Part D supplement insurance card, which K.O. did not possess; and responded she did not have a copy of her deceased spouse's will. The DMAHS refutes each of K.O.'s arguments.

II.

"This court's review of DMAHS's determination is ordinarily limited." C.L. v. Div. of Med. Assistance & Health Services, 473 N.J. Super. 591, 597 (App. Div. 2022). "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 & 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, 27 (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)).

"Deference to an agency decision is particularly appropriate where interpretation of the [a]gency's own regulation is in issue." I.L. v. N.J. Dep't Hum. Servs., Div. of Med. Assistance & Health Servs., 389 N.J. Super. 354, 364 (App. Div. 2006). "Nevertheless, we are 'in no way bound by the agency's interpretation of a statute or its determination of a strictly legal issue.'" C.L., 473 N.J. Super. at 598 (quoting R.S., 434 N.J. Super. at 261).

Moreover, "[i]f our review of the record shows that the agency's finding is clearly mistaken, the decision is not entitled to judicial deference." A.M. v. Monmouth Cnty. Bd. of Soc. Servs., 466 N.J. Super. 557, 565 (App. Div. 2021) (first citing H.K. v. N.J. Dep't of Hum. Servs., 184 N.J. 367, 386 (2005), then citing L.M. v. Div. of Med. Assistance & Health Servs., 140 N.J. 480, 490

(1995)). The same is true "where an agency rejects an ALJ's findings of fact." Ibid. (citing H.K., 184 N.J. at 384).

"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. 2017) (quoting Estate of DeMartino v. Div. of Med. Assistance & Health Servs., 373 N.J. Super. 210, 217 (App. Div. 2004)); see also 42 U.S.C. § 1396-1. To receive federal funding, the State must comply with all federal statutes and regulations. Harris v. McRae, 448 U.S. 297, 301 (1980).

Pursuant to the New Jersey Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 to -19.5, the DMAHS is responsible for administering Medicaid in our State. N.J.S.A. 30:4D-4. Regulations adopted in accordance with the authority granted to the Commissioner of the Department of Human Services govern eligibility for Medicaid in New Jersey. N.J.S.A. 30:4D-7. The DMAHS is the agency within the Department of Human Services that administers the Medicaid program. N.J.S.A. 30:4D-5; N.J.A.C. 10:49-1.1. Through its regulations, the DMAHS establishes "policy and procedures for the application process." N.J.A.C. 10:71-2.2(b). The DMAHS is required to manage the State's Medicaid program in a fiscally responsible manner. See

Dougherty v. Dep't of Hum. Servs., Div. of Med. Assistance & Health Servs., 91 N.J. 1, 4-5, 10 (1982) (remanding back to the agency to consider the public interest and the "increasing social demands for limited public resources"). "[T]o be financially eligible, the applicant must meet both income and resource standards." Estate of Brown, 448 N.J. Super. at 257; see also N.J.A.C. 10:71-3.15; N.J.A.C. 10:71-1.2(a).

One of the objectives of Medicaid is to "'provide[] medical assistance to needy persons who are institutionalized in nursing homes as [a] result of illness or other incapacity.'" R.S., 434 N.J. Super. at 258 (quoting M.E.F. v. A.B.F., 393 N.J. Super. 543, 545 (App. Div. 2007)). The local County Welfare Agency (CWA) "exercise[s] direct responsibility in the application process to . . . [r]eceive applications." N.J.A.C. 10:71-2.2(c)(2). CWA is defined as "that agency of county government, that is charged with the responsibility for determining eligibility for public assistance programs, including [Aid to Families with Dependent Children]-Related Medicaid, Temporary Assistance to Needy Families (TANF), the Food Stamp Program, NJ FamilyCare and Medicaid." N.J.A.C. § 10:71-2.1. Additionally, "[d]epending on the county, the CWA might be identified as the board of social services, the welfare board, the division of welfare or the division of social services." Ibid. The CWA is

charged with evaluating an applicant's eligibility for Medicaid benefits. N.J.S.A. 30:4D-7a; N.J.A.C. 10:71-2.2(a); N.J.A.C. 10:71-3.15.

"The process of establishing eligibility involves a review of the application for completeness, consistency, and reasonableness." N.J.A.C. 10:71-2.9. Applicants must provide the CWA with specific verifications which are identified for the applicant. The CWA is responsible for assisting an applicant "in exploring their eligibility for assistance," N.J.A.C. 10:71-2.2(c)(3), and making known to the applicant "the appropriate resources and services both within the agency and the community, and, if necessary, assist in their use," N.J.A.C. 10:71-2.2(c)(4). The applicant is required to "complete, with the assistance from the CWA if needed, any forms required by the CWA as a part of the application process." N.J.A.C. 10:71-2.2(e)(1). While the applicant is "the primary source of information," the CWA is responsible for making "the determination of eligibility and to use secondary sources when necessary, with the applicant's knowledge and consent." N.J.A.C. 10:71-1.6(a)(2). The CWA is not limited in the use of secondary sources to obtain necessary verification information. It is recognized,

> [t]he CWA shall verify the equity value of resources through appropriate and credible sources . . . . If the applicant's resource statements are questionable, or

> there is reason to believe the identification of resources[3] 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 applicant is responsible for cooperating fully with the verification process if the CWA has to contact the third-party in reference to verifying resources. N.J.A.C. 10:71-4.1(d)(3)(i). The agency may perform a collateral investigation to "verify, supplement or clarify essential information." N.J.A.C. 10:71-2.10(b).

III.

Following a review of the record and applicable legal principles, we conclude the Assistant Commissioner's decision was arbitrary, capricious, and unreasonable, as it was unsupported by the record. The record demonstrates: K.O. timely responded to the three transaction verification requests; K.O. produced numerous substantially compliant documents; the OTA failed to reasonably advise K.O. specifically as to what further verification information was necessary to complete the Medicaid application process; the OTA did not seek to reasonably "verify, supplement, or clarify essential information"; and the OTA failed under N.J.A.C. 10:71-2.2 to communicate with K.O. regarding

[3] A resource is "any real or personal property which is owned by the applicant . . . and which could be converted to cash to be used for his or her support and maintenance." N.J.A.C. 10:71-4.1(b).

the claimed deficiencies and under N.J.A.C. 10:71-2.10(b) to provide an opportunity to verify prior to denial of K.O.'s application.

The Assistant Commissioner's finding that denial was warranted because K.O. did not provide the Citibank account xx58 information and "did not advise Morris County that the account statements requested were for a debit card until after the [June 16, 2021] deadline," is misplaced. On June 7, 2021, prior to the submission deadline, K.O.'s attorney advised the OTA that "there is no Citibank account ending in [xx]85."[4] If K.O. was required to further disprove the existence of the unknown account, which was ultimately determined to be K.O.'s deceased husband's debit card, it was incumbent on the OTA to have provided fair notice of same. Additionally, pursuant to N.J.A.C. 10:71-4.2(b)(3), the OTA could have directly verified K.O.'s representation with the financial institution. N.J.A.C. 10:71-4.1; N.J.A.C. 10:71-4.2; N.J.A.C. 10:71-2.10.

The Assistant Commissioner's holding that K.O. should have provided "documentation from her daughter's account to show that an electronic transfer" occurred, if "she could not provide a check or deposit slip" from her account,

[4] The record contains references to three separate Citibank account numbers: xx58, xx48, and xx85, which appear to all reference account xx58. On July 7, 2021, after the June 16, 2021 OTA submission deadline but prior to the August 6, 2021 denial letter, K.O.'s counsel advised that a Citibank account ending in xx58 did not exist.

again presumes K.O. had sufficient notice to obtain documents not in her possession from a third party. K.O. had provided copies of three of the checks requested; however, two checks or deposit slips were unavailable because they pertained to electronic transfers—not cash or checks—made from K.O.'s daughter's bank account. It is unclear why K.O.'s counsel's July 7, 2021 emails did not yield a letter elucidating any deficiencies, and request more specific information. We recognize K.O. has the primary obligation to "[a]ssist the CWA in securing evidence that corroborates" her statements, pursuant to N.J.A.C. 10:71-2.2(e)(2), but the OTA is also to act reasonably in providing notice of alternative documents sought and in seeking necessary collateral information through secondary sources as necessary. N.J.A.C. 10:71-1.6(a)(2); N.J.A.C. 10:71-2.10.

While the Assistant Commissioner correctly noted that disclosure of all assets and potential financial interests—such as K.O.'s possible elective share, VA benefits, and supplemental insurance—are relevant to determine eligibility, we cannot agree that K.O. did not timely respond and provide responsive documentation to the verification requests. The Assistant Commissioner's denial based on K.O.'s failure to provide a copy of the will is also unsupported. The record demonstrates OTA's request was only to "[v]erify if the former

spouse had a [last] will and testament." Once K.O. advised there was a will, but she did not have a copy, it was incumbent upon the OTA to specifically request further documentation as to her attempts to obtain a copy and any possible elective share information. The Assistant Commissioner finding that the VA benefits letter was insufficient and that "no updated letter was provided" to demonstrate [K.O.] "did not qualify for continued benefits after the 2018 letter" is similarly unsupported. The OTA had only requested from K.O. a "complete current copy" of VA benefits, which K.O. provided. The 2018 VA benefits letter delineates the payments and states, "[w]e stopped your death pension benefits effective August 1, 2018." There are distinctions between what the Assistant Commissioner found was requested and what the OTA actually requested. It is not reasonable, and DMAHS provides no support, for finding an applicant is to anticipate providing more than the documents requested. It is arbitrary to assume K.O. would know the specific potential financial interests sought, such as an elective share or appeal of the termination of VA benefits.

As to the insurance coverage, the Assistant Commissioner held K.O. presented no documentation showing "attempts to obtain a copy of the insurance card" when the June 6, 2021 OTA letter only requested a "copy of both the [P]art C and [P]art D insurance cards." On June 11, 2021, K.O. resubmitted a copy of

the Part C insurance card in her possession, and on March 11, 2021, had provided a March 9, 2021 letter from the SSA stating a $297 medical insurance premium is deducted monthly because K.O. did not have a copy of the Part D insurance card. K.O.'s counsel on multiple occasions inquired whether further supplemental documents were necessary. We conclude that any insufficiency should have been noticed, and K.O. been provided an opportunity to address obtaining further documentation from third parties to cure the deficiencies. Again, the primary obligation is on K.O., but the OTA had the available option to seek verification documents directly from collateral sources to "supplement or clarify essential information." N.J.A.C. 10:71-1.6(a)(2); N.J.A.C. 10:71-2.10. It is well established that State agencies must "turn square corners" in the exercise of statutory responsibilities with members of public. W.V. Pangborne & Co. v. N.J. Dep't of Transp., 116 N.J. 543, 561-62 (1989).

For these reasons, we reverse the Assistant Commissioner's decision and remand the matter to the DMAHS for further proceedings. K.O.'s February 25, 2021 application for Medicaid benefits shall be reinstated. The DMAHS, with the necessary assistance of the OTA, shall: identify the remaining records needed to verify K.O.'s Medicaid eligibility; request, with specificity, any necessary verification documents not in her possession; provide a reasonable

time for her to submit responsive documents; and then make a new eligibility determination for K.O. in a manner consistent with the principles we have outlined here.

To the extent we have not addressed any of plaintiff's remaining arguments, they are without sufficient merit to warrant discussion in a written opinion. R. 2:11-3(e)(1)(E).

Reversed and remanded. We do not retain jurisdiction.

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

CLERK OF THE APPELLATE DIVISION