State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION
OAL DKT. NO. HMA 08152-2026
AGENCY DKT. NO. N/A

M.W.,
Petitioner,
v.
CUMBERLAND COUNTY BOARD OF SOCIAL SERVICES,
Respondent.

M.W., petitioner pro se

Sandra VanCulin, Fair Hearing Liaison, for respondent, pursuant to N.J.A.C. 1:1-5.4(a)(3)

Record Closed: July 9, 2026 Decided: July 22, 2026

BEFORE **KATHLEEN M. CALEMMO**, ALJ:

STATEMENT OF THE CASE

Petitioner, M.W., appealed the decision of respondent, Cumberland County Board of Social Services (Agency), denying eligibility for Managed Long-Term Services and Supports (MLTSS) Medicaid benefits. The Agency determined that petitioner's total

countable resources of $19,184.38 put him over the eligibility resource limit of $2,000. N.J.A.C. 10:71-4.8.

The issue is whether a deferred compensation plan should be included as a resource when access is limited to unforeseeable emergencies. N.J.A.C. 10:71-4.1 mandates that "both liquid and nonliquid resources shall be considered in the determination of eligibility, unless such resources are specifically excluded under the provisions of N.J.A.C. 10:71-4.4." N.J.A.C. 10:71-4.2 reiterates that "[a]ny resource which is not specifically excludable under the provisions of N.J.A.C. 10:71-4.4 shall be considered a countable resource for the purpose of determining Medicaid Only benefits." As a community spouse's deferred compensation plan is not specifically excluded, and the funds are accessible under the broad language of need for medical expenses, the funds must be counted as a resource in petitioner's application.

PROCEDURAL HISTORY

The Division of Medical Assistance and Health Services (DMAHS) transmitted the matter to the Office of Administrative Law (OAL) where it was filed on May 22, 2026, for determination as a contested case. N.J.S.A. 52:14B-1 to -15.

The matter was heard telephonically at the scheduled hearing date of June 24, 2026, and the record initially closed that day. After additional research created some questions, I reopened the record on July 7, 2026, for a telephone conference with the parties. Following the conference, I closed the record on July 7, 2026.

STATEMENT OF FACTS

After considering the testimony and the documentary evidence I **FIND** the following as **FACT**:

M.W. was a recipient of MLTSS under the Medicaid Only program. M.W.'s annual redetermination for MLTSS/Medicaid was due in December 2025. M.W. married M.G.[1] on December 28, 2024. M.W. resides with his spouse in the community. As a result of the marriage, the Agency was required under N.J.A.C. 10:71-4.8, to review the combined countable resources of the couple.

On March 31, 2026, the Agency terminated M.W.'s eligibility because he failed to provide requested information. When the missing bank statements were delivered that same day, March 31, 2026, the Agency reconsidered eligibility. Based on the information provided the Agency determined that the spousal resource assessment put M.W. over the resource limit. The over resource was due to M.G.'s deferred compensation plan through her employer.

Testimony

For respondent

Melissa Morgan is the Aged, Blind, and Disabled (ABD) programs Intake Unit supervisor. Due to the marriage, the Agency was required to assess the couple's resources at M.W.'s annual redetermination of his MLTSS benefits. Ms. Morgan's review of the accounts showed $50,768 in total liquid resources, that included petitioner's community spouse's deferred compensation plan with a balance of $48,588.98, cash, and various checking and saving accounts. (R-2, at 12.)

[1] M.G. was the wife's initials before her marriage. Her initials, after marriage, are the same as her husband's. To distinguish the parties, I will refer to the wife as M.G.

Ms. Morgan used the resource standards listed under N.J.A.C. 10:71-4.8(a)(1) in the Medicaid Commc'n No. 26-01 (Div. of Med. Assistance & Health Servs.), Dec. 26, 2025, to establish the community spouse's share of the couple's resources in the amount of $31,584.[2] She deducted the community spouse's share from the total resources, and still found the total countable resources over $19,184, well above the maximum allowable limit for the program.

Ms. Morgan understood that there was limited accessibility to a deferred compensation plan for medical expenses.

For petitioner

M.G. testified that she is employed by the Agency and was still working. She declared that not only was her deferred compensation plan through her employer not a liquid resource, but also, she could not access the plan's funds unless she was facing severe financial hardship. To support her statement, she provided a letter, dated May 6, 2026, from Great GASB Group, stating that withdrawals from 457(b) deferred compensation plans were restricted by the Internal Revenue Code and the Internal Revenue Service rules. If the member was employed, distribution was permissible only in case of an unforeseeable emergency.

[2] N.J.A.C. 10:71-4.8(a)(1) lists "the greater amount of $23,448 [. . .] or one half of the couple's combined countable resources." The Medicaid Commc'n No. 26-01 standards are based on the SSI eligibility standards, which are greater than N.J.A.C. 10:71-4.8(a)(1), and lists "the greater amount of $31,584 [. . .] or one half of the couple's combined countable resources."

While the letter listed situations that would allow an unforeseeable emergency distribution[3], M.G. asserted there was no unforeseeable emergency that would justify withdrawing funds or taking a distribution.

Although the letter produced by M.G. is hearsay, I considered it because its contents were consistent with IRS regulations regarding access to deferred compensation plans under 46 U.S.C. 457, and the definition of an unforeseen emergency under 26 CFR 1.457-6. Moreover, Ms. Morgan testified that she was familiar with the restrictions on access. While access is restricted, it is allowed when there is a need to pay for medical expenses.

LEGAL ANALYSIS AND CONCLUSIONS

The Medicaid program is a cooperative federal-state venture established by Title XIX of the Social Security Act. 42 U.S.C. §1396 et seq. (the Medicaid Act). It "is designed to provide medical assistance to persons whose income and resources are insufficient to meet the costs of necessary care and services." L.M. v. Div. of Medical Assistance & Health Services, 140 N.J. 480, 484 (1995) (quoting Atkins v. Rivera, 477 U.S. 154, 156, 106 S.Ct. 2456, 91 L.Ed. 2d 131 (1986). See, Mistrick v. Div. of Medical Assistance & Health Services, 154 N.J. 158, 165 (1998).

Although a state's participation in the Medicaid program is optional, those that elect to participate must comply with the requirements imposed by the Medicaid Act and the regulations adopted by the Secretary of the United States Department of Health and Human Services (HHS). Harris v. McRae, 448 U.S. 297, 301, 100 S. Ct. 2671, 65 L. Ed. 2d 784 (1980); Mistrick, 154 N.J. at 166. A participating State must devise and submit a

[3] The May 6, 2026, letter states, in part, that:

> Situations that may constitute unforeseeable emergencies include [. . .]
>
> - A hardship need arising as a result of an illness or accident of the participant, the beneficiary, such parties' spouse or dependent or the participant's designated primary beneficiary.
> - The need to pay for medical expenses, including non-refundable deductibles, as well as the cost of prescription drug medication. [. . .]
>
> [Letter from Great GASB Group to M.G., dated May 6, 2026]

state plan for approval by the secretary of HHS. 42 U.S.C. §1396a. That plan must, among other things, comply with the provisions of the Medicaid Act governing the transfer of assets and the treatment of certain trusts and include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which . . . are consistent with the objectives" of the Medicaid Act. 42 U.S.C.A. §1396a(a)(17)(A); 42 U.S.C. §1396a(a)(18).

New Jersey has elected to participate in the Medicaid program through the enactment of the New Jersey Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 to -19.1. As permitted by the Medicaid Act, New Jersey has opted to provide Medicaid coverage to "optionally categorically needy" individuals receiving long term care in a medical institution through the Medicaid Only program. Mistrick, 154 N.J. at 167. Consistent with the recognized policy that Medicaid is designed for needy individuals, the 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.

In its Medicaid Commc'n No. 26-01, DMAHS describes the latest income and resource standards of eligibility for all individuals who meet an institutional level of care either in a facility or living at home with spouses in the community.

After petitioner married M.G., the Agency was required to determine resource eligibility based on combined countable resources for a couple. "In the determination of resource eligibility for an individual requiring long-term care, the county social services agency shall establish the combined countable resources of a couple. [. . .] The total countable resources of the couple shall include all resources owned by either member of the couple individually or together." N.J.A.C. 10:71-4.8(a).

N.J.A.C. 10:71-4.1 defines "resources" as "any real or personal property which is owned by the applicant (or by those persons whose resources are deemed available to

him or her, as described in N.J.A.C. 10:71-4.6[4]) 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 regulation further mandates that "both liquid and nonliquid resources shall be considered in the determination of eligibility, unless such resources are specifically excluded under the provisions of N.J.A.C. 10:71-4.4."

There are only ten resources classified as excludable:

1. A house occupied [for more than six months per year] by the individual as his or her place of principal residence, and the land appertaining thereto [. . .];

2. In the determination of resources of an individual (and spouse, if any), an automobile shall be excluded or counted as follows:

   i. One automobile is totally excluded regardless of value if it is used for transportation for the individual or a member of the individual's household.

   . . .

3. Personal effects and household goods[5], to the extent that the total equity value of such resources does not exceed $ 2,000.

   . . .

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[4] N.J.A.C. 10:71-4.6 provides that:

(a) When an applicant/beneficiary is an adult residing in the same household with his or her ineligible spouse [. . .], the resources of the ineligible spouse [. . .] is considered in the determination of eligibility. The amount included as resources to the applicant/beneficiary, whether or not it is actually available, is termed deemed resources.

. . .

(d) Applicant/beneficiary living with ineligible spouse: if the applicant/beneficiary lives with an ineligible spouse, all countable resources of the ineligible spouse are deemed to the applicant/beneficiary. The value of the total countable resources is compared to the resource maximum for a couple.
[N.J.A.C. 10:71-4.6(a) and (d)]

[5] The value of a wedding ring and an engagement ring, and of certain prosthetic devices, dialysis machines, hospital beds, wheelchairs, and similar equipment should not be considered in the valuation of personal effects and household goods.

4. The cash surrender value of all life insurance policies owned and in the control of the individual, if the total face value of such policies does not exceed $ 1,500.

. . .

5. Nonhome property that is used in a business or nonbusiness self-support activity that is essential to the means of self-support of an individual and/or spouse, is excluded from resources.

. . .

6. The value of resources which are not accessible to an individual through no fault of his or her own.

    i. Such resources include, but are not limited to, irrevocable trust funds, property in probate, and real property which cannot be sold because of the refusal of a co-owner to liquidate.

. . .

7. In the case of a blind or otherwise disabled person, resources which have been accumulated in connection with a plan to achieve self-support.

. . .

8. The replacement value of excludable resources shall be considered as follows:

    i. For insurance proceeds, the amount received from an insurance company for the purpose of replacing or repairing an originally excludable resource, if repair or replacement of such resource occurs within nine months.

. . .

9. Burial spaces intended for the use of the individual, his or her spouse, or any other member of his or her immediate family and funds which are set aside for the burial expenses of the individual or spouse, subject to [certain] limits;

. . .

10. No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes;

. . .

[N.J. 10-71-4.4.]

As reiterated under N.J.A.C.10:71-4.2, "[a]ny resource which is not specifically excludable under the provisions of N.J.A.C. 10:71-4.4 shall be considered a countable resource for the purpose of determining Medicaid Only benefits."

To be considered in the determination of eligibility, a resource must be "available." A resource shall be considered available when:

1. The person has the right, authority or power to liquidate real or personal property or his or her share of it;

2. Resources have been deemed available to the applicant (see N.J.A.C. 10:71-4.6 regarding deeming of resources); or

3. Resources arising from a third-party claim or action are considered available from the date of receipt by the applicant/beneficiaries, his or her legal representative or other individual acting on his or her legal behalf [. . .].

[N.J.A.C. 10:71-4.1(c)]

As the deferred compensation account holder, M.G. has the burden of proving the funds are unavailable to her. See Mistrick, 154 N.J. 158, at 11 (1998) (citing Ernst & Young's Retirement Planning Guide 84 (1997); The Vanguard Guide to Planning for Retirement 184 (3d ed.1998).) M.G. provided a letter from the plan administrator, which explained that, while she is employed, the employer may permit her to take a distribution due to an unforeseeable emergency. In the list of situations that may constitute an unforeseeable emergency, the plan administrator specified "[t]he need to pay for medical expenses, including non-refundable deductibles, as well as the cost of prescription drug medication."

In Mistrick, the Court held that the Medicare Catastrophic Coverage Act of 1988 (MCCA) superseded the "no more restrictive" provision, and that the community spouse's IRA had to be included to determine the institutionalized spouse's resources. Unlike the spouse in Mistrick, petitioner resides in the community with his spouse. However, under 26 C.F.R. 1.401(k)-1(d)(3)(ii)(B), an applicant does not have to be institutionalized for the

community spouse's retirement plan to be an includable resource for Medicaid Only eligibility. The funds are accessible under the broad language of need to pay for medical expenses. The fact that the applicant may incur early withdrawal or tax penalties in liquidating the resource does not make the resource unavailable, although any such penalties would reduce the value of the resource. Thus, petitioner has not met his burden of proof that the funds are unavailable and inaccessible.

For the foregoing reasons, I **CONCLUDE** the community spouse's deferred compensation plan is considered an available countable resource. The Agency's action in denying petitioner's renewal application for MLTSS Medicaid benefits for being over the eligibility resource limit must be **AFFIRMED**.

ORDER

It is hereby **ORDERED** that the decision of the Cumberland County Board of Social Services denying MLTSS/Medicaid eligibility is **AFFIRMED**. Petitioner's appeal is **DISMISSED**.

I **FILE** this initial decision with the **ASSISTANT COMMISSIONER OF THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES**. This recommended decision is deemed adopted as the final agency decision under 42 U.S.C. § 1396a(e)(14)(A) and N.J.S.A. 52:14B-10(f). The **ASSISTANT COMMISSIONER OF THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES** cannot reject or modify this decision.

If you disagree with this decision, you have the right to seek judicial review under New Jersey Court Rule 2:2-3 by the Appellate Division, Superior Court of New Jersey, Richard J. Hughes Complex, PO Box 006, Trenton, New Jersey 08625. A request for judicial review must be made within 45 days from the date you receive this decision. If you have any questions about an appeal to the Appellate Division, you may call (609) 815-2950.

Kathleen M. Calemmo

July 22, 2026
DATE

KATHLEEN M. CALEMMO, ALJ

Date Received at Agency:

Date Mailed to Parties:

KMC/tat

APPENDIX

WITNESSES

For petitioner

M.G.

For respondent

Melissa Morgan

EXHIBITS

For petitioner

P-1 Letter, dated May 6, 2026, regarding 457 Deferred Compensation Plan

For respondent

R-1 Not applicable

R-2 Fair Hearing Packet on eligibility redetermination: reconsideration and denial letter, dated April 13, 2026; regulations; Medicaid Communication No. 26-01; redetermination summary; MLTSS Medicaid Eligibility Worksheet; Brighthouse Financial statement; Truist account balances and statements.