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DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
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STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
AND HEALTH SERVICES

W.M. PETITIONER, v. DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES AND UNION COUNTY BOARD OF SOCIAL SERVICES, RESPONDENTS.	**ADMINISTRATIVE ACTION** **FINAL AGENCY DECISION** **OAL DKT. NO. HMA 11651-16** **ON REMAND HMA 20504-15**

As the Director of the Division of Medical Assistance and Health Services, I have reviewed the record in this case, consisting of the Initial Decision, the documents in evidence and the entire contents of the OAL file. Both Petitioner

and Respondent filed Exceptions. Procedurally, the time period for the Agency Head to render a Final Agency Decision is April 20, 2017 in accordance with an Order of Extension. The Initial Decision in this case was received on January 18, 2017.

This matter arises from the Union County Board of Social Services (UCBSS) April 13, 2015 denial letter for failure to timely provide information necessary to determine eligibility and excess resources. The issue here is not merely whether Petitioner had properly verified that he had surrendered the Pacific Life Insurance policy, but rather whether that information was timely submitted to the UCBSS.

In December 2012, Petitioner was admitted to Cranford Health and Extended Care (Cranford Health). On September 10, 2013, Petitioner's wife, E.M., submitted a Long Term Care Resource Assessment Form to the Union County Board of Social Services (UCBSS). On December 27, 2013, E.M. filed the first Medicaid application on behalf of Petitioner with UCBSS. That same day, UCBSS requested verifications including pension income, life insurance policies and water and gas statements. E.M. was given until January 27, 2014 to provide the requested documents. On February 2, 2015 and March 26, 2015, UCBSS repeated its request for these verifications and additionally requested proof of spend down including nursing home and household expenses. Although E.M. claimed, and as stated by the ALJ credibly testified, that she never received these requests, she did, at some point during the process provide UCBSS with a breakdown of her expenses (R-24).

By the time of the April 13, 2015 denial letter, Petitioner had still not provided UCBSS with verification of a Lincoln National Life Insurance policy, a Prudential policy, a Pacific Life Mutual IRA or a Sun America account. These documents had been requested in all three UCBSS notices. It wasn't until after the deadline that Shifra Spira provided additional information, including pages 1-29 of the Pacific Life Variable Annuity Interim Statement which did not include a running balance for the period of time corresponding to Petitioner's Medicaid application. Three weeks later Weiss was still unable to provide UCBSS with the requested documentation and instead submitted the Pacific Life Variable Annuity Interim Statement with a handwritten running balance of the account's dollar value. It wasn't until February 1, 2016, nine months after the April 2015 denial, that Weiss finally submitted the Pacific Life Variable Annuity Quarterly Statement for the correct period of time. These submissions, provided after the denial, were either insufficient or untimely.

County Welfare Agencies (CWAs) must determine eligibility for Aged cases within 45 days and Blind and Disabled cases within 90 days. N.J.A.C. 10:71-2.3(a); MedCom No. 10-09, and Fed. Reg. 42 CFR 435.91. The time frame may be extended when "documented exceptional circumstances arise" preventing the processing of the application within the prescribed time limits. N.J.A.C. 10:71-2.3(c). The regulation does not require UCBSS to grant an extension beyond the designated time period. At best, an extension is permissible. N.J.A.C. 10:71-2.3; S.D. vs. DMAHS and Bergen County Board of Social Services, No. A-5911-10 (App. Div. February 22, 2013).

In the Remand Order, I requested the ALJ explore whether or not Petitioner's wife and representative, E.M., had health problems which may have

constituted exceptional circumstances warranting additional time to submit documentation either before or after the April 28, 2015 denial. [1]

Although, UCBSS initially noted that it had provided additional time to provide the requested documentation because E.M. was dealing with her own health concerns and although those health problems, specifically heart surgery, were confirmed by E.M, the ALJ found that E.M. credibly testified she shared that fact with no one at UCBSS. As a result of this finding, it cannot be said that Petitioner asked for, or that there were exceptional circumstances warranting, additional time to provide the requested verifications. Therefore, E.M.'s own testimony supports that no exceptional circumstances existed to warrant the submission of documentation after the April 13, 2015 denial.

Petitioner applied for Medicaid on December 27, 2013. She was asked on three occasions to provide information regarding her financial accounts and life insurance policies. Although E.M. disputes receiving two of these three requests, she does not dispute receiving the April 7, 2015 letter or the April 13, 2015 denial letter which set forth the missing information. In fact, it was after the denial that E.M., through Spira, attempted to submit additional information. UCBSS reviewed the documentation submitted after the April 13, 2015 denial letter. However, the documentation was insufficient to determine eligibility, and on April 28, 2015 the denial was upheld. It was not until February 2016, nine months after the denial and in connection with Petitioner's second Medicaid application,

[1] At all times relevant to this matter, E.M. was Petitioner's representative. Petitioner provided an incomplete Designated Authorized Representative Form (DAR) dated January 2015, naming Sharon Phillips-South of Cranford Rehab and Rehabilitation Extended Care (Cranford Rehab), and then provided a completed DAR dated October 2015 naming Shifra Spira of Cranford Rehab.

that Petitioner finally provided the documentation necessary to determine eligibility.[2]

I FIND that the credible evidence in the record demonstrates that Petitioner failed to provide the needed information prior to the April 13, 2015 denial of benefits or the April 28, 2015 letter affirming the denial of benefits. Without this information, the County was unable to complete its eligibility determination and the denial was appropriate.

Based on my review of the record and for the reasons set forth above, I hereby REVERSE the Initial Decision and reinstate UCBSS' denial.

THEREFORE, it is on this 18th day of APRIL 2017,

ORDERED:

That the Initial Decision is hereby REVERSED.

Meghan Davey, Director
Division of Medical Assistance
and Health Services

[2] The letter from Pacific Life Insurance was not drafted until January 25, 2016, more than a month after Petitioner requested a fair hearing on the denial and four months after he submitted his second application for Medicaid benefits dated September 2015.