State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION
OAL DKT. NO. HMA 01259-25
AGENCY DKT. NO. 0710390009

E.W.,

Petitioner,

v.

ESSEX COUNTY DIVISION OF FAMILY ASSISTANCE AND BENEFITS,

Respondent.

Eliyahu Pekier, Esq, for petitioner (Law Office of Simon P. Wercberger, attorneys)

Denise Collison, Family Services Worker, for respondent under N.J.A.C. 1:1-5.4(a)(3)

Record Closed: May 15, 2025 Decided: May 20, 2025

BEFORE **NANCI G. STOKES,** ALJ:

STATEMENT OF THE CASE

The Essex County Division of Family Assistance and Benefits (Essex) denied the petitioner's August 2024 application for Medicaid's Managed Long-Term Services and Supports (MLTSS) program because the petitioner failed to timely provide all requested verifications, despite Essex's consideration of late materials supplied in October and a

third request for verifications. Is the denial supported? Yes. An applicant must supply timely verifications to establish their Medicaid eligibility. N.J.A.C. 10:72-2.3(a).

PROCEDURAL HISTORY

On October 23, 2024, Essex denied the petitioner's Medicaid application determining that she failed to supply necessary eligibility verifications.

On November 19, 2024, petitioner's designated authorized representative (DAR), Moishe Hirsch, of Future Care Consultants, appealed the denial.

The Division of Medical Assistance and Health Services (DMAHS) transmitted the case to the Office of Administrative Law (OAL), where it was filed on January 16, 2025, as a contested case under the Administrative Procedure Act, N.J.S.A. 52:14B-1 to-15, and the act establishing the OAL, N.J.S.A. 52:14F-1 to-13, for a hearing under the Uniform Administrative Procedure Rules, N.J.A.C. 1:1-1.1 to -21.6.

DMAHS's transmittal notes that this case is subject to its October 23, 2023, Order, which deems this Initial Decision a Final Decision.

Mr. Hirsch requested an adjournment of the hearing scheduled for May 1, 2025, which I granted. Counsel for the petitioner entered an appearance on May 14, 2025, and provided a pre-hearing submission.[1]

I conducted the hearing on May 15, 2025, and closed the record.

[1] Petitioner's submission includes 298 pages representing twenty-four documents or exhibits. This decision will refer to each item by exhibit number, one through twenty-four, rather than by multiple pages for clarity and efficiency. For example, P-1 is the Medicaid application at pages 3 through 21. I take judicial notice of the published regulations in P-22, P-17, and P-18 but do not accept annotations as "evidence."

FINDINGS OF FACT

Based on the testimony the parties provided, and my assessment of its credibility, together with the documents that the parties submitted, and my assessment of their sufficiency, I **FIND** the following as **FACT**:

On August 27, 2024, Mr. Hirsh applied on behalf of E.W., a nursing home resident, for Medicaid MLTSS. He did not attach the required DAR form. He identified E.W.'s income as Social Security but failed to provide the amount. Under the section requiring an applicant to identify accounts that may contain resources, the application stated "verifying" but listed no accounts. P-1. E.W. responded "no" to the question of her disability or blindness.

Essex must verify all sources of income and resources under the Medicaid program to assess financial eligibility. To this end, Essex used electronic databases to obtain certain information, such as Social Security income E.W. received monthly.

On September 4, 2024, Essex sent a Request for Information (RFI) seeking a signed DAR form, a nursing home resident statement showing Medicare's contribution, and five years of bank statements from the account where E.W. deposited her Social Security benefits. P-3. The letter advised E.W. that she had until September 20, 2024, to provide the requested materials.

On September 18, 2024, Mr. Hirsch requested an extension to provide bank account statements as he had difficulty obtaining them. He supplied the other items requested. P-3. Notably, the DAR requires the applicant to initial that "I understand that signing this document does not relieve me of my responsibility to participate in the New Jersey family care eligibility process, including providing information and documents." Id.; R-1.

On September 20, 2024, Essex issued a second RFI, seeking the same missing statements, allowing the petitioner an extension until October 4, 2024, to submit the statements.

On October 6, 2024, Mr. Hirsch supplied the bank statements.

On October 8, 2024, Essex sent a third RFI after reviewing the bank statements. P-6, R-1. Specifically, Essex advised that E.W. must verify the following items from her account ending in 9003:

1. Purpose of withdrawal of $2,500 on May 2, 2020, July 2, 2021, May 3, 2022 and July 1, 2022.
2. Purpose of withdrawal of $2,200 on June 3, 2021.
3. Purpose of the withdrawal of $2,400 on January 3, 2023.
4. Purpose of the withdrawal of $3,019 on October 13, 2022.

Denise Collison, Family Services Worker, processed the August 2024 application for Essex. She noted that the $3,019 withdrawal was for two withdrawals, one of $1,500 and the other of $1,519. The RFI advised E.W. to provide the information by October 22, 2024, or Essex would deny the application. Essex addressed the letter to Mr. Hirsh, but the request asked E.W. to explain the purpose of her withdrawals. The RFI also advised E.W. that if "you cannot obtain the information" or "need help. . . contact the County Welfare Agency." Essex asserts it can reconsider a verification denial once, and then it must deny the case if materials remain missing.

On October 21, 2024, Mr. Hirsch sent a letter stating that "[E.W.] used to withdraw $1,500 - $2,000 every month for rent, household items, food, medicine, transportation, etc. and the months that she was to a little more was since she needed

more spending money for that month." P-7, R-1. Mr. Hirsch testified that the information he wrote came from E.W. In other words, E.W. could have signed a letter with that explanation. Mr. Hirsch requested that Essex advise him if Essex needed anything else.

Ms. Collison highlights that the withdrawals were not monthly and that Essex expected E.W. to provide such verifications or explanations, not Mr. Hirsch, as the DAR form requires. Further, nearly all withdrawals exceeded the range stated in the letter. Mr. Hirsch supplied no documentation, like monthly rent receipts, to support his statements. Because the October 21, 2024, response was insufficient, she denied the case on October 23, 2024, stating that "the applicant failed to provide the requested information required to determine eligibility in a timely manner. 42 C.F.R. 435.952." Essex faxed the denial to Mr. Hirsch that day. R-1. He did not ask Essex why his letter was deficient before filing; he only sent an email asking Essex to confirm it had "everything" for the second application after he received the denial. P-9.

Mr. Hirsch works for Future Care Consultants, a commercial entity that assists individuals, such as E.W., obtain Medicaid benefits. Ms. Collison has worked with Mr. Hirsch on many Medicaid applications.

The August 2024 application was the second one filed on behalf of E.W. Mr. Hirsch filed a third one on behalf of E.W. on October 30, 2024. Essex similarly found the third application deficient when it received no further response to the identical requests concerning the withdrawals. Yet, E.W. filed no appeal or fair hearing request concerning that denial. Thus, other than establishing a procedural history, this decision makes no substantive findings concerning processing that application or propriety of Essex's denial on December 12, 2024. Indeed, the case transmittal clarifies that jurisdiction in this proceeding relates only to the denial of Medicaid on October 23, 2024. Thus, I **FIND** most documents concerning the third application are irrelevant to this case and cannot be considered a complete record.

Mr. Hirsch filed a fourth application on behalf of E.W. on December 30, 2024. Similarly, I **FIND** the documents concerning the fourth application have only certain relevance to this decision. Essex promptly approved the application upon receiving a letter from E.W. on January 15, 2025, not Mr. Hirsch, that stated: "I, [E.W.], used to withdraw $1,500-$2,500 every few months to be used for food, clothing, transportation, household expenses, medications etc. and some months I withdrew some more money for spending money that was needed." P-15. The Medicaid application approval provided an effective date of December 1, 2024, the month of the application, and allowed three months of retroactive coverage from September 2024 through November 2024. Thus, the petitioner's appeal of the denial of the August 29, 2024, application seeks to overturn Essex's determination to obtain additional retroactive benefits from May 2024, or three months before that application.

Mr. Hirsch maintains that he first learned that E.W., rather than he, needed to supply the verifications through conversations with Essex in April 2025 after he filed the fair hearing request in this case. Thus, Mr. Hirsch asserts that Essex did not adequately assist him in providing the necessary verifications for Medicaid eligibility with the August 2024 application, as CWAs must. However, I do **NOT FIND** this testimony credible, especially given Mr. Hirsch's familiarity with the Medicaid application process and program regulations through his employment and his actions as a DAR in many cases. Initially, the DAR form clearly states that the applicant must supply verifications and participate in the eligibility process. Importantly, no evidence suggests that E.W. was incapacitated or unable to supply the information or verification sought by Essex because Mr. Hirsch had *E.W.* do so in January 2025, *not in April* when he states he first learned of that requirement. Further, E.W.'s letter appropriately corrected the discrepancies noted in Mr. Hirsh's letter regarding the purpose of the higher amounts withdrawn and the frequency of those withdrawals. Cf. P-7 and P-15. In sum, I do **NOT FIND** a preponderance of the evidence exists that the petitioner timely supplied the necessary eligibility verifications reasonably requested by Essex regarding the August 2024 MLTSS Medicaid application.

LEGAL DISCUSSION AND CONCLUSIONS OF LAW

Congress created the Medicaid program under Title XIX of the Social Security Act. 42 U.S.C. §§1396 to 1396w. The federal government funds the programs that the states administer. Once the state joins the program, it must comply with the Medicaid statute and federal regulations. Harris v. McRae, 448 U.S. 297, 300 (1980). New Jersey participates in Medicaid through the New Jersey Medical Assistance and Health Services Act (Act). N.J.S.A. 30:4D-1 to -19.5.

The Commissioner of the Department of Human Services (DHS) promulgated regulations implementing New Jersey's Medicaid programs to explain each program's scope and procedures, including income and resource eligibility standards. See, e.g., N.J.A.C. 10:71-1.1 to -9.5 (Medicaid Only); N.J.A.C. 10:72-1.1 to -9.8 (Special Medicaid Programs); E.S. v. Div. of Med. Assistance and Health Servs., 412 N.J. Super. 340, 347 (App. Div. 2010).

The Act established DMAHS within the DHS to perform the administrative functions concerning Medicaid program participation. Bergen Pines County Hosp. v. New Jersey Dep't of Human Serv., 96 N.J. 456, 465 (1984); see also N.J.S.A. 30:4D-4, -5.

County welfare agencies (CWA), such as Essex, assist [DMAHS] in processing applications for Medicaid and determining whether applicants have met the income and resource eligibility standards." Cleary v. Waldman, 959 F. Supp. 222, 229 (D.N.J.1997), aff'd, 167 F.3d 801 (3d Cir.), cert. denied, 528 U.S. 870 (1999). Significantly, an applicant bears the burden of establishing eligibility for Medicaid benefits. D.M. v. Monmouth Cnty. Bd. of Soc. Servs., HMA 6394-06, Initial Decision (April 24, 2007), adopted, Dir. (June 11, 2007), http://njlaw.rutgers.edu/collections/oal/.

Essex must verify all eligibility factors. See Medication Communication No. 22-04; N.J.A.C. 10:71-1.6. Notably, N.J.A.C. 10:71-4.1(d)(3) requires a CWA to verify the value of resources through "appropriate and credible sources."

Notably, an applicant is the primary source of information and must cooperate with the CWA in securing evidence to corroborate their statements. N.J.A.C. 10:71-1.6(2). Further, a CWA must seek verification of questionable information provided by an applicant, N.J.A.C. 10:71-2.2 and -2.3, and permit the applicant to comply. Indeed, the CWA and applicants have responsibilities during the application or redetermination process. Id.

The Medicaid regulations also explain that the valuation of resources held in accounts is "its equity value." N.J.A.C. 10:71-4.1(d). The CWA considers liquid and non-liquid resources in determining eligibility unless N.J.A.C. 10:71-4.4(b) permits an exclusion. A "resource" is any real or personal property owned by the applicant or those whose resources are deemed available and convertible to cash for support and maintenance, i.e., a checking or savings account. N.J.A.C. 10:71-4.1(b)(2). A CWA can verify resources or other eligibility information from collateral investigation to clarify or supplement essential information. N.J.A.C. 10:71-2.10.

For applicants seeking institutional-level care, Medicaid law presumes that any transfer of resources for less than the fair market value during the sixty-month look-back period was to establish Medicaid eligibility. N.J.A.C. 10:71-4.10(a). Notably, the look-back period commences with an institutionalized person's first application for Medicaid benefits. N.J.A.C. 10:71-4.10(b)(9)(ii) If such a transfer occurs, the applicant will be subject to a period of Medicaid ineligibility, irrespective of their other resources. N.J.A.C. 10:71-4.10(a); see Estate of DiMartino v. Div. of Med. Assistance & Health Servs., 373 N.J. Super 210, 219 (App. Div. 2004) (asset disposition penalties are imposed to maximize Medicaid funding for those truly in need).

N.J.A.C. 10:71-4.10(j) allows any applicant or beneficiary to rebut the presumption that they transferred assets to establish Medicaid eligibility by presenting convincing evidence that the applicant or beneficiary transferred the assets exclusively for some other purpose. Though the county welfare agency shall assist the applicant in obtaining information when necessary, the burden of proof rests with the applicant. Ibid. Even If the applicant had some other purpose for transferring the asset, but establishing

Medicaid eligibility appears to have been a factor in the decision to transfer, the applicant did not successfully rebut the presumption. N.J.A.C. 10:71-4.10(l)(2).

When the applicant seeks to rebut the presumption that they transferred assets to establish Medicaid eligibility, the agency must follow certain procedures:

> 1. The *applicant's statement* concerning the circumstances of the transfer shall be included in the case record. The statement shall include, but need not be limited to, the following:
>
> i. The *applicant's stated purpose* for transferring the asset;
>
> ii. The *applicant's* attempt to dispose of the asset at fair market value;
>
> iii. The *applicant's* reasons for accepting less than the fair market value for the asset;
>
> iv. The *applicant's* means of and plans for, supporting himself or herself after the transfer; and
>
> v. The *applicant's* relationship, if any, to the person(s) to whom the asset was transferred.
>
> 2. The *applicant* shall be asked to submit any pertinent evidence (for example, legal documents, realtor agreements, and relevant correspondence) with regard to the transfer.
>
> [N.J.A.C. 10:71-4.10(j) (emphasis added).]

Here, the applicant ultimately provided an adequate explanation, but not with her August 2024 application.

DMAHS issues Medicaid Communications to guide county welfare agencies processing Medicaid cases. Medicaid Communication No. 22-04, updating Medicaid Communication No. 10-09, addresses case processing timeframes. P-24. Medicaid Communication No. 22-04 reiterates that the case processing time limit is forty-five days, or ninety days for disabled individuals, beginning the day the CWA receives the application. N.J.A.C. 71-2.3(a), (b).

Under Medicaid Communication No. 22-04 and 42 CFR 435.952 (c)(2), if verification results in discrepancy, insufficient information, or an error, the CWA will send a Request for Information (RFI) letter. The RFI letter will allow the applicant fourteen days to respond. Ibid. Undeniably, the application lacked significant information that Mr. Hirsch was "verifying." Thus, Essex sent an RFI seeking that information.

If the CWA receives no response, it will deny the application for failure to provide information under 42 CFR 435.952 (c)(2). Here, Mr. Hirsch supplied some items and asked for an extension, which Essex gave him, allowing extra time to supply bank statements through a second RFI identifying the missing documents. See N.J.A.C. 10:71-2.3(c) (permitting an extension of time to issue an eligibility determination when the applicant did not produce information due to exceptional "[c]ircumstances wholly beyond the control of both the applicant and the [CWA]"). Yet, at best, an extension is permissible, not required. Ibid.; S.D. v. Division of Med. Assistance & Health Servs. and Bergen County Bd. of Social Services, 2013 N.J. Super. Unpub. LEXIS 393 (February 22, 2013).

Under Medicaid Communication No. 22-04, the CWA may send an additional RFI letter if the applicant's response to the first RFI prompts the need for further outreach, as Essex did here. Here, I **CONCLUDE** that Essex, as a courtesy, reviewed the late statements it received but needed information regarding the purpose of E.W.'s withdrawals from E.W., but did not receive such an explanation from the applicant on time. In essence, the petitioner suggests Essex should have sent another RFI if it found Mr. Hirsch's letter insufficient. Still, after receiving the denial, Mr. Hirsch did not ask Essex why his letter was deficient; he filed another application. Thus, I **CONCLUDE** that Essex did have an obligation to forward another RFI. The case was beyond the forty-five-day processing time limit, and Essex afforded the petitioner a reasonable opportunity to supply timely verifications for an admittedly incomplete application.

The petitioner relies upon several cases to support her position in this case, but they present different factual circumstances. Indeed, each Medicaid application is specific to the individual applying for benefits.

In M.L. v. Essex Cnty. Div. of Fam. Assistance & Bens., 2025 N.J. Super. Unpub. LEXIS 407, the Appellate Division reversed DMAHS's Final Decision that found the petitioner ineligible for Medicaid given the failure to present timely verifications. P-19. In M.L., the caseworker requested bank statements, which the petitioner provided. After reviewing the account documents, the case worker unfairly denied the application for missing information, such as explanations for withdrawals, without asking for that information in an RFI or otherwise. Unlike that case, Ms. Collison reviewed bank statements and advised the petitioner of the discrepancies that needed an appropriate explanation.

In J.P. v Atlantic Cnty. Dept. of Family and Community Dev., 2024 N.J. AGEN LEXIS 779, DMAHS upheld an ALJ's decision that vacated the CWA's denial and reinstated an application because the CWA provided insufficient information to the petitioner about deficiencies and failed to review significant information it had received. P-20. Yet, the ALJ and DMAHS highlighted unusual circumstances that supported vacating the denial, including the petitioner's timely provision of documents to another state agency that the CWA received after the denial. No such circumstances exist here, and I found Mr. Hirsch's claimed ignorance concerning his letter's deficiencies was not credible.

Similarly, the third decision provided by the petitioner is factually different. In L.G. v. Cumberland Cnty. Bd. of Soc. Svcs., OAL Dkt. No. HMA 17059-24, Initial Decision (January 28, 2025), the ALJ excluded funds from a joint account because the funds belonged to another individual, not the applicant. P-21. Indeed, the petitioner, suffering from Stage IV ovarian cancer, had income only from Retirement, Survivors, and

Disability Insurance (RSDI) of $730.70 monthly deposited in one account held jointly with her mother. She also had another account with her mother to manage her ailing mother's pension and Social Security funds for her mother's care, costing more than her monthly assisted living accommodations, which she explained to the CWA. The CWA acknowledged that if the applicant removed her name from the account used for her mother's care, she would be eligible for Medicaid but never advised the petitioner that she could do so. While the ALJ felt the CWA failed to adequately communicate with the applicant in this "unique" case, the crux of the decision was that the joint account's funding was her mother's and used solely for her mother's care, which the CWA did not consider. Notably, the case involved a private citizen, not an applicant who has assistance from an entity that guides individuals through the Medicaid application process, like here.

Lastly, in K.O. v. Div. of Med. Assistance & Health Servs., 2023 N.J. Super. Unpub. LEXIS 1587, the Appellate Division reversed DMAHS's determination upholding the CWA's denial based on the applicant's failure to supply timely verifications. Instead, the Appellate Division remanded the case back to allow K.O. an opportunity to complete the Medicaid application process. Initially, the Appellate Division noted that DMAHS's decision contained factual inaccuracies about what the CWA requested, and the responses provided by the applicant's attorney. As the ALJ's initial decision highlighted, the applicant responded to each RFI with significant documentation that the CWA, in part, seemingly overlooked. Further, the CWA did not respond to numerous requests from counsel about what deficiencies still existed before issuing its denial. The Appellate Division also noted that the CWA could, but did not, "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." Essex did not overlook the information received. Instead, it reviewed the late bank records and sought only four explanations from the applicant about the purpose of certain withdrawals she made. Mr. Hirsch did not ask Ms. Collison why his letter was insufficient or deficient. Essex did not fail to explore collateral sources; the applicant was the source. The factual circumstances differ here as with the other cases cited by the petitioner. In other words,

I **CONCLUDE** that the cases cited do not support the relief the petitioner seeks in this case because the factual circumstances differ.

Therefore, I **CONCLUDE** that E.W.'s failure to provide timely verifications for her August 2024 Medicaid application made her ineligible and that E.W.'s appeal should be **DISMISSED.**

ORDER

Given my findings of fact and conclusions of law, I **ORDER** that E.W. is ineligible for Medicaid through her August 2024 Medicaid application because she failed to supply necessary verifications and that her appeal is hereby **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.

May 20, 2025

DATE

NANCI G. STOKES, ALJ

Date Record Closed:

Date Filed with Agency:

Date Sent to Parties:

APPENDIX

WITNESSES

For Petitioner:

Moishe Hirsch, Future Care Consultants

For Respondents:

Denise Collison, FSW

EXHIBITS

For Petitioner:

P-1 Medicaid Application
P-2 8/27/2024 Email with Application
P-3 9/18/2024 Response to First RFI
P-4 9/20/2024 Second RFI
P-5 10/06/2024 Response to Second RFI
P-6 10/08/2024 Third RFI
P-7 10/21/2024 Response to Third RFI
P-8 Denial Letter
P-9 Emails with the County
P-10 Subsequent Medicaid Application
P-11 10/30/2024 Email with subsequent Medicaid Application
P-12 11/04/2024 RFI
P-13 Emails with the County regarding subsequent application
P-14 Denial Letter – Subsequent Application
P-15 Letter from Petitioner
P-16 Additional emails regarding subsequent application
P-17 N.J.A.C. 10:71-2.2
P-18 N.J.A.C. 10:71-2.10
P-19 M.L. v. Essex, Docket No. A-0884-23, Appellate Decision
P-20 J.P. v. Atlantic, Docket No. HMA 02735-2024, Final Agency Decision

P-21 L.G. v. Cumberland, Docket No. HMA 17059-2024, Initial Decision

P-22 CFR 435.907

P-23 K.O. v. DMAHS, Docket No. A-3010-21, Appellate Decision

P-24 Medicaid Communication 22-04 P-7 April 15, 2024, letter

For Respondent:

R-1 Fair Hearing packet