State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
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Acting Commissioner

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Director

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

E.C.,

PETITIONER,

v.

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES AND OCEAN COUNTY BOARD OF SOCIAL SERVICES,

RESPONDENTS.

ADMINISTRATIVE ACTION

FINAL AGENCY DECISION

OAL DKT. NO. HMA 00149-13

As Director of the Division of Medical Assistance and Health Services, I have reviewed the record in this matter, consisting of the Initial Decision, the documents in evidence and the OAL case file. No Exceptions to the Initial Decision were filed. Procedurally, the time period for the Agency Head to file a Final Agency Decision is July 25, 2016, in accordance with N.J.S.A. 52:14B-10, which requires an Agency Head to adopt, reject or modify the Initial Decision within 45 days of the agency's receipt. The Initial Decision was received on June 1, 2016.

Based upon my review of the record, I hereby ADOPT the Initial Decision in its entirety and incorporate the same herein by reference. In a thorough and well-reasoned decision, the ALJ concluded that the Ocean County Board of Social Services properly established eligibility as of December 1, 2012. I find no reason to disturb his decision.

At the time of the application on May 21, 2012, Petitioner's spouse signed the Statement of Understanding form which specifically provides that the applicant's resources must be below $4000 as of the first moment of the first day of the month. Petitioner's spouse claims she provided all of the requested information by June 16, 2012 and that the caseworker advised that "everything looked good". However, according to Ocean County, only some of the needed information was provided in June, and on September 13, 2012, the caseworker requested additional information. Petitioner's spouse provided this additional verification on September 27, 2012 and October 3, 2012. Additional questions about the couple's resources arose as a result of this information and the caseworker requested more documentation in order to complete the eligibility determination. Only once all of the requested information was received was the County able to complete the resource assessment and advise Petitioner of the community spouse resource allowance.[1] Under the Medically Needy program, resource eligibility exists when the couple's combined resources less the

[1] The amount of resources that the couple is permitted to retain and still qualify for benefits is based on a "snapshot" of the couple's total combined resources as of the beginning of the continuous period of institutionalization. 42 U.S.C.A. § 1396r-5(c)(1)(A); N.J.A.C. 10:71-4.8(a)(1). The community spouse is permitted to keep the lesser of: one-half of the couple's total resources or the maximum amount set forth in N.J.A.C. 10:71-4.8(a)(1). This is called the Community Spouse Resource Allowance (CSRA). Resources above that amount must be spent down before the institutionalized spouse may financially qualify for Medicaid benefits. 42 U.S.C.A. § 1396(a)(10(17).

community spouse's share of the resources, are less than $4000. N.J.A.C. 10:70-5.1(a). In this case, Petitioner's spouse spent down the resources by November 27, 2012 and eligibility was established as of December 1, 2012. See Initial Decision at pages 3 and 4.

As noted by the ALJ, the caseworker clearly advised Petitioner's spouse of the eligibility requirements in order to qualify for benefits. Yet, all of the needed financial verification was not provided until November, 2012. As a result, Ocean County was unable to calculate the community spouse resource allowance and notify Petitioner of the spend down amount until it received all the documentation necessary to calculate the couple's countable resources. The couple's resources were spent down as of November 27, 2012 and Petitioner was appropriately determined eligible for benefits as of December 1, 2012.

Even assuming that the County caseworker incorrectly told Petitioner's spouse that the Medicaid application was "looking good" and failed to timely notify her that the application remained in pending status, an earlier eligibility date is not the remedy where, as in this case, the Petitioner had excess resources. Indeed, the State cannot grant eligibility where none exists. The Initial Decision's analysis of whether benefits can be granted under equitable estoppel correctly points out that the courts have found that the receipt of delayed or misinformation cannot create eligibility where none exists.

In Gressley v. Califano (7th Cir.1979), 609 F.2d 1265, an applicant was denied disability benefits because of misinformation regarding the eligibility requirements. The federal district court applied the doctrine of estoppel and granted summary judgment in favor of the applicant. In reversing, the Seventh

Circuit held that agencies and courts have no discretion but to limit the payment of benefits to those statutorily entitled to them. Id. at 1268. The court elaborated on the general rule, stating:

> The government could scarcely function if it were bound by its employees' unauthorized representations. Where a party claims entitlement to benefits under federal statutes and lawfully promulgated regulations, that party must satisfy the requirements imposed by Congress. Even detrimental reliance on misinformation obtained from a seemingly authorized government agent will not excuse a failure to qualify for the benefits under the relevant statutes and regulations.
> Id. at 1267.

The United States Supreme Court has addressed this issue in the context of federal disability benefits. In that case the Court held that, under the Appropriations Clause of the Constitution, the payments of benefits from the federal treasury are limited to those authorized by statute. Erroneous advice from a governmental employee regarding those benefits cannot estop the government from denying benefits not permitted by law. Office of Personnel Management v. Richmond, 496 U.S. 414, 110 S. Ct. 2465, 110 L.Ed. 2d 387 (1990). Article VIII, Section II of the New Jersey Constitution also has a similar appropriations language. As the Medicaid Program is a cooperative federal-state program, jointly financed with federal and state funds, payment of Medicaid benefits from the state and federal treasuries must be authorized by law. Petitioner does not claim that he is entitled to benefits under Federal and State law. In essence, he is seeking to have the eligibility standard disregarded due to mistaken or delayed advice. However, absent compliance with the standards set forth in the federal and state Medicaid law, eligibility cannot exist. Since Petitioner's resources exceeded the maximum limit until November 2012, he is

ineligible for benefits prior to December 1, 2012. There is simply no provision in the regulations which permit a relaxation of the eligibility date so long as the countable resources exceed the maximum limit.

THEREFORE, it is on this 18th day of July 2016,

ORDERED:

That the Initial Decision affirming the Ocean County Board of Social Services' decision to grant eligibility as of December 1, 2012 is hereby ADOPTED.

Meghan Davey, Director
Division of Medical Assistance
and Health Services