RECORD IMPOUNDED

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-0024-21

P.R. and U.R.,

Petitioners-Appellants,

v.

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES,

Respondent-Respondent,

and

OCEAN COUNTY BOARD OF SOCIAL SERVICES,

Respondent.

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Argued March 29, 2023 – Decided June 8, 2023

Before Judges Mayer, Enright and Bishop-Thompson.

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

Joshua M. Spielberg argued the cause for appellants

(South Jersey Legal Services, Inc., attorneys; Joshua M. Spielberg and Kenneth M. Goldman, on the briefs).

Elizabeth Tingley, Deputy Attorney General, argued the cause for respondent (Matthew J. Platkin, Attorney General, attorney; Melissa H. Raksa, Assistant Attorney General, of counsel; Jacqueline R. D'Alessandro, Deputy Attorney General, on the brief).

PER CURIAM

Petitioners P.R. (Peter) and U.R. (Uma) challenge a July 29, 2021 final agency decision by respondent Division of Medical Assistance and Health Services (Division) ordering them to reimburse their county welfare agency (CWA), respondent Ocean County Board of Social Services (Board), the sum of $5,335.20. We affirm, in part, and remand, in part, for modification of the final agency's order of reimbursement.

I.

Peter and Uma are married with two children, V.R. (Vera), born March 2009, and J.R. (James), born August 2016. Peter is self-employed and the sole owner of an S corporation in a construction business; Uma does not work outside the home.

In January 2016, while Uma was pregnant with James, she applied for Medicaid benefits for herself and her husband through the New Jersey

FamilyCare (NJFC) program.[1] Vera already had NJFC benefits by this point. In response, the Board sent petitioners a letter requesting additional documentation, including a copy of their most recent personal and business tax returns, and copies of paystubs or a letter from an employer confirming the gross pay of any employed members of petitioners' household.

Approximately one week after Uma received the Board's request for additional documentation, she personally delivered a copy of petitioners' 2014 tax return, their most recent return, to the Board. Uma also claims she submitted copies of Peter's most recent pay stubs with the 2014 tax return.[2]

When Uma applied for Medicaid benefits in January 2016, the income limit for a family of four was $2,795 per month; the income limit for pregnant women in a family of four was $4,030 per month.[3] According to petitioners'

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[1] NJFC "is a state program created to provide subsidized health insurance coverage to low-income children, their parents, and other adults whose family incomes are too high for them to be eligible for traditional Medicaid. The program is jointly funded by the state and federal government." Guaman v. Velez, 421 N.J. Super. 239, 266 (App. Div. 2011).

[2] The Assistant Commissioner and Administrative Law Judge (ALJ) found Uma failed to produce the requested paystubs, notwithstanding her testimony at the initial hearing to the contrary. Whether or not Uma produced the requested paystubs with her January 2016 application did not impact our decision.

[3] Because Uma was pregnant, petitioners were considered a family of four.

2014 tax return, their adjusted gross income was $2,790.08 monthly. Thus, in January 2016, the Board notified petitioners they were eligible for Medicaid benefits effective January 1, 2016. The notice also stated "[a]ny change in household income or living arrangements should be reported to [the Board] without delay."

Petitioners filed their 2015 tax return in March 2016. According to Uma, she provided a copy of the 2015 return to the Board that month.[4] The 2015 return reflected petitioners' adjusted gross monthly income of $4,073, rendering them ineligible for Medicaid benefits in 2016.

In August 2016, Uma returned to the Board's office to inform the agency she gave birth to James. Later that month, the Board confirmed James was eligible for Medicaid benefits.

In November 2016, the Board notified petitioners of their upcoming deadline to apply for renewal of their Medicaid benefits. Uma promptly submitted petitioners' renewal application with a copy of their 2015 tax return.

On January 31, 2017, the Board notified petitioners that their 2015 income

[4] The Board's electronic reception log reflects Uma's March 2016 visit, but the agency's file only showed Uma brought "documents" to the office. The same log showed Uma visited the Board's office again in April 2016 to address "[i]ncome questions."

rendered them ineligible for Medicaid benefits, effective February 28, 2017. The letter also stated Vera and James would be "referred to the State for NJFC coverage" and there would be no lapse in the children's existing coverage.

Between January and May 2019, the Board issued a series of letters to petitioners, advising them they needed to reimburse the agency for excess Medicaid benefits they received when they were financially ineligible. The Board calculated Peter received improperly paid benefits in the sum of $3,978.06 between March 2016 to February 2017, and Uma received improperly paid benefits between November 2016[5] and February 2017 totaling $1,357.04. Thus, the Board sought reimbursement from petitioners in the sum of $5,335.20.

In February 2019, petitioners went to the Board's office to challenge the reimbursement request. Because the issue was not resolved, petitioners promptly asked for a fair hearing to contest the amounts sought by the Board. Their request went unanswered. Four months later, petitioners again asked for a fair hearing but received no response.

[5] A pregnant woman's coverage continues until the last day of the month, sixty days after the month in which the baby is born. N.J.A.C. 10:72-3.4(a)(1)(i). Therefore, because James was born in August 2016, Uma's pregnant woman coverage lasted until October 31, 2016.

In January 2020, petitioners received a letter from a debt collection agency regarding the Board's claim for reimbursement. Petitioners answered the letter, advising they "dispute[d] the validity of the debts." They also stated they "were never given an opportunity to present [their] case" to challenge the amount sought by the Board. Four months later, petitioners were notified by New Jersey's Set-Off Program that the Division intended to intercept their state income tax refund of $1,819; the intercept occurred thereafter.

In June 2020, after reviewing petitioners' updated income information, NJFC notified petitioners they were again eligible for benefits as of July 1. Petitioners opted not to seek Medicaid benefits, wishing to avoid "more problems" with the Board. They also retained counsel and were able to secure a fair hearing date in December 2020. Due to delays resulting from the COVID-19 pandemic and petitioners' request for a virtual hearing, the matter was rescheduled to a date in April 2021.

A month before the hearing, the Board prepared a case summary stating it could "lower the amount of the overpayment sought [from] each [petitioner] by $1,018.76 for a total reduction of $2,037.52." The case summary contained the following explanation for the discounted amount the Board sought:

> The difference represents the time period of [December 2016 to February 2017]. We have recently been

> granted permission to forgive claims for overpayment time periods caused by agency error. As . . . [petitioners' renewal] application was received on [November 9, 2016] but the termination was not processed until [February 28, 2017], the subsequent months of overpayment ([from December 2016 to February 2017]) may be removed from the debt because they were caused by agency error. The revised total debt [due] for both [petitioners] will be $3,297.68. The previous total debt amount was $5,335.20.

The initial hearing was conducted remotely on April 28 and 30, 2021. Jacqueline Lesko, a Human Services Specialist, testified on behalf of the Board, and at the commencement of the hearing, she stated the Board originally sought reimbursement in the sum of $5,335.20 from petitioners, but was "able to revise the debt and the total amount [due] now is $3,297.68." Lesko explained, "we found that the case should have been closed earlier and therefore, . . . we're not charging [petitioners] for December 2016 to February of 2017." She further clarified the agency's "error was that [it] did not act quickly enough to terminat[e]" petitioners' benefits after they verified "their income was in excess of the allowable amount."

In response to this testimony, the ALJ asked Lesko, "So, the County is only looking for the lower amount right now?" Lesko replied, "Yes, Your Honor." Lesko reiterated on cross-examination that the Board "eliminated" the months of December 2016 to February 2017 from its reimbursement request,

and only sought the reduced amount of $3,297.68 from petitioners.

Additionally, Lesko testified that the Board's reception log reflected Uma brought documents to its office on March 23, 2016. Lesko admitted she could not determine if petitioners' 2015 tax return was delivered that day, but she had "looked for evidence of that." She also conceded she was unsure if Uma dropped off petitioners' 2015 tax return in April or August 2016 when Uma visited the Board's office. Lesko did not dispute, however, that by November 2016, petitioners submitted their renewal application for benefits and the application included a copy of petitioners' 2015 tax return. Further, she testified the Board notified petitioners on January 31, 2017 of their ineligibility for benefits, effective February 28, 2017, because "their income was in excess of the allowable amount."

During Lesko's cross-examination, petitioners' counsel attempted to ask Lesko "about the overpayment" sought by the Board "and the [twenty-five] percent share of the overpayment that [would be] allocated to" the Board upon recovery of the debt petitioners purportedly owed. The ALJ interjected and stated "this [was] an area" about which Lesko had not testified. And because Lesko stated she was not "involved with the decisions made about collections and [the] sharing of collected overpayments with the State or Federal

government," the ALJ concluded Lesko did not need to answer any further questions on this topic.

At the conclusion of Lesko's testimony, each petitioner testified. During Uma's testimony, she stated when she found out in January 2016 that she was pregnant with James, she applied for Medicaid benefits. Further, she testified she went to the Board's office in person on January 20, 2016 with the additional documents requested by the Board, including petitioners' most recent income tax returns and her husband's paystubs. Uma also stated she provided petitioners' 2015 tax return to the Board in March, August, and November of 2016.

Peter testified his income varied "from year to year" and "from month to month" so it was "not possible" to report his "total business income . . . from month to month." He explained, "one month [it] looks like I make a lot of money because I [get] check[s] for [a] couple of jobs and [the] next month[,] nothing."

On June 11, 2021, the ALJ issued a written decision. She first addressed her credibility findings and determined "Lesko testified credibly . . . but . . . was unable to explain gaps in the documentary record, particularly with respect to the date on which petitioners first provided their 2015 tax return." Additionally, the ALJ found Uma "was credible in her recounting of the long and somewhat

confusing process of obtaining and maintaining Medicaid benefits." However, the ALJ determined petitioners' statements that they were "unable to verify their total annual income until their accountant finishe[d] their tax returns" was "difficult to find credible," considering Peter's testimony that their household expenses did not "fluctuate" much and his wages generally were "sufficient to cover family expenses."

The ALJ next found the Board "had notice of the change in petitioners' monthly income in March 2016, when it first received petitioners' 2015 tax return," and the Board "gave no explanation as to why this information was not used when it was received." Moreover, the ALJ concluded "[petitioners] did not provide paystubs to verify [Peter's] wages" in 2016, but she credited Lesko's testimony that she "did not believe petitioners intended to deceive" the Board in their dealings with the agency.

Further, the ALJ found if the Board had acted "within a reasonable time, . . . petitioners would not [have] face[d] such a significant penalty." She added:

> The Commissioner has the duty "[t]o take all necessary action to recover the cost of benefits incorrectly provided to . . . a recipient." However, the Commissioner or his designee . . . also has the authority "[t]o compromise, waive, or settle . . . any claim . . . in whole or in part, either in the interest of the Medicaid

> program or for any other reason which the [C]ommissioner by regulation shall establish." N.J.S.A. 30:4D-7(l); see also[] N.J.A.C. 10:49-14.3(a).
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> [(first and second alterations in original)].

Based on these principles, the ALJ found:

> At the very least, there is blame to share, and . . . the exercise by the Director of discretion is appropriate under these circumstances. The interests of the Medicaid program are served by the waiver of one-half of the overpayment made through November 2016, and as has already been offered by respondent, waiver of the entire overpayment made between December 2016 and February 2017.

Finally, she concluded petitioners' argument "that the regulation directing the Division to remit twenty-five percent of an overpayment recovery to [the Board was] contrary to federal law" was not properly before the Office of Administrative Law (OAL).

Based on her findings, the ALJ ordered that the Board's claim for reimbursement be reduced to $1,648.84, deeming "repayment of one-half of the overpayment resulting from benefits provided to [Peter] between January and November 2016, and to [Uma] in November 2016" waived. Similarly, she deemed "the overpayment resulting from benefits provided to [petitioners] between December 2016 and February 2017" waived.

On July 22, 2021, the Division's Assistant Commissioner issued a final

decision. First, he determined the ALJ's "order with regard to waiver of overpayment [was] outside the scope of the OAL's jurisdiction." Next, the Assistant Commissioner highlighted the Division's authority to seek reimbursement of overpayments from Medicaid recipients. He stated, "[w]hile fraud may be considered as part of the particular facts and circumstances of each case, it is not a pre[]requisite for collection or waiver." He also concluded that whether petitioners submitted their 2015 tax return in March 2016 or months later was "not dispositive of the overpayment issue" because the Division was "directed to recover these benefits pursuant to N.J.[S.A.] 30:4D-7(i)."

Further, the Assistant Commissioner found it was "undisputed . . . that [p]etitioner[s] received benefits from March 2016 through February 2017 when they were ineligible due to excess income." After reiterating the Division's obligation under N.J.S.A. 30:4D-7(i) to recover improperly paid benefits, the Assistant Commissioner stated, "While the law grants [the Division] the discretion to waive the collection in the interests of the Medicaid program, the exercise of this discretion is based on the intrinsic facts of the particular case. Nothing in the record demonstrates any financial harm or hardship that warrants a waiver." Accordingly, he ordered petitioners to "reimburse the [Board] for incorrectly paid benefits in the amount of $5,335.20[,] pursuant to a reasonable

repayment plan."

II.

On appeal, petitioners argue the Division's determination was "arbitrary and capricious" because it "disregard[ed] the findings of fact and conclusions of law of the ALJ without any basis in the record for doing so." They also contend recovery of any "alleged overpayment" to petitioners "is barred because: federal Medicaid law only authorizes recovery of overpayments from Medicaid providers, not Medicaid beneficiaries"; and the Board's retention of twenty-five percent of the amount it collects from overpayments "conflicts with federal law." We are not persuaded.

Our role in reviewing an administrative agency's final decision is limited. Univ. Cottage Club of Princeton N.J. Corp. v. N.J. Dep't of Env't Prot., 191 N.J. 38, 48 (2007) (citation omitted). We will not reverse an agency's decision unless it was arbitrary, capricious, or unreasonable; it violated express or implied legislative policies; it offended the State or Federal Constitution; or the findings on which it was based were not supported by substantial, credible evidence in the record. Ibid. The party challenging the administrative action bears the burden of showing they are entitled to relief from the final agency decision. Lavezzi v. State, 219 N.J. 163, 171 (2014) (citation omitted).

Reviewing courts "do not reverse an agency's determination 'because of doubt as to its wisdom or because the record may support more than one result.'" In re Freshwater Wetlands Gen. Permits, 372 N.J. Super. 578, 593 (App. Div. 2004) (quoting In re N.J. Pinelands Comm'n Resol., 356 N.J. Super. 363, 372 (App. Div. 2003)). Also, where an agency's expertise is a factor, we will defer to that expertise, particularly in cases involving technical matters within the agency's special competence. See Allstars Auto Grp. v. N.J. Motor Vehicle Comm'n, 234 N.J. 150, 158 (2018). This deference is even stronger when the agency, "has been delegated discretion to determine the specialized and technical procedures for its tasks." Newark v. Nat. Res. Council, Dep't of Env't Prot., 82 N.J. 530, 540 (1980).

We also afford particular deference to an agency's interpretation of the regulations it is charged with enforcing unless such interpretation is "plainly unreasonable." US Bank, N.A. v. Hough, 210 N.J. 187, 200 (2012) (citation omitted). However, we are "in no way bound by the agency's interpretation of a statute or its determination of a strictly legal issue." Ibid. (quoting Univ. Cottage Club, 191 N.J. at 48). We also interpret regulations de novo. Id. at 198-99 (citing Bedford v. Riello, 195 N.J. 210, 221-22 (2008)).

The Medicaid program was created when Congress added Title XIX to the Social Security Act, 42 U.S.C.A. §§ 1396 to 1396w-5, "for the purpose of providing federal financial assistance to [s]tates that choose to reimburse certain costs of medical treatment for needy persons." Harris v. McRae, 448 U.S. 297, 301 (1980). If a state chooses to participate in the Medicaid program, it must adopt a state plan that complies with the federal Medicaid Act and the regulations adopted by the Department of Human Services. 42 U.S.C.A. § 1396a; Est. of G.E. v. Div. of Med. Assistance and Health Servs., 271 N.J. Super. 229 (App. Div. 1994). "The Medicaid provisions of the Affordable Care Act [ACA]. . . require[d] [s]tates to expand their Medicaid programs by 2014" and "[t]he [ACA] provide[d] that the Federal Government [would] pay 100 percent of the costs of covering . . . newly eligible individuals through 2016." Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 575-76 (2012) (citing 42 U.S.C. § 1396d(y)(1)).

New Jersey participates in the federal Medicaid program pursuant to the New Jersey Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 to -19.5. The Division is a part of the Department of Human Services that operates the Medicaid program in New Jersey. N.J.S.A. 30:4D-4. The Commissioner of the Division has the power to issue regulations dealing with eligibility for

medical assistance. N.J.S.A. 30:4D-7. Additionally, a CWA, such as the Board, grants or denies applications for Medicaid benefits, N.J.A.C. 10:71-3.15, after determining a petitioner's "income and resource eligibility." N.J.A.C. 10:71-3.15(a). "The eligibility of Medicaid beneficiaries . . . must be renewed once every [twelve] months," 42 C.F.R. § 435.916(a)(1), and those applying for Medicaid benefits must report any change in circumstances affecting eligibility, 42 C.F.R. § 435.916(c); N.J.A.C. 10:71-2.2(e)(3).

If Medicaid benefits are incorrectly paid, the Division has a duty to recoup those funds. Indeed, under N.J.S.A. 30:4D-7(i), the Division is required "[t]o take all necessary action to recover the cost of benefits incorrectly provided to or illegally obtained by a recipient." N.J.A.C. 10:49-14.4(b)(1)(i) also provides that "[r]ecoveries . . . can be made from those persons specified in N.J.S.A. 30:4D-7(i)." Further, by statute, "No recovery action shall be initiated more than five years after an incorrect payment has been made to a recipient when the incorrect payment was due solely to an error on the part of the . . . agency." N.J.S.A. 30:4D-7(i).

Under N.J.S.A. 30:4D-7(l), the Commissioner is "authorized and empowered . . . [t]o compromise, waive, or settle and execute a release of any claim arising under this act . . . in whole or in part, either in the interest of the

Medicaid program or for any other reason which the [C]ommissioner by regulation shall establish." As noted, the Assistant Commissioner specifically recognized this authority in his July 22 opinion, acknowledging he had "discretion to waive . . . collection . . . based on the intrinsic facts of [a] particular case."

Here, petitioners do not dispute their increased income in 2015 rendered them ineligible for benefits for the periods at issue. Therefore, we have no reason to second-guess the Division's decision to timely seek recovery of the incorrectly paid benefits that petitioners received. But under the unique circumstances of this case, where the Board specifically waived reimbursement of benefits improperly paid from December 2016 to February 2017, and it repeatedly represented during the fair hearing it would not seek to recoup these benefits, we are convinced the final agency's decision not to abide by this waiver was arbitrary, capricious, and unreasonable. Accordingly, we affirm, in part, the final agency's order for reimbursement, and remand, in part, for modification of the order, to exclude repayment for improperly paid benefits for the period from December 2016 to February 2017. Thus, petitioners shall reimburse the Board in the sum of $3,297.68, minus any payments already credited against this debt, such as the aforementioned tax intercept. This result is consistent with the

Board's repeated waiver statements during the fair hearing, a waiver on which petitioners presumably relied when they later testified.

We need not address at length petitioners' contentions that recovery of any overpayment is barred under federal law. As we have mentioned, if a state chooses to participate in the Medicaid program, it must adopt a state plan that complies with the federal Medicaid Act and the regulations adopted by the Department of Human Services. 42 U.S.C.A. § 1396a; Est. of G.E., 271 N.J. Super. at 232. In that regard, under the federal Medicaid anti-lien statute, "No lien may be imposed against the property of any individual . . . on account of medical assistance paid . . . on [their] behalf under the State [Medicaid] plan." 42 U.S.C. § 1396p(a)(1). But an exception to the statute permits liens "pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual." 42 U.S.C. § 1396p(a)(1)(A). Accordingly, consistent with the agency's authority under N.J.S.A. 30:4D-7(i), we are satisfied the anti-lien statute does not preclude the Division's recovery of incorrectly paid benefits from petitioners.[6]

[6] Other states have upheld laws similar to N.J.S.A. 30:4D-7(i), thereby permitting state agencies to recoup overpayments made to beneficiaries. See Geston v. Olson, 857 F. Supp. 2d 863, 886 (D.N.D. 2012) (interpreting the federal anti-lien statute to allow "a state [to] recover medical benefits incorrectly

Petitioners also challenge the validity of N.J.A.C. 10:49-14.4,[7] contending it impermissibly conflicts with 42 U.S.C. § 1396d(y)(1), and that "New Jersey is . . . obligated to reimburse 100% of any overpayment collected to the federal government," rather than collect "an incentive fee of 25%." They cite to no binding authority for this proposition.

N.J.A.C. 10:49-14.4 addresses the collection of benefits incorrectly paid to a recipient and sets forth certain "principles and procedures [for] those collection activities in which [the Division] . . . and/or a [CWA] may be involved." In that regard, N.J.A.C. 10:49-14.4(b)(1)(i) provides, in part, "[i]n instances involving incorrect eligibility for medical assistance, . . . [t]he CWA shall . . . attempt recovery of medical assistance incorrectly granted" and "[r]ecoveries or attempts at recoveries can be made from those persons specified in N.J.S.A. 30:4D-7(i)." Also, N.J.A.C. 10:49-14.4(b)(5) provides:

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paid" to a beneficiary "under the [state's] Medicaid plan"); McAlary v. State ex rel. Okla. Dep't of Hum. Servs., 233 P.3d 399, 408 n.26 (Okla. Civ. App. 2009) (describing a state law which permits the Oklahoma Health Care Authority to recoup Medicaid overpayments from a beneficiary); Oxenhorn v. Fleet Tr. Co., 722 N.E.2d 492, 495-96 (N.Y. 1999) (upholding a New York law permitting the state's Department of Social Services to "take all necessary steps to correct any overpayment," including "payments made to ineligible persons," even in the absence of fraud).

[7] Petitioners mistakenly refer to this provision as "N.J.A.C. 10:49-4."

> When a CWA recovers . . . for medical assistance improperly granted, the CWA shall remit the proceeds to DMAHS. The reimbursement shall be made to the Treasurer, State of New Jersey, who will then reimburse the CWA in the amount of 25 percent of the gross recovery on a periodic basis to be determined by DMAHS.

While these regulations pertain to "incorrectly paid benefits," 42 U.S.C. § 1396d(y)(1) addresses the federal government's responsibility to pay for Medicaid expansion coverage. In part, the statute confirms "the federal government must cover a significant portion of the expansion cost[,] 100% in 2014-2016," "to make additional segments of the population eligible to receive [Medicaid] coverage." Maryland v. United States, 360 F. Supp. 3d 288, 298 (2019) (citing 42 U.S.C. § 1396d(y)(1)(A)-(E)); see also Philbrick v. Azar, 397 F. Supp. 3d 11, 30 (2019).

Read together, we are not convinced the regulations conflict with 42 U.S.C. § 1396d(y)(1) or that their coexistence bars the Division from compelling petitioners to reimburse the Board for benefits improperly provided to them when they were financially ineligible. To hold otherwise would render N.J.A.C. 30:4D-7(i) and 42 U.S.C. § 1396p(a)(1)(A) – both of which permit recovery for benefits incorrectly paid to a recipient − meaningless. Moreover, there is nothing in the record before us to suggest the Division, or the Board for that

matter, have taken any action which fails to comply with the federal Medicaid Act, or the regulations adopted by the Department of Human Services.

To the extent we have not addressed any remaining arguments advanced by petitioners, they lack sufficient merit to warrant discussion in a written opinion. R. 2:11-3(e)(1)(D) and (E).

Affirmed in part and remanded in part, consistent with this opinion. 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