STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: March 7, 2006
CASE #: **********
CENTER #: MAP
FH #: 4506226R

In the Matter of the Appeal of **********	**DECISION AFTER FAIR HEARING**
from a determination by the New York City Department of Social Services	

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on June 4, 2007, in **********, before Betsy Segal, Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

**********, Appellant (by telephone)
**********, representative

For the Social Services Agency

Philomena Offurum, Fair Hearing Representative

ISSUE

Was the Appellant's fair hearing request timely, for a fair hearing to review the Agency's determination to accept the Appellant's application for Medical Assistance subject to monthly excess income of $882.00, for the period commencing June 1, 2005?

Assuming the fair hearing request was timely, was the Agency's determination to accept the Appellant's application for Medical Assistance subject to monthly excess income of $882.00, for the period commencing June 1, 2005, correct?

Was the Agency's determination to discontinue the Appellant's entire household's Medical Assistance benefits for failure to return a Medical Assistance recertification statement to the Agency correct?

FACT FINDINGS

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age 57, resides with his wife, age 55, two daughters, age 22 and 19, and son, age 20.

2. The Appellant has been in receipt of Medical Assistance benefits, subject to an excess income amount. Appellant's wife and children have also been in receipt of Medical Assistance benefits under the same case number.

3. Fair hearing #********** was held to review the Agency's determination to discontinue Appellant's Medical Assistance. Decision after fair hearing #********* dated July 28, 2005, directed the Agency to restore the Appellant's Medical Assistance retroactive to the discontinuance date.

4. Fair hearing decision notice dated September 13, 2005, advised Appellant that "as per fair hearing your medical assistance coverage is active subject to a monthly surplus of $882.00 effective June 1, 2005."

5. The notice advised the Appellant that a fair hearing must be requested within sixty days of the Agency's action concerning Medical Assistance.

6. The Agency mailed the notice to the Appellant's address as contained in the Appellant's case record.

7. The Agency's Notice dated September 13, 2005, did not include a copy of the budget or the basis for the computation.

8. On March 4, 2006, Appellant's child ********** turned age 21.

9. On March 7, 2006, the Appellant requested a hearing.

10. On April 9, 2006, the Agency prepared for mailing to Appellant a recertification form affecting Appellant's entire household's Medical Assistance, which form stated it should be completed and returned to the Agency by mail by May 8, 2006.

11. By notice dated May 18, 2006, the Agency advised the Appellant that the agency had determined to discontinue the Appellant's entire household's Medical Assistance benefits, effective May 31, 2006, due to Appellant's failure to return a Medical Assistance recertification statement to the Agency.

APPLICABLE LAW

Section 22 of the Social Services Law provides that applicants for and recipients of Public Assistance, Emergency Assistance to Needy Families with Children, Emergency Assistance for Aged, Blind and Disabled Persons, Veteran Assistance, Medical Assistance and for any services authorized or required to be made available in the geographic area where the person resides must request a fair hearing within sixty days after the date of the action or failure to act complained of.

A recipient of Public Assistance, Medical Assistance or Services has a right to an adequate notice when the Agency proposes to discontinue, suspend, reduce or change the manner of payment of such benefits. 18 NYCRR 358-3.3(a). In addition, in most circumstances, a Food Stamp recipient has a right to an adequate adverse action notice when the Agency proposes to take any action to discontinue, suspend or reduce the recipient's Food Stamp benefits during the certification period. 18 NYCRR 358-2.3; 18 NYCRR 358-3.3(b). However, pursuant to 18 NYCRR 358-3.3(e), there is no right to an adverse action notice when, for example, the change is the result of a mass change, the Agency determines that all members of the household have died or the household has moved from the district or when the household has failed to reapply at the end of the certification period.

A timely notice means a notice which is mailed at least 10 days before the date upon which the proposed action is to become effective. 18 NYCRR 358-2.23. However, pursuant to 18 NYCRR 358-3.3(d), there is no right to timely notice for a Public Assistance or Medical Assistance recipient when, for example, the Agency has factual information confirming the death of the recipient; the Agency has received a clear written statement from the recipient that they no longer wish to receive Public Assistance or Medical Assistance; the Agency has reliable information that the recipient has been admitted to an institution or prison; the recipient’s whereabouts are unknown and mail has been returned to the Agency; or the recipient has been accepted for Public Assistance or Medical Assistance in another district.

An adequate notice is a notice of action, an adverse action notice or an action taken notice which sets forth the action that the Agency proposes to take or is taking, and if a single notice is used for all affected assistance, benefits or services, the effect of such action, if any, on a recipient's other assistance, benefits or services. In addition, the notice must contain:

- for reductions, the previous and new amounts of assistance or benefits provided;
- the effective date of the action;
- the specific reasons for the action;
- the specific laws and/or regulations upon which the action is based;
- the recipient's right to request an agency conference and fair hearing;

o the procedure for requesting an agency conference or fair hearing, including an address and telephone number where a request for a fair hearing may be made and the time limits within which the request for a fair hearing must be made;

o an explanation that a request for a conference is not a request for a fair hearing and that a separate request for a fair hearing must be made;

o a statement that a request for a conference does not entitle one to aid continuing and that a right to aid continuing only arises pursuant to a request for a fair hearing;

o the circumstances under which public assistance, medical assistance, food stamp benefits or services will be continued or reinstated until the fair hearing decision is issued;

o a statement that a fair hearing must be requested separately from a conference;

o a statement that when only an agency conference is requested and there is no specific request for a fair hearing, there is no right to continued public assistance, medical assistance, food stamp benefits or services;

o a statement that participation in an agency conference does not affect the right to request a fair hearing;

o the right of the recipient to review the case record and to obtain copies of documents which the agency will present into evidence at the hearing and other documents necessary for the recipient to prepare for the fair hearing at no cost;

o an address and telephone number where the recipient can obtain additional information about the recipient's case, how to request a fair hearing, access to the case file, and/or obtaining copies of documents;

o the right to representation by legal counsel, a relative, friend or other person or to represent oneself, and the right to bring witnesses to the fair hearing and to question witnesses at the hearing;

o the right to present written and oral evidence at the hearing;

o the liability, if any, to repay continued or reinstated assistance and benefits, if the recipient loses the fair hearing;

o information concerning the availability of community legal services to assist a recipient at the conference and fair hearing; and

o a copy of the budget or the basis for the computation, in instances where the social services agency's determination is based upon a budget computation.

18 NYCRR 358-2.2

Section 360-2.2(e) of Title 18 NYCRR and Section 369-ee of the Social Services Law provide that the Agency must redetermine a Medical Assistance or Family Health Plus recipient's eligibility at least once every twelve months and whenever there is a change in the recipient's circumstances that may affect eligibility.

A personal interview is not required as part of the redetermination of eligibility for Medical Assistance. Social Services Law 366-a(5). In addition, no personal interview is required to recertify eligibility for Family Health Plus. Social Services Law 369-ee.

Section 351.22(c) of the Regulations provides that, when a recipient fails to respond to an eligibility mailout questionnaire within the time period described in the questionnaire, the Agency must send another eligibility mailout questionnaire with a 10-day notice of proposed discontinuance. If the recipient does not respond to the mailout questionnaire within the 10-day period, the case must be closed at the end of the 10-day period. If the recipient does respond to the eligibility mailout questionnaire during the 10-day notice period, the 10-day notice of proposed discontinuance must be nullified.

A person who is sixty-five years of age or older, blind or disabled who is not in receipt of Public Assistance and has income or resources which exceed the standards of the Federal Supplemental Security Income Program (SSI) but who otherwise is eligible for SSI may be eligible for Medical Assistance, provided that such person meets certain financial and other eligibility requirements under the Medical Assistance Program. Social Services Law Section 366.1(a)(5).

To determine eligibility, an applicant's or recipient's net income must be calculated. In addition, resources are compared to the applicable resource level. Net income is derived from gross income by deducting exempt income and allowable deductions. The result - net income - is compared to the statutory "standard of need" set forth in Social Services Law Section 366.2(a)(7) and 18 NYCRR Subpart 360-4. If an applicant's or recipient's net income is less than or equal to the applicable monthly standard of need, and resources are less than or equal to the applicable standard, full Medical Assistance coverage is available.

Regulations at 18 NYCRR 360-4.6 provides for income disregards for applicants and recipients who are 65 years of age or older, certified blind or certified disabled. These disregards include:

the first $20 per month of any unearned income.

health insurance premiums.

The amount by which net income exceeds the standard of need is considered "excess income". If the applicant or recipient has any excess income, he/she must incur bills for medical care and services equal to or greater than that excess income to become eligible for Medical

Assistance. In such instances Medical Assistance coverage may be available for the medical costs which are greater than the excess income. If a person has expenses for in-patient hospital care, the excess income for a period of six months shall be considered available for payment. For other medical care and services the excess income for the month or months in which care or services are given shall be considered available for payment of such care and services. 18 NYCRR 360-4.1, 360-4.8.

Section 366(1)(a) of the Social Services Law sets forth the conditions under which individuals and families may qualify for Medical Assistance Low-Income Families With Children (LIF) may qualify for Medical Assistance if they meet specific eligibility standards. Categorically, Low Income Families With Children include the following:

- Parents and/or other caretakers residing with children under 21 years of age, and all such children;

- Persons under 21 residing without a parent, including children in foster care but not eligible for payments under Title IV-E of the Social Security Act; and/or

- Pregnant women.

Low Income Families With Children may include those currently receiving Public Assistance, as well as those who, although not currently receiving Public Assistance, have insufficient income and resources to meet the costs of necessary medical care and services for the family, including those who could qualify for Public Assistance were they to apply.

LIF eligibility is to be determined using Family Assistance methodology found in Parts 351, 352 and 369 of the Regulations. Under this methodology, income is subject to (i) a gross income test, under which its gross income must be no greater than 185 percent of its Public Assistance standard of need; (ii) a federal poverty level test, under which its income must be no greater than 100 percent of the federal poverty level for a family of comparable size; and (iii) a net income test, under which net income, after deducting all authorized disregards, is no greater than the applicable Public Assistance standard of need. In addition, the family resources must not exceed certain levels. If the family income and resources meet all of those tests, the family may qualify for Medicaid with full coverage. No "spend-down" of income exceeding the applicable standard is permissible using LIF budgeting methodology.

A family who fails the LIF budgeting methodology, may qualify for full Medicaid coverage if it qualifies for Transitional Medical Assistance ("TMA"). Under an Administrative Directive (97 OMM/ADM-2) issued by the NYS Department of Health on December 3, 1997, TMA must be provided to families that received Medicaid for at least three of the most recent six months and have lost full Medicaid coverage under the "LIF" category solely as a result of employment income.

For families that do not qualify for Medicaid under LIF budgeting or for TMA, Medicaid may still be obtained under "ADC-related" medically needy budgeting methodology. Under this

methodology, the amount of the family's available net income will be determined using the exemptions and disregards applicable to the "ADC-related" medically needy budgeting methodology. All earnings must be offset by (i) $90 (per employed family member) for Work Related Expenses; (ii) in accordance with 97 OMM/ADM-2, the $30 and 1/3 earned income disregard when the family received Medicaid under LIF in at least one of the past four months; and (iii) Child Care Expenses as authorized in Section 360-4.6 of the Regulations. After adding the remaining earnings to all other countable income received by the family, the local district must then compare the total net income to the higher of EITHER:

(a) the Public Assistance Standard of Need (the same as that required for Family Assistance); OR

(b) the Medicaid Income Exemption Standard. For a family of four, the Medicaid Income Exemption Standard was $ 992.00 per month in the year 2005.

Pregnant women and certain children may qualify for full coverage of their own medical needs if family income does not exceed the following "Expanded Eligibility" limits set forth in Section 360-4.7(b) of the Regulations:

Under Section 360-4.8(c) of the Regulations, Medicaid with a "spend-down" may be authorized for children when family income exceeds the higher of the Public Assistance standard or the Medicaid Income Exemption standard. In addition, parents may also be eligible with a "spend-down" when their income exceeds such level when the children are deprived of parental support or care ("deprivation factor". Families subject to a "spend-down" may become eligible for coverage for outpatient care and services if it has medical bills in any month that are equal to or more than the amount of excess income. Such families may become eligible for outpatient and inpatient medical care and services if a family owes or has paid an amount for medical bills equal to the sum of its monthly excess income for six months.

Administrative Directive 87 ADM-4 provides detailed instructions regarding the appropriate application of medical bills to offset excess income so that an individual can become eligible for Medical Assistance. This offsetting process is called "spenddown". Said Directive further provides that whenever a spenddown is indicated, the Agency is required to include a copy of the letter "Explanation of the Excess Income Program" along with the Notice to the recipient whenever an acceptance, intended change, denial, or discontinuance indicates a spenddown liability situation. Administrative Directive 87 ADM-4 provides that some over-the-counter drugs and medical supplies such as bandages and dressings may be applied to offset determined excess income if they have been ordered by a doctor or are medically necessary. Bills for cosmetics and other non-medical items may not be so applied.

Local Commissioners Memorandum 95 LCM-68 advises, in part, that all Medical Assistance co-payments, including pharmacy co-payments, may be applied toward an applicant's/recipient's spenddown when determining financial eligibility for Medical Assistance.

Administrative Directive 91 ADM-27 explains changes in federal law affecting the Medicaid budgets of blind, disabled, and aged persons. In relevant portion, the ADM states:

C. Household Size for SSI-Related Applicants/Recipients

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2. Income

a. When a household consists of an SSI-related couple (neither of whom receives a PA grant or SSI cash), with or without children, the household size for the SSI-related couple is two.

b. When a household (with or without children), consists of an SSI-related spouse and a non-SSI-related spouse whose income **is equal to or more than** the allocation amount after allocating to any child(ren) under the age of 18 years, income is deemed and the household size is two for the SSI-related spouse. (The allocation amount is the difference between the MA level for two and the MA level for one and is $217, effective January 1, 1991.)

If a non-SSI-related spouse's income is **below** the allocation amount after allocation to any child(ren) under the age of 18 years, the non-SSI-related spouse's income is not deemed to the SSI-related spouse, and that spouse is not counted in the MA income household size for the SSI-related spouse. In such instances, the SSI-related applicant's household size is one. However, to determine resource eligibility, a household of two is used. An example of such a case is detailed in Attachments E and F of this Directive.

c. For all other SSI-related adults or children, the household size is one.

3. Related Issues

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d. SSI-related A/Rs must be offered a choice between the SSI and ADC budgeting methodologies, if the A/Rs meet the categorical requirements for ADC. It may be more advantageous if there are children or a pregnant woman in the household to use the ADC methodology, which allows the income and resources to be compared to a larger household size.

Administrative Directive 05 OMM/ADM-5, dated November 7, 2005, advises that certain individuals who have used their prescription costs to help meet their spenddown, may find that Medicare covers their drug spending and they no longer "spend down" as quickly to become Medicaid eligible. However, with Medicare paying for their prescription drugs, they will have more available income. Any out-of-pocket costs paid or incurred for items such as Part D premium, coinsurance, deductible or co-payments may be used to meet a spenddown. Medical expenses other than prescription drug costs may continue to be used to meet their spenddown. Although the premium amount may be used as a deduction from income, there is no State authority to pay or reimburse the recipient for the Medicare Part D premium.

Local social services districts now provide a "Pay-In" program, established under provisions of Section 366(2)(b)(3) under which Medicaid recipients having excess income may simply remit the amount of the excess to the local district each month, and receive an uninterrupted authorization for full coverage for all costs (at the Medicaid rate) of all necessary medical services by participating providers.

DISCUSSION

The Appellant, age 57, resides with his wife, age 55, two daughters, age 22 and 19, and son, age 20. Fair hearing #******** was held to review the Agency's determination to discontinue Appellant's Medical Assistance. Decision after fair hearing #******** dated July 28, 2005, directed the Agency to restore the Appellant's Medical Assistance retroactive to the discontinuance date. Fair hearing decision notice dated September 13, 2005, advised Appellant that "as per fair hearing your medical assistance coverage is active subject to a monthly surplus of $882.00 effective June 1, 2005." Although the Agency's notice advised the Appellant that a fair hearing must be requested within sixty days of the Agency's action concerning Medical Assistance, the Appellant failed to request this hearing until March 7, 2006, which was more than sixty days after the Agency's determination. However, because the notice did not include a copy of the budget or the basis for the computation, the notice is defective. The statute of limitations may be tolled and the notice voided.

The uncontroverted evidence establishes that Agency determined to discontinue the Appellant's entire household's Medical Assistance benefits due to a failure to timely return a Medical Assistance recertification statement to the Agency. With respect to this determination, however, the Agency failed to establish that the recertification statement was mailed to the Appellant, inasmuch as the Agency's affidavits of mailing procedures failed to establish that the particular notice at issue was mailed in accordance with the described mailing system.

Therefore, the Agency's determination to discontinue the Appellant's entire household's Medical Assistance benefits cannot be sustained.

DECISION AND ORDER

The Agency's determination dated September 13, 2005, to accept the Appellant's application for Medical Assistance subject to monthly excess income of $882.00, for the period commencing June 1, 2005, was not correct and is reversed.

1. The Agency is directed to recalculate the Appellant's monthly excess income (spenddown) for the period of June 1, 2005, to present, after first allowing Appellant a reasonable opportunity to document his household's income, payment of health insurance premiums, household composition, and any other relevant information with regard to the period in question.

2. In performing an SSI-related budget or budgets, the Agency is directed to determine whether the income (post allocation to children) of Appellant's spouse, if she had or has any, and her needs, should be included in said budget(s).

3. The Agency is directed to provide Appellant with the most favorable of either ADC-related budgeting or SSI-related budgeting, in accordance with relevant provisions of 91 ADM-27.

4. The Agency is directed to thereafter inform Appellant in writing of the Agency's new computation and determination.

5. If (and only if) the Agency calculated too high a spenddown amount, the Agency is in such case directed to allow Appellant a reasonable opportunity to submit receipts for out-of-pocket payments for consideration for possible reimbursement, to the extent and in the amount, if any, that may be appropriate.

The Agency's determination to discontinue Appellant's entire household's Medical Assistance benefits is not correct and is reversed.

1. The Agency is directed to cancel its notice dated May 18, 2006, and to continue the Appellant's entire household's Medical Assistance benefits, subject to appropriate excess income amounts, if any.

2. The Agency is directed to restore any lost Medical Assistance benefits for the entire household.

3. The Agency is directed to allow the Appellant an opportunity to return a Medical Assistance recertification statement to the Agency.

4. The Agency is directed to consider investigating the continued eligibility of 22 year old household member ********** for Medical Assistance, as well as the continued eligibility of any other members of the household.

It is noted that the Appellant and any household members over the age of 21 (on their own behalf, with the exception of a spouse of the head of household) must cooperate in the recertification process in order to continue receiving assistance and/or benefits.

Should the Agency need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Agency promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
12/11/2007

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee