STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST September 11, 2003
CASE # MXXXXXX
CENTER # Nassau
FH # 3976629P

In the Matter of the Appeal of :

MD **DECISION**
: **AFTER**
FAIR
HEARING

from a determination by the Nassau County
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 December 3, 2003, in Nassau County, before Dennis D'Andrea, Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

MC, Appellant; Douglas Ruff, Esq., Nassau-Suffolk Law Services

For the Social Services Agency

Israel Karol, Fair Hearing Representative

ISSUE

Was the Appellant's request for a fair hearing to review the Agency determination to discontinue the Appellant's Medical Assistance benefits timely?

Assuming the request was timely, was the Agency's determination to discontinue the Appellant's Medical Assistance benefits on the ground the Appellant was ineligible because Appellant's whereabouts were unknown to the Agency correct?

Was the Agency's action to not provide reimbursement at the private-pay rate correct?

FACT FINDING

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 has been in receipt of Medical Assistance benefits for her own needs.

2. On May 14, 2003, the Agency sent a Notice of Intent to the Appellant setting forth its determination to discontinue Appellant's Medical Assistance

benefits on the grounds that Appellant's whereabouts were unknown to the Agency.

3. The notice advised the Appellant that a fair hearing must be requested within sixty days of the date of the Agency's action.

4. The Agency mailed the notice to the Appellant's address as contained in the Appellant's case record in the Medical Assistance Unit, but not to the address in the case record in the Public Assistance Unit. The Appellant is the Public Assistance grantee for her four grandchildren.

5. The Appellant continues to reside at the address listed in the Agency's records in the Public Assistance Unit.

6. The Appellant's Medical Assistance was discontinued effective May 24, 2003, and re-opened September 26, 2003, effective April 1, 2003.

7. During the period from May 24, 2003, to September 26, 2003, the obtained medical coverage through private pay.

8. On September 11, 2003, the Appellant requested this fair hearing.

APPLICABLE LAW

Regulations at 18 NYCRR 360-7.5(a)(1) provide that payment for services or care under the Medical Assistance Program may be made to a recipient or the recipient's representative at the Medical Assistance rate or fee in effect at the time such care or services were provided when an erroneous determination by the Agency of ineligibility is reversed. Such erroneous decision must have caused the recipient or the recipient's representative to pay for medical services which should have been paid for under the Medical Assistance Program. Note: the policy contained in the regulation limiting corrective payment to the Medical Assistance rate or fee at the time such care or services were provided has been enjoined by Greenstein et al. v. Dowling et al. (S.D.N.Y.).

Regulations at 18 NYCRR 360-7.5(a)(5) provide that payment for services or care under the Medical Assistance Program may be made to a recipient or the recipient's representative at the Medical Assistance rate or fee in effect at the time such services or care were provided for paid medical bills for medical expenses incurred during the period beginning three months prior to the month of application for Medical Assistance and ending with the recipient's receipt of a Medical Assistance identification card, provided that the recipient was eligible in the month in which the medical care and services were received and that the medical care and services were furnished by a provider enrolled in the Medical Assistance Program. The provisions of this regulation which limit reimbursement for paid medical bills only to providers enrolled in the Medical Assistance Program when such bills were incurred during the period from three months prior to the month the recipient applied for Medical Assistance to the date of application has been declared invalid in the courts in Seittelman, et al v. Sabol, et al. (N.Y., 1998) and Carroll et al. v. DeBuono, et al. (N.D.N.Y., 1998). Further, the Court in Seittelman held that limiting reimbursement to the Medical Assistance fee or rate was permissible for such period.

Section 360-2.4(c) of the Regulations provides that an initial authorization for Medical Assistance will be made effective back to the first

day of the first month for which eligibility is established. A retroactive authorization may be issued for medical expenses incurred during the three month period preceding the month of application for Medical Assistance, if the applicant was eligible for Medical Assistance in the month such care or services were received.

General Information System Message GIS 98 MA/011 notified the local district offices of the following: this is to advise you (the local districts) of adverse decisions in the cases of Carroll, et al., v. DeBuono, et al. and Seittelman, et al. v. Sabol, et al.

Both decisions involve Department regulation 360-7.5(a)(5). The regulation provides that the Medicaid program must reimburse a recipient or the recipient's representative for Medicaid services purchased during the recipient's retroactive eligibility period if the recipient was eligible when the services were purchased and the services were furnished by providers enrolled in the Medicaid program.

The court invalidated 18 NYCRR 360-7.5(a)(5) to the extent that it denies direct reimbursement for services purchased from non-Medicaid enrolled providers on or after the first day of the third month prior to the month of application for Medicaid and ending on the day the recipient applied for Medicaid. The court also found that Medicaid applicants are not adequately notified of the possibility of reimbursement during the retroactive period or that reimbursement of medical expenses incurred between the time of application and receipt of a Medicaid card is limited to medical services rendered by Medicaid enrolled providers.

Effective for applications and/or requests for reimbursement filed or pending on or after March 11, 1998, you (the local district) must modify your direct reimbursement procedures to assure that Medicaid recipients receive reimbursement for Medicaid services purchased from non-Medicaid enrolled providers during the retroactive eligibility period, if otherwise eligible. This does not apply to services purchased from non-Medicaid enrolled providers after the day of application and before the day the recipient received a Medicaid identification card. For example, a recipient who applied for Medicaid on March 11 is now entitled to direct reimbursement for Medicaid services purchased from non-Medicaid enrolled providers, as well as for Medicaid services purchased from Medicaid enrolled providers, from December 1 through March 11, and reimbursement for Medicaid enrolled providers from March 12 until the date the Medicaid identification card is received, if eligible during this period.

Also, effective immediately, the local district must ensure that each Medicaid applicant (including applicants who apply at outreach sites such as hospitals, clinics and PCAP offices) is informed in writing of the availability of reimbursement of paid medical expenses during the three month period prior to the month of application and that, if determined eligible, direct reimbursement will be made for Medicaid services between application date and date of receipt of the identification card only if furnished by Medicaid-enrolled providers.

The Department has developed required wording for the notice to all applicants. This wording, in both English and Spanish, was e-mailed with this GIS message to all local commissioners. This wording was incorporated into the next revision of the DSS 4148B, "What You Should Know About Social

Services Programs."

All reimbursement to the recipient or the recipient's representative for Medicaid services purchased prior to receipt of the Medicaid identification card is limited to the Medicaid rate or fee in effect when the service was provided. (Please be advised, however, that the recipient or the recipient's representative may receive greater reimbursement when he or she purchased Medicaid services as a result of social services district error or delay. Please refer to the Greenstein v. Dowling GIS, which was transmitted by electronic mail May 19, 1994, for further information.)

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. In addition, any person aggrieved by the decision of a social services official to remove a child from an institution or family home may request a hearing within sixty days. Persons may request a fair hearing on any action of the social services district relating to food stamp benefits or the loss of food stamp benefits which occurred in the ninety days preceding the request for a hearing. Such action may include a denial of a request for restoration of any benefits lost more than ninety days but less than one year prior to the request. In addition, at any time within the period for which a person is certified to receive food stamp benefits, such person may request a fair hearing to dispute the current level of benefits.

DISCUSSION

In response to the fair hearing opening statement, "If you asked the Agency for documents necessary for your hearing and the Agency failed to provide them, please bring this to my (the Administrative Law Judge's) attention," the Appellant's legal council noted that he could not obtain the Public Assistance file. The Agency responded that it tried to find the Public Assistance folder at the F District office but could not do so. The Appellant elected to go forward without the folder.

On May 14, 2003, the Agency notified the Appellant that it had determined to discontinue the Appellant's Medical Assistance benefits.

Although the Agency's notice advised the Appellant that a fair hearing must be requested within sixty days of its action, the Appellant failed to request this fair hearing until September 11, 2003, which was more than sixty days after the Agency's determination.

The Appellant contended, through legal counsel, that the notice of May 14, 2003, was mailed to X B Parkway, H, New York, XXXXX, but the Appellant lived at XX J Street, R, New York, XXXXX, and had moved there on April 1, 2003, several weeks in advance of the notice. The Appellant entered into evidence the Case Record of Assistance Issued Direct Payments List reporting two expenditures each in the amount of $1,880.00 to cover security and the broker's fee. The Appellant contended that when she moved in the past she needed to only inform the Public Assistance worker, not both the Public Assistance and Medical Assistance workers, but that she did not know how the Medical Assistance Unit was informed of the changes. For the recent move,

the Appellant contended that she notified the foster care worker and the Public Assistance worker, but not the Medical Assistance worker.

The Agency responded that the Public Assistance Unit knew of the move but not the Medical Assistance Unit. The Agency further responded that the Appellant had a responsibility to inform the Medical Assistance Unit of the move, and that such information does not automatically come to the Medical Assistance (MA) Unit.

A review of the application at the fair hearing showed that the application instructs that changes must be reported to the "Agency;" the "Medical Assistance Unit" is not the wording used. The Agency was on notice that the Appellant had moved and had in fact approved and financed the move. The record establishes a sufficient basis for tolling the statute of limitations.

Prior to the above determination, on April 24, 2003, the Agency sent a prior notice to the wrong address advising the Appellant to complete an enclosed recertification form and return it by May 8, 2003. When the form was not timely returned, the Agency issued the discontinuance notice of May 14, 2003. That action was an erroneous decision because mailing the recertification questionnaire to an incorrect address was good cause for the Appellant's failure to timely respond. Therefore, the Agency's determination to discontinue the Appellant's Medical Assistance benefits on the ground the Appellant was ineligible because Appellant's whereabouts were unknown to the Agency was not correct and is reversed.

The Medical Assistance discontinuance was effective May 24, 2003, and the Agency determination of September 26, 2003, accepts the new application of July 7, 2003, for coverage retroactive to April 1, 2003, leaving no uncovered period, but the Agency had determined to reimburse the Appellant at the Medical Assistance rate, not at the private pay rate. The Appellant received coverage through only private pay from the effective date of the first notice, May 24, 2003, to September 26, 2003, the date of the second notice. The Appellant entered into evidence the Walgreens Confidential Patient Information Prescription Profile reporting that she owed $553.00 for the period. Regulations at 18 NYCRR 360-7.5(a)(1) provide that payment under the Medical Assistance Program may be made to a recipient at the Medical Assistance rate in effect when an erroneous determination by the Agency of ineligibility is reversed. The policy contained in the regulation limiting corrective payment to the Medical Assistance rate has been enjoined by Greenstein et al. v. Dowling et al. (S.D.N.Y.). The recipient may receive greater reimbursement when she purchased Medicaid services as a result of social services district error or delay. An erroneous decision by the Agency discontinued the Appellant's Medical Assistance, and as a result of this error she purchased prescription needs through private pay. Therefore, the Agency's action to reimburse the Appellant at the Medicaid rate rather than the private pay rate for the disputed period is not correct and is reversed.

DECISION AND ORDER

As there was good cause for requesting this hearing more than sixty days after the Agency determination sought to be reviewed, the Commissioner has jurisdiction to review the local Agency's determination.

The Agency's determination to discontinue Appellant's Medical Assistance

benefits because the Appellant's whereabouts were unknown to the Agency is not correct and is reversed.

The Agency's action to not provide reimbursement at the private pay rate is not correct and is reversed.

1. The Agency is directed to review the bills presented at the fair hearing.

2. The Agency is directed to reimburse the Appellant for the viable bills for the period May 24 to September 26, 2003, at the private-pay rate.

3. Should the Agency find the bills for the disputed period are not viable, it must issue a new determination in writing.

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 required, 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
December 15, 2003

NEW YORK STATE DEPARTMENT
OF HEALTH

By

Commissioner's Designee