STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: March 15, 2006
CASE #: **********
CENTER #: MAP
FH #: 4513979P

In the Matter of the Appeal of

****

from a determination by the New York City Department of Social Services

DECISION AFTER FAIR HEARING

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 19, 2006, in *********, before Theodore Vassilakis, Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

**********, Esq., Representative

For the Social Services Agency

Linda Cole, Fair Hearing Representative

ISSUE

Was the Agency's determination of February 23, 2006 to reduce the Appellant's Medicaid benefits, 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, age 75 was in receipt of a Medical Assistance Authorization, subject to no spenddown of excess income. The Appellant's household consists of the Appellant and the Appellant's husband, age 78, whose Medical Assistance Authorization is not an issue in this fair hearing.

2. By Notice of Intent dated February 23, 2006, the Agency advised the Appellant of its

determination to reduce the Appellant's Medicaid benefits, effective March 1, 2006, on the grounds that the Appellant's monthly excess income has changed to $1,141.00 monthly.

3. On March 15, 2006, the Appellant requested this fair hearing.

APPLICABLE LAW

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. At the fair hearing, the agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such documents must be provided to the appellant and appellant's authorized representative where such documents were not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). In addition, a representative of the agency must appear at the hearing along with the case record and a written summary of the case. 18 NYCRR 358-4.3(b).

According to 18 NYCRR section 358-2.23, a "timely" notice is a notice which is mailed at least 10 days before the date upon which the proposed action is to become effective.

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;
- 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;
- 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;
- 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;

- 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;

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

- 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;

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

- 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;

- 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;

- 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;

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

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

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

- 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

Administrative Directive 96 ADM-15, provides instructions regarding the "Pay-In" program under which individuals with monthly excess income may elect to pre-pay to local districts the amount of their monthly excess income for periods from one to six months.

DISCUSSION

The evidence establishes that by Notice of Intent dated February 23, 2006, the Agency advised the Appellant of its determination to reduce the Appellant's Medicaid benefits, effective

March 1, 2006, on the grounds that the Appellant's monthly excess income has changed to $1,141.00 monthly.

At the hearing, the Agency's representative presented the Agency's Notice of Intent dated February 23, 2006 to show that the Appellant's household has earned income from salaries, wages of $2,947.01 monthly. However, the record in this case establishes that the Agency's Reduction Notice of February 23, 2006 has an effective date of March 1, 2006, that is less than 10 days before the date upon which the proposed action is to become effective. Pursuant to 18 NYCRR Section 358-2.23, a "timely" notice is a notice which is mailed at least 10 days before the date upon which the proposed action is to become effective.

Furthermore, the record establishes that the aforesaid Notice of Intent lacks the previous amount of assistance or benefits provided to the Appellant. Pursuant to Section 18 NYCRR 358-2.2 of the regulations with regard to Notices pertaining to the reductions of benefits, the Notice should include the previous and new amounts of assistance or benefits provided. It is noted that, as per the Welfare Management (computer) System, Appellant's Medical Assistance was subject to no spenddown of excess income prior to the effective date of the Agency's determination here at issue.

The above-noted defects in the Agency's notice render such notice void. Therefore, the Agency's determination of February 23, 2006 to reduce the Appellant's Medical Assistance benefits cannot be sustained.

It is noted that, according to computer records, Appellant appears to have paid to the Agency sums representing her purported excess income amount or spenddown during a period or periods commencing in or about March 1, 2006.

DECISION AND ORDER

The Agency's determination of February 23, 2006 to reduce the Appellant's Medical Assistance benefits is not correct and is reversed

1. The Agency is directed to restore the Appellant's Medical Assistance benefits by adjusting Appellant's Medical Assistance-related excess income amount back to zero dollars, retroactive to March 1, 2006, the effective date of the Agency's action.

2. The Agency is directed to continue to authorize the Appellant to receive Medical Assistance subject to no spenddown of excess income.

3. The Agency is directed to assist Appellant in obtaining an appropriate reconciliation as to her account with the "Pay-In" Program, regarding excess income amounts paid to the Agency by means of said "Pay-In" Program for the period from March 1, 2006 up until the date of compliance with this Fair Hearing Decision, including processing refunds, as appropriate.

4. In the event that the Agency determines to implement its previously contemplated action, the Agency is directed to provide the Appellant with a notice that meets the requirements set forth in 18 NYCRR 358-2.2 and in 18 NYCRR Section 358-2.23.

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
04/16/2007

NEW YORK STATE DEPARTMENT
OF HEALTH

By

Commissioner's Designee

NOTICE OF INTENT TO CHANGE MEDICAL ASSISTANCE

Human Resources Administration
Medical Assistance Program
MAP-2087B (E-S) Rev. 08/23/05

[redacted]

DATE: 2-23-06

CASE NUMBER: [redacted]

EFFECTIVE DATE: _____

If you have any questions, call the HRA InfoLine at 877-472-8411.

Dear Consumer:

told told

We are sending you this notice to tell you that the Medical Assistance Program will:

☒ **REDUCE** your Medical Assistance (MA) coverage starting: 3-1-06

☐ **INCREASE** your Medical Assistance (MA) coverage starting: _____

Your total monthly income is $ 3633.62. Your total monthly deductions are $ 1592.61

The difference between these is your NET income for Medicaid. This is $ 2041.00 The allowable level for a family household your size is: $ 900.00. The difference between your Net Income and this level is $ 1141.00. This is called your monthly excess income. Your monthly excess income has changed from $ _____ to $ 1141.00. If your medical expenses equal this amount in any month, MA will pay those covered medical expenses incurred during the months which are more than your excess income amount.

If you have an inpatient bill more than $ 6846.00 (your excess income for six months) you can also receive Medicaid (MA) coverage. See attached budget explanation.

This decision is based on Social Services Law: 360-4-8.1(c)

Persons with excess income cannot join Medicaid Managed Care. Consumers already enrolled in Managed Care, will be disenrolled if they become eligible with excess income.

WORKER	TITLE	SECTION

YOU HAVE THE RIGHT TO APPEAL THIS DECISION

We will review this decision with you if you call us at 212-630-0996 and ask for a **Local Conference**. You also have the right to ask or a **State Fair Hearing**. You must request a **State Fair Hearing** within 60 days of the date on top of this notice. You must meet this deadline to request a **State Fair Hearing** even if you ask for a **Local Conference** first. **The State Fair Hearing** is held by the NYS, OTDA, Office of Administrative Hearings.

Regulations require that you immediately notify this department of any changes in needs, income, resources, living arrangements, or address.

BE SURE TO READ THE ENCLOSED FORM MAP-2086B FOR YOUR RIGHTS ON HOW TO APPEAL THIS DECISION

Human Resources Administration
Medical Assistance Programs

CONFERENCE AND FAIR HEARING INFORMATION

CONFERENCE (Informal meeting with us): If you think our decision was wrong or if you do not understand our decision, please call us or write to us to arrange a meeting. Sometimes this is the fastest way to solve any problems you may have. We encourage you to do this even when you ask for a fair hearing. The address to write to is Medical Assistance Programs, Conference Unit, 330 W. 34th Street, Third Floor, New York, NY 10001. The telephone number to call is (212) 630-0996.

STATE FAIR HEARING

Deadline for Request: If you want the State to review our decision about your medical assistance, you must ask for a fair hearing within 60 days from the date of the enclosed notice.

How to Request a Fair Hearing: You can request a fair hearing in writing, by telephone, by fax or in person.

Write: Complete this form and mail it **WITH THE ENCLOSED NOTICE** to Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, NY 12201-1930. Please keep copies for yourself.

Or Call: (212) 417-6550

Or Fax: Fax the enclosed notice and a complete copy of this form to Fax No. (518) 473-6735.

Or in Person: Bring the enclosed notice to the New York State Office of Temporary and Disability Assistance at 80 Centre Street, Third Floor, New York, NY, or 330 W. 34th St. Third Floor, New York, NY.

If you cannot reach the State by phone or fax, be sure you write or come in before the hearing request deadline.

REQUEST FOR A FAIR HEARING

☐ I want a Fair Hearing. The agency's action is wrong because: _____

_____

_____

Print Name: _____ **Case Number:** _____

Address: _____ **Telephone:** _____

Signature: _____ **Date:** _____

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers."

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will send you free copies of the documents from your files, which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will send you free copies of other documents from your files which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at (212) 630-0993, or write to us at: Records Management Unit, Medicaid Fair Hearing Division, 330 W. 34th St. New York, NY 10001. If you want copies of documents from your case file, you should ask for them ahead of time. Usually, they will be sent to you within three working days of when you asked for them. If your hearing is within three working days of when you ask for them, your case file documents may be given to you at your hearing.

INFORMATION: If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at (212) 630-0996.

MAP-2060 (E-S) face
Rev. 02/21/03

Human Resources Administration
Medical Assistance Programs

BUDGET EXPLANATION

CASE NAME: [redacted] **CIN:** [redacted]

We computed your Medical budget for the period beginning _____ as follows:

GROSS INCOME	AMOUNT
Employment	$ 2947.01
Interest Income	$
Social Security	$ 686.60
Child Support	$
Other (specify):	$
Other (specify):	$
Other (specify):	$
TOTAL MONTHLY GROSS INCOME	$ 3633.61
☐ Allowance for disabled, aged or blind persons	$ 20.00
☐ Work Related Expenses	$
☐ Family Care Expenses	$
☐ Health Care Expenses disregard	$ 1441.01
☐ Child Support Exemption disregard	$ 66.60
☐ Other (specify): disregard	$ 65.00
TOTAL MONTHLY DEDUCTIONS ALLOWED TO YOU:	$ 1592.61
Net Monthly Income (gross income minus deductions)	$ 2041.00
☐ The monthly Medicaid allowance for your household is:	$
☐ The monthly FHP allowance for your household is:	$
☐ The monthly FPBP allowance for your household is:	$
☐ The monthly Public Assistance Standard of Need for your household is:	$
☐ The monthly Public Assistance Standard of Need for your household is: (185%)	$

After subtracting the appropriate monthly allowance from your net monthly income, we have determined that your income exceeds this allowance by: $ 1141.00

RESOURCES (exempt resources such as money held in a burial fund are not shown below)

Bank Accounts	$
Other (specify):	$
Other (specify):	$
Other (specify):	$
TOTAL RESOURCES	$
☐ Medicaid Resource Allowance	$
☐ Public Assistance Resource Allowance	$

After subtracting the appropriate resource allowance from your countable resources, we have determined that your resources exceed this allowance by: $_____

(Vea al dorso para ver esta notificación en Español)