STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: August 19, 2008
CASE #: 00027170637G
CENTER #: MAP
FH #: 5096859Q

In the Matter of the Appeal of

Lucille S

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 October 27, 2008 and December 1, 2008, in New York City, before Christopher Gallagher, Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

Lucille S Appellant; Winnie C Social Worker, Jewish Home Lifecare

For the Social Services Agency

Bryan Giff, Fair Hearing Representative (October 27, 2008);
Sharon Guy, Fair Hearing Representative (December 1, 2008)

ISSUE

Was the Agency's determination to reduce the Appellant's Medical Assistance by increasing the monthly spenddown of excess income towards medical expenses from zero dollars to $564.00 effective August 1, 2008 by means of the Agency's July 15, 2008 "Notice of Acceptance" correct?

FINDINGS OF FACT

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 71, had been in receipt of full Medicaid, subject to no spenddown of excess income.

2. At all times relevant to the present hearing, the Appellant resided at the Alma Rangel Gardens facility, which is a Congregate Care Level III facility.

3. By "Notice of Acceptance" dated July 15, 2008, the Agency advised the Appellant of the Agency's determination to, in effect, reduce the Appellant's Medical Assistance by increasing the Appellant's Medicaid-related excess income amount from zero dollars monthly to $564.00 effective August 1, 2008.

4. At the time of the Agency's Notice, the Appellant was in receipt monthly gross Social Security benefits of $1,405.40 and paid a Medicare premium of $96.40.

5. On August 19, 2008, the Appellant requested this fair hearing.

APPLICABLE LAW

A recipient of Public Assistance, Medical Assistance or Services has a right to a timely and 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).

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:

o for reductions, the previous and new amounts of assistance or benefits provided;

o the effective date of the action;

o the specific reasons for the action;

o the specific laws and/or regulations upon which the action is based;

o 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 366(1)(a) of the Social Services Law, describes the eligibility requirements for the Medical Assistance ("Medicaid") program, and authorizes such assistance for individuals who meet all categorical and financial eligibility requirements. An adult who is at least 21 years of age but who is under the age of 65 and who has no dependent children, is not pregnant and is not certified blind or certified disabled is considered eligible for Medicaid if he or she meets the financial eligibility requirements of the Safety Net Assistance Program.

A person not receiving public assistance may qualify for Medicaid if he or she does not have sufficient income and resources (inclusive of support from responsible relatives) to meet the costs of medical care and services as defined under the Social Services Law.

A person subject to an employment sanction under Section 342 of the Social Services Law may nevertheless be eligible for Medicaid.

Section 352.18(a) of the Regulations provides that no household shall be eligible for a grant of Public Assistance in any month in which Gross Income exceeds 185 percent of its applicable Standard of Need, computed in accordance with Section 131-a.2 of the Social Services Law, under which most allowances depend on the number of persons in the household. The household's "Standard of Need" includes a basic allowance, an amount for shelter, and amount for fuel-for-heat when heat is not included in the cost of shelter, a home energy allowance, a supplemental home energy allowance, and such additional allowances as may be authorized to meet other verified needs.

Section 360-5.2(b) of the Regulations defines "disability" as the inability of an individual to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months. Section 360-5.3 of the Regulations provides that the medical criteria to be used in determining disability for medical assistance eligibility shall be the same medical criteria set forth in Federal regulations for determining disability for social security and SSI purposes.

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.

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.

Regulations at 360-4.6(a) list the income which is disregarded for all applicants for or recipients of Medical Assistance except for those who are being budgeted using Safety Net criteria. Regulations at 18 NYCRR 360-4.6 provides for additional income disregards for applicants and recipients who are 65 years of age or older, certified blind or certified disabled. These disregards are to be applied in the following order:

> the first $20 per month of any unearned income. Only one $20 disregard is permitted per couple. A certified blind or certified disabled child living with parents is entitled to a separate $20 disregard from his/her total unearned income. If a person's unearned income is under $20, the balance will be deducted from earned income;
>
> health insurance premiums;

Section 352.8(c) provides, in part, that each social services district must establish:

(4) An allowance for each recipient receiving care in a Level 1, Level 2 or Level 3 certified congregate care facility. The allowance is based on the rates provided for care and maintenance under the Supplemental Security Income Program for SSI beneficiaries residing in the same facility, less the amount of any personal needs allowance included in the SSI rate. The facilities included are:

(i) Level 1. Family-type homes certified by the Office of Children and Family Services and family care homes certified by the Office of Mental Health or the Office of Mental Retardation and Developmental Disabilities.

(ii) Level 2. Residences for adults certified by the Department of Health; programs providing intensive residential rehabilitation services, community residential services or supportive living services certified by the Office of Alcoholism and Substance Abuse Services; supportive community residences, supervised community residences and individualized residential alternatives certified by the Office of Mental Retardation and Developmental Disabilities; and apartment treatment, congregate treatment and congregate support facilities certified by the Office of Mental Health. For purposes of this subparagraph, congregate care Level 2 facilities do not include intermediate care facilities or respite care facilities.

(iii) Level 3. Adult homes and enriched housing programs certified by the Department of Health and schools for the mentally retarded certified by the Office of Mental Retardation and Developmental Disabilities.

The applicable SSI benefits level (C. Care Level III) effective January 2007 is $1,264.00.

The applicable SSI benefits level (C. Care Level III) effective January 2008 is $1,293.00.

Regulation 360-4.8(c) provides in relevant portion, speaking of "MA" (Medical Assistance):

(1) Except as provided in paragraphs (4) and (5) of this subdivision, if an otherwise eligible MA applicant's or recipient's net available income exceeds the appropriate income standard, he/she will be eligible for MA only after incurring medical expenses equal to or greater than the amount of excess income, provided such medical expenses are not subject to payment by a third party other than another public program of the State or any of its political subdivisions. Once deduction of incurred medical expenses reduces income to the income standard, the MA applicant or recipient is eligible for MA; however, no MA payment will be made for those incurred medical expenses used to establish eligibility. The social services district will deduct from the applicant's income the following medical expenses incurred by the applicant, by family members living with the applicant for whom the applicant is legally responsible, and by legally responsible relatives living with the applicant, in the order listed below and regardless of whether these expenses are subject to payment by another public program of the State or any of its political subdivisions:

(i) expenses incurred for Medicare and other health insurance premiums, deductibles, or coinsurance charges;

(ii) expenses incurred for necessary medical and remedial services that are recognized under State law but are not covered by MA; and

(iii) expenses incurred for necessary medical and remedial services that are covered under the MA Program.

(2) Budgeting periods.

(i) To be eligible for MA coverage for acute care in a medical facility, an applicant/recipient must incur medical expenses equal to or greater than the amount of his/her excess income for a period of six months. Once that amount of medical expenses has been incurred, the applicant/recipient may receive full MA coverage for a period of six months.

(ii) To be eligible for MA coverage of all medical care, services and supplies outside the medical facility, as well as prosthetic appliances (including dentures), the applicant/recipient must incur medical expenses in the month equal to or greater than the

> amount of his/her excess monthly income. When that amount of medical expenses has been incurred, the applicant/recipient will receive MA outpatient coverage for any additional medical expenses incurred in that month.

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.

Administrative Directive 91 ADM-11, among other things, advises of the existence of the Elderly Pharmaceutical Insurance Coverage Program (EPIC). According to a year 2008 Department of Health announcement, some EPIC participants will be charged a fee.

General Information Services Message GIS 98 MA/024 describes State policy with regard to the counting of retirement funds as either resources or as income, depending upon the circumstances of the particular case. In relevant portion, the GIS Message states (speaking of applicants/ recipients, or "A/R's"): Medicaid A/Rs who are eligible for periodic retirement benefits must apply for such benefits as a condition of eligibility. If there are a variety of payment options, the individual must choose the maximum income payment that could be made available over the individual's life time. (By federal law, if the Medicaid A/R has a spouse, the maximum income payment option for a married individual will usually be less than the maximum income payment option that is available to a single individual.) Once an individual is receiving periodic payments, the payments are counted as unearned income on a monthly basis, regardless of the actual frequency of the payment. For example, if the periodic benefit is received once a year, the amount is to be divided by twelve to arrive at a monthly income amount.

Once an individual is in receipt of or has applied for periodic payments, the principal in the retirement fund is not a countable resource. This includes situations where a Medicaid applicant has already elected less than the maximum periodic payment amount and this election is irrevocable. In such situations, only the periodic payment amount received is counted as income and the principal is disregarded as a resource.

DISCUSSION

The Appellant requested this hearing to review the Agency's determination to reduce the Appellant's Medical Assistance benefits based on its Notice of "Acceptance" dated July 15, 2008. The hearing record establishes that the effect of this Agency determination was to increase

Appellant's Medicaid-related excess income amount (or "spenddown") from zero dollars to $564.00, monthly, effective August 1, 2008.

Basic due process requires that a Notice of action be accurate in stating the action contemplated. The Agency's July 15, 2008 Notice failed to state that it was a reduction of Medical Assistance, and implied that the Appellant was an applicant for Medical Assistance, while, in fact, she was already a recipient. The July 15, 2008 Notice was in effect a reduction of the Appellant's Medical Assistance.

In addition, the Agency's July 15, 2008 Notice fails to state the amount of the Appellant's spenddown (zero dollars monthly) prior to the intended action.

For the above-stated reasons, the Agency's Notice was not adequate as defined in the Regulations and is void.

The Agency's determination is not sustained.

DECISION

The Agency's determination to reduce the Appellant's Medical Assistance by increasing the monthly spenddown of excess income towards medical expenses from zero dollars to $564.00 effective August 1, 2008 by means of the Agency's July 15, 2008 "Notice of Acceptance" was not correct and is reversed.

1. The Agency is directed to cancel its July 15, 2008 Notice, and to restore the Appellant's Medical Assistance benefits by readjusting the Appellant's monthly Medical Assistance-related excess income to zero dollars monthly, retroactive to August 1, 2008.

2. The Agency is directed to continue to authorize the Appellant to receive full Medical Assistance benefits, subject to a monthly excess income amount of zero dollars.

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 adequacy requirements set forth in Part 358 of Regulations.

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

DATED: Albany, New York
05/05/2009

NEW YORK STATE
DEPARTMENT OF HEALTH

By

D A Braun

Commissioner's Designee