STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST January 19, 2000
CASE #
CENTER # Monroe
FH # 3264417J

In the Matter of the Appeal of

G H

DECISION AFTER FAIR HEARING

from a determination by the Monroe 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 April 25, 2000, in Monroe County, before James Parwulski, Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant (by telephone)

G H Appellant; Loretta Callahan Scheg, Appellant's Representative

For the Social Services Agency

Ms. Sekelsky, Fair Hearing Representative

ISSUES

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 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 receiving Medical Assistance benefits for her own needs.

2. The Appellant has resided in a skilled nursing facility since 1998. The Appellant's spouse, W H , resides in the community. However, since December 1998, W H has been hospitalized and he also has resided for a time in a skilled nursing facility.

3. By letter dated January 14, 1999, the Agency requested the Appellant's spouse to respond in writing, by February 1, 1999, and to provide information pertaining to bank and credit union account transactions.

4. By notice dated February 5, 1999, mailed to the Appellant's home address, the Agency notified the Appellant of its determination to discontinue the Appellant's Medical Assistance benefits as a result of failure to provide required documentation.

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

6. The Appellant's spouse requested a fair hearing on February 26, 1999. A fair hearing (FH# 3074622Z) was scheduled for March 19, 1999. The Appellant's spouse failed to appear for the scheduled fair hearing on March 19, 1999. He requested another fair hearing on August 24, 1999 and he failed to appear for the scheduled fair hearing on November 17, 1999.

7. On January 19, 2000, the Appellant requested this fair hearing.

APPLICABLE LAW

Medical Assistance Application

Pursuant to Section 366-a(1) of the Social Service Law, any person requesting medical assistance may make application in person, through another in his behalf, or by mail.

Sections 360-2.2(d) and (f) of the Department's Regulations provide in part as follows:

(d) Application for MA only.

(1) Persons may apply for MA without applying for ADC, HR, or SSI. Persons may also apply for MA separately from an application for SSI. Such applicants must complete and sign a State-prescribed form in ink. Spouses living together and applying for MA together must both sign the State-prescribed application form. The form may be completed and signed by anyone the applicant designates to represent him/her in the application process. The completed form must be returned to the social services district in the county in which the applicant lives.

(f) Personal interview for applicants and recipients.

(1) The social services district must conduct a personal interview with anyone applying for MA or for recertification of MA, except as provided in paragraphs (2) and (3) of this subdivision. If the applicant/recipient cannot be interviewed due to his/her physical or mental condition, the person who applied on his/her behalf must be interviewed. The district must conduct the interview before making any decision concerning an applicant's/recipient's eligibility for MA.

Responsibility to Present Documentation

Sections 351.1 and 351.2 of 18 NYCRR require that to demonstrate eligibility, applicants for and recipients of Public Assistance or care must present appropriate documentation of such factors as identity, residence, family composition, rent payment or cost of shelter, income, savings or other resources and, for aliens, lawful residence in the United States.

Section 360-2.3 of the Regulations provides that the Medical Assistance applicant and recipient has a continuing obligation to provide accurate and complete information on income, resources and other factors which affect eligibility. An applicant or recipient is the primary source of eligibility information. However, the Agency must make collateral investigation when the recipient is unable to provide verification. The applicant's or recipient's failure or refusal to cooperate in providing necessary information is a ground for denying an application for a Medical Assistance Authorization or for discontinuing such benefits.

Statute of Limitations

Federal regulations at 42 CFR 431.221(d) governing requirements for fair hearings for applicant/recipients of Medical Assistance provide that an appellant must be provided with a reasonable time not to exceed 90 days from the date the notice of action is mailed in which to appeal such action. In New York State, "a reasonable time" has been determined to be 60 days as set forth in Section 22 of the Social Services Law which provides that a request by such an applicant/recipient for a fair hearing to review an Agency's determination must be made within sixty days of the date of the Agency's action or failure to act.

Abandonment of Fair Hearing Request

Department regulations at 18 NYCRR 358.5.5 provide, in pertinent part, as follows:

(a) The Department will consider a fair hearing request abandoned if neither the appellant nor appellant's authorized representative appears at the fair hearing unless either the appellant or appellant's authorized representative has:

(1) contacted the Department within 15 days of the scheduled date of the fair hearing to request that the fair hearing be rescheduled; and

(2) provided the Department with a good cause reason for failing to appear at the fair hearing on the scheduled date; or

(3) contacted the Department within 45 days of the scheduled date of the hearing and establishes that the appellant did not receive the notice of fair hearing prior to the scheduled hearing date.

(b) The Department will restore a case to the calendar if the appellant or appellant's authorized representative has met the requirements of subdivision (a) of this section.

Right to a Notice

A recipient of Medical Assistance 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).

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.18 NYCRR 358-2.2

Corrective Medical Assistance Payment

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.).

DISCUSSION

Following the Agency's determination to discontinue the Appellant's Medical Assistance benefits, the Appellant reapplied for Medical Assistance. The record reflected that the Agency has accepted the Appellant's application and provided Medical Assistance coverage retroactive

to May 1, 1999. The only issue for review at the present time is whether the Agency properly determined to discontinue the Appellant's Medical Assistance benefits effective February 15, 1999 on the ground that requested documentation necessary to determine continuing eligibility was not provided.

The Agency argued at the hearing that the Commissioner has no jurisdiction to review its discontinuance of Medical Assistance benefits because the Appellant did not request this hearing in a timely manner and abandoned two previous fair hearing requests.

The Appellant argued that the statute of limitations is inapplicable because she was not notified of the Agency's determination to discontinue Medical Assistance benefits or that a fair hearing had been scheduled for February 26, 1999 or November 17, 1999.

The record reflects that the Agency sent a Notice of Decision to the Appellant at her home address. It was not shown that the Agency sent a Notice of Decision to the Appellant at the skilled nursing facility or that the Agency notified the skilled nursing facility that the Appellant's Medical Assistance would be discontinued. Pursuant to Department regulation, as set forth above, a recipient of Medical Assistance has a right to an adequate notice when the Agency proposes to discontinue benefits. The Appellant is not incompetent and it was not shown that her spouse was acting as her attorney-in-fact. Therefore, the Appellant had a right to receive notice of the proposed discontinuance. Since the Appellant did not receive a notice, in accordance with established policy, the statute of limitations is inapplicable and the Commissioner has jurisdiction to review the Agency's action.

The record indicated that the Agency authorized the Appellant's spouse to act as the Appellant's representative to file the application for Medical Assistance. Presumably, this was done as a convenience in order that required face-to-face eligibility interviews need not be conducted in the skilled nursing facility. It was not shown, however, that the Appellant designated her spouse as her representative. The documentary evidence provided at the hearing indicated that there was no response to the Agency's letter dated January 14, 1999 requesting the Appellant's spouse to provide an explanation regarding bank account transactions. However, the letter in question was not sent to the Appellant. Unless the Appellant's spouse was authorized by the Appellant to act as her representative, either as her general attorney-in-fact or by specific written authorization, the Agency should have requested the Appellant herself to submit information regarding the financial transactions in question. Had the Agency requested the Appellant to provide the information and she failed to provide the information without good cause, then the Agency would have had a proper basis to take action. The Agency failed to provide sufficient evidence in support of its determination to discontinue the Appellant's Medical Assistance. Accordingly, the Agency's determination cannot be sustained.

DECISION AND ORDER

The Agency's determination to discontinue the Appellant's Medical Assistance benefits for failure to provide documentation necessary to

determine the Appellant's continuing eligibility for assistance is not correct and is reversed.

The Agency is directed to restore lost benefits retroactive to February 15, 1999, the date of its discontinuance of the Appellant's Medical Assistance benefits.

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

DATED: Albany, New York
May 11, 2000

NEW YORK STATE DEPARTMENT
OF HEALTH

By

Commissioner's Designee