STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: May 30, 2007
CASE #: MAxxxxxxxbb
AGENCY: Monroe
FH #: 4801218L

In the Matter of the Appeal of

K J

from a determination by the Monroe County 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 July 10, 2007 and August 16, 2007, in Monroe County, before David State, Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant
K J, Appellant;
Lori OBrien, Esq. (Monroe County Legal Assistance Center);
Joy VanRiper (Intern with Monroe County Legal Assistance Center, appeared on 7/10/2007);
L S (Director of Social Work, BS, appeared on 8/16/2007)

For the Social Services Agency
Luis Zamot , Fair Hearing Representative (appeared on 7/10/2007);
Mitchell Henry-Walker (Fair Hearing Representative, appeared on 8/16/2007)

ISSUE

Was the Agency's April 20, 2007 determination that the Appellant was in permanent absent status and subject to Chronic Care Medical Assistance budgeting status effective July 1, 2006 timely?

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. On July 20, 2006, the Appellant, age 53, was admitted to BS, a skilled nursing facility.

2. Prior to being admitted to BS, the Appellant was hospitalized at H Hospital.

3. The Appellant was admitted to BS for "short term rehab" stemming from a wound in her sacral area and ORSA in her urine. (Appellant Exhibits #2 and #3).

4. At the time of her admission to BS, the Appellant had an active Medical Assistance case with a spenddown. (Agency Exhibit #1 at page 8; Appellant Exhibit #3). The Agency record showed that the Appellant was in receipt of Medical Assistance since June 2004.

5. The Appellant has been diagnosed with multiple sclerosis, a sacral pressure ulcer, and depression among other ailments. (Appellant Exhibit #1 at page 3).

6. On April 20, 2007, the Agency determined that the Appellant "has been approved for Medical Assistance coverage of institutional services effective July 1, 2006." (Agency Exhibit #2).

7. On May 30, 2007, the Appellant requested this fair hearing.

APPLICABLE LAW

Under provisions of Section 366.1(a)(5) of the Social Services Law and Section 360-4.8 of the Regulations, a person who is permanently disabled, and who has not qualified for Medical Assistance ("Medicaid") by reason of financial eligibility for receipt of Public Assistance or Federal Supplemental Security Income (SSI) but who may otherwise be eligible for SSI, may be eligible for "Medicaid" if he or she meets certain financial and other eligibility requirements under the Medicaid program.

Sections 360-4.1 and 360-4.8(b) of the Regulations provide that all income and resources actually or potentially available to a Medicaid applicant or recipient must be evaluated, and such income and/or resources as are available must be considered in determining eligibility for Medicaid. A Medicaid applicant or recipient whose net available non-exempt resources exceed the resource standards will be ineligible for Medicaid coverage until he or she incurs medical expenses equal to or greater than the excess resources. In 2007, the Medicaid resource standard (a general exemption) for a single individual is $4200.00.

Section 360-1.4(c) of the Regulations defines Chronic Care budgeting as a procedure used for individuals who are in "Permanent Absence" status. For such individuals, Chronic Care budgeting begins as of the first day of the calendar month following the month in which the individual is determined to be in permanent absence status.

Under Section 360-1.4(k) of the Regulations, Permanent Absence status means an individual is not expected to return home. Unless overcome by adequate medical evidence, it will be presumed that an individual will not return home if:

(1) a person enters a skilled nursing or intermediate care facility;

(2) a person is initially admitted to acute care and is then transferred to an alternative level of care, pending placement in a residential health care facility (RHCF); or

(3) a person having no community spouse remains in an acute care hospital for more than six calendar months.

To determine financial eligibility, a person's net income must be calculated. Ordinarily, for cases NOT involving Chronic Care, net income is derived by deducting exempt income and allowable deductions from gross income. Section 360-4.6 of the Regulations sets forth allowable exemptions, disregards and deductions from income. In determining net income for a person in Chronic Care, the amount required for payment of health insurance premiums is allowed as a deduction, and the amount of $50 is deducted as a monthly Personal Needs Allowance (PNA) for a resident of a Residential Health Care Facility (RHCF) or a person in permanent absence status in an acute care hospital. Residents of psychiatric care facilities, developmental centers or intermediate care facilities under Article 31 of the Mental Hygiene Law is allowed a PNA of $35. A PNA of up to $90 is allocated to a person receiving a pension under 38 U.S.C.5503(f) or who has elected a greater compensation benefit under 38 CFR 3.701 in lieu of such pension. An amount will be set aside to meet maintenance needs of dependents in the Appellant's former household. 18 NYCRR 360-4.9.

In addition pursuant to 18 NYCRR 360-4.9, certain income of a person residing in a RHCF who does not have a spouse living in the community is also not required to be applied toward the cost of medical care:

(i) money received as the result of a legal action against the RHCF because of improper and/or inadequate treatment;

(ii) income necessary to achieve a plan of self-support;

(iii) SSI benefits paid under section 1611(e)(1)(E) of the Social Security Act;

(iv) German reparation payments;

(v) benefits paid to eligible Japanese-Americans and Aleuts under the federal Civil Liberties Act of 1988 and the Aleutian and Pribil of Islands Restitution Act;

(vi) payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, and payments received from court proceedings brought for personal injuries sustained by veterans resulting from exposure to dioxin or phenoxy herbicides in connection with the war in Indochina in the period of January 1, 1962 through May 7, 1975;

(vii) payments made by the Austrian government under paragraphs 500 to 506 of the Austrian General Social Insurance Act provided that the payments remain identifiable as such; and

(viii) income equal to the amount of a reduced pension pursuant to 38 U.S.C. 5503(f), for a veteran's surviving spouse who receives such a pension; such income will count toward the personal needs allowance.

A Medicaid authorization may be issued for necessary medical costs exceeding the net available income (NAMI).

358-3.3 Notice requirements.

(a) Public assistance, medical assistance and services: notice of action.

(1) Action to discontinue, suspend, reduce, restrict; changes in the manner of payment for child care services; denial of an extension of a waiver of public assistance program requirements or termination or modification of such waiver. Except as set forth in subdivision (d) of this section, you have a right to timely and adequate notice when a social services agency proposes to:

(i) take any action to discontinue, suspend, or reduce your public assistance grant, medical assistance authorization or services; or

(ii) change the manner or method or form of payment of your public assistance grant; or

(iii) restrict your medical assistance authorization; or

(iv) make changes in the manner of payment for your child care services and such change results in the discontinuance, suspension, reduction or termination of benefits, or forces you to make changes in child care arrangements; or

(v) make changes in the manner of payment for your supportive services provided to enable you as a recipient of public assistance to participate in work activities pursuant to Part 385 of this Title and such changes result in the discontinuance, suspension, reduction or termination of benefits, or force you to change child care arrangements; or

(vi) deny an extension of a waiver of public assistance program requirements under section 351.2(l) of this Title or such waiver has been terminated or modified.

18 NYCRR 358-2.23 Timely notice provides as follows:

Timely notice means a notice which is mailed at least 10 days before the date upon which the proposed action is to become effective.

DISCUSSION

The Agency's April 20, 2007 determination that the Appellant was permanently absent and in Chronic Care Medical Assistance budgeting status retroactive to July 1, 2006 was not timely.

Initially it is noted that although the Appellant appeared and participated in the fair hearing on July 10, 2007 the Appellant did not appear at the adjourned date of August 16, 2007. The matter was specifically adjourned to August 16, 2007 for the Appellant's attorney to call an additional witness, L S, on the Appellant's behalf. The Appellant's attorney waived the Appellant's appearance at the continuation of the fair hearing on August 16, 2007.

It is undisputed that the Appellant entered a skilled nursing facility (BS) on July 20, 2006 where she continues to reside. The Appellant does not contest the income or resources used by the Agency in determining the Appellant's chronic care budget. The Appellant raises two points: **(1)** a timeliness objection in view of the Agency's April 20, 2007 determination which retroactively approved the Appellant's Medical Assistance coverage effective July 1, 2006 with monthly income contributions of $604.00 from 7/1/2006 – 7/31/2006 and $1,266.00 effective 8/1/2006, effectively increasing the contribution to the cost care from its status prior to her admission to skilled nursing facility . (Agency Exhibit #2); and **(2)** the Appellant contends that she has rebutted the presumption that she will not return home and that the Agency improperly used chronic care budgeting because the Appellant is not in Permanent Absent status. (See, 18 NYCRR Section 360-1.4(k)).

The Agency's April 20, 2007 determination to increase the Appellant's contribution to her medical costs retroactive to July 1, 2006 was not timely. The Agency's case record establishes that the Appellant had active Medical Assistance coverage with a spenddown at the time of her admission to BS. Although there is a notation on 9/12/2006 that the Appellant's "case closed 9/22/06 has not met SD from 6/06" the Agency did not produce a CNS or manual notice to that effect and the MA coverage history provided by the Agency shows provisional coverage for the period from 6/1/2006 – 9/22/2006 and full coverage from 7/1/2006 – 2/29/2008. (Agency Exhibit #1 at page 8). Additionally, there was unrefuted testimony that the Appellant was subject to a $606.00 Medical Assistance spenddown when she entered BS in July 2006. The Appellant points to the holding of a prior Fair Hearing decision of the Commissioner dated July 10, 2003 (FH #386882N)("there is no legal authority to change a Medicaid authorization without timely and adequate notice" (Appellant Exhibit #1 at page 4) noting that the impact of the regulations on timely and adequate notice have import especially when "the person notified has had no forewarning of the action, and is adversely affected by the untimeliness of the notice." (Appellant Exhibit #1 at page 5). In this case, it is evident that the Agency's April 20, 2007 notice may have adversely impacted the Appellant's ability to identify medical evidence during the critical period, starting with the beginning of her admission in July 2006, to overcome the presumption that she will not return home.

Moreover, for the period from on or about April 20, 2007 when the Agency's determination should have been effective to comply with timely notice requirements, the burden is on the Appellant to show "adequate medical evidence" to overcome the presumption that she "will not return home. (See, 18 NYCRR Section 360-1.4(k)). Although the record establishes that the Appellant was admitted for "short term rehab" on July 21, 2006 for "wound care" relating to a bed sore (i.e. sacral ulcer)(Appellant Exhibit #2 and Appellant Exhibit #3 at page 6), there is scant medical evidence covering the period from April 2007 forward (other than progress notes covering the period from 3/21/2007 – 5/21/2007, See Appellant #1 pages 2-8). The most recent progress note signed by a physician is dated 5/21/2007. (Appellant Exhibit #1 at page 4). Although Ms. S, the Director of Social Work for BS, testified that she does have knowledge of and is involved with client medical care due to her position sitting on the care team; reviewing care plans; and interaction with physical therapists and physicians on discharge determinations, her testimony and social work progress notes in this case do not constitute sufficient "adequate medical evidence to overcome the presumption that the Appellant "will not return home. For example, Ms. S testified that the Appellant's wound has healed but noted a recent hospitalization due to the depth of her wound increasing and that the Appellant's wound has not healed to the point where she can be discharged home. Ms. S did not produce any medical evidence that would support her testimony as to wound depth and it is evident that there is a lack of medical documentation covering the period from on or about April 20 2007 forward. In view of the previously discussed problem with the timeliness of the Agency's notice, this matter is remanded back to the Agency to allow the Appellant an opportunity to submit any additional "adequate medical evidence" in an attempt to rebut the presumption that the Appellant "will not return home." (See, 18 NYCRR Section 360-1.4(k)).

It is noted that Ms. S did credibly explain how the term "institutionalized" appeared on a BS form and that the worker who entered that information and that the worker failed to follow the proper protocol for making an initial determination about whether a patient should be classified as "expected to return home or will they remain institutionalized." (Agency Exhibit #1 at page 2)

DECISION AND ORDER

The Agency's April 20, 2007 determination to change the Appellant's Medical Assistance authorization, to the extent said notice sought to make the change retroactive to July 1, 2006, is not correct, and is reversed.

1. The Agency is directed to take no action on so much of its April 20, 2007 notice as sought to provide "Medical Assistance coverage of institutional services effective July 1, 2006" and to authorize coverage in the manner authorized for recipients not in "chronic case."

2. This matter is remanded to the Agency and the Agency is directed to permit the Appellant a reasonable opportunity to submit "adequate medical evidence" to rebut the presumption that the Appellant "will not return home" and after this opportunity to provide the Appellant timely and adequate notice of its determination.

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
August 27, 2007

NEW YORK STATE
DEPARTMENT OF HEALTH

By

[[Signature]]

Commissioner's Designee