STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: September 17, 2004
CASE NO: M
CENTER : Erie
FH No. : 4192841L

In the Matter of the Appeal of :
: DECISION
DCH : AFTER
: FAIR
from a determination by the Erie County : HEARING
Department of Social Services :

JURIDICTION

Pursuant to Section 22 of the New York State Social Services Law (herinafter referred to as "the Social Services Law") and Part 358 of Title 18 of the New York Code of Rules and Regulations (18 NYCRR, hereinafter referred to as "the Regulations"), a Fair Hearing was held on October 19, 2004, in Buffalo, New York, before Administrative Law Judge Snitzer. The following persons appeared:

For the Appellant

D C-H, the Appellant;
Karen Welch, the Appellant's attorney (NLS)

For the Erie County Department of Social Services
(herein referred to as "the Agency")

Ms.Kazukiewicz, Examiner

ISSUE

Was action affecting the adequacy of coverage authorized for the Appellant under Family Health Plus, more specifically, action to exclude her from such coverage under that program because she is a medically-disabled person currently enrolled in Medicare Part A, correct?

FACT FINDINGS

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, 2004, the Appellant and her husband applied for Health Coverage for their entire family under the Family Health Plus program (a Medical Assistance program alternate authorized under the Health Care Reform Act of 2000 ("HCRA").

a. By said application, the Agency was informed that the family (consisting of two adults and four children) had been covered by private health insurance, but such insurance would end July 31st.

2. On September 10, 2004, the Agency determined to accept the July 20th application for the Appellant and her husband, and to enroll them in Community Blue, the Health Plan chosen for the family.

a. Said notice indicated that the acceptance of the application involved a finding that the family's countable gross income totalled $3,032 per month, and said amount was below the monthly income eligibility limit of $3,152 applicable to a six-person family.

b. Also issued to the Appellant and her husband at that time was a separate notice indicating the Agency's finding that the family did not qualify for (traditional) Medicaid coverage, because its countable income of $1,808 exceeded the income standard applicable to a six-person household.

3. Some time thereafter, and without issuance of any written notice, the Agency verbally advised the Appellant that it could not include her in the family's Family Health Plus enrollment, because she is enrolled in other health coverage under Medicare Part A.

a. The Appellant has been officially found to be medically disabled by reason of a long-term illness (Multiple Sclerosis), and is receiving Social Security Disability income based on that status.

b. Because she is receiving Social Security, she is also enrolled in Medicare Part A, an enrollment that covers limited medical care and services.

4. On September 17, 2004, a request for a Fair Hearing was made by or on behalf of the Appellant, seeking review of the Agency's verbal advice that she could not be included in the Family Health Plus with all other members of her family.

APPLICABLE LAW

An Administrative Directive issued by the NYS Department of Health on November 2, 2001 (01 OMM/ADM-4) advised local districts of the Eligibility requirements for the Family Health Plus program ("FHPlus"). Section IV-2 (f) of said Directive advised that, unlike Medicaid, applicants with health insurance are not eligible for FHPlus except in limited instances.

Attachment IX of said Directive lists all exceptions to the above policy, concluding that, unless an adult applying for coverage under Family Health Plus has coverage that is specifically listed as an exception, any adult having other health coverge is not eligible for Family Health Plus, regardless of the limited nature of such coverage. Said Attachment lists the following exceptions:

1) Accident-only coverage or disability income insurance
2) Coverage issued as a supplement to liability insurance
3) Liability insurance, including Auto insurance
4) Worker's compensation or similar insurance
5) Automobile medical payment insurance
6) Credit-only insurance
7) Coverage for on-site medical clinics
8) Dental-only or vision-only, or long term care insurance; Specified disease coverage
9) Hospital indemnity or other fixed dollar indemnity coverage

10) Medicare supplemental only or CHAMPUS supplemental coverage
11) Health New York-(individual only, not employer based coverage)
12) specified disease coverage

Another Administrative Directive issued by the Department of Health February 7, 2002 (02/OMM/INF-01) clarified the above policy, advising local districts that if a Family Health Plus applicant has Medicare A, Medicare B, or both A and B at the time of application, said applicant shall be ineligible for enrollment, based on having other insurance.

Section 358-3.3(a) of the Regulations provides that a recipient has a right to timely and adequate notice when a social services agency proposes to take any action to discontinue, suspend, or reduce a Temporary Assistance grant, Medical Assistance authorization or services. Section 358-2.2 of the Regulations defines "adequate" notice, referring to the content thereof. Section 358-2.23 of the Regulations defines "timely" notice as that which is mailed at least ten days prior to the date upon which it is to be effective.

DISCUSSION

Solely because the Agency failed to issue a proper written notice of what may be viewed as a reduction of the family's FHPlus for the purpose of excluding or disenrolling the Appellant due to her on-going coverage under Medicare Part A, any action taken to provide FHPlus coverage for fewer than all members of the Appellant's family cannot be affirmed. The absence of a written notice, while evidently viewed by the Agency representative as a mere technicality, renders wholly ineffectual any determination to limit or restrict the FHPlus coverage. The Agency's procedural defect, one affecting the Appellant's right to due process, cannot be cured merely by the fact that a timely request for a Fair Hearing was made in this instance.

Having rendered an unconditional notice of acceptance of the July 20, 2004 application for FHPlus, indicating that the Appellant and her husband had met all eligibility requirements for enrollment in a selected Health Plan for the family, the only proper course of action the Agency could have considered taking, upon determining that the inclusion of the Appellant in that authorization was a mistake, was to issue a written notice of its intent to disenroll her from the Health Plan based on her ineligibility. The issuance of such notification would have been consistent with current state law and policy regarding Family Health Plus, which provides that an adult who has "equivalent" health insurance is not eligible for Family Health Plus.

At the hearing, the Agency representative explained that when she initially accepted the family's application for Family Health Plus, the Appellant was included because Medicare Part A was not understood to be considered "equivalent coverage"; Family Health Plus covers a comprehensive range of medical services and supplies, while Medicare Part A covers only

hospitalization. She later discovered, however, that this was not correct, and felt obligated to advise the Appellant of the error. The Department specifically advising local districts (in 02-OMM/INF-01 issued February 7, 2002) that persons who have Medicare Part A are not eligible for Family Health Plus.

It was noted that the Appellant is the primary consumer of health services in her family. Although the children require periodic check-ups and occassional treatment, the Appellant's illness requires very costly medical services and supplies on a continuing basis.

The materials submitted by the Agency included a letter received October 18th from the Appellant's husband, stating he would not need FHP benefits because his wife does not qualify for FHP due to her disability status and Medicare Part A benefits. At this hearing, however, the Appellant's counsel asked that the letter be disregarded, as the family can't actually afford private health insurance; she expressed her understanding that the husband felt, at the time he wrote the letter, that if the Appellant, whose necessary medical care is so costly, could not be included in the FHPlus, it might be advantageous to have the prior coverage reinstated. At one point in the hearing, it was mentioned that the premium cost of private health insurance had been $599 per month.

DECISION AND ORDER

Any action taken without the issuance of a timely and adequate written notice to exclude the Appellant from her family's enrollment in Family Health Plus, and/or to disenroll her from that program, based on her on-going enrollment in Medicaid Part A, is not correct, and is reversed.

* The Agency is directed to restore coverage authorized at the time of application and to take all action consistent with the law and policy cited above, including the issuance of proper written notice of any determination to change the authorization for Family Health Plus to limit such authorization or enrollment, and/or to exclude the Appellant or to disenroll her from a previously-selected Health Plan, based on her current Medicare Part A coverage.
* The Agency is also directed to evaluate the Appellant's financial eligibility for coverage under the Medicaid program.

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

DATED: Albany, New York
November 22, 2004

NEW YORK STATE DEPARTMENT OF HEALTH

By

Commissioner's Designee