STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: July 26, 2019
[redacted]
AGENCY: MAP
FH #: 8001003R

In the Matter of the Appeal of

[redacted]

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 29, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Social Services Agency

Diane McAulay, Fair Hearing Representative

ISSUES

Was the determination of the Agency as to the reduction of Appellant's Medical Assistance coverage correct?

Was the Managed Long Term Care Plan determination that Appellant owes $21,993 for several months unpaid spenddowns 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 51 and certified disabled, has been in receipt of a Medical Assistance authorization for herself. Appellant has been enrolled in Managed Long Term Care with Centers Plan for Healthy Living.

2. By notice dated January 28, 2019, and effective February 9, 2019 (actually March 1, 2019), the Agency informed the Appellant her Medicaid coverage was being reduced by having her monthly spenddown increased from $1,284.00 to $1,296.00.

3. Effective April 1, 2019, the Agency has imposed a monthly spenddown of $1,703.00 on Appellant.

4. Effective for 2019, Appellant receives $1,734.50 a month from Social Security Disability and $983.00 from a union pension.

5. Appellant pays a Medicare Part B Premium of $135.50.

6. On July 26, 2019, the Appellant requested this fair hearing.

APPLICABLE LAW

Section 22 of the Social Services Law provides that applicants for and recipients of Public Assistance, Emergency Assistance to Needy Families with Children, Emergency Assistance for Aged, Blind and Disabled Persons, Veteran Assistance, Medical Assistance and for any services authorized or required to be made available in the geographic area where the person resides must request a fair hearing within sixty days after the date of the action or failure to act complained of. In addition, any person aggrieved by the decision of a social services official to remove a child from an institution or family home may request a hearing within sixty days.

As per Matter of Bryant v. Perales, 161 A.D.2d 1186 (4th Dept.1990), the 60 day Statute of Limitations starts from the Appellant's receipt of the pertinent notice.

An applicant or recipient has the right to challenge certain determinations or actions of a social services agency or such agency's failure to act with reasonable promptness or within the time periods required by other provisions of this Title, by requesting that the Department provide a fair hearing. An applicant or recipient does not have the right to a fair hearing in all situations. 18 NYCRR 358-3.1(a), (f).

Regulations at 18 NYCRR 358-3.3(a) provide that a recipient of Public Assistance, Medical Assistance or services has a right to notice when the agency proposes to take any action to discontinue, suspend, or reduce a Public Assistance grant, Medical Assistance authorization or services. In general, a recipient of Public Assistance, Medical Assistance or Services (including child care and supportive services) has a right to a timely and adequate notice when the Agency proposes to discontinue, suspend, reduce or change the manner of payment of such benefits. An adequate, though not timely, notice is required where the Agency has accepted or denied an application for Public Assistance, Medical Assistance or Services; or has increased the Public Assistance grant; or has determined to change the amount of one of the items used in the calculation of a Public Assistance grant or Medical Assistance spenddown; or has determined

that an individual is not eligible for an exemption from work requirements. 18 NYCRR 358-3.3(a).

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

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

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.

Administrative Directive 93 ADM-9 provides, in pertinent part, that weekly income of an applicant, including average weekly income, must be multiplied by 4.333 to obtain a monthly figure. In practice, 4.333333 is employed.

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 provide 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:…

(iii) 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' unearned income is under $20, the balance will be deducted from earned income;
(iv) the first $65 of earned income;
(v) for disabled MA applicants/recipients, nonmedical, impairment-related work expenses;
(vi) one half of the remaining earned income after the disregards listed in subparagraphs (ii)-(v) of this paragraph have been applied;
(vii) health insurance premiums;….
…

As per GIS 18/MA 15, for a household of 1, the Medically Needy level for SSI/ADC-related is **$859.00** in 2019

According to General Information Services Message GIS 04 MA/027, most interest income can no longer be budgeted in computing the excess income of SSI-related Medicaid recipients, effective July 1, 2004. This results from the Social Security Protection Act of 2004, Public Law 108-203. The new interest/dividend income exclusion for SSI-related A/Rs only applies to community budgeting, NOT to chronic care budgeting.

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 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.

Administrative Directive 91 ADM-27 explains budgeting of Medicaid in the SSI-related category, and states, in part:

> This Administrative Directive advises social services districts about changes in the Medical Assistance (MA) eligibility requirements which were enacted by Chapter 938 of the Laws of 1990. Pursuant to Chapter 938, resource exemption standards are being reduced and certain income exemptions are being eliminated. In addition, the method for

determining household size is revised for Supplemental Security Income (SSI)-related adult applicants/recipients (A/Rs).

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Court-ordered support payments are no longer deducted from income, except as specified below. (Note, the abbreviation "A/R" refers to an applicant/ recipient, that is, an applicant for or recipient of Medicaid).

Court-Ordered Support Payments

Social services districts must continue to deduct court-ordered support in the following situations:

a. when determining the amount of income to be deemed to:

1) an SSI-related A/R from a non-SSI-related spouse living with the A/R; and

2) an SSI-related child from a parent (of any category) living with the child;

NOTE: In the two situations above, deduct the amount of the support payments from the LRR's income before determining the amount of income to be deemed to the SSI-related A/R.

b. when determining the otherwise available income (OAI) of a non-applying community spouse and family member in accordance with 89 ADM-47;

c. when determining the OAI of a non-applying spouse living apart from an SSI-related A/R for the purpose of calculating the requested contribution; and

d. when determining the eligibility of an institutionalized spouse, and the amount of income to be applied to the cost of care, the amount of any court-ordered support for the community spouse is an allowable deduction. The community spouse monthly income allowance must not be less than the amount of the court-ordered support for the community spouse in accordance with 90 ADM-36.

These are the only instances in which court-ordered support payments are allowable income exemptions. With the exception of these specified instances, the MA worker must not allow these eliminated income exemptions in determining the available income of an LRR or the OAI of a

community spouse and family member.

NOTE: In chronic care cases involving an institutionalized spouse, continue to enter the amount of the court-ordered support payment from the institutionalized spouse to the community spouse in excess of the calculated community spouse income allowance on MBL as Additional Allowance Code 19.

General Information Services Message 13 MA/018 provides, in part (speaking of Managed Long-Term Care, or "MLTC," and the local department of social services, or "LDSS"):

Monthly Spenddown

Medicaid recipients with a monthly spenddown are eligible for participation in MLTC. Once the LDSS receives verification that an individual is eligible for participation in a MLTC plan, 06 (provisional coverage) or 19 (community coverage with community based long term care) coverage, as applicable, should be authorized. Currently, Coverage Code 06 will not convert to the Prepaid Capitation Plan (PCP) Coverage Code 30 (PCP full coverage) in order to allow payment to the MLTC plan. However, a system change is pending that will convert the 06 to 30, when there is a prospective MLTC enrollment line in the PCP subsystem. Until districts are notified of the effective date of this change, 01 (full coverage) must be authorized.
The MLTC plan is responsible to collect the amount of the spenddown from the enrollee. The LDSS must inform both the Medicaid eligible applicant/recipient and the plan of the amount of the spenddown. A copy of the eligibility notice with just the enrollee's information displayed may be used for this purpose. Additionally, WMS will pass the spenddown amount to the MLTC plan on a monthly roster. A list of providers that participate in MLTC can be found on the website of the Division of Long Term Care.

Since certain out-of-pocket medical expenses (e.g. co-insurance charges) and expenses for necessary medical and remedial services that are recognized under State law but are not covered by Medicaid, which are the responsibility of the enrollee, must be used first to meet a spenddown liability, the amount owed to a MLTC plan must be reduced by these costs. Receipts, bills or other evidence of incurred expenses must be submitted to the LDSS by the enrollee. The district will need to advise both the MLTC enrollee and the plan when such expenses have been applied toward the monthly spenddown. The LDSS-3183, "Provider/Recipient Letter (Financial Obligation of Recipient Toward Medical Expenses)" has been revised for use in providing this notification. The revised letter is attached to this GIS.

18 NYCRR section 360-4.8 (c) provides in relevant portion that spenddowns (excess income amounts) for medical care, services and supplies outside of medical facilities, and offset of such spenddowns, are on a month to month basis. The same Regulation provides that spenddowns (excess income amounts) for medical care, services and supplies outside of medical facilities, and offset of such spenddowns, are on a basis of the monthly spenddown multiplied by six.

DISCUSSION

By notice dated January 28, 2019, and effective February 9, 2019 (actually March 1, 2019), the Agency informed the Appellant her Medicaid coverage was being reduced by having her monthly spenddown increased from $1,284.00 to $1,296.00. Effective April 1, 2019, the Agency has imposed a higher monthly spenddown of $1,703.00 on Appellant, as shown by a computer budgeting sheet produced. The Appellant requested this hearing on July 26, 2019 for review of the current spenddown.

It is noted that this hearing was requested more than 60 days after the April 1 effective date. However, there was no showing whatsoever that any notice was received by Appellant more than 60 days before she requested this hearing. Accordingly, the Statute of Limitations is inapplicable here and This Tribunal may proceed with review as desired.

A. As to the Amount Imposed

Appellant has stated the amount of the spenddown was way too high and said she could only pay $50.00 a month. The Appellant's income was uncontested-- Appellant receives $1,735.50 a month from Social Security Disability and $983.00 from a union pension. It was otherwise uncontested Appellant has a Medicare Part B premium of $135.50 and is entitled to a $20 unearned income deduction. *No contested facts existed here.*

No evidence was presented that Appellant qualified for other deductions or exemptions. Appellant testified that half her union pension goes to her ex-husband as part of her divorce settlement. However, as per 91 ADM 27, alimony and support payments are not deducted from income except under limited circumstances which do not apply here.

The Appellant, like others similarly situated, said she can not afford her current spenddown. Unfortunately for Appellant and others similarly situated, non-medical expenses do not count for Medicaid purposes. Stated inability to pay the spenddown also does not matter under applicable policy and regulations.

Based on the foregoing, a proper calculation of the Appellant's Medical Assistance entitlement for the period at issue is as follows:

Unearned Income

Social Security Disability	$1,734.50
Union Pension	$983.00

Monthly Unearned Income	$2,718.50
Subtract	
$20 Disregard	$ 20.00
Medicare Part B Premium	$135.50
Net Monthly Unearned Income	$2,563.00
Gross Monthly Earned Income	$0.00
Total Net Income	$2,563.00
Subtract	
Medical Assistance standard of need for 1	$859.00
Excess Income	$1,703.00

Although quite high, the amount calculated by the Agency was in accordance with proper procedures.

B. As To Implementation of the New Spenddown April 1

The Agency failed to produce any proof that it created or sent a notice informing Appellant of the change in the spenddown from $1,296.00, as was effective March 1, to $1,703.00 as of April 1, 2019. Without any proof a proper notice was sent as required, the Agency's adverse upward change can not be upheld.

C. As to the Managed Long Term Care Plan's Financial Claims Against Appellant

Appellant also requested this hearing because she stated that on or about September, 2019, she received a bill for $21,993 from her Managed Long Term Care Plan, stating this was owed for prior months' unpaid spenddowns.

It is noted that Managed Long Term Care Plans are authorized under the regulations to collect spenddowns from enrollees. Because of the decision above, Appellant will now owe approximately $2,800 less, the difference with 7 months' spenddown, than she would otherwise once the Agency notifies the MLTCP. However, the rest of the Managed Long Term Care Plan's claims against Appellant for unpaid debts are matters for Civil Court, not an administrative hearing (Fair Hearing) from the Office of Administrative Hearings of the Office of Temporary and Disability Assistance, on behalf of the New York State Department of Health. The Commissioner lacks jurisdiction as to the MLTCP's monetary claims against Appellant.

DECISION AND ORDER

The Commissioner lacks jurisdiction over the Managed Long Term Care Plan's financial claims against Appellant.

The Agency determination, increasing Appellant's monthly spenddown from $1,296.00 to $1,703.00, effective April 1, 2019, was not correct and is reversed.

1. The Agency is directed to retroactively adjust Appellant's Medical Assistance-related excess income amount to $1,296.00 monthly, effective April 1, 2019.

2. The Agency is directed to continue to authorize Appellant to receive Medical Assistance, subject to an excess income amount of $1,296.00 monthly.

3. The Agency is directed to promptly notify Appellant's MLTCP of this adjustment.

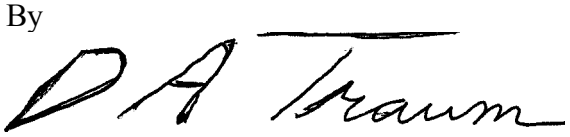
4. In the event that the Agency determines to implement its previously contemplated action, the Agency is directed to provide the Appellant with a notice that meets the requirements set forth in 18 NYCRR 358-2.2.

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

DATED: Albany, New York
11/18/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee