STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: September 8, 2016
[redacted]
AGENCY: MAP
FH #: 7376400Q

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 28, 2016, 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

Barbara Allen, Fair Hearing Representative

ISSUE

Was the Agency's determination not to pay the Appellant's invoice from his Managed Long Term Care Plan for his Medicaid surplus 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 has been in receipt of Medical Assistance benefits with a spenddown.

2. The Appellant requested this fair hearing because the Agency has not paid an invoice from the Appellant's Managed Long Term Care Plan for his Medicaid surplus incurred from June 1, 2016 to October 31, 2016.

APPLICABLE LAW

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 initial authorization for Medical Assistance will be made effective back to the first day of the first month for which eligibility is established. A retroactive authorization may be issued for medical expenses incurred during the three month period preceding the month of application for Medical Assistance, if the applicant was eligible for Medical Assistance in the month such care or services were received. 18 NYCRR 360-2.4(c).

Payment may be made to a recipient or the recipient's representative for reimbursement of paid medical bills for services received during the recipient's retroactive eligibility period, provided that the recipient was eligible in the month in which the services were received. For services received during the period beginning on the first day of the third month prior to the month of the Medical Assistance application and ending on the date the recipient applied for Medical Assistance payment can be made without regard to whether the provider of services was enrolled in the Medical Assistance program. However, if the services were furnished by a provider who was not enrolled, the provider must have been otherwise lawfully qualified to provide such services, and must not have been excluded or otherwise sanctioned from the Medical Assistance Program. If services were provided when the recipient was temporarily absent from the State, payment will be made if: Medical Assistance recipients customarily use medical facilities in the other state; or the services were obtained to treat an emergency medical condition resulting from an accident or sudden illness. 18 NYCRR 360-7.5(a).

For services received during the period beginning after the date the recipient applied for Medical Assistance and ending on the date the recipient received his or her Medical Assistance identification card, payment may be made only if the services were furnished by a provider enrolled in the Medical Assistance program. 18 NYCRR 360-7.5(a).

Reimbursement is limited to the Medicaid rate or fee in effect at the time the services were provided. 18 NYCRR 360-7.5(a).

Department Regulations at 18 NYCRR 360-7.5(a) set forth how the Medical Assistance Program will pay for medical care. Generally the Program will pay for covered services which are necessary in amount, duration and scope to providers who are enrolled in the Medical Assistance program, at the Medical Assistance rate or fee which is in effect at the time the services were provided.

In instances where an erroneous eligibility determination is reversed by a social services district discovering an error, a fair hearing decision or a court order or where the district did not determine eligibility within required time periods, and where the erroneous determination or delay caused the recipient or his/her representative to pay for medically necessary services which would otherwise have been paid for by the Medical Assistance Program, payment may be made directly to the recipient or the recipient's representative. Such payments are not limited to the Medical Assistance rate or fee but may be made to reimburse the recipient or his/her representative for reasonable out-of-pocket expenditures. The provider need not have been enrolled in the Medical Assistance program as long as such provider is legally qualified to provide the services and has not been excluded or otherwise sanctioned from the Medical Assistance Program. An out-of-pocket expenditure will be considered reasonable if it does not exceed 110 percent of the Medical Assistance payment rate for the service. If an out-of-pocket expenditure exceeds 110 percent, the social services district will determine whether the expenditure is reasonable. In making this determination, the district may consider the prevailing private pay rate in the community at the time services were rendered, and any special circumstances demonstrated by the recipient. 18 NYCRR 360-7.5(a).

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(c)(2).

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.

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.

Regulations at 360-4.6(a) list the income which is disregarded for all applicants for or recipients of Medical Assistance. Income which is disregarded includes:

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.

Local social services districts now provide a "Pay-In" program, established under provisions of Section 366(2)(b)(3) under which Medical Assistance recipients having excess income may simply remit the amount of the excess to the local district each month, and receive an uninterrupted authorization for full coverage for all costs (at the Medicaid rate) of all necessary medical services by participating providers.

DISCUSSION

The record establishes that the Appellant has been in receipt of Medical Assistance benefits with a monthly surplus or spenddown in the amount $575.00. The Appellant requested this fair hearing because the Agency has not paid an invoice from Centers Plan for Healthy Living, the Appellant's Managed Long Term Care Plan, for his Medicaid surplus. The invoice submitted at the hearing establishes that the bill, dated October 5, 2016, in the amount of $2,875.00, is for the Appellant's monthly surplus incurred from June 1, 2016 to October 31, 2016.

The record establishes that the Appellant is a recipient of Managed Long Term Care. It is common for Managed Long Term Care Plans to bill patients for the entire amount of a surplus or spenddown (excess income amount), as the local Agency and/or State pays the Plan the Medicaid monthly rate, less the spenddown amount. To make use of other incurred medical expenses and pharmacy co-pays, and so on, Appellant could try to submit receipts for such expenses to the Agency (the social services district); after offset, the Agency might then advise the Managed Long Term Care Plan of the amount of spenddown remaining to pay to the Plan for the particular month or months.

DECISION

The Agency's determination not to not to pay the Appellant's invoice for his Medicaid surplus is correct.

FH# 7376400Q

DATED: Albany, New York
11/07/2016

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee