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In the Matter of the Appeal of  
██████████

from a determination by the Onondaga County  
Department of Social Services

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**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 April 18, 2011, in Onondaga County, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

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For the Social Services Agency

Nancy Wentworth, Fair Hearing Representative; Sandra Ridley, Agency witness

**ISSUE**

Was the Agency's determination to discontinue the Medical Assistance Authorization for Appellant, ██████████, on the grounds that the Appellant's household has income which exceeds the applicable Medical Assistance income standards 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 was in receipt of medical assistance for himself, his ██████████, and his ██████████.
2. By notice dated January 14, 2011, the Agency informed the Appellant of its determination to discontinue the Medical Assistance Authorization for Appellant, ██████████.

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██████████ effective January 24, 2011 on the grounds that the Appellant's household has income of \$4,140.65 which exceeds the applicable Medical Assistance income standard of \$1,285. The notice also advised the Appellant of the Agency's determination that the Appellant and his spouse were not eligible for Family Health Plus on the grounds that gross income of \$4,230.65 exceeded the applicable income limit of \$2,289.

3. The Agency determined that the Appellant's household's monthly excess income for the purposes of computing Medical Assistance eligibility is \$2,855.65.

4. The Agency calculated the Appellant's household monthly income as follows:

<b>Household Member</b>	<b>Source</b>	<b>Earned Income</b>
Appellant	Earned	\$216.67
		<b>Gross Earned Income \$216.67</b>
<b>Household Member</b>	<b>Source</b>	<b>Unearned Income</b>
Appellant	██████████	\$616.72
Spouse	██████████	\$3,397.26
		<b>Gross Unearned Income \$4,013.98</b>

5. The Agency computed the Appellant's household's unearned income based on distributions to the Appellant and his spouse from ██████████ ██████████ (██████). The Appellant received a distribution from his ████████ in May 2010 in the amount of \$4,400.59. The Appellant received a distribution from his ████████ in July 2010 in the amount of \$3,000.00. The Appellant's spouse received a distribution from her ████████ in June 2010 in the amount of \$40,767.08. The Agency divided these amounts by 12 to arrive at monthly income in the amount of \$616.72 and \$3,397.26 respectively.

6. The balance remaining in the Appellant's ████████, current value, effective July 31, 2010, was \$4,275.43. The balance remaining in the Appellant's spouse's ████████, current value, effective June 30, 2010, was \$4,177.53.

7. The Appellant's 2009 1040A (line 11a) established that the Appellant's spouse received taxable ████████ distributions in the amount of \$7,500.00 in 2009. 2009 Form 1099-R indicates that this distribution was to the Appellant's spouse.

8. The Agency calculated the Appellant's household's eligibility for Medical Assistance as follows:

**Earned Income:**

Gross Earnings (\$50.00 x 4 1/3

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(the number of weeks per average month))	\$216.67	
<b>Less: Authorized Deductions</b>		
Work Related Expenses	-\$90.00	
<b>Total Deductions from Earnings</b>	-\$90.00	
<b>Countable Earned Income</b>		\$126.67
<b>Other Income:</b>		
[REDACTED] (Mr.)		\$616.72
[REDACTED] (Mrs.)		\$3,397.26
<b>Total Other Income</b>		\$4,013.98
<b>Total Income</b>		\$4,140.65
<b>Sub-Total: Countable Net Income</b>		\$4,140.65
<b>Less Medicaid Standard for three persons:</b>	-\$1,285.00	
100% (Child 6-9 years)		\$1,526.00
Family Health Plus 150%		\$2,289.00
<b>Excess Income ("spend-down" amount)</b>		\$2,855.65

9. On January 6, 2011, the Appellant requested this fair hearing. The Appellant is not receiving aid continuing benefits.

### **APPLICABLE LAW**

Section 366(1)(a) of the Social Services Law sets forth the conditions under which individuals and families may qualify for Medical Assistance. Low-Income Families With Children (LIF) may qualify for Medical Assistance if they meet specific eligibility standards. Categorically, Low Income Families With Children include the following:

- Parents and/or other caretakers residing with children under 21 years of age, and all such children;
- a child under the age of twenty-one years who was in foster care under the responsibility of the state on his or her eighteenth birthday;

Low Income Families With Children may include those currently receiving Public Assistance, as well as those who, although not currently receiving Public Assistance, have insufficient income and resources to meet the costs of necessary medical care and services for the family, including those who could qualify for Public Assistance were they to apply.

Social Services Law §366(1)(a)(8) provides that in the LIF category a family is eligible if net available income is not in excess of one hundred thirty percent of the highest amount that ordinarily would have been paid to a person without any income or resources under the family assistance program to be increased annually by the same percentage as the percentage increase in the federal consumer price index. The net available income of a family shall be determined using the methodology of the family assistance program. No "spend-down" of income exceeding the applicable standard is permissible using LIF budgeting methodology.

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Pursuant to GIS 08 MA/022 income levels to determine eligibility for Low Income Families have been standardized and are referred to as the Medicaid Standard. The GIS provides that the Public Assistance Standard of Need is no longer used to determine eligibility for Low Income Families.

For families that do not qualify for Medicaid under LIF budgeting or for TMA, Medicaid may still be obtained under "ADC-related" medically needy budgeting methodology. Under this methodology, the amount of the family's available net income will be determined using the exemptions and disregards applicable to the "ADC-related" medically needy budgeting methodology. All earnings must be offset by (i) \$90 (per employed family member) for Work Related Expenses; (ii) in accordance with 97 OMM/ADM-2, the \$30 and 1/3 earned income disregard when the family received Medicaid under LIF in at least one of the past four months; and (iii) Child Care Expenses as authorized in Section 360-4.6 of the Regulations. After adding the remaining earnings to all other countable income received by the family, the local district must then compare the total net income to the higher of EITHER:

- (a) the Medicaid Standard; OR
- (b) the Medicaid Income Exemption Standard. For a family of 3, the Medicaid Income Exemption Standard is \$1285.00 per month.

Pregnant women and certain children may qualify for full coverage of their own medical needs if family income does not exceed the following "Expanded Eligibility" limits set forth in Section 360-4.7 of the Regulations:

- children, between six and nineteen BUT only if born after September 30, 1983, if available family income does not exceed 100 percent of the FPL. (Social Services Law Section 366(4)(q)(1));

Effective January 1, 1999, Section 366(4)(s) of the Social Services Law provides that children determined eligible under low income family (LIF) budgeting or using federal poverty levels are to be provided 12 continuous months of Medicaid coverage regardless of any changes in income or circumstances. An interpretation of this law in 99 OMM/ADM-3, provides that effective August 30, 1999, continuous coverage applies also to children whose eligibility was determined using the ADC-related budgeting methodology. Children are guaranteed 12 months of continuous coverage every time eligibility is determined or redetermined. Continuous coverage can run concurrently with an extension, such as Transitional Medical Assistance (TMA). If a child becomes ineligible for Medicaid, the child will receive the longest available period of additional coverage, whether provided by the extension or by continuous coverage. The expansion of continuous coverage by this provision of the Social Services Law does not apply to children whose eligibility is determined using the "standard" medically needy Medicaid income level.

Under Section 360-4.8(c) of the Regulations, Medicaid with a "spend-down" may be authorized for children when family income exceeds the higher of the Public Assistance standard

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or the Medicaid Income Exemption standard. In addition, parents may also be eligible with a "spend-down" when their income exceeds such level when the children are deprived of parental support or care ("deprivation factor". Families subject to a "spend-down" may become eligible for coverage for outpatient care and services if it has medical bills in any month that are equal to or more than the amount of excess income. Such families may become eligible for outpatient and inpatient medical care and services if a family owes or has paid an amount for medical bills equal to the sum of its monthly excess income for six months.

Pursuant to section 369-ee of the Social Services Law, a person is eligible to receive health care services under the Family Health Plus Program if he or she:

- (i) resides in New York state and is at least age nineteen, but under sixty-five years of age;
- (ii) is not eligible for medical assistance solely due to income or resources or is eligible for medical assistance only through the application of excess income toward the costs of medical care and services;
- (iii) does not have equivalent health care coverage under insurance or equivalent mechanisms;

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- (v)(A) in the case of a parent or stepparent of a child under the age of twenty-one who lives with such child, has gross family income equal to or less than the applicable percent of the federal income official poverty:

(III) October 1, 2002 – 150%; or

01 OMM/ADM-6

There are Additional requirements in order to be eligible for Family Health Plus relating to the existence of health care coverage and insurance. Pursuant to GIS 09 MA/027, effective January 1, 2010, eligibility shall be determined without regard to resources..

Every person determined eligible for or receiving Family Health Plus coverage must enroll in a family health insurance plan.

150% of the Federal Poverty Line for a household of 3 is \$2289 per month in the year 2011.

**UNEARNED INCOME**  
**RETIREMENT FUNDS**

An individual is eligible for periodic payments if he/she is authorized to receive distributions on a regularly scheduled basis without having a penalty assessed. An individual is not entitled to periodic payments if he/she is not permitted to take regularly scheduled withdrawals penalty free. Ordinary taxes are not considered a penalty. Once periodic payments

are received, the periodic payments are unearned income, and the fund is not a countable resource. An A/R, who ordinarily might not be eligible for benefits, may be able to access his/her retirement fund sooner, without incurring a penalty under certain circumstances. The circumstances can vary, depending on the type of account and rules for the specific retirement fund. Examples of possible situations: when an A/R may be able to receive periodic benefits without incurring a penalty, when the A/R is found to be disabled (a finding of disability), or when the withdrawal of distributions are considered as part of a series of substantially equal periodic payments. If an A/R can receive distributions from a retirement fund on a regularly scheduled basis without having a penalty assessed, the individual would be considered to be eligible for periodic payments. The A/R would be required to file for maximized periodic payments as a condition of Medicaid eligibility.

If the individual has a choice between periodic payments and a lump sum, the individual must choose the periodic payments. The individual must apply for the maximum payment amount that could be made available over the individual's lifetime. By federal law, if the Medicaid A/R has a living spouse, the maximum income payment option that is available will usually be less than the maximum income payment option available to a single individual. This provision applies to all Medicaid A/Rs. Medicaid Reference Guide, pages 135-136; GIS 98 MA/024.

## **DISCUSSION**

The Agency's determination to discontinue the Medical Assistance Authorization for Appellant, [REDACTED] on the grounds that the Appellant's household has income which exceeds the applicable Medical Assistance income standards cannot be sustained.

The following facts were not in dispute. The Appellant received a distribution from his [REDACTED] in May 2010 in the amount of \$4,400.59 and a distribution from his [REDACTED] in July 2010 in the amount of \$3000. The Appellant's spouse received a distribution from her [REDACTED] in June 2010 in the amount of \$40,767.08. The Agency divided \$7,400.59 and \$40,767.08 by 12 to arrive at monthly [REDACTED] income of \$616.72 and \$3397.26, respectively. The record showed that the Appellant's spouse also received taxable [REDACTED] distributions in the amount of \$7,500 in 2009. The balance remaining in the Appellant's [REDACTED], effective July 31, 2010, was \$4,275.43. The balance remaining in the Appellant's spouse's [REDACTED], effective June 30, 2010, was \$4,177.53.

The Appellant contended that the Agency incorrectly included the distributions from the [REDACTED] [REDACTED]s as income for both the Appellant and his spouse, and thus incorrectly computed the Appellant's net available monthly income for Medical Assistance purposes. The Appellant's representative argued that Agency policy as set forth in the Medicaid Reference Guide refers to individuals with [REDACTED]s that are in pay-out status, which is not the case here, as the Appellant merely withdrew irregular amounts as needed. The direct testimony of the Appellants was offered in support of the proposition that the withdrawals at issue herein were non-periodic, made as needed, and were not part of a regularly scheduled pay-out.

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In response, the Agency argued that the Appellants are taking periodic payments, and as such are budgeted as income. The Agency cited the Medicaid Reference Guide, which states that once periodic payments are received, the periodic payments are unearned income and if a recipient can receive distributions from a retirement fund on a regularly scheduled basis without having a penalty assessed, the individual would be considered to be eligible for periodic payments.

The record in this case showed that the Appellants are not receiving a regular schedule of payments. To the contrary, the Appellants provided otherwise unrefuted testimony that they have not contacted the financial institution administering the [REDACTED] IRAs to request any type of regularly scheduled payment, but merely withdraw funds on an as needed basis. The fact that the Appellant's spouse withdrew \$7,500 in 2009, over \$40,000.00 in 2010, and only has approximately \$4,000.00 left from which to make future withdrawals tends to support the testimony that the withdrawals were irregular, and not part of a regularly scheduled pay-out. Similarly, the Appellant's withdrawals for 2010, made in May and July in differing amounts tend to support the testimony that the withdrawals at issue are non-periodic, and not part of a regularly scheduled payment. Non-periodic distributions, such as the withdrawals from retirement funds at issue herein, are considered a conversion of a resource and not countable income, particularly as of the effective date of discontinuance at issue herein. As the remaining household income falls below the applicable income limit, the Agency determination cannot be sustained, and the Agency is directed to reinstate the Appellant's Medical Assistance coverage, and to restore lost coverage retroactive to the date of discontinuance.

### **DECISION AND ORDER**

The Agency's determination to discontinue the Medical Assistance Authorization for Appellant, [REDACTED] on the grounds that the Appellant's household has income which exceeds the applicable Medical Assistance income standards cannot be sustained.

The Agency is directed to reinstate the Appellant's Medical Assistance coverage, and to restore lost coverage retroactive to the date of discontinuance.

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

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DATED: Albany, New York  
06/14/2011

NEW YORK STATE  
DEPARTMENT OF HEALTH

By

A handwritten signature in black ink, appearing to be 'C. A. M.', written in a cursive style.

Commissioner's Designee