

STATE OF NEW YORK
OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

REQUEST: April 6, 2011

AGENCY: Chemung

FH #: 5773586M

In the Matter of the Appeal of
[REDACTED]

from a determination by the Chemung 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 May 20, 2011, in Chemung County, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[REDACTED]

For the Social Services Agency

Donna Truax, Fair Hearing Representative

ISSUE

Was the Agency's determination to deny Medical Assistance and Family Health Plus for Appellant and his spouse, on the grounds Appellant's household has income which exceeds the applicable 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. On November 22, 2010, ([REDACTED]), and his spouse ([REDACTED]), applied for Medical Assistance for themselves only, seeking retroactive Medical Assistance to September 1, 2010. Hereinafter [REDACTED], will be referred to as "Appellant(s)".

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2. Neither Appellant is a caretaker or parent of a child residing in the household.
3. Neither Appellant is employed.
4. Neither Appellant is disabled or certified blind.
5. The Agency determined that Appellant's household was in receipt of monthly gross income of \$20,000.00, which was over 185% of the monthly Medicaid Standard for a two person, single-childless couple household, of \$1,633.55 in 2011.
6. Appellant (wife) received withdrawals from an Inherited Individual Retirement Account (IRA) in March, 2010 in the amount of \$20,000.00; in April, 2010 of \$20,000.00; in May, 2010 of \$20,000.00; in July, 2010 of \$20,000.00; in September, 2010 of \$20,000.00; and in November, 2010 of \$20,000.00. Each of these withdrawals was initiated by Appellant (wife) through submission of a separate individual request to the financial institution administering the IRA, and were made on an as needed basis.
7. The balance remaining in the Appellant (wife) IRA, effective November 30, 2010, was approximately \$7,800.00.
8. The Agency calculated Appellants monthly eligibility for the month of application as follows:

Inherited IRA distribution (wife)	\$20,000.00 (November)
Total Monthly Income	\$20,000.00
Less 185% of the Medicaid Standard for two:	-\$1,633.55
Excess Income	\$18,366.45
9. In evaluating Appellant's eligibility for Family Health Plus, the Agency determined that Appellant household's monthly gross income of \$20,000.00 exceeded the Family Health Plus monthly income limit (100% Federal Poverty Level) of \$1,215.00 in 2011.
10. By CNS notice dated February 24, 2011, the Agency informed Appellants of its determination to deny the November 22, 2010 Medical Assistance application for Appellants on the grounds that their household had monthly gross income of \$20,000.00, which exceeds 185% of the applicable Medical Assistance income standard of \$1,633.55. The notice also advised the Appellants of the Agency's determination that they were not eligible for Family Health Plus on the grounds their monthly gross income of \$20,000.00 exceeded the applicable monthly income limit of \$1,215.00.
11. On January 6, 2011, Appellants requested this fair hearing.

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 adult who is at least 21 years of age but who is under the age of 65 and who has no dependent children, is not pregnant and is not certified blind or certified disabled is considered eligible for Medicaid if he or she meets the financial eligibility requirements of the Safety Net Assistance Program except that:

- (i) such person may have income up to one hundred thirty percent of the highest amount that ordinarily would have been paid to a person without any income or resources under the safety net program to be increased annually by the same percentage as the percentage increase in the federal consumer price index;
- (ii) such person shall not be subject to a resource test;

Social Services Law §366(1)(a)(1).

Social Services Law §366(1)(a)(1)(iii) provides that a person whose income is within the limit set forth in clause (i) of this subparagraph shall be deemed to have unmet needs for purposes of the eligibility requirements of the safety net program.

Section 352.18(a) of the Regulations provides that no household shall be eligible for a grant of Public Assistance in any month in which Gross Income exceeds 185 percent of its applicable Standard of Need, computed in accordance with Section 131-a.2 of the Social Services Law, under which most allowances depend on the number of persons in the household.

Pursuant to GIS 08 MA/022 income levels to determine eligibility for single/childless couples 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 single/childless couples. Additional allowances continue to apply, where appropriate. The 185% maximum income test and 100% federal poverty level test still apply. The 185% maximum income test is performed by comparing the household's total gross monthly income to 185% of the Medicaid Standard. See, Medicaid Reference Guide p. 220.

Pursuant to GIS 10 MA/026, the Medicaid Standard income levels for single/childless couples effective January 1, 2011 are as follows:

Family Size	Income Level
2	\$883

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

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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).

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).

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

Family Health Plus:

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;

- (B) in the case of an individual who is not a parent or stepparent living with his or her child under the age of twenty-one, has gross family income equal to or less than 100% of the federal income official poverty line for a family of the same size.

100% of the Federal Poverty Line for a household of 2 is \$1,215.00. per month in the year 2011.

GIS 98 MA/024 page 1 and 2 states in part as follows:

The clarification reflects the eligibility requirements of the Supplemental Security Income (SSI) program; however, the clarification applies to all Medicaid applicants/recipients.

Medicaid A/Rs who are eligible for periodic retirement benefits must apply for such benefits as a condition of eligibility. If there are a variety of payment options, the individual must choose the maximum income payment that could be made available over the individual's life time.

Once an individual is receiving periodic payments, the payments are counted as unearned income on a monthly basis, regardless of the actual frequency of the payment. For example, if the periodic benefit is received once a year, the amount is to be divided by twelve to arrive at a monthly income amount. Once an individual is in receipt of or has applied for periodic payments, the principal in the retirement fund is not a countable resource.

From the Medicaid Reference Guide, November 2007, at pages 92 to 92.1:

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

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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.

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.

DISCUSSION

The Agency's determination to deny Appellant's Medical Assistance application on the grounds that Appellant's household has income which exceeds the applicable income standards cannot be sustained.

The record shows that Appellants meet none of the alternative categorical eligibility requirements for Medicaid, and thus may qualify for such coverage only when financially eligible under the Medicaid Standard for single/childless couples. It was undisputed that in the nine months leading up to the Appellants' application for Medical Assistance, the Appellant (wife) withdrew a combined \$120,000.00 from an inherited individual retirement account (IRA), including a withdrawal of \$20,000.00 in the month of application (November 2010), and a withdrawal of \$20,000.00 in the look-back period (September 2010). No withdrawals were made in August 2010 or October 2010, and as of December 1, 2010, there was approximately \$7,800.00 remaining in the account. It was also undisputed that none of the withdrawals were made as part of a planned periodic distribution, but rather, were made by separate individual requests for withdrawals from the Appellant (wife) on an as needed basis. As of the date of application, the household had no other source of income.

The Agency determined to budget the withdrawal of \$20,000.00 made in November 2010 as income for that month. Appellants argue that since the IRA was not in periodic payout status; it should not be viewed as income, but rather as a resource, and that the non-periodic withdrawal in November 2010 was merely a conversion of a resource and therefore not countable income. The Appellants argue that the resources of approximately \$28,000.00 as of November 1, 2010 should have no bearing on their eligibility for Medical Assistance since they would only qualify for Medical Assistance under the Single/Childless Couples category, which does not have a resource test.

The record in this case shows that Appellant (wife) is not receiving a regular schedule of payments from her IRA. Appellant (wife) provided otherwise unrefuted evidence that no contact was made with the financial institution administering the IRA requesting the issuance of any regularly scheduled payments, and that she merely executed individual withdrawals from the account on an as needed basis. These types of irregular withdrawals would be considered a conversion of resources from an IRA to cash and would not constitute countable income in determining eligibility for Medical Assistance. As the record disclosed that the household has no

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other source of income, Appellants appear to fall below the applicable Medicaid income limit, and therefore the Agency determination under review cannot be sustained. In view of this finding, there is no need to reach the Family Health Plus determination.

It will be noted that there does not appear to be any dispute in this case as to the Appellant (wife's) eligibility for periodic distributions, and that pursuant to GIS 98 MA/024, the Agency could have required the Appellant (wife) as a condition of eligibility to apply for periodic payments from the IRA at the maximum amount available. At such time as periodic payments were made, those payments would be budgeted as income. However, there is no evidence to suggest that the Agency requested this as a condition of eligibility in the case at bar. Therefore, this decision is limited to the facts as presented, which supports a finding of irregular withdrawals constituting a conversion of a resource from the IRA to cash.

DECISION AND ORDER

The Agency's determination to deny Appellant's November 22, 2010 application for Medical Assistance on the grounds that their household had income which exceeded the applicable Medical Assistance income standards cannot be sustained.

1. The Agency is directed to re-evaluate the Appellant's November 22, 2010 application for Medical Assistance consistent with the findings set forth herein, and if the Appellant is otherwise eligible to authorize coverage retroactive to November 1, 2010 in accordance with verified degree of need.
2. The Agency is further directed to re-evaluate the Appellant's eligibility for Medical Assistance within the three months prior to the month of eligibility, and if the Appellant is otherwise eligible to authorize coverage in accordance with verified degree of need.
3. The Agency is directed to give Appellants the opportunity to present any paid or unpaid medical bills they may have incurred retroactive to August 1, 2010.
4. In the event the Agency determines that the Appellant is ineligible for Medical Assistance due to excess income, the Agency is directed to evaluate the Appellants eligibility for Family Health Plus.
5. The Agency is directed to advise Appellants in writing as to the results of its redetermination.

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.

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DATED: Albany, New York
07/06/2011

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