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

from a determination by the New York City
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 10, 2013, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

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For the Social Services Agency

Paula Porter, Fair Hearing Representative (October 2, 2012 only)
Sylvia Kalvin, Fair Hearing Representative (April 10, 2013 only)
Maria Vardaros, OLA HRA (April 10, 2013 only)

ISSUES

Was Appellant's request timely for a fair hearing regarding the Agency's determination dated January 3, 2008, to deny Appellant's application for institutional Medical Assistance?

Assuming the fair hearing request was timely, was the Agency's determination on January 3, 2008 to deny the Appellant's application for institutional Medical Assistance, correct?

Was Appellant's request timely for a fair hearing regarding the Agency's determination dated September 23, 2008, to deny Appellant's application for institutional Medical Assistance?

Assuming the fair hearing request was timely was the Agency's determination on September 23, 2008 to deny the Appellant's application for institutional Medical Assistance, correct?

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Was Appellant's request timely for a fair hearing regarding the Agency's determination dated December 16, 2008, to deny Appellant's application for institutional Medical Assistance?

Assuming the fair hearing request was timely, was the Agency's determination, dated December 16, 2008, to deny the Appellant's application for institutional Medical Assistance due to failure to provide documentation/ information necessary to determine the Appellant's eligibility thereon, 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. Appellant, age 82, was admitted to a residential health care facility, ("RHCF"), [REDACTED], on July 13, 2006.
2. On October 23, 2007, an application for institutional Medical Assistance coverage for residential health care and services, with a requested effective (pick-up) date of July 1, 2007, was filed on Appellant's behalf. The application indicated home ownership and unpaid medical bills.
3. On November 27, 2007, the Agency requested further documents from Appellant at the RHCF:
 - A/R co owns a house with three owners, need to know they are still alive and what relationship to A/R.
 - Need letter from NYCERS to verify A/R's pension for 2007.
 - A/R privately paid to NH for \$85,740 for 7/15/06 thru 6/30/07, need to submit all bank statements from 1/2006 thru present to verify A/R's private payments come from.
4. On or about January 3, 2008, the Agency determined to deny the Appellant's application for institutional Medical Assistance.
5. A request that the Agency reconsider its determination to deny the Appellant's application for institutional Medical Assistance was made.
6. On or about September 23, 2008, the Agency again determined to deny the Appellant's application for institutional Medical Assistance.
7. On October 30, 2008, a request that the Agency reconsider its determination to deny the Appellant's application for institutional Medical Assistance effective October 1, 2007 was made.
8. On December 16, 2008, the Agency sent a Denial Notice to the RHCF setting forth its determination to deny the Appellant's application for institutional Medical Assistance on the grounds that the Appellant failed to provide documentation/ information necessary to determine

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her eligibility thereon:

“Account where Social Security and pension checks been deposit, submit 36 months for savings and 6 months for checking up to present.”

“7-7-08 A/R 3 Fam hm trnf 12-07 with aprx value of \$762,000 * 3 = \$254,000 (\$254,000-\$85,000 PD NH = \$169,000 BAL to A/R). Need to provide financial statement reflecting exact payments to NH through your newly requested pick up date).

Submit gross amount of pension from Chase Manhattan (not addressed).

Submit current gross of NYCERS pension for 2008 (not addressed)

9. On July 19, 2010, the Appellant reapplied for Medical Assistance coverage for residential health care and services, with a requested effective (pick-up) date of April 1, 2010.

10. By Notice of Acceptance dated May 2, 2011, the Agency determined to accept the Appellant’s July 19, 2010 application for institutional Medical Assistance, for the period commencing April 1, 2010, subject to net available monthly income (NAMI) of \$2218.23 calculated as follows:

Social Security	\$1570.00
Pension	\$ 698.23
Monthly gross income	\$2268.23
Less:	
Personal Needs Allowance	\$ 50.00
NAMI	\$2218.23

11. By fax to the Agency on May 19, 2011, the RHCF’s representatives asked the Agency to revise Appellant’s NAMI calculation “to allow Ms. Argento’s current net available monthly income to be applied towards the facility’s viable bill.”

12. By notice of intent to change your NAMI contribution towards chronic care costs dated May 27, 2011, the Agency decreased Appellant’s NAMI to zero dollars, due to “outstanding medical bill \$240,271.95.”

13. On June 28, 2011, this fair hearing was requested.

14. On or about September 2010, the RHCF filed a petition seeking appointment of a guardian of the property of Appellant. By order of the Supreme Court of ██████ County, dated July 11, 2011, Integral Guardianship Services was appointed guardian of the property of Appellant. Integral Guardianship authorized the RHCF and/ or its attorneys, Abrams Fensterman, et al to represent Appellant regarding Medicaid eligibility, including but not limited to, fair hearing representation.

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.

Administrative Directive 06-ADM-05 Revised April 27, 2006, consolidates the existing policy guidelines of the Commissioner of the Office of Temporary and Disability Assistance (OTDA) regarding access to benefits, programs and services by persons with disabilities and/or Limited English Proficiency (LEP). Subsequently, the Agency issued its Policy Directive #06-25-ELI on August 18, 2006, clarifying its policies and procedures regarding persons with physical and/or mental disabilities pursuant to the Federal law entitled the Americans with Disabilities Act (ADA).

Administrative Directive 10 OHIP/ADM-5 advises regarding the revised DOH-4220, Access NY Health Care application (Attachment I) and companion forms. This ADM also introduces the Access NY Supplement A, DOH-4495A (Attachment II), which must be completed in addition to the Access NY Health Care application for certain populations. The ADM states in part that Section A of the application now allows an applicant to identify another person who should receive copies of Medicaid notices on his/her behalf, and the contact information for that person. The applicant can identify the role of this person to: apply for and/or renew Medicaid; discuss his/her Medicaid application or case, if needed; and/or get copies of notices and agency correspondence. If this section is completed by the applicant and the applicant is the person signing the application, there is no need for him/her to provide a separate document authorizing a representative. However, if the representative is the person signing the application, the LDSS must obtain separate authorization from the applicant or a copy of legal guardianship. This authorization continues until it is revoked by the recipient; a reauthorization is not required at renewal. If an applicant indicates that someone else should get copies of notices and correspondence, the LDSS must also send the notices and correspondence to the applicant. **NOTE:** Federal Medicaid regulations provide, in the case of an incompetent or incapacitated individual, for the submission of an application by someone acting responsibly on the individual's behalf. In these situations, a copy of legal guardianship papers is not required nor is a separate document authorizing the representative. The LDSS is authorized to discuss the application/case and send notices and related correspondence to the responsible individual in addition to the applicant.

Informational Letter 10 OHIP/ INF-1 advises that The Office of Health Insurance Programs (OHIP) recently issued policy directives regarding the elimination of the personal interview for Medicaid and Family Health Plus (FHPlus) applicants (10 OHIP/ADM-4); the revised Access NY Health Care application (DOH-4220) and DOH-4495A, Access NY

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Supplement A (10 OHIP/ADM-5); and policy guidance concerning financial maintenance (10 OHIP/ADM-6).

The purpose of this release is to provide answers to questions raised by local departments of social services (LDSS) relating to these topics.

46. Question: What is an authorized representative?

Answer: An authorized representative is an individual authorized by the applicant to apply for Medicaid on his/her behalf. The Access NY Health Care application allows the applicant to choose what actions his/her authorized representative is permitted to do on his/her behalf. When the applicant is incompetent or incapacitated, an individual acting responsibly on behalf of the applicant may apply for Medicaid, discuss the application/case and receive notices for the applicant as explained in 10 OHIP/ADM-5, "Revised DOH-4220: Access NY Health Care Application and Release of DOH-4495A: Access NY Supplement A", specifically in Section IV.A.1.

The purpose of General Information System (GIS) message GIS 11 MA/015 is to advise local departments of social services (LDSS) of the policy regarding required signatures on Medicaid/Family Health Plus (FHPlus) applications and renewals. Currently, signatures are required at application and renewal for all adults applying for Medicaid/FHPlus. Effective September 1, 2011, only the signature of one applying adult will be required at renewal. If an adult is requesting to be added to a Medicaid case at renewal, his/her signature is required.

Section 358-3.1 of Title 18 NYCRR provides, in pertinent part, that an applicant has the right to challenge certain determinations or actions of a social services agency within the time periods required by other provisions of this Title, by requesting that the OAH provide a fair hearing. The right to request a fair hearing cannot be limited or interfered with in any way. An applicant of assistance, benefits or services has a right to a fair hearing if the application has been denied by a social services agency.

An applicant of Medical Assistance or Services has a right to a timely and an adequate notice when the Agency proposes to accept or deny the application. 18 NYCRR 358-3.3(a).

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. In addition, the notice must contain:

- o the procedure for requesting an agency conference or fair hearing, including an address and telephone number where a request for a fair hearing may be made and the time limits within which the request for a fair hearing must be made;
- o the right of the recipient to review the case record and to obtain copies of documents which the agency will present into evidence at the hearing and other documents necessary for the recipient to prepare for the fair hearing at no cost;

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- o an address and telephone number where the recipient can obtain additional information about the recipient's case, how to request a fair hearing, access to the case file, and/or obtaining copies of documents;
- o the right to representation by legal counsel, a relative, friend or other person or to represent oneself, and the right to bring witnesses to the fair hearing and to question witnesses at the hearing;
- o the right to present written and oral evidence at the hearing;
- o the liability, if any, to repay continued or reinstated assistance and benefits, if the recipient loses the fair hearing;
- o information concerning the availability of community legal services to assist a recipient at the conference and fair hearing 18 NYCRR 358-2.2

Section 360-1.2 of Title 18 NYCRR provides that all regulations relating to Public Assistance and care shall apply to Medical Assistance, except those which are inconsistent with specific State law and regulations dealing with the Medical Assistance Program.

Under provisions of Section 366.1(a)(5) of the Social Services Law and Section 360-4.8 of the Regulations, a person who is permanently disabled, and who has not qualified for Medical Assistance ("Medicaid") by reason of financial eligibility for receipt of Public Assistance or Federal Supplemental Security Income (SSI) but who may otherwise be eligible for SSI, may be eligible for "Medicaid" if he or she meets certain financial and other eligibility requirements under the Medicaid program.

An applicant for or recipient of public assistance is exempt from complying with any requirement concerning eligibility for public assistance if the applicant or recipient establishes that good cause exists for failing to comply with the requirement. Except where otherwise specifically set forth in the Regulations, good cause exists when the applicant or recipient has a physical or mental condition which prevents compliance; the applicant's or recipient's failure to comply is directly attributable to Agency error; or other extenuating circumstances, beyond the control of the applicant or recipient, exist which prevent the applicant or recipient from being reasonably expected to comply with an eligibility requirement. The applicant or recipient is responsible for notifying the Agency of the reasons for failing to comply with an eligibility requirement and for furnishing evidence to support any claim of good cause. The Agency must review the information and evidence provided and make a determination of whether the information and evidence supports a finding of good cause. 18 NYCRR 351.26.

Section 360-2.3 of the Regulations provides that the Medical Assistance applicant and recipient has a continuing obligation to provide accurate and complete information on income, resources and other factors which affect eligibility. An applicant or recipient is the primary source of eligibility information. However, the Agency must make collateral investigation when the recipient is unable to provide verification. The applicant's or recipient's failure or refusal to

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cooperate in providing necessary information is a ground for denying an application for a Medical Assistance Authorization or for discontinuing such benefits.

Section 351.5 of the Regulations provides that if the applicant or recipient has previously verified necessary information which is not subject to change and the Agency possesses documentation of such verification in its files, the applicant or recipient is not required to resubmit verification of such information.

Sections 360-4.1 and 360-4.8(b) of 18 NYCRR (herein referred to as "the Regulations") provide that all income and resources actually or potentially available to a Medicaid applicant or recipient must be evaluated, but only such income and/or resources as are found to be available may be considered in determining eligibility for Medicaid. A Medicaid applicant or recipient whose available non-exempt resources exceed the resource standards will be ineligible for Medicaid coverage until he or she incurs medical expenses equal to or greater than the excess resources.

Section 360-1.4(c) of the Regulations defines Chronic Care budgeting as a procedure used for individuals who are in "Permanent Absence" status. For such individuals, Chronic Care budgeting begins as of the first day of the calendar month following the month in which the individual is determined to be in permanent absence status.

To determine financial eligibility, a person's net income must be calculated. Ordinarily, for cases NOT involving Chronic Care, net income is derived by deducting exempt income and allowable deductions from gross income. Section 360-4.6 of the Regulations sets forth allowable exemptions, disregards and deductions from income. In determining net income for a person in Chronic Care, the amount required for payment of health insurance premiums is allowed as a deduction, and the amount of \$50 is deducted as a monthly Personal Needs Allowance (PNA) for a resident of a Residential Health Care Facility (RHCF) or a person in permanent absence status in an acute care hospital. Residents of psychiatric care facilities, developmental centers or intermediate care facilities under Article 31 of the Mental Hygiene Law is allowed a PNA of \$35. A PNA of up to \$90 is allocated to a person receiving a pension under 38 U.S.C.5503(f) or who has elected a greater compensation benefit under 38 CFR 3.701 in lieu of such pension. An amount will be set aside to meet maintenance needs of dependents in the Appellant's former household. 18 NYCRR 360-4.9.

In addition pursuant to 18 NYCRR 360-4.9, certain income of a person residing in a RHCF who does not have a spouse living in the community is also not required to be applied toward the cost of medical care.

A Medicaid authorization may be issued for necessary medical costs exceeding the net available income (NAMI).

Under Section 360-4.4 of the Regulations, "Resources" are defined to include any liquid or easily liquidated resources in the control of an applicant or recipient, or anyone acting on his or behalf, such as a conservator, representative, or committee. Certain resources of a Medicaid-

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qualifying trust, as described in Section 360-4.5 of the Regulations, may also be counted in evaluating Medicaid eligibility.

For applications filed on or after August 1, 2006, for Medical Assistance coverage of nursing facility services, the "look-back period" is the period immediately preceding the date that an institutionalized individual is both institutionalized and has applied for Medical Assistance. Beginning February 1, 2009 the look back period will increase from 36 months to 37 months and each month thereafter it will increase by one month until February 1, 2011 when a 60 month look-back period will be in place for all types of transfers of assets. 06 OMM/ADM-5. The uncompensated value of an asset is the fair market value of such asset at the time of transfer less any outstanding loans, mortgages, or other encumbrances on the asset, minus the amount of the compensation received in exchange for the asset. Social Services Law 366.5(e).

Sections 366.5(d) and (e) of the Social Services Law provide that an individual will not be ineligible for Medicaid as a result of a transfer of assets if:

- (a) the asset transferred was other than a homestead and was a disregarded or exempt asset under Section 360-4.4(d), 360-4.6, and/or 360-4.7 of the Regulations; or
- (b) the asset transferred was a home, and title to the home was transferred to:
 - (1) the individual's spouse; or
 - (2) the individual's child, who is blind, disabled, or under the age of 21; or
 - (3) the individual's sibling, who has an equity interest in the home and was residing in the home for a period of at least one year immediately before the date the person became an institutionalized individual, or
 - (4) the individual's child, who was residing in the home for a period of at least two years immediately before the date the person became an institutionalized individual, and who provided care to the person which permitted her or him to continue residing at home rather than enter into an institution or facility; or
- (c) the asset was transferred:
 - (i) to the individual's spouse or to another for the sole benefit of the spouse; or
 - (ii) from the individual's spouse to another for the sole benefit of the spouse; or

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- (iii) to the individual's child who is blind or disabled, or to a trust established solely for the benefit of such child; or
 - (iv) to a trust established solely for the benefit of a disabled person under 65 years of age.
- (d) a satisfactory showing is made that:
- (i) the individual or his or her spouse intended to dispose of the asset either at fair market value, or for other valuable consideration; or
 - (ii) the asset was transferred exclusively for a purpose other than to qualify for Medicaid; or
 - (iii) all assets transferred for less than fair market value have been returned to the individual.

In addition, Sections 366.5(d) and (e) of the Social Services Law provide that an individual will not be ineligible for Medicaid as a result of a transfer of assets if denial of eligibility will result in an undue hardship. Section 360-4.4 of the Regulations provides that denial of eligibility will result in an undue hardship if:

- (i) the individual is otherwise eligible for Medicaid;
- (ii) said person is unable to obtain appropriate medical care without the provision of Medicaid; and
- (iii) despite his or her best efforts, said person or his or her spouse is unable to have the transferred asset returned or to receive fair market value for the asset. Best efforts include cooperating, as deemed appropriate by the commissioner of the social services district, in efforts to seek the return of the asset.

For transfers made on or after February 8, 2006, section 366.5(e)(4)(iv) of the Social Services Law provides that an individual shall not be ineligible for services solely by reason of any such transfer to the extent that denial of eligibility would cause an undue hardship such that application of the transfer of assets provision would deprive the individual of medical care such that the individual's health or life would be endangered, or would deprive the individual of food, clothing, shelter or other necessities of life. The Department of Health in 06 OMM/ADM-5 has incorporated in addition to the deprivation of food, clothing, shelter or other necessities of life as set forth in the statute, the regulatory grounds set forth in Section 360-4.4 of the Regulations as stated above.

A transfer for less than fair market value, unless it meets one of the above exceptions, will cause an applicant or recipient to be ineligible for nursing facility services for a period of

months equal to the total cumulative uncompensated value of all assets transferred during or after the look-back period, divided by the average cost of care to a private patient for nursing facility services in the region in which such person seeks or receives nursing facility services, on the date the person first applies or recertifies for Medicaid as an institutionalized person. For purposes of this calculation, the cost of care to a private patient in the region in which the person is seeking or receiving such long-term care will be presumed to be 120 percent of the average Medicaid rate for nursing facility care for the facilities within the region. The average regional rate is updated each January first.

For uncompensated transfers made on or after February 8, 2006, the penalty period starts the first day of the month during or after which assets have been transferred for less than fair market value, or the first day of the month the otherwise eligible individual is receiving services for which Medical Assistance would be available but for the transfer penalty, whichever is later, and which does not occur during any other period of ineligibility. Social Services Law 366.5(e).

Administrative Directive 91 ADM-17 advises local districts of procedures for the treatment of Medical Assistance applications in cases where an applicant/recipient has resources in excess of the applicable resource standard. Potential MA eligibility for all applicant/recipients who have resources above the applicable resource standard must be investigated when applicant/recipients have outstanding medical bills. Eligibility determinations must include a snapshot comparison of excess resources as of the first of the month to viable bills. This comparison must be done for each month in which eligibility is sought, including each of the retroactive months. The client is not eligible until the amount of viable bills is equal to or greater than the amount of excess resources remaining after the purchase of burial-related items. Eligibility will be authorized after excess resources and any excess income are fully offset by viable bills. Excess resources must be offset by viable bills before such bills are used to offset excess income. Said Directive further provides that whenever a notice is sent to an applicant accepting the applicant with a spend down requirement or denying an application because of excess resources, the Agency is required to include a copy of the "Explanation of the Excess Resource Program" along with the Notice.

With respect to bank accounts, 96 ADM-8 provides that as long as an SSI-related applicant or recipient is designated as the sole owner by the account title, and can withdraw funds and use them for his or her support and maintenance, the applicant or recipient is presumed to own all of the funds in the account, regardless of their source. This presumption cannot be rebutted. In the absence of evidence to the contrary, if an SSI-related applicant or recipient is a joint account holder, it is presumed that all of the funds in the account belong to the applicant or recipient. If there is more than one SSI-related applicant or recipient who is a holder of the joint account, it is presumed that the funds in the account belong to them in equal shares. This presumption may be rebutted.

Administrative Directive (ADM) 00 OMM/ADM-6 advises social services districts of the actions to be taken when a change in an institutionalized Medicaid recipient's income or other circumstances results in an increased or decreased amount of net available monthly income (NAMI). The NAMI amount is the portion of the recipient's monthly income which must be

applied toward the cost of care.

For individuals in permanent absence status in a medical facility, or for an institutionalized spouse as defined in Section 360-4.10(a)(7) of State regulations, after Medicaid eligibility is established, posteligibility rules are used to determine the amount of income that is to be applied toward the cost of care. When an increase in an individual's income or other circumstances results in an increase in the NAMI amount, timely and adequate notice must be provided to the individual. Timely notice must be mailed at least 10 days in advance of the date the social services district increases the NAMI amount. In addition, because income contributions are applied on a monthly basis, any increase in an individual's NAMI is made effective on the first day of the month which is at least 10 days after the notice is mailed.

In accordance with the post-eligibility rules under federal regulations 42 CFR 435.725 and 435.832 (and the spousal impoverishment provisions at 42 U.S.C. 1396r-5), in determining the amount of an individual's income to be applied toward the cost of care, monthly income will be projected for a prospective budget period. At the end of the budget period, or when any significant change occurs, the social services district must reconcile projected income with actual income received.

If a change in income or circumstances results in an increase in the amount that an individual should have paid to a facility, an adjustment will be made to the individual's NAMI in a future month(s) (following 10-day notice) to reflect the amount that should have been contributed for the budget period. In situations where the full amount of an adjustment together with an individual's on-going NAMI exceeds the monthly Medicaid rate, the adjustment is limited to the difference between the on-going NAMI and the Medicaid rate. The balance of the adjustment is carried over and added to the following month's NAMI. This process continues until the full amount of an adjustment has been applied toward the cost of care.

It should be noted that adjustments may only be made in cases where an individual continues to be financially eligible for Medicaid. If an income change or change in circumstances renders an individual ineligible for Medicaid, the social services district is not able to make an adjustment prospectively.

Social services districts are to take the following actions when changes in a recipient's income or circumstances result in a change in the individual's NAMI.

Note: These procedures apply to individuals who are in permanent absence status, and are to be used once chronic care budgeting begins (the first day of the month following the month in which an individual is determined to be in permanent absence status).

A. Determination of Income

In determining the amount of an individual's income to be applied toward the cost of care, social services districts are to project total monthly income for the prospective budget period. For income that is received regularly in fixed amounts (e.g., social security benefits), the projection is to be based on the current amount received. For income that is irregularly received or that fluctuates in amount (e.g., interest and dividends), social services districts should base the projection on the average amount received in the preceding six-month period. For income that is received annually (e.g., an annuity payment), the projection should be based on an average monthly amount. Social services districts are to project monthly income solely on the basis of income currently being received and expected to continue during the prospective budget period. Income that an individual may receive in the future is not to be considered.

At recertification, or when notified of a change in a recipient's income or circumstances, the

social services district must reconcile estimated income with actual income received. The reconciliation may be made for a period up to six months prior to the month the reconciliation is done. Since timely notice must be provided before the district can increase an individual's NAMI, the month(s) that it will take to provide timely notice must be taken into account in determining the amount that should have been contributed.

In determining the amount that an individual's NAMI is to be increased, the adjustment and the individual's on-going NAMI cannot exceed the monthly Medicaid rate for the type of services the individual is receiving (i.e., nursing home level of care, or in the case of an institutionalized spouse, long term home health care or acute care in a hospital). If the full amount of an adjustment and the on-going NAMI exceeds the applicable Medicaid rate, the excess amount is to be carried over and applied to the subsequent month's NAMI.

For purposes of the above calculation, any available third party insurance benefits must be considered in determining the amount of Medicaid expenditures for a particular month. After applying any third party insurance benefits, the total amount of an individual's on-going NAMI and adjustment amount is compared to the amount of Medicaid expenditures for the month.

Administrative Directive 06 OMM/ADM-5 advises in part that the first step, after receiving an application for Medicaid coverage of nursing facility services, or a request for an increase in coverage, along with the requested documentation, is to determine the individual's financial eligibility for Medicaid. Eligibility for institutionalized individuals is to be calculated as follows: For single individuals, after applying any applicable resource disregards based on community budgeting rules and the individual's category of assistance, the remaining countable resources are compared to the Medicaid resource level for one. For institutionalized spouses, the resources are to be calculated in accordance with the spousal impoverishment provisions; subtract from the couple's total countable resources, the maximum community spouse resource allowance and the Medicaid resource level for one for the institutionalized spouse. If there are resources in excess of the Medicaid resource level for one, social services districts must determine whether the institutionalized individual has medical expenses, not covered by a third party, that offset the amount of the excess resources for the month coverage is sought. Bills incurred for nursing facility services may be used to offset excess resources. Individuals may also spend excess resources on an irrevocable pre-need funeral agreement.

If the institutionalized individual has medical bills that offset the amount of the individual's excess resources, the individual is resource eligible. The next step is for the district to determine the individual's income eligibility for the month coverage is sought.

For single individuals and couples where there is an institutionalized spouse, to calculate income eligibility, the following deductions are to be applied to the institutionalized individual's gross monthly income (after deducting any categorical disregards such as interest income):

- From the individual's gross monthly income, deduct the applicable income disregards under community budgeting rules based on the individual's category of assistance (e.g., for SSI-related A/Rs, deduct the \$20 income disregard and any health insurance premiums).
- Deduct from the remaining net income, the Medicaid income level for one.
- Compare the remaining income to the amount of the individual's unpaid medical bills that are not subject to payment by a third party other than a public program of the State or any of its political subdivisions. Any portion of unpaid bills, including bills incurred for nursing facility services, not used to offset any excess resources, may be used to establish income eligibility.

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- If the individual has medical bills that equal or exceed the individual's net monthly income, the individual is income eligible. If the individual does not have medical bills that at least equal the amount of the individual's net monthly income, the individual is not income eligible.

Note: A community spouse's income is not counted when determining an institutionalized spouse's financial eligibility for nursing facility services.

For institutionalized individuals who are financially eligible for Medicaid, social services districts must review resource documentation for the past 36-month look-back period (or 60 months for trusts) immediately preceding the date the individual requests Medicaid coverage to begin. As noted on page 10 of this directive, the 36-month look-back period will increase to 60 months in one month increments starting February 1, 2009.

If an institutionalized individual has not made a prohibited transfer and is financially eligible for Medicaid, the district must determine the individual's liability toward the cost of care using chronic care/post-eligibility budgeting (Budget Type 07, 08, 09 or 10, as applicable).

Section 360-2.4(c) of the Regulations provides that 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.

DISCUSSION

The uncontroverted evidence establishes that the Appellant, age 82, was admitted to a residential health care facility, ("RHCF"), [REDACTED], on July 13, 2006, and that on October 23, 2007, an application for Medical Assistance coverage for residential health care and services, with a requested effective (pick-up) date of July 13, 2006, was filed by the RHCF. On November 27, 2007, the Agency requested further documents from Appellant at the RHCF in order to determine eligibility. According to Agency computer records, on or about January 3, 2008, the Agency determined to deny the Appellant's application thereon. The record also establishes that a reconsideration of the Agency's determination to deny the Appellant's application for a Medical Assistance authorization was requested, and that according to Agency computer records, on or about September 23, 2008, the Agency again determined to deny the Appellant's application thereon.

The record further establishes that on October 30, 2008, the Appellant's representative requested that the Agency reconsider its determination to deny the Appellant's application for a Medical Assistance authorization with a requested effective (pick-up) date of October 1, 2007, and that on December 16, 2008, the Agency sent a Denial Notice to the RHCF setting forth its determination to deny the Appellant's application for Medical Assistance benefits, on the grounds that the Appellant failed to provide documentation/ information necessary to determine her eligibility thereon. The record then establishes that on July 19, 2010, a reapplication for Medical Assistance coverage for residential health care and services was filed on behalf of Appellant, with a requested effective (pick-up) date of April 1, 2010, and that by Notice of Acceptance dated May 2, 2011, the Agency determined to accept the Appellant's July 19, 2010 application for a Medical Assistance authorization, for the period commencing April 1, 2010

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subject to net available monthly income (NAMI) of \$2218.23. By notice of intent to change your NAMI contribution towards chronic care costs dated May 27, 2011, the Agency decreased Appellant's NAMI to zero dollars, due to "outstanding medical bill \$240,271.95."

On or about September 2010, the RHCF filed a petition seeking appointment of a guardian of the property of Appellant. By order of the Supreme Court of ██████ County, dated July 11, 2011, Integral Guardianship Services was appointed guardian of the property of Appellant. Integral Guardianship authorized the RHCF and/ or its attorneys, Abrams Fensterman, et al to represent Appellant regarding Medicaid eligibility, including but not limited to, fair hearing representation.

The record establishes that on June 28, 2011, this fair hearing was requested. At this hearing, and also by a Memorandum, the Agency invoked the Statute of Limitations, arguing that the Commissioner is without jurisdiction to review the local Agency's determinations because this Hearing was requested more than 60 days after the Agency's determinations to deny the Appellant's application for a Medical Assistance authorization. Appellant's Representative, at this hearing and also via Memorandums, argues that the Statue of Limitations should be tolled because "the Appellant lacked the capacity to accept and understand the consequences" of the Agency denials due to a severe mental impairment, and cited prior Fair Hearing determinations (FH# ██████ and FH# ██████, in particular) in an effort to substantiate this claim. The Agency argued that, at the time of the determinations, the Appellant possessed the requisite mental capacity to understand the Agency determinations, as evidenced by the fact that a guardian petition was not filed until September 17, 2010, and that a petition would have been filed sooner otherwise. Appellant's Representative attempted to rebut the Agency's argument by introducing documentation that the Appellant suffered from dementia as early as September, 2007 and was "incapable of meaningful participation in her care". The Agency then argued that, assuming arguendo that the Appellant lacked capacity at the time of the Agency's determinations, that the RHCF and their representative(s) "acted as the Appellant's liaison, i.e. applying for Medicaid on her behalf, assisting her in providing the appropriate documents needed for the application, etc. To demonstrate further the role of the Nursing Home in relation to their residents, a master agreement/ contract is signed between Nursing Home representative and the resident stating that the Nursing Home and their representative(s) have the authority to act on behalf of the resident regarding applications for Medicaid. Therefore, it cannot be said that because the Appellant was without a Guardian they were without assistance and proper representation." Appellant's Representative then argues that the RHCF and its representative(s) were not, in fact, legally authorized to act on the Appellant's behalf.

Regarding the determinations made by the Agency on January 3, 2008 and September 23, 2008, it is noted that, at this hearing, neither the Appellant nor the Agency produced copies of a Denial notice regarding the Agency determinations thereon. The Regulations require the Agency to provide an applicant for a Medical Assistance authorization with an adequate and timely notice, one that includes Fair Hearing rights, when the Agency proposes to accept or deny the application. As such, the failure by the Agency to produce copies of an adequate and timely notice relating to the determinations made on January 3, 2008 and September 23, 2008 provide a

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sufficient basis for tolling the Statute of Limitations and as it relates to these two determinations, only.

Regarding the Notice dated December 16, 2008, the record did not establish that the notice dated December 16, 2008, had included the required language regarding the 60 day statute of limitations. Such language did not appear in the front of the notice; the Agency had submitted a copy of the front with an attached second page including the 60 day language but bearing a different notice number. Appellant's representative submitted only the first page. Additionally the Appellant's representative contended the Appellant had been unable to meaningfully participate in her care or Medicaid application from September, 2007. Documentation presented at this hearing, including Minimum Data Sets ("MDS"), completed during the periods of September 4, 2007 through September 6, 2007; and November 28, 2007 through November 30, 2007; and November 8, 2008 through October 10, 2008, addressed Appellant's state of mind. The MDS establish that the Appellant suffers from dementia, is severely impaired regarding her cognitive skills for daily decision making, rarely/never makes herself understood, and rarely/never understands others. Furthermore, it is not in dispute that the Appellant, due to "cognitive deficits which result in certain functional limitations which impair her ability to provide for her property management", was appointed a guardian of the property by the Supreme Court of the State of New York, ██████ County, on July 11, 2011. As such, the record establishes a sufficient basis for tolling the sixty day statute of limitations regarding the Agency's notice dated December 16, 2008.

Regarding the determinations made by the Agency on January 3, 2008 and September 23, 2008, and regarding the Notice dated December 16, 2008, it is not in dispute that the Agency denied the Appellant's application for assistance due to her failure to provide the information/documentation requested by the Agency to establish her eligibility for a Medical Assistance authorization. Furthermore, it is not in dispute that the Appellant failed to provide said information/documentation. However, the record substantiates the Appellant's Representative's argument that, due to mental impairment, the Appellant had good cause for not providing said information/documentation, or in being unable to assist the representative in obtaining and providing requested documentation. Appellant's Medicaid application had been filed on behalf of Appellant by the RHCF, there was no community spouse of Appellant and there was no evidence presented at this hearing of anyone else who might have assisted with Appellant's Medicaid application.

As such, the Appellant has established good cause in her failure to provide information/documentation necessary to establish her eligibility for a Medical Assistance authorization. Therefore, the Agency's determinations to deny the initial Medicaid application dated October 23, 2007, cannot be sustained.

By Notice of Acceptance dated May 2, 2011, the Agency determined to accept the Appellant's July 19, 2010 application for a Medical Assistance authorization, for the period commencing April 1, 2010, subject to net available monthly income (NAMI) of \$2218.23. By fax to the Agency on May 19, 2011, the RHCF's representatives asked the Agency to revise Appellant's NAMI calculation "to allow Ms. ██████'s current net available monthly income

to be applied towards the facility's viable bill." By notice of intent to change your NAMI contribution towards chronic care costs dated May 27, 2011, the Agency decreased Appellant's NAMI to zero dollars, due to "outstanding medical bill \$240,271.95." It is noted that this outstanding medical bill was incurred at the RHCF due to the prior denials of the Appellant's initial Medicaid application. Retroactive review and Medicaid coverage is being sought herein for the same bills which the Agency had applied against Appellant's NAMI to find no ongoing liability of Appellant, for the costs of care in the RHCF.

Administrative Directive (ADM) 00 OMM/ADM-6 advises social services districts that for individuals in permanent absence status in a medical facility, or for an institutionalized spouse as defined in Section 360-4.10(a)(7) of State regulations, after Medicaid eligibility is established, posteligibility rules are used to determine the amount of income that is to be applied toward the cost of care. In accordance with the post-eligibility rules under federal regulations 42 CFR 435.725 and 435.832 (and the spousal impoverishment provisions at 42 U.S.C. 1396r-5), in determining the amount of an individual's income to be applied toward the cost of care, monthly income will be projected for a prospective budget period.

DECISION AND ORDER

The Agency's determination on January 3, 2008, to deny Appellant's application for Medical Assistance is not correct and is reversed.

The Agency's determination on September 23, 2008, to deny Appellant's application for Medical Assistance is not correct and is reversed.

The Agency's determination dated December 16, 2008, to deny Appellant's application for Medical Assistance due to failure to provide documentation/ information necessary to determine the Appellant's eligibility thereon is not correct and is reversed.

1. The Agency is directed to continue to process the Appellant's October 23, 2007 application for a Medical Assistance authorization.
2. The Agency is directed to notify Appellant, her Guardian and her representative in writing of any further information/documentation necessary to determine Appellant's Medical Assistance eligibility.
3. The Agency is directed to provide Appellant, her guardian and her representative a reasonable period of time in which to submit any such further information/documentation necessary to determine Appellant's Medical Assistance eligibility for July 1, 2007, to April 1, 2010.
4. The Agency is directed to make a new determination concerning Appellant's eligibility for institutional Medical Assistance, for July 1, 2007, to April 1, 2010.

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5. The Agency is directed to notify Appellant, her guardian and her representative in writing of its determination.

Should the Agency need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant, her Guardian and her representative 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 Section 358-6.4 of the Regulations, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
08/07/2013

NEW YORK STATE
DEPARTMENT OF HEALTH

By

A handwritten signature in black ink, appearing to be a stylized name, located below the word "By".

Commissioner's Designee