STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: June 8, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000005551

[redacted]

Dear [redacted],

On March 21, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's January 13, 2015 eligibility determination notice.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the Account ID at the top of this notice.

Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

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DEPARTMENT OF HEALTH
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Decision

Decision Date: June 8, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000005551

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NYSOH properly determine that you were conditionally eligible for Medicaid, effective January 1, 2015?

Procedural History

NYSOH received your initial application for health insurance on January 12, 2015, in which you attested to an expected yearly income of $15,600.00. You also attested in that application that you were expecting a child with an anticipated due date of [redacted]

On January 13, 2015, NYSOH issued an eligibility determination notice based on the information contained in your January 12, 2015 application. It stated that you were conditionally eligible for Medicaid pending the receipt of documentation to confirm your income before January 29, 2015. This eligibility determination was effective January 1, 2015.

On April 23, 2015, NYSOH issued a disenrollment notice stating that your Medicaid Fee-For-Service would be discontinued as of May 31, 2015.

On December 15, 2015, you contacted NYSOH's Account Review Unit and requested an appeal of the January 13, 2015 eligibility determination notice insofar as your eligibility for conditional Medicaid during the month of February 2015 was not upgraded to being eligible for full Medicaid, and your medical expenses associated with the delivery of your child were not covered.

On March 21, 2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

A review of the record support the following findings of fact:

1) You submitted your initial application for health insurance on January 12, 2015, in which you attested to an expected yearly income of $15,600.00, and that you were expecting a child with an anticipated due date of [redacted]

2) On January 13, 2015, you were found conditionally eligible for Medicaid pending the receipt of income documentation before January 29, 2015 to confirm your eligibility.

3) The record reflects that NYSOH did not receive any income documentation from you before January 29, 2015.

4) Your son was born on [redacted].

5) You were disenrolled from your Medicaid Fee-For-Service coverage, effective May 31, 2015.

6) You testified that NYSOH representative did not tell you that if you did not provide the requested income documentation that the expenses associated with your delivery may not be covered.

7) You testified that while your prenatal care had been covered through Medicaid, you received a bill for approximately $26,000.00 in connection with the birth of your child on [redacted].

8) You testified that you were seeking for your Medicaid eligibility during the month of February 2015 to be upgraded to full Medicaid coverage, with the effect that your medical expenses associated with the delivery of your child will covered.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Appeal Timeliness

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by the Marketplace (45 CFR § 155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

Income Verification

For all individuals whose income is needed to calculate the household's eligibility for Medicaid, the Marketplace must request data that will allow the Marketplace to verify the household's income (45 CFR § 155.320(c)(2)(i)). If the Marketplace cannot verify the income information required to determine eligibility, it must attempt to resolve the inconsistency by providing the individual an opportunity to submit satisfactory documentary evidence (42 CFR § 435.952(c)(2)).

Legal Analysis

The only issue under review is whether NYSOH properly determined that you were *conditionally* eligible for Medicaid.

You were found to be conditionally eligible for Medicaid through NYSOH effective January 1, 2015, based on the household income of $15,600.00 listed in your application, for a two-person household; this included your unborn child. Your eligibility was conditional upon production of proof of your household income before January 29, 2015.

No documentation was received from you before January 29, 2015.

Because the income listed in your application was not consistent with information obtained from data sources, NYSOH determined that your eligibility for Medicaid was conditional, effective January 1, 2015, and directed you to provide income documentation. Therefore, the January 13, 2015 eligibility determination notice is AFFIRMED.

You were conditionally enrolled in Medicaid Fee-For-Service coverage between January 1, 2015 and May 31, 2015. You testified that you were seeking to have your Medicaid eligibility upgraded to a level which would provide you coverage for medical costs you incurred associated with the birth of your son during the month February 2015. However, the Appeals Unit does not have the authority to determine what medical expenses ought to be covered through your Medicaid Fee-For-Service coverage during that month.

Therefore, your case is RETURNED to NYSOH to review whether the appropriate medical expenses you incurred during the month of February 2015 were covered to the extent permitted by your Medicaid plan.

Decision

The January 13, 2015 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to review whether the appropriate medical expenses you incurred during the month of February 2015 were covered to the extent permitted by your Medicaid plan.

Effective Date of this Decision: June 8, 2016

How this Decision Affects Your Eligibility

Your eligibility has not changed.

You were eligible for Medicaid Fee-For-Service, on a conditional basis, between January 1, 2015 and May 31, 2015.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

You may bring a lawsuit on any Appeals Unit decision in New York State court in accordance with Article 78 of the New York Civil Practice Law and Rules. This must be done within four months of the Decision Date, which appears on the first page of this Decision.

Additionally, Appeals Unit decisions on issues involving eligibility for qualified health plans, advance premium tax credits, and cost-sharing reductions may be appealed to the U.S. Department of Health and Human Services. This must be done within 30 days of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

If You Have Questions about this Decision (Customer Service Resources):

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The January 13, 2015 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to review whether the appropriate medical expenses you incurred during the month of February 2015 were covered to the extent permitted by your Medicaid plan.

Your eligibility has not changed.

You were eligible for Medicaid Fee-For-Service, on a conditional basis, between January 1, 2015 and May 31, 2015.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

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