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

Notice of Decision

Decision Date: December 7, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000009580

[redacted]

Dear [redacted],

On November 29, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's May 11, 2016 eligibility determination.

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 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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NY State of Health Account ID: [redacted]
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Issue

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

> Did NY State of Health (NYSOH) properly find that you were not eligible for retroactive Medicaid coverage for October, 2015?

Procedural History

On January 20, 2016, NY State of Health (NYSOH) received your updated application for financial assistance.

On January 21, 2016, NYSOH issued an eligibility determination notice based on your January 20, 2016 application. The determination found you conditionally eligible for Medicaid effective January 1, 2016. You were asked to provide additional information to confirm your third party health insurance by providing documentation before February 4, 2016. The notice further stated you had requested assistance paying for medical costs for the three month period prior to your application.

On May 5, 2016, NYSOH received your income documentation for the month of October, 2015.

On May 11, 2016, NYSOH issued an eligibility determination finding you ineligible for Medicaid for October 1, 2015 through October 31, 2015. The notice stated this was because your monthly household income you provided of $2,991.85 was over the allowable monthly income limit of $2,961.00.

On May 12, 2016, you contacted NYSOH's Account Review Unit and appealed the May 11, 2016 denial of retroactive Medicaid coverage for October 2015.

On November 29, 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 supports the following findings of fact:

1) You are seeking insurance for yourself for the month of October, 2015.

2) Your January 20, 2016 application reflects that you will be filing your 2015 taxes as single. You testified this was correct.

3) Your application reflects that you will be claiming your newborn child as a dependent on your tax return. You testified this was correct.

4) You testified you were told you were pregnant on [redacted].

5) You testified you incurred medical costs in the amount of approximately $621.00 for the visit to your doctor on October 30, 2015. You explained your employer's insurance would not cover the cost of the visit based on the $750.00 deductible not being met yet for 2015.

6) You testified although you were covered under your employer's insurance for the month of October, 2015, you did not use your employer's insurance for the visit.

7) The record supports you requested retroactive coverage under Medicaid for the month of October 2015 on January 20, 2016.

8) You provided income documentation to NYSOH on May 5, 2016.

9) The documentation consisted of three paystubs dated October 2, 16, and 30, 2015 in the gross amounts of $1,011.93, $994.20, and $985.72 respectively. See Document: [redacted]

10) You testified that the income documentation you provided to NYSOH is an accurate reflection of the income you received in the month of October, 2015.

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

Applicable Law and Regulations

Medicaid for Adults between the Ages of 19 and 65

Medicaid through NYSOH can be provided to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the federal poverty level (FPL) for the applicable family size (42 CFR §§ 435.119(b), 435.911(b)(1), 435.603(d)(4); N.Y. Soc. Serv. Law § 366(1)(b)).

Medicaid is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the FPL for the applicable family size (see 42 CFR § 435.116(c); NY Department of Health Administrative Directive 13ADM-03).

Household Composition

For purposes of Medicaid eligibility, however, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

In an analysis of Medicaid eligibility, the determination is based on the FPL “for the applicable budget period used to determine an individual's eligibility” (42 CFR § 435.4). On the date of the month you are seeking coverage for, that was the 2015 FPL, which is $15,930.00 annually for a two-person household (80 Fed. Reg. 3236, 3237).

Medicaid Retroactive Coverage

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of application if the individual received medical services that would have been covered under Medicaid and the individual would have been eligible for Medicaid at the time he received the services if he had applied. (42 CFR 435.915(a)).The Department of Health may make eligibility effective for fee-for-service Medicaid on the first day of the month if an individual was eligible any time during that month (42 CFR 435.915(b)).

Legal Analysis

The issue under review is whether NYSOH properly determined you were ineligible for retroactive Medicaid coverage for the month of October, 2015.

On January 20, 2016, NYSOH received your application for financial assistance. It then provided you an eligibility determination that day. The determination found you conditionally eligible for Medicaid effective January 1, 2016.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's application if the individual received medical services that would have been covered under Medicaid and if they would have been eligible for Medicaid in those three months had they applied.

When calculating family size for Medicaid purposes, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman but also the number of children she expects to deliver. You testified that you were pregnant in the month of October 2015, therefore NYSOH determined your eligibility for Medicaid using a two-person household.

To be eligible for Medicaid in October, 2015, you would have needed to meet the non-financial criteria and have an income no greater than 223% of the 2015 federal poverty level, which is $2,961.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during October, 2015.

The documentation you provided was in the form of three paystubs dated October 2, 16, and 30, 2015 in the gross amounts of $1,011.93, $994.20, and $985.72 respectively. The result of these documents shows you received a total gross income of $2,991.85 for the month of October, 2015.

Since your income of $2,991.85 was more than the $2,961.00 per month Medicaid limit for October, 2015, NYSOH properly determined you to be ineligible for that month. Therefore, May 11, 2016, eligibility determination denying your request for Medicaid for the month of October, 2015, was correct and is AFFIRMED.

Decision

May 11, 2016, eligibility determination is AFFIRMED.

Effective Date of this Decision: December 7, 2016

How this Decision Affects Your Eligibility

You are not eligible for Medicaid for the month of October, 2015.

This decision does not affect your current Medicaid eligibility.

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 after the date 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 date 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:

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  Albany, NY 12211

- By fax: 1-855-900-5557

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Summary

May 11, 2016, eligibility determination is AFFIRMED.

You are not eligible for Medicaid for the month of October, 2015.

This decision does not affect your current Medicaid eligibility.

Legal Authority

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

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).

A Copy of this Decision Has Been Provided To:

[redacted]

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