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

Notice of Decision

Decision Date: December 27, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000010658

[redacted]

Dear [redacted],

On December 20, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's May 18, 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 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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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 determine that you were not eligible for Medicaid from December 1, 2015 through December 31, 2015?

Procedural History

On January 28, 2016, you updated your application for financial assistance with health insurance.

On January 29, 2016, NYSOH issued a notice of eligibility determination finding you eligible for Medicaid effective January 1, 2016 based on your January 28, 2016 application.

Also on January 29, 2016, NYSOH issued a notice of enrollment confirming your enrollment in your Medicaid Managed Care plan with a start date of March 1, 2016 based on your January 28, 2016 plan selection.

On February 22, 2016, you updated your application to indicate you were seeking help with paying medical bills for the three months prior to your application, specifically December 1, 2015 to December 31, 2015.

On February 23, 2016 NYSOH issued a notice advising you that income documentation for your household needed to be submitted in order to determine your eligibility for Medicaid from December 1, 2015 to December 31, 2015.

On February 26, 2016, April 26, 2016, May 5, 2016 and May 12, 2016 income documentation was uploaded to your NYSOH account.

On May 18, 2016, NYSOH issued a notice of eligibility determination stating that you were not eligible for Medicaid from December 1, 2015 through December 31, 2015 because the monthly household income you provided of $3,801.00 was over the allowable monthly income limit of $3,268.00.

On July 1, 2016, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination insofar as it denied you retroactive Medicaid for the month of December 2015.

On December 21, 2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing Spanish Interpreter # interpreted and acted as your Authorized Representative and assisted you with your testimony. 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) On January 28, 2016, you updated your application for financial assistance with health insurance. Based on that application you were found eligible for Medicaid, effective January 1, 2016, as documented in the January 29, 2016 eligibility determination notice.

2) Your authorized representative testified that only you are seeking Medicaid coverage for December 2015.

3) Your authorized representative testified that you filed your 2015 income tax return as married filing jointly and intend to file your 2016 income tax return as married filing jointly. Your authorized representative further testified that you claimed three dependents in 2015 and would claim three dependents for 2016.

4) You testified that you had no income for December 2015. You testified that your younger two children had no income in 2015 or 2016. You also testified that your oldest child had no income in 2015.

5) You testified that your spouse only had one employer in 2015 and has remained with the same employer throughout 2016.

6) Your authorized representative testified that your spouse is paid weekly.

7) Your authorized representative testified that your spouse received five paychecks in December 2015, 4 paychecks in January 2016, and 4 paychecks in February 2016.

8) Your authorized representative testified that you currently reside in Suffolk County and that you lived in Suffolk County throughout 2015.

9) You testified that in 2015 your spouse earned $41,244.00 and will earn about the same amount in 2016.

10) You testified that you earned approximately $4,000.00 in 2015 and your expected annual income for 2016 is $3,000.00.

11) You submitted five paystubs for your spouse for December 2015. The first is for pay date December 4, 2015 for gross pay amount $840.00; the second is for pay date December 11, 2015 for gross pay amount $840.00; the third is for pay date December 18, 2015 for gross pay amount $840.00; the fourth is for pay date December 24, 2015 for a gross pay amount of $672.00; and the fifth is for pay date December 31, 2015 for gross pay amount $609.00.

12) Your authorized representative testified that it is your position that your spouse's pay for pay date December 4, 2015 should not be included in determining your eligibility for Medicaid for December 1, 2015 to December 31, 2015 as this was pay for work performed in November 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)).

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 your application, that was the 2015 FPL, which is $28,410.00 for a five-person household (80 Fed. Reg. 3236, 3237).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

Retroactive Medicaid

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of an initial 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 USCA § 1396A(34); 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 that you were not eligible for retroactive Medicaid coverage from December 1, 2015 through December 31, 2015.

You are in a five-person household, you file your taxes with a tax filing status of married filing jointly and claim three dependents on your tax return.

You were initially found eligible for Medicaid in the January 29, 2016 eligibility determination notice based on an application submitted on January 28, 2016. According to this notice, your coverage with Medicaid began January 1, 2016.

Your authorized representative testified that you are seeking to have your Medicaid coverage retroactively applied for the month of December 2015.

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.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size. To be eligible for Medicaid in December 2015, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $3,268.00 per month. There is no indication in the record that you would

have been ineligible for Medicaid based on non-financial criteria during December 2015.

You testified that neither you nor any of your children had income in December 2015. You testified that your spouse is paid weekly. You uploaded your spouse's paystubs for December 2015 which included a paystub for pay date December 4, 2015 for a gross pay amount of $840.00, a paystub for pay date December 11, 2015 for a gross pay amount of $840.00, a paystub for pay date December 18, 2015 for a gross pay amount of $840.00, a paystub for pay date December 24, 2015 for a gross pay amount of $672.00, and a paystub for pay date December 31, 2015 for a gross pay amount of $609.00. Therefore, the record indicates that in the month of December 2015, your household received income in the amount of $3,801.00.

Since the income your household received from December 1, 2015 to December 31, 2015 of $3,801.00 was more than the $3,268.00 monthly Medicaid limit for December 2015, NYSOH properly determined that you were not eligible for Medicaid coverage during that month. Therefore, the May 18, 2016 eligibility determination stating that you were not eligible for Medicaid from December 1, 2015 to December 31, 2015, is correct and is AFFIRMED.

Decision

The May 18, 2016 eligibility determination is AFFIRMED.

Effective Date of this Decision: December 27, 2016

How this Decision Affects Your Eligibility

You are not eligible for Medicaid from December 1, 2015 to December 31, 2015

Your eligibility for Medicaid was effective as of January 1, 2016.

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:

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

Summary

The May 18, 2016 eligibility determination is AFFIRMED.

You are not eligible for Medicaid from December 1, 2015 to December 31, 2015

Your eligibility for Medicaid was effective as of January 1, 2016.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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).