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

Notice of Decision

Decision Date: February 17, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000012007

[redacted]

Dear [redacted],

On December 15, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's August 14, 2016 eligibility determination notice.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of the 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 the NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification Number at the top of this letter.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(b).

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: February 17, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000012007

[redacted]

Issue

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

> Did New York State of Health (NYSOH) properly determine that you, your spouse, and child were not eligible for retroactive Medicaid coverage for the month of July 2016?

Procedural History

On May 17, 2016, you submitted an application for financial assistance through NYSOH.

On May 18, 2016, NYSOH issued a notice stating that you, your spouse, and child may be eligible for health insurance but more information was needed to confirm your eligibility. The notice directed you to submit proof of income by June 2, 2016, to confirm your eligibility.

Also on May 18, 2016, NYSOH issued a disenrollment notice stating that you and your spouse's Essential Plan, and your child's Medicaid fee-for-service would be discontinued June 30, 2016.

On May 27, 2016, you uploaded income documentation from [redacted] to your NYSOH account [redacted].

On June 8, 2016, your NYSOH account was updated.

On June 9, 2016, NYSOH issued an eligibility determination notice that you and your spouse were eligible for up to $458.00 of advance premium tax credit and cost-sharing reductions as of July 1, 2016. Furthermore, your child was found eligible for Child Health Plus with a $15.00 per month premium effective as of July 1, 2016.

On June 17, 2016, you updated your NYSOH account.

Also on June 17, 2016, you uploaded additional income documentation from [redacted] to your NYSOH account [redacted].

On June 18, 2016, NYSOH issued a notice stating that you, your spouse, and child may be eligible for health insurance but more information was needed to confirm your eligibility. The notice directed you to submit proof of income by July 3, 2016, to confirm your eligibility.

On June 20, 2016, you uploaded employment information from [redacted] to your NYSOH account [redacted].

On June 23, 2016, NYSOH issued a notice stating that you have submitted documentation to inconsistency with your account; however, the documentation appears to be insufficient to resolve the request. The notice requested that you provide additional proof of income confirm your eligibility.

On July 1, 2016, you uploaded an explanation of the income and employment documentation you uploaded to your NYSOH account [redacted].

On July 8, 2016, NYSOH issued a notice stating that the documentation you submitted does not confirm the information in your application. The notice stated that you needed to submit additional proof of income by August 1, 2016, to confirm your eligibility.

On August 5, 2016, you uploaded termination letters from [redacted] to your account [redacted]).

On August 10, 2016, NYSOH updated your account.

On August 11, 2016, NYSOH issued an eligibility determination notice stating that you, your spouse, and child were eligible for Medicaid effective as of August 1, 2016.

On August 13, 2016, you updated your account.

On August 14, 2016, NYSOH issued an eligibility determination notice stating that you, your spouse, and child were newly eligible to purchase a qualified health plan at full cost through NYSOH effective September 1, 2016.

Also on August 14, 2016, NYSOH issued an eligibility determination notice that you, your spouse, and your child's request for help with paying medical bills for July 1, 2016 through July 31, 2016 is denied because the program you were eligible for cannot pay for any care you received in the past.

On August 16, 2016, you uploaded a letter of employment and an Earnings Statement [redacted]. to your account [redacted]).

On September 14, 2016, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as your, your spouse, and child's eligibility for retroactive Medicaid coverage for the month of July 2016.

On December 15, 2016, you had a scheduled telephone hearing with a Hearing Officer from the Appeals Unit of NYSOH. Your testimony was taken during the hearing, and the record was left open to allow you to submit your June 2016 earnings statement [redacted]. On the same day you uploaded the documentation to your account [redacted]. The record is now complete and closed.

Findings of Fact

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

1. You are applying for health insurance through NYSOH for yourself, your spouse, and two-year-old child.

2. You testified that you expected to file a 2016 federal income tax return, with the tax status of married filing jointly, and expected to claim one dependent on that return.

3. On August 11, 2016, NYSOH issued an eligibility determination notice stating that you, your spouse and child were eligible for Medicaid, effective August 1, 2016.

4. According to your NYSOH account, you indicated on your August 13, 2016 application that you wanted help paying for medical bills for the last 3 months for your entire family.

5. You were employed by [redacted] as a part-time employee from January 25, 2016 through May 31, 2016 in 2016. Your last paycheck was received on May 31, 2016 [redacted].

6. You were employed at The New School as a part-time lecturer from February 1, 2016 through May 16, 2016 in 2016 [redacted].

7. You testified that the last paycheck you received from [redacted] was in June 2016.

8. On June 24, 2016, you were issued $1,414.32 from [redacted].

9. Your employment at [redacted]. began on July 20, 2016, and your first date of pay was July 29, 2016 [redacted].

10. On July 29, 2016, you were issued $611.54 in federal taxable wages by [redacted]).

11. You testified you incurred $211.01 in medical expenses in the month of July 2016.

12. You testified that you want your family to be found eligible for retroactive Medicaid for July 2016 to cover the medical expenses that you incurred in that month.

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

Applicable Law and Regulations

Medicaid:

Medicaid can be provided through the Marketplace 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 that is at or below 138% of the federal poverty for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.603(d)(4)), N.Y. Soc. Serv. Law § 366(1)(b)).

In the case of an individual who expects to file a tax return and does not expect to be claimed by another taxpayer, the household consists of the taxpayer and all persons whom such individual expects to claim as a tax dependent (42 CFR § 435.603(f)(1)).

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the FPL for the applicable family size (42 CFR § 435.118(c); New York Department of Health Administrative Directive 13ADM-03).

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 2016 FPL, which is $20,160.00 for a three-person household (81 Fed. Reg. 4036).

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 by the US Department of Health and Human Services, March 19, 2014).

Medicaid Retroactive Coverage:

NYSOH must make Medicaid eligibility effective no later than the third month before the month of application if the individual received medical services that would have been covered under Medicaid and would have been eligible for Medicaid at the time he received the services if they had applied (42 CFR 435.915(a)). NYSOH 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 you, your spouse, and child are eligible for retroactive Medicaid coverage for the month of July 2016.

The record reflects that you expect to file your 2016 federal income tax return jointly with your spouse, and expect to claim your child as a dependent on that return. The record supports that your household size for Medicaid purposes was three.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's application if they would have been eligible for Medicaid in those three months had they applied.

The record supports that you were found eligible for Medicaid effective August 1, 2016, and it was indicated in your August 13, 2016 application that you were seeking help paying for medical bills for the last 3 months.

Medicaid can be provided through the NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size.

Children who are at least one year of age but younger than nineteen are eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the FPL for the applicable family size

On the dates of your applications, the FPL was $20,160.00 for a three-person household. Financial eligibility for Medicaid applicants who are not currently receiving Medicaid benefits may be based on current monthly household income and family size. In order for an adult to be eligible for Medicaid in a household of three, their monthly must not exceed $2,319.00. Furthermore, a child between the age of one and nineteen is eligible for Medicaid in a household of three if their monthly income does not exceed $2,588.00.

The credible record supports that you are no longer employed by [redacted], and your final paychecks were received on May 31, 2016 and June 24, 2016. Furthermore, your employment at [redacted] began on July 20, 2016, and you were issued $611.54 in July 2016.

The credible record supports that you were issued $611.54 in federal taxable wages in the month of July 2016. Therefore, your household income did not exceed the income threshold for you, your spouse, and child to be found eligible for Medicaid for July 2016.

Therefore, the August 14, 2016, eligibility determination notice stating that you, your spouse, and child were not eligible for Medicaid for the period of July 1, 2016, through July 31, 2016 is RESCINDED.

Your case is RETURNED to NYSOH to effectuate your, your spouse, and child's coverage for July 2016.

Decision

The August 14, 2016, eligibility determination notice stating that you, your spouse, and child were not eligible for Medicaid for the period of July 1, 2016, through July 31, 2016 is RESCINDED.

Effective Date of this Decision: February 17, 2017

How this Decision Affects Your Eligibility

You, your spouse, and child were eligible for retroactive Medicaid coverage from July 1, 2016 through July 31, 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 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:

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

- By fax: 1-855-900-5557

Summary

The August 14, 2016, eligibility determination notice stating that you, your spouse, and child were not eligible for Medicaid for the period of July 1, 2016, through July 31, 2016 is RESCINDED.

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).

You, your spouse, and child were eligible for retroactive Medicaid coverage from July 1, 2016 through July 31, 2016.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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