



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

Notice of Decision

Decision Date: November 08, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000008355

[REDACTED]

Dear [REDACTED],

On September 28, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's March 29, 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 NY State of Health 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).

This page intentionally left blank.



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

Decision

Decision Date: October 20, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000008355



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 your daughter was not eligible for retroactive Medicaid from January 1, 2016 through January 31, 2016?

Procedural History

On March 28, 2016, NYSOH received your daughter's completed application for health insurance. That day, a preliminary eligibility determination was prepared with regard to that application, stating that your daughter was eligible for Child Health Plus at a cost of \$15.00 per month, effective May 1, 2016.

Also on March 28, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination as it related to the start date of your daughter's Child Health Plus plan.

On March 29, 2016 NYSOH issued an eligibility determination notice based on the information contained in the March 28, 2016 application, stating that your daughter was eligible for Child Health Plus at a cost of \$15.00 per month, effective May 1, 2016.

Also on March 29, 2016, NYSOH issued an eligibility determination, stating that your daughter is not eligible for help paying medical bills for December 2015, January 2016 and February 2016 because the program she was eligible for cannot pay for any care she received in the past.

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).

On May 19, 2016 the income information in your NYSOH account was updated.

On May 20, 2016 NYSOH issued an eligibility determination notice stating that your daughter was eligible for Medicaid, effective May 1, 2016.

Also on May 20, 2016, NYSOH issued an issued an eligibility determination, stating that your daughter was eligible for Medicaid for February 2016, March 2016 and April 2016 because your monthly household income of \$736.68 was at or below the allowable monthly income limit of \$2,588.00.

On September 28,2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During your testimony, you indicated you are seeking retro-active Fee-For Service Medicaid for the month of January 2016 for your daughter because your daughter has medical bills. The record was kept open until October 12, 2016 in order for you to provide income documentation for the month of January 2016. You did not provide any income documentation and the record is now closed.

Findings of Fact

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

- 1) You testified, and your NYSOH account reflects, that you and your daughter were residing with your daughter's father in the month of January 2016.
- 2) Your daughter's NYSOH account shows that she has Medicaid Fee-For Service, effective February 1, 2016.
- 3) You testified you are seeking retro-active Fee-For Service Medicaid for the month of January 2016 for your daughter because your daughter has medical bills.
- 4) You testified that in the month of January 2016 you received payments from your short-term disability program.
- 5) You uploaded documentation from [REDACTED] stating that you were receiving disability benefits in the amount of \$170.00 per week from December 25, 2015 to February 26, 2016.
- 6) You testified during the hearing that you were unsure the amount of money that your daughter's father earned in the month of January 2016.

- 7) You uploaded documentation from your daughter's father showing his income for the weeks of February 21, 2016, February 28, 2016, March 6, 2016 and March 13, 2016.
- 8) You were asked to provide documentation of your daughter's father income for the month of January 2016. No documentation was received by NYSOH Appeals Unit.

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

Applicable Law and Regulations

Medicaid for Children

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 Social Services Administrative Directive 13ADM-03).

In the case where a child is claimed by one parent as a dependent and who is living with both parents who are not filing a joint tax return (42 CFR § 435.603(f)(2)(ii)), the child's family includes the following persons, if living with the child: (1) the child's parents, (2) the child's spouse, (3) the child's children and siblings under the age of 19, or 21 if a full-time student (42 CFR § 435.603(f)(3)).

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).

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

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).

The issue under review is whether NYSOH properly determined that your daughter was not eligible for retroactive Medicaid from January 1, 2016 through January 31, 2016.

On March 28, 2016 NYSOH received your completed application for health insurance. On March 29, 2016, NYSOH issued an eligibility determination, stating in part that your daughter was not eligible for help paying medical bills for January 2016. You testified that you are seeking to have your daughter found eligible for Medicaid coverage for the month of January 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. There is no indication in the record that your daughter would have been ineligible for Medicaid based on any non-financial criteria during January 2016.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

When calculating household size for a child who is living with both parents but only being claimed by one parent as a tax dependent, the household consists of the child, both parents and any siblings under the age of 19. On the date of your application, your child resided with you and her father. Therefore, your child is in a three-person household.

To be eligible for Medicaid in January 2016, your daughter would have needed to meet the non-financial criteria and have an income no greater than 154% of the federal poverty level (FPL), which is \$2,587.00 per month.

You testified that in the month of January 2016 you received payments from your short-term disability program. You uploaded documentation from [REDACTED] stating that you were receiving disability benefits in the amount of \$170.00 per week from December 25, 2015 to February 26, 2016. Therefore, for the month of January 2016 you would have received \$850.00.

You testified during the hearing that you were unsure the amount of money that your daughter's father earned in the month of January 2016. You uploaded documentation from your daughter's father showing his income for the weeks of February 21, 2016, February 28, 2016, March 6, 2016 and March 13, 2016. You were asked to provide documentation of your daughter's father income for the month of January 2016.

NYSOH Appeals Unit kept the record open for 15 days in order for you to supply income documentation but you failed to supply any such documentation and the record closed.

Since you failed to supply income documentation for your daughter's father within the 15 days provided to you by the NYSOH Appeals Unit, the record does not contain sufficient information on the household's income to determine whether your daughter was eligible for retroactive Medicaid Fee-For Service in the month of January 2016. Therefore, the March 29, 2016 eligibility determination notice stating that your daughter was denied help with paying medical bills in January, 2016 is AFFIRMED.

Decision

The March 29, 2016 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: October 20, 2016

How this Decision Affects Your Eligibility

Your daughter is not eligible for Medicaid in the month of January 2016.

This does not affect your daughter's current eligibility determination.

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 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).

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 March 29, 2016 eligibility determination notice is **AFFIRMED**.

Your daughter is not eligible for Medicaid in the month of January 2016.

This does not affect your daughter's current eligibility determination.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

