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

Notice of Decision

Decision Date: April 03, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013621

[redacted]

Dear [redacted],

On March 1, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 29, 2016 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 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).

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

Decision

Decision Date: April 03, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000013621

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 and your child were not eligible for Medicaid for July 1, 2016 through August 31, 2016?

Procedural History

On October 5, 2016, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for July, August, and September 2016. You also uploaded documentation to your NYSOH account on that day.

On October 6, 2016, NYSOH issued a notice stating that your October 5, 2016 application had been reviewed, but that more information was needed to determine your eligibility for financial assistance. The notice directed you to provide documentation of your income by October 20, 2016.

That same day, NYSOH issued a notice of enrollment confirmation, confirming your child's enrollment in a Medicaid Managed Care plan as of November 1, 2016.

Also on October 6, 2016, NYSOH issued a notice stating that your child was eligible for Medicaid in the month of September 2016. The notice further requested proof of income for the month of August 2016.

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On October 10, 2016, NYSOH issued a notice of eligibility determination stating that your child was eligible for Medicaid, effective October 1, 2016. The notice again stated that you needed to provide income documentation by October 20, 2016.

On October 19, 2016, NYSOH issued a notice stating that the documentation you submitted to NYSOH did not confirm the information in your application, and that you needed to submit income documentation by November 4, 2016.

Also on October 19, 2016, NYSOH issued a notice stating that your child was eligible for Medicaid in the month of August 2016.

That same day, you uploaded further documentation to your NYSOH account.

On October 25, 2016, you updated your NYSOH application, and you uploaded documentation to your NYSOH account.

On October 26, 2016, NYSOH issued a notice stating that your October 25, 2016 application had been reviewed, but that more information was needed to determine your eligibility for financial assistance. The notice directed you to submit documentation of your income by November 4, 2016.

On October 29, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective October 1, 2016.

Also on October 29, 2016, NYSOH issued a notice of eligibility determination stating that you were not eligible for Medicaid in the month of July 2016 because your monthly household income of $1,906.87 was over the allowable monthly income limit of $1,843.00. The notice also stated that you were not eligible for Medicaid in the month of August 2016 because your monthly household income of $2,454.00 was also over that income limit.

On November 29, 2016, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as it denied retroactive Medicaid for the months of July and August 2016, and you also appealed that your child had not been found eligible for Medicaid in the month of July 2016.

On March 1, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open through March 16, 2017, to allow you to submit documentation of your income for in the month of July 2016.

On March 14, 2017, you uploaded documentation to your NYSOH account. The record is now closed.

Findings of Fact

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

1) You testified that you are seeking Medicaid from July 1, 2016 through August 31, 2016 for yourself and your child.

2) You testified that you expect to file your 2016 federal income tax return as head of household, and to claim one dependent.

3) You first submitted an application for financial assistance on October 5, 2016.

4) Your NYSOH account reflects that you and your child were both found eligible for Medicaid as of October 1, 2016.

5) Your child was found eligible for retroactive Medicaid for the months of August and September 2016.

6) Your NYSOH account reflects that you live with your child and domestic partner, who is the child's father.

7) Your NYSOH account reflects that you were pregnant in the month of July 2016, and that you gave birth to your child on

8) You testified that you had health insurance through your employer through the end of September 2016.

9) You testified that you received two disability payments when you went out on leave to have your child.

10) You testified that you are seeking Medicaid coverage for the months of July and August 2016 because you have outstanding medical bills that were not covered by your employer-sponsored health insurance.

11) On October 5, 2016, you uploaded documentation to your NYSOH account that included the following:

    a. Three biweekly paystubs from your employer for the following pay dates and gross pay amounts:
        i. July 29, 2016: $1,166.44;
        ii. August 12, 2016: $964.07;
        iii. August 26, 2016: $432.80;
    b. Two statements from for benefit payments for the following dates and gross benefit amounts:

i. August 15, 2016: $170.00;
ii. August 28, 2016: $340.00

(Document [redacted]).

12) After the hearing, you uploaded three separate documents on March 14, 2017, consisting of the following:
a. A one-page handwritten note from your domestic partner regarding his income in the months of July and August 2016;
b. A biweekly paystub for you, with a playdate of July 1, 2016, for gross pay of $1,281.32;
c. A biweekly paystub for you, with a pay date of July 15, 2016, for gross pay of $1,286.39

These three documents are marked and entered into the record collectively as “Appellant’s Exhibit One.”

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 can be provided through NYSOH 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), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services 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 2016 FPL, which is $16,020.00 for a two -person household (81 Federal Register 4036).

Household Composition – Pregnant Women

For purposes of Medicaid eligibility, 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).

FPL for Pregnant Women

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).

Medicaid for Children

A child who is under one year of age 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 223% of the FPL for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-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).

Household Composition – Dependent Claimed by One Parent

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)).

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

You testified during the hearing that you are looking for retroactive Medicaid for your child. However, the record reflects that she was found eligible for retroactive Medicaid coverage for the month of August 2016, and therefore had coverage for that month. Since your child was born on [redacted] she is not eligible for retroactive coverage for the month of July 2016, as it predates her birth. Therefore, there are no issues to be addressed regarding your child's eligibility.

The only issue under review is therefore whether NYSOH properly determined that you were not eligible for Medicaid in the months of July and August 2016 on the basis that your household income was over the allowable limit.

You are in a two-person household; you plan to file your 2016 taxes with a tax filing status of head of household, and to claim one dependent.

You submitted an application for financial assistance on October 5, 2016, and requested help in paying for medical bills for July 1, 2016 through September 30, 2016.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's initial 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.

The record reflects that you were found eligible for Medicaid, effective October 1, 2016, and that your request for retroactive Medicaid was approved for the month of September 2016, and not approved for the months of July and August 2016.

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

Since you were pregnant in July and did not give birth until [redacted] your eligibility in those months is based on a higher income level. To be eligible for Medicaid in July and August 2016, you would have needed to meet the non-financial criteria, and have an income no greater than 223% of the FPL, which is $2,978.00 per month for a household of two, consisting of you and the child you were expecting. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during July and August 2016.

You provided documentation to show that you received three biweekly paychecks in the month of July 2016, for gross pay of $1,281.32, $1,286.39, and $1,166.44. Therefore, the record indicates that in the month of July 2016, you had a gross monthly household income of $3,734.15.

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Since your income of $3,734.15 was more than the $2,978.00 monthly Medicaid limit for July 2016, NYSOH properly determined that you were not eligible for Medicaid coverage during that month.

You also provided documentation to show that you received two biweekly paychecks in the month of August 2016 for gross pay of $964.07 and $432.80. Additionally, you uploaded documentation showing that you received two disability payments in the month of August for gross amounts of $170.00 and $340.00. As such, the record indicates that in the month of August 2016, you had a gross monthly household income of $1,906.87.

Since your income of $1,906.87 was less than the $2,978.00 monthly Medicaid income limit for August 2016, NYSOH's determination that you were not eligible for Medicaid coverage in the month of August 2016 based on income was not correct.

Therefore, the October 29, 2016 eligibility determination is MODIFIED to reflect that although you were not eligible for Medicaid in the month of July 2016 based on your monthly income, you may be eligible for Medicaid in the month of August 2016.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for Medicaid for the month of August 2016, based on a household size of two, and household income of $1,906.87. NYSOH is directed to use the expanded eligibility level for a pregnant woman (223%FPL) in making this determination.

Decision

Your child was granted retroactive Medicaid coverage for the month of her birth, therefore there is no issue to review regarding her eligibility.

The October 29, 2016 eligibility determination is MODIFIED to reflect that although you were not eligible for Medicaid in the month of July 2016 based on your monthly income, you may be eligible for Medicaid in the month of August 2016.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for August 2016, based on a household size of two and household income of $1,906.87 for the month of August 2016. NYSOH is directed to use the expanded eligibility level for a pregnant woman (223% FPL) in making this determination.

Effective Date of this Decision: April 03, 2017

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How this Decision Affects Your Eligibility

Your child was granted retroactive Medicaid for August and September 2016, so there is nothing to review regarding her retroactive Medicaid eligibility, as she was born on [redacted].

You are not eligible for Medicaid in the month of July 2016, as your income was over the allowable income limit.

You may be eligible for retroactive Medicaid in the month of August 2016.

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your eligibility based on the income information in the record.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to the Federal Marketplace 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 Federal Marketplace. 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 have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:

  Health Insurance Marketplace
  Attn: Appeals
  465 Industrial Blvd.
  London, KY 40750-0061
- By fax: 1-877-369-0129

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

Your child was granted retroactive Medicaid coverage for the month of her birth, therefore there is no issue to review regarding her eligibility.

The October 29, 2016 eligibility determination is MODIFIED to reflect that although you were not eligible for Medicaid in the month of July 2016 based on your monthly income, you may be eligible for Medicaid in the month of August 2016.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for August 2016, based on a household size of two and household income of $1,906.87 for the month of August 2016. NYSOH is directed to use the expanded eligibility level for a pregnant woman (223% FPL) in making this determination.

Your child was granted retroactive Medicaid for August and September 2016, so there is nothing to review regarding her retroactive Medicaid eligibility, as she was born on [redacted].

You are not eligible for Medicaid in the month of July 2016, as your income was over the allowable income limit.

You may be eligible for retroactive Medicaid in the month of August 2016.

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your eligibility based on the income information in the record.

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).

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية(Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

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Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई निःशुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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