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

Notice of Decision

Decision Date: May 8, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014809

[redacted]

Dear [redacted],

On April 17, 2017, you and your application counselor Mary Mercado appeared by telephone at a hearing on your appeal of NY State of Health's failure to issue a determination of your eligibility for retroactive Medicaid in the month of July 2016.

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: May 8, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014809

[redacted]

Issue

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

> Did NY State of Health properly determine that you and your newborn child were not eligible for Retro Medicaid for July 1, 2016 through July 31, 2016?

Procedural History

On August 24, 2016, NY State of Health (NYSOH) received your initial application for financial assistance with your health insurance.

On August 25, 2016, NYSOH issued a notice stating more information was needed to confirm your eligibility. The notice asked that you provide proof of your current income by September 8, 2016, as well as proof of your newborn child's Citizenship Status, and Social Security Number by November 22, 2016.

On September 29, 2016, and October 12, 2016, NYSOH received your income documentation.

On October 26, 2016, NYSOH issued a notice stating the documentation that was reviewed does not confirm the information in your application. You were asked to provide more proof of your income by December 7, 2016.

On November 4, 2016, a notice was issued requesting additional information to confirm your eligibility by providing proof of your current income by December 7, 2016.

On November 10, 2016, the documentation you provided on October 12, 2016 was rescanned into your NYSOH account.

On December 2, 2016, a notice was issued stating the documentation reviewed did not confirm the information in your application. You were asked to provide proof of your current income by December 22, 2016.

Also on December 2, 2016 you faxed in additional income documentation.

On December 29, 2016, NYSOH issued a notice stating the income information in your application does not match what NYSOH received from state and federal date sources. You were asked to provide additional proof of your current income by December 22, 2016.

On January 12, 2017, NYSOH received your updated application for financial assistance. That day, a preliminary eligibility determination was made with regard to the last application finding you and your child eligible for Medicaid effective January 1, 2017, and your child eligible for Medicaid for the month of November, 2016.

On January 12, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination insofar as you were not found eligible for retroactive Medicaid for the month of July, 2016.

On January 13, 2017, NYSOH issued a notice of eligibility determination stating you and your child were eligible for Medicaid effective January 1, 2017.

On January 13, 2017, NYSOH issued a notice stating your child was eligible for Medicaid for November 1, 2016 through November 30, 2016.

On April 17, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, your Certified Application Counselor also appeared and testified on your behalf. The record was developed during the hearing and closed at the end of proceeding.

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 to July 31, 2016 for you and yourself.

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

3) In the month of July 2016, you were pregnant with one child.

4) You submitted an application for financial assistance on August 24, 2016.

5) Your application on August 24, 2016 requested help paying for medical bills for the prior three months.

6) You testified you received the response that you needed to provide income documentation which you provided to the application counselor who was helping you with that application from the hospital you were admitted to for the birth of your child.

7) Your Application Counselor testified her organization became involved after the August 24, 2016 application and provided your income documentation to NYSOH on September 29, 2016 via fax.

8) The paystubs you provided on September 29, 2016, show check dates of July 9, 2016, and July 23, 2016, in the gross amounts of $1,298.72, and $1,328.58 respectively. You testified this was the only income you received in the month of July, 2016. You testified you had not received any income since those last two checks as you were on leave from your job.

9) On December 2, 2016, a letter from your employer dated November 22, 2016 was uploaded to your NYSOH account. The letter states you were out on Family Medical Leave since July 14, 2016. Your last day worked was on July 14, 2016, and your YTD earnings at the time was $21,217.49.

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 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 Fed. Reg. 4036).

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).

Household Composition

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).

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 and your newborn child were not eligible for retro Medicaid for July 1, 2016 through July 31, 2016.

You submitted an application for financial assistance on August 24, 2016 and requested help in paying for medical bills for the last three months.

When an individual files an initial application for Medicaid, his or her eligibility for retroactive Medicaid depends on the date of application. To this end, it does not

matter whether or not that initial application resulted in Medicaid going forward. Instead, an individual, who has filed an initial application for Medicaid through NYSOH, has the right to be evaluated for Medicaid for the three months before the month of his or her application.

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.

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 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.

During the month of July, 2016 you were pregnant with your child, consequently, NYSOH would have needed to evaluate your eligibility based on a two-person household.

Based on a two-person household, to be eligible for Medicaid in July 2016, you would have needed to meet the non-financial criteria and have an income no greater than 223% of the 2016 Federal Poverty Level, which is $2,978.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during July, 2016.

The paystubs you provided on September 29, 2016, show check dates of July 9, 2016, and July 23, 2016, in the gross amounts of $1,298.72, and $1,328.58 respectively. You testified this was the only income you received in the month of July, 2016. Therefore, the record indicates that in the month of July, 2016, you had a monthly household income of $2,627.30.

Based on the record as developed, it does not appear that NYSOH has issued a determination of your and your newborn child's eligibility for retroactive Medicaid in the month of July 2016. Accordingly, your case is RETURNED to NYSOH to determine your and your child's eligibility for the month of July 2016. Since you were pregnant as of July 1, 2016, NYSOH is directed to determine your eligibility for retroactive Medicaid in the month of July based on a household consisting of one pregnant woman expecting one child with a monthly household income of $2,627.30. Since your newborn child was born [redacted], NYSOH is directed to determine his eligibility for retroactive Medicaid in the month of July as of July 23, 2016 based on a household of two people with a monthly household income of $2,627.30.

Decision

Your case is RETURNED to NYSOH to determine your and your newborn child's eligibility for the month of July 2016.

Since you were pregnant as of July 1, 2016, NYSOH is directed to determine your eligibility for retroactive Medicaid in the month of July based on a household consisting of one pregnant woman expecting one child with a monthly household income of $2,627.30.

Since your newborn child was born [redacted], NYSOH is directed to determine his eligibility for retroactive Medicaid in the month of July [redacted] based on a household of two people with a monthly household income of $2,627.30.

Effective Date of this Decision: May 8, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your or your child's eligibility for Medicaid in the month of July 2016.

Your case is being sent back to NYSOH to determine your eligibility for Medicaid in the month of July 2016.

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 case is RETURNED to NYSOH to determine your and your newborn child's eligibility for the month of July 2016.

Since you were pregnant as of July 1, 2016, NYSOH is directed to determine your eligibility for retroactive Medicaid in the month of July based on a household consisting of one pregnant woman expecting one child with a monthly household income of $2,627.30.

Since your newborn child was born [redacted], NYSOH is directed to determine his eligibility for retroactive Medicaid in the month of July as of July 23,

2016 based on a household of two people with a monthly household income of $2,627.30.

This is not a final determination of your or your child's eligibility for Medicaid in the month of July 2016.

Your case is being sent back to NYSOH to determine your eligibility for Medicaid in the month of July 2016.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

[redacted]

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।

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).

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.

اردو (Urdu)

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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