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

Notice of Decision

Decision Date: May 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015106

Dear [redacted],

On April 12, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 28, 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.

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

Decision

Decision Date: May 24, 2017

NY State of Health Account ID
Appeal Identification Number: AP000000015106

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 oldest child was not eligible for Medicaid for the month of October 2015?

Procedural History

On December 11, 2015, NYSOH received a revised application in which you requested financial assistance. This application reflected that you were seeking help paying medical bills incurred by your oldest child during the three months prior to your application.

On December 12, 2015, NYSOH issued a notice stating that more information was needed to determine your oldest child's eligibility for health insurance. You were requested to provide income documentation by December 27, 2015 so that the information in your application could be confirmed.

On December 29, 2015, NYSOH received (1) an earnings statement issued to your oldest child by his employer on July 17, 2015, (2) an earnings statement issued to you by your employer, , on November 13, 2015 and December 24, 2016.

On December 30, 2015, NYSOH issued another notice stating that more information was needed to determine your oldest child's eligibility for health insurance. You were requested to provide income documentation by January 14, 2016 so that the information in your application could be confirmed.

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On January 4, 2016, NYSOH received an earnings statements issued to by [redacted] on October 16, 2015, October 30, 2015 and November 13, 2015.

On January 8, 2016, NYSOH received an earnings statement issued by [redacted] to you on December 11, 2015 and December 24, 2015.

On January 21, 2016, NYSOH redetermined your eligibility for financial assistance for purchasing health insurance based on information contained in your account as of December 29, 2015. You were seeking help paying medical bills incurred by your oldest child during the three months prior to your application.

On January 22, 2016, NYSOH issued an eligibility determination notice stating that your oldest child was eligible for Medicaid, effective December 1, 2015. The notice also stated that NYSOH would be sending you a separate notice telling you if your oldest child was eligible for Medicaid during the three months prior to your application.

On December 27, 2016, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills incurred by your oldest child during October 2015.

On December 28, 2016, NYSOH issued a notice of eligibility determination stating that your oldest child was eligible to enroll in the Essential Plan, effective February 1, 2017.

On December 28, 2016, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid for September 1, 2015 through November 30, 2015 because the program you are eligible for could not pay for any care you received in the past.

On January 24, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as it denied retroactive Medicaid for your oldest child during the month of October 2016.

On April 12, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and remained open as the Hearing Officer directed you to provide as additional evidence to corroborate your testimony: (1) an earnings statement issued to you by your employer on or about October 2, 2016, or a letter reflecting your gross income received during the month of October 2016 and (2) a letter of termination issued to your oldest child reflecting the end date of his employment. The record was to be closed 15 days after the hearing date, or upon the receipt of the above referenced documents, whichever occurred earlier. No additional documents were received from you by April 27, 2017.

Accordingly, the record was closed on April 27, 2017.

Findings of Fact

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

1) As of [redacted], your oldest child was [redacted] years old.

2) You testified that you are seeking Medicaid for your oldest child during the month of [redacted], since that was the month you incurred medical bills for him because of a hospitalization.

3) You testified that you filed your 2015 federal income tax return as head of household, and claimed your two children as dependents.

4) You submitted an application for financial assistance on December 27, 2016.

5) Your application submitted on December 27, 2016, states that for the month of October 2015 your income was $1,677.92 and that your oldest child's income was $916.67.

6) You uploaded earning statements issued by your employer reflecting that you received (1) $1,153.75 on October 16, 2015 and (2) $1,189.63 on October 30, 2015.

7) You uploaded an earnings statement issued to your child by his employer reflecting that he received $173.44 on July 17, 2015.

8) You testified that during the summer of 2015, your oldest child was employed; however, his employment ended prior to October 2015.

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

Applicable Law and Regulations

<u>Medicaid for Children</u>

A child aged 19 or 20, whose primary residence is with their parents, 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 155% of the federal poverty level (FPL) for the applicable family size (NY Social Services Law § 366(b)(7);

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New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

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).

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 December 11, 2015 application, that was the 2015 FPL, which is $20,090.00 for a three-person household (80 Federal Register 3236, 3237).

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 your oldest child was not eligible for Medicaid for the month of October 2015.

You are in a three-person household; you attested that you filed your 2015 tax return with a tax filing status of head of household and claimed two dependents.

You submitted your initial application for financial assistance on December 11, 2015 and requested help in paying for medical bills incurred by your oldest child during the month of October 2015.

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 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 the individual would have been eligible for Medicaid in those three months had he or she applied.

You testified that you are seeking Medicaid for your oldest child during the month of October 2015.

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

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 October 2015, your 20-year-old child would have needed to meet the non-financial criteria and have a household income no greater than 155% of the FPL, which is $2,595.00 per month. There is no indication in the record that he would have been ineligible for Medicaid based on any non-financial criteria during October 2015.

You testified that you are paid bi-weekly. You uploaded earnings statements reflecting that you received $1,153.75 on October 16, 2015 and $1,189.63 on October 30, 2015. Since you are paid bi-weekly, the record reflects that you would have received an additional earning statement on or about October 2, 2015. The Hearing Officer requested that you provide this earnings statement or, in the alternative, a letter issued by your then employer reflecting the total gross earnings you received during the month of October 2015 by April 27, 2016. No additional documents were received by NYSOH by April 27, 2017.

Additionally, the record reflects that your oldest child was employed during July 2015. The Hearing Officer requested that you provide a termination letter reflecting your oldest child's end date of employment. Again, no additional documents were received by NYSOH by April 27, 2017.

Since we are unable to assess your household's monthly income during October 2015 based on the available record, we are unable to return your case to NYSOH to redetermine your oldest child's eligibility for Medicaid during that month.

Therefore, the December 28, 2016 eligibility determination notice must be AFFIRMED.

Decision

The December 28, 2016 eligibility determination is AFFIRMED.

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).

Effective Date of this Decision: May 24, 2017

How this Decision Affects Your Eligibility

Your oldest child remains ineligible for Medicaid in the month of October 2015.

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

The December 28, 2016 eligibility determination is AFFIRMED.

Your oldest child remains ineligible for Medicaid in the month of October 2015.

Legal Authority

We are issuing this determination in accordance with 45 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).

A Copy of this Decision Has Been Provided To:

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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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