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

Notice of Decision

Decision Date: August 24, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000018419

Dear ,

On August 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 21, 2017, 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
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Decision

Decision Date: August 24, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000018419

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 your child was ineligible for retroactive Medicaid coverage for the month of February 2017?

Procedural History

On March 30, 2017, you submitted an application for financial assistance through NYSOH.

On March 31, 2017, NYSOH issued three notices:

(1) An eligibility determination notice stating that your child was eligible for Medicaid, effective as of March 1, 2017;

(2) A plan enrollment notice confirming that as of March 30, 2017, your child was enrolled in a Medicaid Managed Care (MMC) plan with an enrollment start date of June 1, 2017;

(3) A notice stating that additional information was required to determine your child's eligibility for Medicaid for the period of February 1, 2017, to February 28, 2017. The notice directed you to submit additional income documentation by April 14, 2017.

On April 12, 2017, you faxed additional income documentation to NYSOH (*see* Documents ██████████).

On April 21, 2017, NYSOH issued an eligibility determination notice stating that your child was not eligible for Medicaid from February 1, 2017 through February 28, 2017, because their monthly household income was over the allowable monthly income limit for that program.

On April 26, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as your child was ineligible for retroactive Medicaid for the month of February 2017.

On August 7, 2017, you had a telephone hearing with a Hearing Officer from the Appeals Unit of NYSOH. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) According to your NYSOH account and testimony, you are applying for health insurance for your child; specifically, retroactive Medicaid for the month of February 2017.

2) According to your NYSOH account, your child was born on ██████ ████.

3) According to your March 30, 2017 application, you requested help paying for medical bills for the month of February 2017.

4) According to your NYSOH account and testimony, you expect to file your 2017 federal income tax return with the tax status of single, and expect to claim your child as your only dependent on that tax return.

5) You testified you were employed at ██████████. in February 2017, and that was your only source of income in that month.

6) You testified that you were paid on a biweekly basis, every other Wednesday.

On April 12, 2017, you submitted earnings statements dated February 1, 2017 and February 15, 2017 to NYSOH. Each statement shows that you were issued gross income of $1,543.00 with pre-tax deductions of $120.39 (see Documents ██████████; uploaded ████).

7) According to your NYSOH account, you do not expect to claim any deductions on your 2017 federal income tax return.

8) You testified that your child has outstanding medical bills for the month of February 2017, and you want them to be found eligible for retroactive Medicaid coverage to cover those medical bills.

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

Applicable Law and Regulations

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term "modified adjusted gross income" means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (see 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)).

Medicaid Eligibility - 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 Department of Health Administrative Directive 13 OHIP/ADM-03).

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)). Generally, in cases when an individual is claimed as a tax dependent by another taxpayer for the taxable year in which a determination is being made, their household is the household of the taxpayer claiming such individual as a tax dependent (42 CFR § 435.603(f)(2)).

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 2017 FPL, which is $16,240.00 for a two-person household (82 Federal Register 8831).

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).

<u>Medicaid Retroactive Coverage:</u>

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 NYSOH properly determined that your child was ineligible for retroactive Medicaid coverage for the month of February 2017.

The record reflects that you expect to file your 2017 federal income tax return, with the tax status of single, and expect to claim any your child as a dependent on that tax return. Therefore, your child is in a two-person household for purposes of this analysis.

The record supports that your child was found eligible for Medicaid effective March 1, 2017.

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.

Medicaid can be provided through NYSOH to children under the age of one who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 223% of the FPL for the applicable family size.

On the date of your March 30, 2017 application, the FPL was $16,240.00 for a two-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 a child, younger than one, to be eligible for Medicaid in a household of two, their monthly income must not exceed 223% of the FPL, which equals $3,018.00 per month.

You testified you were employed in February 2017, and your earnings from that employment were your household's only source of income in that month. Further, you testified that you were paid on a biweekly basis, every other Wednesday. Based on the documentation submitted, you were issued ($1,543.00 (-) $120.39) $1,422.61 in federal taxable wages, each earnings statement. Therefore, your federal taxable wages in February 2017 were $2,845.22 ($1,422.61 X 2).

Since your child's income threshold was $3,018.00, your household income did not exceed the monthly household allowable income limit for your child to be eligible for Medicaid in February 2017.

Therefore, the April 21, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your child's eligibility for retroactive Medicaid coverage for the month of February 2017 based on a two-person household for a child under the age of one, with a monthly household income of $2,845.22.

Decision

The April 21, 2017, eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your child's eligibility for retroactive Medicaid coverage for the month of February 2017 based on a two-person household for a child under the age of one, with a monthly household income of $2,845.22, and to notify you accordingly.

Effective Date of this Decision: August 24, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your child's eligibility for financial assistance during the month of February 2017.

Your case is being sent back to NYSOH to redetermine your child's eligibility for retroactive Medicaid for the month of February 2017, based on the information stated above. NYSOH will notify you of its redetermination once it has been rendered.

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 April 21, 2017, eligibility determination notice is RESCINDED.

Your case is RETUNED to NYSOH to effectuate your child’s retroactive Medicaid coverage for the month of February 2017.

Your child was eligible for retroactive Medicaid coverage from February 1, 2017, through February 28, 2017.

Legal Authority

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

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:

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)

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).

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।

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 नि:शुल्क 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 کرم 1-855-355-5777 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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