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

Notice of Decision

Decision Date: December 1, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022416

[redacted]

[redacted]

On November 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 8, 2017 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: December 1, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022416

[redacted]

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 newborn was not eligible for Medicaid for June 1, 2017 through June 30, 2017?

Procedural History

[redacted] you updated your household's application for financial assistance with health insurance, specifically, you added your newborn to your account. In that application, you indicated that you were seeking help paying for medical bills for June 2017, July 2017, and August 2017.

On July 15, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH had received from state and federal data sources and that additional information was needed to confirm the information in your application. This notice directed you to submit documentation of your household income by July 29, 2017 in order to determine your newborn's eligibility for financial assistance.

On July 27, 2017, you updated your household's application for financial assistance with health insurance.

On July 28, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH had received from state and federal data sources and that additional information was needed to confirm the information in your application. This notice directed you to submit documentation

of your household income by August 13, 2017 in order to determine your newborn's eligibility for financial assistance.

No income documentation was submitted by August 13, 2017.

On September 8, 2017, NYSOH issued a notice of eligibility determination stating that your newborn was eligible to purchase a qualified health plan at full cost through NYSOH, effective October 1, 2017.

Also on September 8, 2017, NYSOH issued an eligibility determination notice stating that your newborn was not eligible for Medicaid for June 1, 2017 through June 30, 2017 because you failed to provide documentation of your household income.

Additionally, on September 8, 2017, you updated your household's application for financial assistance and you uploaded income documentation to your NYSOH account.

On September 9, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH had received from state and federal data sources and that additional information was needed to confirm the information in your application. This notice directed you to submit documentation of your household income by September 23, 2017 in order to determine your newborn's eligibility for financial assistance.

On September 11, 2017, NYSOH verified the income documentation you submitted.

On September 12, 2017, NYSOH issued a notice of eligibility determination stating that your newborn was eligible for Medicaid. This eligibility was effective as of September 1, 2017.

Also on September 12, 2017, NYSOH issued an eligibility determination notice stating that your newborn was eligible for Medicaid for July 1, 2017 through August 31, 2017.

On September 14, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as your newborn was denied retroactive Medicaid for the month of June 2017.

On November 14, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing held open until November 28, 2017, to allow you to submit supporting documents.

As of November 29, 2017, the Appeals Unit has not received any additional documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day.

Findings of Fact

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

1) You testified that you are seeking for your newborn to have Medicaid from June 1, 2017 to June 30, 2017.

2) You testified that your newborn was born on [redacted]

3) Your NYSOH account indicates that at the time of your newborn's birth, neither you nor your spouse had coverage through NYSOH.

4) You testified that you and your spouse expect to file your 2017 federal income tax return as married filing jointly and claim two dependents on that return.

5) You submitted applications for financial assistance on July 14, 2017 and July 27, 2017.

6) Your applications submitted on July 14, 2017 and July 27, 2017, state that for the month of June 2017 your income was $0.00 and your spouse's income was $2,335.67.

7) You testified that you were not working for most of 2017 and began working on September 28, 2017. You testified that you received no unemployment benefits or short-term disability benefits in 2017. You further testified that you had no income in June 2017.

8) You testified that your spouse is paid on a weekly basis. You explained that his income varies based on the availability of work and the weather. You testified that in June 2017 your spouse's income was approximately $1,200.00. You went on to explain that your spouse was not working from [redacted] through July 3, 2017 as he took time off due to [redacted]. You also testified that as a result, your spouse may have missed one paycheck in June 2017.

9) The Hearing Officer directed you to submit your spouse's paystubs for June 2017 as well as his first paystub after he returned to work in July 2017 by November 28, 2017. As of November 29, 2017, these paystubs have not been submitted.

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 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 federal poverty level (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 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 application, that was the 2017 FPL, which is $24,600.00 for a four-person household (82 Fed. Reg. 8831).

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 newborn was not eligible for Medicaid for June 1, 2017 through June 30, 2017.

You and your spouse file your taxes with a tax filing status of married filing jointly and will claim two dependents on your 2017 tax return. Therefore, your newborn is in a four-person household.

[redacted]

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.

You testified that you are seeking Medicaid for your newborn from June 1, 2017 to June 30, 2017.

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 June 2017, your newborn would have needed to meet the non-financial criteria and have an income no greater than 223% of the FPL, which is $4,572.00 per month. There is no indication in the record that your newborn would have been ineligible for Medicaid based on non-financial criteria during June 2017.

The applications that you submitted on July 14, 2017 and July 27, 2017 listed your spouse's income for the month of June 2017 as $2,335.67, however, you testified that your spouse's income for the month of June 2017 was only $1,200.00.

The Hearing Officer directed you to submit documentation of your spouse's income for the month of June 2017 and left the record open until November 28, 2017 to allow you to submit this documentation. As of November 29, 2017, this documentation has not been submitted nor is it viewable in your NYSOH account.

Therefore, you have produced insufficient proof to disturb the September 8, 2017 determination that your newborn was not eligible for Medicaid for June 2017. The September 8, 2017 eligibility determination notice stating that your newborn was not eligible for Medicaid for June 1, 2017 through June 30, 2017 is AFFIRMED.

Decision

The September 8, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: December 1, 2017

How this Decision Affects Your Eligibility

Your newborn is not eligible for Medicaid in the month of June 2017.

Your newborn's eligibility for Medicaid was effective as of July 1, 2017.

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 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 September 8, 2017 eligibility determination notice is AFFIRMED.

Your newborn is not eligible for Medicaid in the month of June 2017.

Your newborn's eligibility for Medicaid was effective as of July 1, 2017.

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)

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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 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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