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

Notice of Decision

Decision Date: February 07, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024868

[redacted]

[redacted]

On January 24, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 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
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Decision

Decision Date: February 07, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024868

[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 child was not eligible for Medicaid for September 1, 2017 through September 30, 2017?

Procedural History

On October 13, 2017 you applied for financial assistance with health insurance on behalf of your newborn child, and indicated that you were seeking help for paying for medical bills for September 2017.

On October 25, 2017, NYSOH issued a notice of eligibility determination stating that your child was eligible for Medicaid, effective October 1, 2017.

Also on October 25, 2017, NYSOH issued a notice stating that you needed to submit documentation of your household income in the month of September 2017.

On November 6, 2017, you uploaded documentation to your NYSOH account.

On November 7, 2017, NYSPOH reviewed your documents and determined your child's eligibility for Medicaid in the month of September 2017.

On November 8, 2017, NYSOH issued a notice of eligibility determination stating that your child was not eligible for Medicaid in the month of September 2017

because the monthly household income of $4,140.50 is over the allowable monthly income limit of $3,795.00.

On November 27, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice, insofar as it denied retroactive Medicaid for your child for the month of September 2017.

On January 24, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing closed at the end of the hearing.

Findings of Fact

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

1) You testified that you are seeking Medicaid from for your child for the month of September 2017.

2) You testified that you are not sure whether your spouse will be included on your 2017 income tax return because she cannot currently work, due to her immigration status.

3) You testified that you are married and live with your spouse, and expect to claim your child as a dependent on your 2017 income tax return.

4) You applied for financial assistance on behalf of your child on October 13, 2017.

5) You testified that your child was born on [redacted] and that she had to be transferred immediately to [redacted].

6) You testified that you and your spouse have medical insurance, and that your child was on this insurance for one month.

7) You testified this insurance covered some of your newborn's hospital bills, but that you still have close to $5,000.00 in unpaid medical bills from the time of your child's birth.

8) You submitted documentation to NYSOH on November 6, 2017 consisting of:

   a. A paystub dated 9/15/17 from [redacted] for gross earnings of $324.00;

b. A paystub dated 9/29/17 from [redacted] for gross earnings of $432.00;
c. A paystub dated 9/8/17 from [redacted] for gross earnings of $2,175.00;
d. A paystub dated 9/22/17 from [redacted] for gross earnings of $1,207.50;
e. A letter from "[redacted]" stating that you are a [redacted], and that your gross year-to-date income, as of November 3, 2017, was $17,456.25. The letter also stated that your monthly income is typically between $1,690.00 and $1,860.00, but that you earned much more in September 2017 because of a [redacted] project that required overtime hours, and that your typical monthly income is not that high; [redacted].

9) NYSOH reviewed the documentation you submitted and calculated your September household income to be $4,140.50.

10) On December 19, 2017, you uploaded all of your paystubs for 2017, from both of your jobs, to your NYSOH account, including a paystub for 9/1/17 from [redacted] for gross earnings of $360.00 ([redacted]).

11) You testified that you cannot afford to pay the outstanding medical bills for your child, and that you have other outstanding medical bills for your spouse as well.

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 $20,420.00 for a three-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 child was not eligible for Medicaid for September 1, 2017 through September 30, 2017.

Your child is in a three-person household and will be claimed as a dependent on your 2017 tax return. You applied for financial assistance on behalf of your child on October 13, 2017, and requested help in paying for medical bills for her from the month of September 2017.

When an individual file's an application for Medicaid, his or her eligibility for retroactive Medicaid assistance 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 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. To be eligible for Medicaid in September 2017, your child would have needed to meet the non-financial criteria and have an income no greater than 223% of the FPL, which is $3,795.00 per month. There is no indication in the record your child

would have been ineligible for Medicaid based on non-financial criteria during September 2017.

You uploaded paystubs on November 6, 2017 that NYSOH utilized to determine that your gross household income was $4,140.50 in the month of September 2017. On December 19, 2017, you uploaded additional documentation, including a paystub for $360.00 not previously provided, dated September 1, 2017. Therefore, the record indicates that in the month of September 2017, your gross monthly household income was $4,498.50, based on the documentation you provided. You confirmed this amount in your testimony.

You testified that your September 2017 income was much higher than your typical monthly income, and provided documentation from your employer which confirms that this is so; nevertheless, your child's eligibility for Medicaid in the month of September 2017 can only be determined based on your household income in that month. Therefore, the Appeals Unit is constrained to find that your household income in the month of September 2017 was $4,498.50.

Since your income of $4,498.50 was more than the $3,795.00 monthly Medicaid limit for September 2017, NYSOH properly determined that your child was not eligible for Medicaid coverage during that month. Therefore, the November 8, 2017 eligibility determination stating that your child was not eligible for Medicaid in the month of September 2017 is correct, and is AFFIRMED.

Decision

The November 8, 2017 eligibility determination is AFFIRMED.

Effective Date of this Decision: February 07, 2018

How this Decision Affects Your Eligibility

Your child was not eligible for Medicaid in the month of September 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 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 November 8, 2017 eligibility determination is AFFIRMED.

Your child was not eligible for Medicaid in the month of September 2017.

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।

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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 तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई 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 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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