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

Notice of Decision

Decision Date: February 15, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025041

[redacted]

[redacted]

On January 22, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 12, 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).

This page intentionally left blank.

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).

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

Decision

Decision Date: February 15, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025041

[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 child (child) was not eligible for Medicaid for the month of May 2017?

Procedural History

On June 19, 2017, you submitted an application for financial assistance with health insurance and indicated that you were seeking help paying for medical bills for your child in May 2017.

On June 20, 2017 and July 18, 2017, pursuant to NYSOH's request, you submitted a statement from your employer, dated June 7, 2017, a letter from your employer, dated June 28, 2017, and copies of your spouse's four consecutive current paystubs, dated June 16, 2017 through July 17, 2017 ([redacted]

On July 19, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid from May 1, 2017 through May 31, 2017 because the monthly household income of $4,771.67 was over the allowable monthly income limit of $2,829.00. The notice did not state whether your child was eligible for Medicaid for May 2017.

Also on July 19, 2017, NYSOH issued an eligibility determination notice stating that your child was conditionally eligible for Medicaid as of June 1, 2017. The

notice directed you to provide your child's Social Security number before September 17, 2017, to confirm her eligibility.

On November 12, 2017, NYSOH issued an eligibility determination notice stating that your child was not eligible for Medicaid from May 1, 2017 through May 31, 2017, because you failed to provide proof of household income to confirm her eligibility.

On November 29, 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 May 2017.

On January 22, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to February 6, 2018, to allow you time to submit supporting documents.

As of February 6, 2018, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day and this Decision is based on the record as developed at the time of the hearing.

Findings of Fact

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

1) According to your NYSOH account, on June 19, 2017, you added your child to your NYSOH account and requested help paying for her medical bills for the month of May 2017.

2) You testified that you are seeking retroactive Medicaid for your child for the month of May 2017, which is the month of her birth.

3) According to your NYSOH account and your testimony, you expect to file your 2017 federal income tax return as married filing jointly and claim two dependents.

4) The application for financial assistance you submitted on June 19, 2017, stated that your child had a gross monthly household income for May 2017 of $4,771.67, consisting of $1,305.00 you earned in employment income and $3,466.67 your spouse earned in employment income.

5) You testified that you were unsure of what your income was in May 2017, and that you believed your spouse's income was $3,200.00 for that month.

6) On June 20, 2017, you submitted a statement from your employer, dated June 7, 2017. This document shows that your net income for May 2017 was $1,377.71 [redacted]. It does not show what your gross income was for May 2017.

7) You testified that you are requesting Medicaid for the month of May 2017 for your child to cover her medical bills for that month.

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 newborn's application, that was the 2017 FPL, which was $24,600.00 for a four-person household (82 Federal Register 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 child was not eligible for Medicaid for the month of May 2017.

According to your NYSOH account and your testimony, you expect to file your 2017 federal income tax return as married filing jointly and claim two dependents. Therefore, for purposes of this analysis, your child is in a four-person household.

You submitted an application for financial assistance on your child's behalf on June 19, 2017, and requested help paying for her medical bills for the month of May 2017.

Your child was initially found eligible for Medicaid in the July 19, 2017 eligibility determination notice. According to this notice, her coverage with Medicaid began June 1, 2017.

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 they would have been eligible for Medicaid in those three months had they applied.

You testified that you are seeking your child's Medicaid coverage retroactively applied for the month of May 2017, which is the month of her birth.

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 May 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 $4,572.00 per month for a four-person household. There is no indication in the record that your child would have been ineligible for Medicaid based on non-financial criteria during May 2017.

You testified that you were unsure what your gross household income was in May 2017 and that you believed your spouse only earned $3,200.00 in that month. The record was held open for you to submit documentation of your child's gross household income for May 2017. You did not provide any further documentation to prove this and, therefore, this analysis is based on the record and available income information within your NYSOH account.

The application for financial assistance you submitted on June 19, 2017, stated that you have a gross monthly household income for May 2017 of $4,771.67, consisting of $1,305.00 you earned in employment income and $3,466.67 your spouse earned in employment income. Notwithstanding that your income documents reflect that you received $1,377.71 in employment income in May 2017; for purposes of this analysis, your household's monthly income was $4,771.67, as was attested to in your child's June 19, 2017 application.

Since your household's income of $4,771.67 is more than the $4,572.00 maximum allowable monthly Medicaid limit for a child residing in a four-person household in May 2017, NYSOH properly determined that she was not eligible for Medicaid coverage during that month. Therefore, the November 12, 2017 eligibility determination notice stating that your child was not eligible for Medicaid in the month of May 2017, is correct and is AFFIRMED.

Decision

The November 12, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: February 15, 2018

How this Decision Affects Your Eligibility

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

Your child's eligibility for Medicaid was effective as of June 1, 2017.

This Decision does not affect any subsequent eligibility determinations.

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 12, 2017 eligibility determination notice is AFFIRMED.

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

Your child's eligibility for Medicaid was effective as of June 1, 2017.

This Decision does not affect any subsequent eligibility determinations.

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)

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 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.

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).