



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

Notice of Decision

Decision Date: March 29, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000014617

[REDACTED]

Dear [REDACTED]

On March 22, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 10, 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.

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: March 29, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000014617

[REDACTED]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

Did NY State of Health (NYSOH) properly determined that your child was not eligible for Medicaid from October 1, 2016 through November 30, 2016?

Procedural History

On December 9, 2016, you submitted an application for financial assistance with health insurance and indicated that you were seeking help paying for medical bills for your child for October 2016 and November 2016.

On December 10, 2016, NYSOH issued a notice of eligibility determination stating that your child was eligible for Medicaid. This eligibility was effective as of December 1, 2016.

Also on December 10, 2016, NYSOH issued an eligibility determination notice stating that your child was not eligible for Medicaid for October 1, 2016 through November 30, 2016 because the monthly household income of \$3,250.00 was over the allowable monthly income limit of \$2,978.00.

On January 4, 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 October 2016 and November 2016.

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).

On March 7, 2017, you were scheduled to have a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. You requested that your hearing be adjourned so that you could get a letter from your employer outlining your income for the month of October 2016.

On March 22, 2017, you had an adjourned telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, you waived your right to formal notice on the record. 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) You testified that you are seeking Medicaid for your child from October 1, 2016 to November 30, 2016.
- 2) You testified that you expect to file your 2016 federal income tax return as single, and you are unsure if you will claim one dependent.
- 3) You testified that your child resides with you.
- 4) You testified that your child is an only child and has no other siblings residing with her.
- 5) You submitted an application for financial assistance on December 9, 2016.
- 6) Your application submitted on December 9, 2016, states that for the month of October 2016 and November 2016 your income was \$3,250.00. You testified that amount was incorrect because you went out on leave from employment after having your child.
- 7) On November 19, 2016, you uploaded a letter to your NYSOH account from your employer stating that your last day of work was [REDACTED]. The letter also states that you have been out on disability since October 28, 2016 to present and that you are not receiving a salary.
- 8) On March 20, 2017, you uploaded a letter to your NYSOH account from your employer stating that in the month of October 2016 you received \$1,575.00.
- 9) You testified that you do not plan on taking any deductions on your tax return.

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 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 2016 FPL, which is \$16,020.00 for a two- person household (81 Fed. Reg. 4036).

A child's family size includes the following persons, if living with the child: (1) the child's parents, (2) the child's spouse, (3) the child's children and siblings under the age of 19, or 21 if a full-time student (42 CFR § 435.603(f)(3)).

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 from October 1, 2016 through November 30, 2016.

Your child is in a two-person household; you file your taxes with a tax filing status of single and while you are unsure whether you will claim your child as a dependent on your tax return, your child was living with you fulltime during the months of October 2016 and November 2016 and your child had no other siblings residing with her.

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).

You submitted an application for financial assistance on December 9, 2016 and requested help paying for medical bills for your child from October 2016 and November 2016.

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 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 child from October 1, 2016 to November 30, 2016.

For your child to be found eligible for Medicaid in October 2016 and November 2016, your child would have needed to meet the non-financial criteria and have a monthly household income no greater than 223% of the FPL, which is \$2,978.00 per month. There is no indication in the record that your child would have been ineligible for Medicaid based on non-financial criteria during October 2016 or November 2016.

You testified that you stopped working after your daughter was born. On November 19, 2016, you uploaded a letter to your NYSOH account stating that your last day of work was [REDACTED]. On March 20, 2017, you uploaded a letter to your NYSOH account from your employer stating that in the month of October 2016 you received \$1,575.00.

Therefore, the record indicates that in the month of October 2016, you had a monthly household income of \$1,575.00 and for the month of November 2016 you had a monthly household income of \$0.00.

Since the record now contains a more accurate representation of what your income was for the months of October 2016 and November 2016, your case is RETURNED to NYSOH to consider your request for retroactive coverage for your child for October 2016 and November 2016 based on a household size of a two people with a household income of \$1,575.00 for the month of October 2016 and a household income of \$0.00 for the month of November 2016.

Decision

The December 10, 2016 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for your child for October 2016 and November 2016 based on a household size of a two people with a household income of \$1,575.00 for the month of October 2016 and a household income of \$0.00 for the month of November 2016.

Effective Date of this Decision: March 29, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your child's eligibility based on the evidence you presented at the hearing.

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

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).

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 9, 2016 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for your child for October 2016 and November 2016 based on a household size of a two people with a household income of \$1,575.00 for the month of October 2016 and a household income of \$0.00 for the month of November 2016.

This is not a final determination of your child's eligibility. Your case is sent back to NYSOH to redetermine your child's eligibility based on the evidence you presented at the hearing.

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 مجاناً.

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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye bεtumi ama wo obi a okyerε 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 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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