nystateofhealth
The Official Health Plan Marketplace

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

Notice of Decision

Decision Date: October 04, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020544

[redacted]

Dear [redacted],

On September 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 13, 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
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Decision

Decision Date: October 04, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020544

[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 April 1, 2017 through April 30, 2017?

Procedural History

On June 1, 2017, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for the last three months.

On June 2, 2017, NYSOH issued a notice of eligibility determination stating that your child was eligible for Medicaid, effective May 1, 2017.

On June 2, 2017, NYSOH issued a notice stating additional information was required for your child to determine their eligibility for Medicaid for the months of February to April 2017, by June 16, 2017.

On July 11, 2017, you uploaded a copy of your income documentation in the form of a letter from your employer.

On July 13, 2017, NYSOH issued an eligibility determination notice stating your child was not eligible for Medicaid for the month of April 2017 because the household income of $2,350.00 was over the allowable monthly income limit of $2,085.00.

On July 17, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as it denied retroactive Medicaid for the month of April 2017.

On September 28, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open until October 13, 2017.

On September 29, 2017, NYSOH received the requested documentation and it was incorporated into the record as Appellant's Exhibit #1, the record was closed that day.

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 April 1, 2017 to April 30, 2017.

2) You testified that you expect to file your 2017 federal income tax return as head of household, and claim your child as a dependent.

3) Your child at the time of the June 1, 2017 application was [redacted].

4) You submitted an application for financial assistance on June 1, 2017.

5) Your application submitted on June 1, 2017, states that for the month of April 2017 your income was $1,500.00.

6) You testified that you are paid bi-weekly and on average receive $800.00 per paycheck before taxes.

7) On May 24, 2017, you uploaded a paystub dated April 20, 2017 for a gross pay amount of $770.00.

8) You provided NYSOH a letter from your employer dated July 10, 2017, stating your hourly rate was $20.00 per hour and your gross salary for the month of April 2017 was $2,350.00.

9) On September 29, 2017, NYSOH received an additional paystub dated April 6, 2017 with a gross pay amount of $820.00 in Appellant's Exhibit 1, pg. 2.

10) You testified that you do not plan on taking any deductions on your tax return.

11) You reside in Suffolk County, NY.

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 at least one year of age but younger than nineteen 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 154% 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 $16,240.00 for a two-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 child was not eligible for Medicaid for April 1, 2017 through April 30, 2017.

Your child is in a two-person household; you file your taxes with a tax filing status of head of household and claim one dependent on your tax return.

You submitted an application for financial assistance on June 1, 2017, and requested help in paying for medical bills for April 1, 2017 through April 30, 2017. Your child at the time of your application was [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 from April 1, 2017 to April 30, 2017 for your child.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

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 April 2017, your child would have needed to meet the non-financial criteria and have an income no greater than 154% of the FPL, which is $2,085.00 per month. There is no indication in the record that your child would have been ineligible for Medicaid based on non-financial criteria during April 2017.

You testified that you are paid bi-weekly. You provided NYSOH a letter from your employer dated July 10, 2017, stating your hourly rate was $20.00 per hour and your gross salary for the month of April 2017 was $2,350.00. NYSOH used this information in making its July 13, 2017 determination on your child's ineligibility for Medicaid for the month of April 2017. However, you provided copies of your paystubs dated April 6, and April 20, 2017 for gross pay amounts of $820.00, and $770.00 respectively.

Therefore, the credible evidence in the record indicates that in the month of April 2017, you had a monthly household income of $1,590.00.

Since your child's household income of $1,590.00 was less than the $2,350.00 monthly Medicaid limit for April 2017, NYSOH improperly determined your child was ineligible for Medicaid based on the monthly income you received in that month. Therefore, the July 13, 2017, eligibility determination stating that your child was not eligible for Medicaid in the month of April 2017, is RESCINDED in part.

Since the record now contains a more accurate representation of what your income was for the month of April 2017, your case is RETURNED to NYSOH to consider your request for retroactive coverage for your [redacted] child for April 2017 based on a household size of two-people and household income of $1,590.00 for the month of April 2017.

Decision

The July 13, 2017, eligibility determination notice stating that your child was not eligible for Medicaid in the month of April 2017, is RESCINDED in part.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for your [redacted] for April 2017 based on a household size of two-people and household income of $1,590.00 for the month of April 2017.

Effective Date of this Decision: October 04, 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
  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 July 13, 2017, eligibility determination notice stating that your child was not eligible for Medicaid in the month of April 2017, is RESCINDED in part.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for your [redacted] for April 2017 based on a household size of two-people and household income of $1,590.00 for the month of April 2017.

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.

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.

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