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

Notice of Decision

Decision Date: November 30, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022854

[redacted]

[redacted]

On November 17, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 6, 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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Decision

Decision Date: November 30, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022854

[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 daughter was not eligible for retroactive Medicaid assistance from June 1, 2017 through June 30, 2017?

Procedural History

On August 7, 2017, you submitted an application for financial assistance with health insurance.

On August 8, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal sources. The notice directed you to provide proof of income by August 22, 2017.

On August 15, 2017, you submitted an updated application for financial assistance to NYSOH.

On August 16, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal sources. The notice directed you to provide proof of income by August 22, 2017.

On August 17, 2017, you uploaded income documentation to your NYSOH account and submitted an updated application for financial assistance.

On August 18, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal sources. The notice directed you to provide proof of income by August 22, 2017.

On August 19, 2017, NYSOH issued a notice stating that the documentation you provided did not confirm the information in your application. The notice directed you to provide proof of income by September 6, 2017.

On August 23, 2017, NYSOH issued a notice of eligibility determination stating that you and your daughter were eligible for Medicaid. This eligibility was effective as of August 1, 2017.

On August 30, 2017, NYSOH issued an enrollment confirmation notice stating that you and your daughter were enrolled in a Medicaid Managed Care plan, effective October 1, 2017.

On September 27, 2017, you spoke to NYSOH's Account Review Unit and requested retroactive Medicaid coverage for your daughter for the month of June 2017.

On October 10, 2017, you updated your NYSOH account and asked for help paying for your daughter's medical bills for the last three months.

On October 11, 2017, NYSOH issued an eligibility determination notice stating that you and your daughter were no longer eligible for Medicaid, but that your Medicaid coverage would be continued through July 31, 2018. The notice also stated that your daughter requested help with paying medical bills for the three-month period prior to your application and that you would receive a notice advising your daughter of her eligibility after NYSOH received all documents needed to confirm her eligibility.

On November 6, 2017, NYSOH issued a notice stating that your request for retroactive Medicaid for your daughter for the month of June 2017 was denied because you did not provide proof of income for a determination to made regarding your daughter's eligibility.

On November 17, 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 27, 2017 to allow you to submit supporting documents.

On November 21, 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 retroactive Medicaid coverage for your daughter from June 1, 2017 to June 30, 2017.

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

3) You submitted an application for financial assistance on August 7, 2017.

4) On August 23, 2017, NYSOH issued a notice of eligibility determination stating that your daughter was eligible for Medicaid, effective August 1, 2017.

5) You testified that your daughter had $0.00 income during the month of June 2017.

6) NYSOH records reflect that your daughter [redacted]

7) You uploaded a letter from your employer dated November 21, 2017, stating that you had a gross pay amount of $1,000.00 for the month of June 2017.

8) Your daughter uploaded a letter dated November 21, 2017, stating that she is a full-time student and had no income for the month of June 2017.

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

10) You testified that you are seeking assistance for a medical bill in the amount of $200.00 incurred by your daughter during the month of June 2017.

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

You are 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.

On August 7, 2017, you submitted an application for financial assistance with health insurance. On August 23, 2017, NYSOH issued a notice of eligibility determination stating that your daughter was eligible for Medicaid, effective August 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 Medicaid assistance for your daughter 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 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 daughter would have been ineligible for Medicaid based on non-financial criteria during June 2017.

You uploaded a letter from your employer dated November 21, 2017, stating that you had a gross pay amount of $1,000.00 for the month of June 2017. Your daughter uploaded a letter dated November 21, 2017, stating that she is a full-time student and had no income for the month of June 2017. Therefore, the record indicates that in the month of June 2017, you had a monthly household income of $1,000.00.

Since the November 6, 2017 notice of eligibility determination found your daughter was not eligible for Medicaid for June 1, 2017 through June 30, 2017, because you did not provide proof of income for a determination to made regarding your daughter's eligibility, it is RESCINDED.

Since the record now contains a more accurate representation of what your income was for the month of June 2017, your case is RETURNED to NYSOH to consider your request for retroactive coverage for your daughter for June 2017 based on a household size of two people and household income of $1,000.00 for the month of June 2017.

Decision

The November 6, 2017 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for your daughter for June 2017 based on a household size of two people and household income of $1,000.00 for the month of June 2017.

Effective Date of this Decision: November 30, 2017

How this Decision Affects Your Eligibility

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for your daughter for June 2017 based on a household size of two people and household income of $1,000.00 for the month of June 2017.

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your daughter'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 November 6, 2017 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for your daughter for June 2017 based on a household size of two people and household income of $1,000.00 for the month of June 2017.

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your daughter'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:

[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.

□□□□□ (Bengali)

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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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)

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).

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).