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

Notice of Decision

Decision Date: April 12, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027126

[redacted]

[redacted]

On March 28, 2018, you appeared by telephone at a hearing on your request for retroactive Medicaid assistance for your daughter for the months of August 2017 and September 2017.

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
Albany, NY 12211

Decision

Decision Date: April 12, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027126

[redacted]

Issue

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

> Is your daughter eligible for retroactive Medicaid assistance for the months of August 2017 and September 2017?

Procedural History

On October 4, 2017, you applied for financial assistance with health insurance to NYSOH and indicated that your daughter was seeking help for paying for medical bills for August 2017 and September 2017.

On January 10, 2018, NYSOH issued a notice of eligibility determination stating that your daughter was eligible for Medicaid, effective January 1, 2018.

On January 11, 2018, you spoke to NYSOH's Account Review Unit seeking retroactive Medicaid coverage for your daughter for the months of August and September 2017.

On January 21, 2018, NYSOH issued a notice of enrollment confirmation stating that your daughter was enrolled in a Medicaid Managed Care plan with a start date of March 1, 2018.

On March 28, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. 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) Your daughter is in a one-person household and files her taxes with a tax filing status of single.

2) On October 4, 2017, you applied for financial assistance with health insurance to NYSOH and indicated that your daughter was seeking help for paying for medical bills.

3) You testified that your daughter is seeking retroactive Medicaid assistance for August and September 2017.

4) You testified that your daughter has outstanding medical bills which were incurred in August 2017 and September 2017.

5) According to your NYSOH account, your daughter is 20 years old.

6) You uploaded income information for your daughter on which included a pay stub dated August 4, 2017 with a gross pay amount of $386.04, a pay stub dated August 18, 2017 with a gross pay amount of $362.76, a pay stub dated August 25, 2017 with a gross pay amount of $199.44.

7) You testified that your daughter did not work the week of August 11, 2017 and that she does not get paid for the days she does not work.

8) You uploaded an employee earnings record for your daughter which verified that she received no pay during the week of August 11, 2017.

9) Your daughter's income for the month of August 2017 was $948.24.

10) You uploaded income information for your daughter which included a pay stub dated September 1, 2017 with a gross pay amount of $414.12, a pay stub dated September 8, 2017 with a gross pay amount of $209.88, a pay stub dated September 15, 2017 with a gross pay amount of $418.08, a pay stub dated September 22, 2017 with a gross pay amount of $514.20 and a pay stub dated September 29, 2017 with a gross pay amount of $432.24. An employee earnings record for your daughter indicated that she received no pay during the week of August 11, 2017.

11) Your daughter's income for the month of September 2017 was $1,988.52.

12) You testified that NYSOH has not issued a determination regarding your daughter's request for retroactive Medicaid coverage for August 2017 and September 2017.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Medicaid for Adults between the Ages of 19 and 65

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

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 $12,060.00 for a one-person household (81 Federal Register 4036).

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 your daughter is eligible for retroactive Medicaid coverage for the months of August 2017 and September 2017.

On October 4, 2017, you applied for financial assistance with health insurance to NYSOH and indicated that your daughter was seeking help for paying for medical bills.

When an individual applies 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.

You testified that NYSOH has not issued a determination regarding your daughter's request for retroactive Medicaid coverage for August 2017 and September 2017.

You uploaded income information for your daughter which included a pay stub dated August 4, 2017 with a gross pay amount of $386.04, a pay stub dated August 18, 2017 with a gross pay amount of $362.76, a pay stub dated August 25, 2017 with a gross pay amount of $199.44.

You testified that your daughter did not work the week of August 11, 2017 and that she does not get paid for the days she does not work. You uploaded an employee earnings record for your daughter which verified that she received no pay during the week of August 11, 2017.

Therefore, in the month of August 2017, your daughter's income was $948.24.

You uploaded income information for your daughter which included a pay stub dated September 1, 2017 with a gross pay amount of $414.12, a pay stub dated September 8, 2017 with a gross pay amount of $209.88, a pay stub dated September 15, 2017 with a gross pay amount of $418.08, a pay stub dated September 22, 2017 with a gross pay amount of $514.20 and a pay stub dated September 29, 2017 with a gross pay amount of $432.24.

Therefore, in the month of September 2017, your daughter's income was $1,988.52.

Decision

Your case is RETURNED to NYSOH to consider your daughter's request for retroactive coverage for August 2017 and September 2017 based on a one-person household and a household income of $948.24 for August 2017 and $1,988.52 for September 2017.

Effective Date of this Decision: April 12, 2018

How this Decision Affects Your Eligibility

Your case is returned to NYSOH to reconsider your request for retroactive Medicaid assistance for August 2017 and 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

Your case is RETURNED to NYSOH to consider your daughter's request for retroactive coverage for August 2017 based on a one-person household and a household income of $948.24.

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 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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