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

Notice of Decision

Decision Date: March 31, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000011375

[redacted]

Dear [redacted]

On March 2, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 22, 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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Decision Date: March 31, 2017

NY State of Health Account ID: [redacted]
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Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Was your appeal of NY State of Health's March 22, 2016 eligibility determination timely?
>
> Did NY State of Health properly decline to determine your child's eligibility for Medicaid from July 1, 2014 through September 30, 2014?

Procedural History

On October 6, 2014, you submitted an application for financial assistance with health insurance for your household.

On December 2, 2014, NY State of Health (NYSOH) issued a notice of eligibility determination stating that your child was eligible for Medicaid, effective October 1, 2014.

On January 11, 2016, you submitted an application for financial assistance with health insurance for your household and indicated that you were seeking help for paying for medical bills for your child for the months of July 2014, August 2014, and September 2014.

On January 12, 2016, NYSOH issued a notice of eligibility determination stating that your son was no longer eligible for Medicaid, however, his Medicaid coverage would continue until September 30, 2016. This notice also requested income documentation for your household by January 26, 2016.

On March 21, 2016 NYSOH issued a notice of eligibility determination stating that your child was eligible for Medicaid, effective March 1, 2016. This notice also requested income documentation for your child's father by April 5, 2016.

Also on March 21, 2016, you updated your application for financial assistance with health insurance for your household.

On March 22, 2016, NYSOH issued an eligibility determination addressing your eligibility for retroactive Medicaid for September 1, 2014 through September 30, 2014. This notice did not address your child's eligibility for Medicaid from July 1, 2014 through September 30, 2014.

On August 11, 2016, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as it did not address your child's eligibility for retroactive Medicaid for July 1, 2014 through September 30, 2014.

On March 2, 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 to March 23, 2017, to allow you to submit supporting documents.

As of March 24, 2017, 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) You testified that you are seeking Medicaid for your child from July 1, 2014 to September 30, 2014.

2) The record reflects that your child has continue to have Medicaid since October 1, 2014.

3) You testified that in 2014, your child's father claimed your child as a dependent. You testified that you believe your child's father filed his 2014 tax return as single. You do not know if your child's father claimed any other dependents in 2014, however, your child has no siblings.

4) The record reflects that your child resided with you in 2014.

5) You submitted an application for financial assistance on October 6, 2014.

6) You testified that you are not sure what your income in July 2014 was, but your income in August 2014 was $0.00 and September 2014 was $0.00. You explained that you were not working and not receiving unemployment benefits.

7) You testified that when you were working in 2014 you were paid biweekly and received $230.00 per week.

8) You testified that you do not know what income your child's father had in July 2014, August 2014, or September 2014. You testified that you did not know if your child's father received unemployment benefits or Social Security benefits in 2014. You further testified that you did not know how often he was paid or what he was paid.

9) You have produced no documentation of your or your child's father's income.

10) You testified that you are receiving bills for treatment your child received in July 2014, August 2014, and September 2014.

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

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR §155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

However, where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a

reasonable timeframe as determined by NYSOH that failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal (45 CFR §155.520(d)(2)(i)(D)).

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 2014 FPL, which is $19,790.00 for a three-person household (79 Fed. Reg. 3593).

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)).

Verification Process

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income (45 CFR §155.320(c)(1)(i), 42 CFR § 435.945).

If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR §155.315(f) 42 CFR § 435.952).

Legal Analysis

The first issue under review is whether your appeal of NYSOH's March 22, 2016 eligibility determination notice was timely.

The record reflects that you first contacted NYSOH to file a formal appeal regarding the failure of NYSOH to determine your child's eligibility for retroactive Medicaid for July 1, 2014 through September 30, 2014 on August 10, 2016.

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH.

However, NYSOH has never issued a determination as to whether your child is eligible for retroactive Medicaid for July 1, 2014 through September 30, 2014.

As NYSOH has never issued a notice of eligibility determination addressing your child's eligibility for retroactive Medicaid for July 1, 2014 through September 30, 2014, the 60-day period from which an appeal should have been filed never began to run.

Therefore, your appeal is timely and will be addressed.

The second issue under review is whether NYSOH properly declined to determine your child's eligibility for Medicaid from July 1, 2014 through September 30, 2014.

You testified that in 2014 your child's father claimed your child as a dependent. You further testified that your child has no siblings, but you are not sure if your child's father claimed any additional dependents on his 2014 tax return. The record reflects that your child resided with you during July 2014, August 2014, and September 2014. Therefore, your child was in a three-person household during July 2014, August 2014, and September 2014.

You initially submitted an application for financial assistance for your household through NYSOH on October 6, 2014 and subsequently requested help in paying for medical bills for your child for July 1, 2014 through September 30, 2014.

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 for your child from July 1, 2014 through September 30, 2014.

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 July 2014, August 2014, and September 2014, your child would have needed to meet the non-financial criteria and have an income no greater than 154% of the FPL, which is $2,539.72 per month. There is no indication in the record that your child would have been ineligible for Medicaid based on non-financial criteria during July 2014, August 2014, and September 2014.

You have produced no income documentation for yourself or your child's father for July 2014, August 2014, or September 2014. Therefore, there remains insufficient evidence in the record for a determination on your child's eligibility for retroactive Medicaid to be determined for the months of July 2014, August 2014, and September 2014.

Therefore, the March 22, 2016 eligibility determination which declined to address your child's eligibility for retroactive Medicaid for July 1, 2014 through September 30, 2014 is AFFIRMED.

Decision

The March 22, 2016 eligibility determination is AFFIRMED.

Effective Date of this Decision: March 31, 2017

How this Decision Affects Your Eligibility

Your child's eligibility for retroactive Medicaid for July 1, 2014 through September 30, 2014 has not be determined as you have failed to submit income documentation for your child's household for those months.

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

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).

- By fax: 1-855-900-5557

Summary

The March 22, 2016 eligibility determination is AFFIRMED.

Your child's eligibility for retroactive Medicaid for July 1, 2014 through September 30, 2014 has not be determined as you have failed to submit income documentation for your child's household for those months.

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 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)

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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