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

Notice of Decision

Decision Date: August 9, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000017935

Dear

On July 26, 2017, you appeared by telephone at a hearing on your appeal of your child's eligibility for retroactive Medicaid coverage for the month of February 2017.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of the 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 the NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification Number at the top of this letter.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(b).

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: August 9, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017935

Issue

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

> Did New York State of Health (NYSOH) fail to determine your child eligible for retroactive Medicaid coverage for the month of February 2017?

Procedural History

On February 2, 2017, you submitted an application for financial assistance through NYSOH.

On February 3, 2017, you faxed income documentation to NYSOH (*see* Documents [redacted]).

Also on February 3, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal data sources. The notice directed you to submit proof of income by February 17, 2017, to confirm your child's eligibility.

On March 3, 2017, your NYSOH account was updated.

On March 4, 2017, NYSOH issued an eligibility determination notice stating, in relevant part, that your child was eligible for Child Health Plus with a monthly premium of $9.00, effective April 1, 2017.

On March 21, 2017, your NYSOH account was updated.

On March 22, 2017, NYSOH issued an eligibility determination notice, in relevant part, stating that your child was eligible for Child Health Plus with a monthly premium of $9.00, effective May 1, 2017.

Also on March 22, 2017, NYSOH issued a plan enrollment notice confirming that, as of March 21, 2017, your child was enrolled in a Child Health Plus plan with an enrollment start date of May 1, 2017.

On April 12, 2017, NYSOH issued a notice confirming that on April 11, 2017, you requested an appeal to review: “Request for retroactive coverage for February 2017” (*see* Document [redacted]).

On July 25, 2017, you had a scheduled telephone hearing with a Hearing Officer from the Appeals Unit of NYSOH. You were unable to proceed with the hearing at that time, and the Hearing Officer adjourned the hearing until July 26, 2017.

On July 26, 2017, your telephone hearing was conducted with a Hearing Officer from the Appeals Unit of NYSOH. Your testimony was taken during the hearing, and the record was left open until July 26, 2017, to allow you to submit proof of your February 2017 income.

On July 26, 2017, you faxed four-pages of documentation to NYSOH’s Appeals Unit. That documentation has been made part of the record as “Appellant Exhibit A.” The record is now complete and closed.

Findings of Fact

A review of the record supports the following findings of fact:

1) According to your NYSOH account and testimony, you are applying for health insurance for yourself and child.

2) You testified that you want your child to be found eligible for retroactive Medicaid coverage for the month of February 2017.

3) According to your NYSOH account and testimony, your child was born on [redacted].

4) According to your NYSOH account and testimony, you expect to file your 2017 federal income tax return with the tax status of Head of Household (with qualifying individual), and expect to claim your child as your only dependent on that return.

5) You testified that you are employed and your earnings from your employment are your only source of income.

6) On February 3, 2017 and July 26, 2017, you submitted your weekly earnings statements from your employer to NYSOH. The statements reflect that you were issued gross income of:

   (a) $629.37 on 1/27/2017, with year-to-date (YTD) gross income of $2,154.82;
   (b) $497.24 on 2/10/2017, with YTD gross income of $3,135.80;
   (c) $492.87 on 2/17/2017, with YTD gross income of $3,625.07;
   (d) $603.99 on 2/24/2017, with YTD gross income of $4,225.46

   (*see* Document [redacted]; Appellant Exhibit A pp. 2-4).

7) According to the year-to-date gross income of $2,154.82, as stated on the 1/27/17 earnings statement and $3,135.80 as stated on the 2/10/17 earnings statement, your gross income received the first week of February 2017 was $483.74 ($3,135.80 - $497.24 - $2,154.82) (*id.*).

8) According to your NYSOH account, you do not expect to claim any deductions on your 2017 federal income tax return.

9) You testified that your child has outstanding medical bills for the month of February 2017, and you want her to be found eligible for retroactive Medicaid coverage to cover those medical bills.

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

Applicable Law and Regulations

<u>De Novo Review</u>

NYSOH Appeals Unit must review each appeal de novo and “consider all relevant facts and evidence adduced during the appeals process” (45 CFR § 155.535(f)). “De novo review means a review of an appeal without deference to prior decisions in the case” (45 CFR § 155.500).

<u>Medicaid Eligibility - Children:</u>

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 FPL for the

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applicable family size (42 CFR § 435.118(c); New York Department of Health Administrative Directive 13 OHIP ADM-03).

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)). Generally, in cases when an individual is claimed as a tax dependent by another taxpayer for the taxable year in which a determination is being made, their household is the household of the taxpayer claiming such individual as a tax dependent (42 CFR § 435.603(f)(2)).

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 annually for a two-person household, or $2,085.00 monthly (82 Fed. Reg. 8831).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

<u>Medicaid Retroactive Coverage:</u>

NYSOH must make Medicaid eligibility effective no later than the third month before the month of application if the individual received medical services that would have been covered under Medicaid and would have been eligible for Medicaid at the time he received the services if they had applied (42 CFR 435.915(a)). NYSOH 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 failed to determine your child eligible for retroactive Medicaid coverage for the month of February 2017.

You testified that you are seeking to have your child found eligible for retroactive Medicaid coverage for the month of February 2017 to cover medical bills. However, the record does not contain any notice of eligibility determination regarding the issue of retroactive Medicaid coverage.

Here, the lack of a notice of eligibility determination on the issue of retroactive Medicaid does not prevent the Appeals Unit from reaching the merits of the case

or constitute material error. Under 45 CFR § 155.505(b), you are as entitled to appeal NYSOH failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination. On April 11, 2017, NYSOH issued a notice confirming that you requested an appeal to review your, "Request for retroactive coverage for February 2017" for your child (*see* Document ████████). That notice is sufficient to deduce that NYSOH denied your request for retroactive Medicaid coverage for your child.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to the eligibility determination notice had it been issued.

The record reflects that you expect to file your 2017 federal income tax return, with the tax status of Head of Household (with qualifying individual), and expect to claim any your child as a dependent on that tax return. Therefore, you are in a two-person household for purposes of this analysis. The record also reflects that your child was one year of age at the time you submitted your applications in 2017.

The record further demonstrates that your child was found eligible for Child Health Plus effective April 1, 2017.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's application if they would have been eligible for Medicaid in those three months had they applied.

Medicaid can be provided through NYSOH to children who are at least one year old and under the age of nineteen who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 154% of the FPL for the applicable family size.

On the dates of your applications, the FPL was $16,240.00 for a two-person household. Financial eligibility for Medicaid applicants who are not currently receiving Medicaid benefits may be based on current monthly household income and family size. In order for a child, at least one year of age but younger than nineteen to be eligible for Medicaid in a household of two, their monthly income must not exceed $2,085.00, which is 154% of the applicable FPL on a monthly basis.

You testified that your earnings from your employment are your only source of income. Based on the documentation submitted to NYSOH account, you were issued $2,077.84 ($483.74 + $497.24 + $492.87 + $603.99) in gross income from your employer in February 2017.

Therefore, your case is RETURNED to NYSOH to consider your child's eligibility for retroactive Medicaid for the month of February 2017, using a two-person

household with a monthly income of $2,077.84 for a child between the ages of one and nineteen years of age, and to notify you accordingly.

Decision

Your case is RETURNED to NYSOH to consider your child's eligibility for retroactive Medicaid for the month of February 2017, using a two-person household with a monthly income of $2,077.84 for a child between the ages of one and nineteen years of age, and to notify you accordingly.

Effective Date of this Decision: August 9, 2017

How this Decision Affects Your Eligibility

Your child's current eligibility and enrollment is not affected by this Decision.

This is not a final determination of your child's eligibility for financial assistance for February 2017.

Your case is being sent back to NYSOH to redetermine your child's eligibility for retroactive Medicaid for the month of February 2017 based on the information provided above. NYSOH will notify you once a determination in this regard has been made.

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 child's eligibility for retroactive Medicaid for the month of February 2017, using a two-person household with a monthly income of $2,077.84 for a child between the ages of one and nineteen years of age, and to notify you accordingly.

Your child's current eligibility and enrollment is not affected by this Decision.

This is not a final determination of your child's eligibility for financial assistance for February 2017.

Your case is being sent back to NYSOH to redetermine your child's eligibility for retroactive Medicaid for the month of February 2017 based on the information

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provided above. NYSOH will notify you once a determination in this regard has been made.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(a).

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)

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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।

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.

(Urdu)اردو

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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