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

# Notice of Decision

Decision Date: September 01, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019304

[redacted]

Dear [redacted],

On August 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's denial of retroactive Medicaid coverage for the month of April 2016.

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

# Decision

Decision Date: September 01, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019304

[redacted]

## Issue

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

> Did NY State of Health properly determine that your youngest child was not eligible for Medicaid for April 1, 2016 through April 30, 2016?

## Procedural History

On March 22, 2016, NY State of Health (NYSOH) received your family's application for financial assistance with health insurance.

Also on March 22, 2016, you faxed a four-page document to NYSOH.

On March 23, 2016, NYSOH issued a notice stating that the information you entered into your application did not match what NYSOH received from state and federal data sources. This notice further directed you to submit income documentation for you household by April 7, 2016 in order to confirm the information you provided in your application was accurate.

On April 1, 2016, your four-page fax containing your income documentation was uploaded to your NYSOH account.

On April 7, 2016, NYSOH validated your income documentation, and an updated application was submitted on your family's behalf.

On April 8, 2016, NYSOH issued an eligibility determination stating that your children were eligible for a full cost qualified health plan, effective May 1, 2016.

This notice further stated that this was because your children were enrolled into employer sponsored health insurance that is affordable and meets minimum value. This notice also stated that your children were not eligible for Medicaid because the household income you provided was over the allowable income limit for that program.

On April 26, 2016, NYSOH received an updated application for financial assistance with health insurance. On this application, you also indicated that you needed help paying for medical bills for your family for the last three months.

On April 27, 2016, NYSOH issued an eligibility determination stating that your children were eligible to enroll in a Child Health Plus plan with a $9.00 monthly premium, effective June 1, 2016. This notice further stated that your children were not eligible for Medicaid because your income was over the allowable income limit for that program.

On April 27, 2016, NYSOH issued a plan enrollment notice confirming your children's enrollment in their Child Health Plus plans, effective June 1, 2016.

Also on April 27, 2016, NYSOH issued an eligibility determination stating that your youngest child was not eligible for help paying for medical bills for March 1, 2016 through March 31, 2016.

On May 18, 2017, you spoke with NYSOH's Accounts Review Unit on this date, and requested retroactive Medicaid coverage for the month of April 2016 for your youngest child.

On May 26, 2016, you spoke to NYSOH's Accounts Review Unit and appealed the start date of your children's Child Health Plus plans insofar as the plans started on July 1, 2017, and not June 1, 2017.

On August 28, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Under oath, you withdrew your appeal in regards to your children's Child Health Plus plan start dates, as this issue had already been resolved. However, you stated that you would like to continue with your appeal of NYSOH's denial of retroactive Medicaid coverage for April 2016 for your youngest child. The record was developed during the hearing and the record was closed at the end 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 the month of April 2016 for your youngest child.

2) You testified that you filed your 2016 federal income tax return as head of household, and claimed three dependents on that tax return. You further testified that you did not take any deductions on your 2016 tax return.

3) The record indicates that on May 18, 2017, you contacted NYSOH and requested retroactive Medicaid coverage for your youngest child for the month of April 2016. (See Incident [redacted]).

4) The record indicates that on or around May 26, 2017, NYSOH denied your request for retroactive Medicaid for the month of April 2016 for your youngest child because your household monthly income for April 2016 was over the income limit for Medicaid. (See Incident [redacted]).

5) There is no indication in the record that NYSOH issued a notice regarding your request for retroactive Medicaid coverage for your youngest child for April 2016.

6) You testified that you were paid biweekly in the month of April 2016.

7) You further testified that in April 2016, you were working on average 37.5 hours a week, and made $18.20 an hour.

8) You provided income documentation, on May 22, 2017, which indicated that your gross income was $3,733.46 in April 2016.

9) You testified that you recently learned that you are being sued by your youngest child's health care provider for unpaid medical bills for the month of April 2016.

10) You testified that you are seeking retroactive Medicaid for the month of April 2016 for your youngest child because she has unpaid medical bills from that month.

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).

Medicaid for Children between the Ages of 1 and 18

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 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 2016 FPL, which is $11,880.00 for a one-person household (81 Fed. Reg. 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 NYSOH properly determined that your youngest child was not eligible for Medicaid for the month of April 2016.

You testified that you are appealing the denial of retroactive Medicaid for your youngest child for the month of April 2016. However, the record does not contain a notice of eligibility determination or redetermination on the issue of retroactive coverage for your youngest child for the month of April 2016.

Here, the lack of a notice of eligibility determination on the issue of retroactive Medicaid coverage for April 2016 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.

Your credible testimony, along with the May 26, 2017 incident note stating that NYSOH denied your youngest child retroactive Medicaid coverage for the month of April 2016, permits an inference that NYSOH did deny your request for retroactive Medicaid coverage for your youngest child for the month of April 2016. (See Incident [redacted]).

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 financial criteria for Medicaid can be provided through NYSOH to children between the ages of 1 and 18 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 154% of the federal poverty level (FPL) for the applicable family size.

Your youngest child was in a four-person household in the month of April 2016; you testified that you filed your 2016 taxes with a tax filing status of head of household, and you claimed three dependents on that tax return.

You submitted an application for financial assistance on April 26, 2016.

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 youngest child for the month of April 2016.

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 2016, your youngest child would have needed to meet the non-financial criteria and have a household income no greater than 154% of the 2016 FPL, which is $3,119.00 per month for a four-person family. There is no indication in the record that your youngest child would have been ineligible for Medicaid based on non-financial criteria during April 2016.

You credibly testified, and submitted income documentation that your monthly income for April 2016 was $3,733.46. Since the income documentation you provided shows that you earned $3,733.46 in the month of April 2016, your youngest child does not qualify for retroactive Medicaid in the month of April 2016.

Therefore, NYSOH's denial of retroactive Medicaid for your youngest child for the month of April 2016 is AFFIRMED.

## Decision

NYSOH's denial of retroactive Medicaid for your youngest child for the month of April 2016 is AFFIRMED.

## Effective Date of this Decision: September 01, 2017

## How this Decision Affects Your Eligibility

Your youngest child is not eligible for Medicaid in the month of April 2016.

## 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

NYSOH's denial of retroactive Medicaid for your youngest child for the month of April 2016 is AFFIRMED.

Your youngest child is not eligible for Medicaid in the month of April 2016.

## 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।

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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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