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

Notice of Decision

Decision Date: November 20, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021017

[redacted]

Dear [redacted],

On October 13, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 1, 2017 eligibility determination notice and denial of retroactive Medicaid coverage.

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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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 (NYSOH) April 1, 2017 eligibility determination notice timely?
>
> Did NYSOH properly determine that your child was not eligible for Medicaid from August 2016 through February 2017?

Procedural History

On November 8, 2016, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for your child for the last three months.

On November 9, 2016, NYSOH issued a notice requesting additional information to confirm your household's eligibility. The notice directed you to provide proof of your child's income by November 23, 2016 and of your income by February 6, 2017.

On December 6, 2016, you faxed income documentation.

On February 1, 2017, NYSOH invalidated your documentation.

On March 31, 2017, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for your child for the last three months.

On April 1, 2017, NYSOH issued an eligibility determination notice, stating that your child was eligible for Child Health Plus, effective May 1, 2017.

Also on April 1, 2017, NYSOH issued an enrollment confirmation notice, stating that your child was enrolled in a Child Health Plus plan, effective May 1, 2017.

Also on April 1, 2017, NYSOH issued an eligibility determination notice stating that your child was not eligible for Medicaid from December 1, 2016 through February 28, 2017 because the program he is eligible for cannot pay for any care he received in the past.

On July 31, 2017, you spoke to NYSOH's Account Review Unit requested an appeal insofar as your child was denied retroactive Medicaid for from August 1, 2016 through February 28, 2017.

On October 13, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing held open up to October 27, 2017, to allow you to submit supporting documents.

On October 26, 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 Medicaid for your child from August 2016 through February 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 applications for financial assistance on November 8, 2016 and March 31, 2017 seeking help for paying for medical bills for your child for the prior three months.

4) You testified that you are paid weekly and that you have earned $7.50 per hour plus tips since August 2016.

5) You submitted a letter from your employer dated October 21, 2017, which stated that your gross earnings for August 2016 were $991.43, for September 2016 were $894.22, for October 2016 were $1,013.37,

for November 2016 were $890.18 and for December 2016 were $1,017.09.

6) The cover letter to your October 26, 2017 fax indicates that you are seeking retroactive Medicaid coverage for your child from August 2016 through April 2017. However, during the hearing, you testified that you are seeking only August 2016 through February 2017.

7) You faxed the following paystubs:
   a. dated January 13, 2017 for a gross $129.04
   b. dated January 20, 2017 for a gross $331.53
   c. dated January 27, 2017 for a gross $622.63
   d. dated February 3, 2017 for a gross $616.04
   e. dated February 10, 2017 for a gross $458.89
   f. dated February 17, 2017 for a gross $511.70
   g. dated February 24, 2017 for a gross $391.25
   h. dated March 3, 2017 for a gross $434.25
   i. dated March 10, 2017 for a gross $835.14
   j. dated March 17, 2017 for a gross $295.60
   k. dated March 24, 2017 for a gross $804.07
   l. dated March 31, 2017 for a gross $764.85
   m. dated April 7, 2017 for a gross $200.03
   n. dated April 14, 2017 for a gross $270.02
   o. dated April 21, 2017 for a gross $215.64
   p. dated April 28, 2017 for a gross $320.27

8) You did not submit the January 6, 2017 paystub. However, the January 27, 2017 paystub indicates that your year to date gross earnings was $1,083.20.

9) You earned $1,977.88 in February 2017.

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

11) The record reflects that your certified application counselor contacted NYSOH on December 5, 2016 regarding your child's coverage. An appeal was not filed at that time, despite your application counselor notifying NYSOH of an issue with your child's coverage.

12) The record reflects that on March 31, 2017, you spoke with a NYSOH representative and requested retroactive Medicaid coverage for your child from August 2016 through December 2016. An appeal was not filed at that time, despite your request for retroactive coverage.

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)).

Appealable Issues

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 NYSOH 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)).

De Novo Review

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

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 November 8, 2016 application, that was the 2016 FPL, which is $16,020.00 for a two-person household (81 Fed. Reg. 4036). On the date of your March 31, 2017 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 first issue under review is whether your appeal of NYSOH's April 1, 2017 eligibility determination notice was timely.

The record reflects that you filed an appeal with NYSOH regarding your child's eligibility on July 31, 2017.

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

For an appeal to have been valid on the issue of your child's denial of retroactive Medicaid coverage as stated in the April 1, 2017 notice, an appeal should have

been filed by May 31, 2017. There was no notice regarding your child's retroactive coverage for 2016.

Although your appeal was untimely on its face with regard to the April 1, 2017 notice, the record reflects that you spoke with NYSOH on March 31, 2017, the same day that you submitted an application which resulted in a denial of retroactive coverage for your child. The record also reflects that your application counselor contacted NYSOH on December 5, 2016, less than a month after your November 8, 2016 application, seeking coverage for your child.

As you or your application counselor originally contacted NYSOH within sixty (60) days of your November 8, 2016 application and March 31, 2017 that you submitted the application resulting in the April 1, 2017 eligibility determination notice that stated your child was not eligible for retroactive Medicaid coverage, your failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal.

The issue under review is whether NYSOH properly determined that your child was not eligible for Medicaid from August 2016 through February 2017.

You testified that you are appealing the denial of retroactive Medicaid coverage for your child from August 2016 through February 2017. However, the record does not contain a notice of eligibility determination on the issue of retroactive Medicaid from August 1, 2016 through November 30, 2016.

Here, the lack of a notice of eligibility determination on the issue of retroactive Medicaid coverage from August 1, 2016 through November 30, 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 August 1, 2017 appeal confirmation notice stating that the reason for your appeal was "eligibility determination" for your child, permits an inference that NYSOH did deny your child retroactive Medicaid from August 2016 through February 2017.

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.

Your child is 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.

You submitted an application for financial assistance on November 8, 2016 and requested help in paying for medical bills for your child for the previous three

months. You also submitted an application for financial assistance on March 31, 2017 and requested help in paying for medical bills for your child for the previous three months.

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 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 from August 1, 2016 through February 28, 2017. You submitted documentation following the hearing with a cover letter that stated that you are seeking coverage for your child through May 2017. However, when the issue was clarified during the hearing, it was limited to August 2016 through February 2017. Therefore, this Decision will not address coverage for the months of March 2017 or April 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 for August 2016 through February 2017, your child would have needed to meet the non-financial criteria and have an income no greater than 154% of the FPL, which was $1,335.00 per month at the time of your November 8, 2016 application and was $1,354.00 at the time of your March 31, 2017 application. There is no indication in the record that your child would have been ineligible for Medicaid based on non-financial criteria from August 2016 through February 2017.

You testified that you are paid weekly. You submitted a letter from your employer dated October 21, 2017, which stated that your gross earnings for August 2016 were $991.43, for September 2016 were $894.22, for October 2016 were $1,013.37, for November 2016 were $890.18 and for December 2016 were $1,017.09. You uploaded paystubs dated January 13, 2017 for a gross $129.04, dated January 20, 2017 for a gross $331.53, dated January 27, 2017 for a gross $622.63, dated February 3, 2017 for a gross $616.04, dated February 10, 2017 for a gross $458.89, dated February 17, 2017 for a gross $511.70, dated February 24, 2017 for a gross $391.25. The January 27, 2017 paystub indicates that your year to date gross earnings was $1,083.20.

Since the April 1, 2017 notice of eligibility determination found your child was not eligible for Medicaid for December 1, 2016 through February 28, 2017, because

the program he was eligible for cannot pay for any care he received in the past, this is RESCINDED.

Since the record now contains a more accurate representation of what your income was for August 2016 through February 2017, your case is RETURNED to NYSOH to consider your request for retroactive coverage for your child for August 2016 through February 2017 based on a household size of two people and household income of $991.43 for August 2016, $894.22 for September 2016, $1,013.37 for October 2016, $890.18 for November 2016, $1,017.09 for December 2016, $1,083.20 for January 2017, and $1,977.88 for February 2017.

Decision

The April 1, 2017 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for your child for August 2016 through February 2017 based on a household size of two people and household income of $991.43 for August 2016, $894.22 for September 2016, $1,013.37 for October 2016, $890.18 for November 2016, $1,017.09 for December 2016, $1,083.20 for January 2017, and $1,977.88 for February 2017.

Effective Date of this Decision: November 20, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your child's eligibility. Your case is sent back to NYSOH to redetermine your child'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 April 1, 2017 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for your child for August 2016 through February 2017 based on a

household size of two people and household income of $991.43 for August 2016, $894.22 for September 2016, $1,013.37 for October 2016, $890.18 for November 2016, $1,017.09 for December 2016, $1,083.20 for January 2017 and $1,977.88 for February 2017.

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

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)

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).

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.

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.

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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