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

Notice of Decision

Decision Date: January 25, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024295

On January 4, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's 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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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).

nystateofhealth
The Official Health Plan Marketplace

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

Decision

Decision Date: January 25, 2018

NY State of Health Account ID
Appeal Identification Number: AP000000024295

Issues

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

> Did you timely appeal your and your youngest child's denial for retroactive Medicaid Coverage for the months of May 2017, June 2017, and July 2017?
>
> Did NY State of Health (NYSOH) address your eligibility for Medicaid for the months of May 2017, June 2017, and July 2017?
>
> Did NYSOH address your youngest child's eligibility for Medicaid for the months of May 2017, June 2017, and July 2017?

Procedural History

On July 1, 2017, you submitted a paper application for health insurance for you and your household.

On August 2, 2017, NYSOH issued a notice stating your application, dated July 1, 2017, was received but a determination could not be made because more information was needed regarding your household demographics, income, and health insurance coverage.

On August 18, 2017, a NYSOH account was created for you but no application was submitted for your household.

Your application for financial assistance was completed on November 1, 2017.

The application on November 1, 2017 states you were seeking financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for August, September, and October 2017.

On November 2, 2017, NYSOH issued an eligibility determination notice stating that, effective November 1, 2017, you and your youngest child was eligible for Medicaid.

On November 2, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid from August 1, 2017 through October 31, 2017, because your monthly household income of $1,608.00 was below the monthly income limit of $2,829.00 to qualify for Medicaid.

On November 13, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal insofar as you were seeking retroactive Medicaid coverage for you and your youngest child for the months of May 2017, June 2017, and July 2017.

On January 4, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing held open to January 19, 2018, to allow you to submit supporting documents.

On January 19, 2018, NYSOH received the requested documentation in the form of three-page fax, which was made part of 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 retroactively for you and your youngest child for the months of May 2017, June 2017, and July 2017.

2) Your youngest child was [redacted] in May 2017, June 2017, and July 2017.

3) Your application states you do not expect to file income taxes for 2017. You testified this was correct.

4) Your application states you have a domestic partner and [redacted]. You testified this was correct.

5) Your application states your only source of income is Social Security Benefits

6) You provided income documentation on November 9, 2017 and January 4, 2018, showing you receive a monthly amount of $1,072.00, and your two youngest children each receive $268.00 per month (*see* ; Appellant's Exhibit 1, p. 2).

7) You testified your only source of income for the months of May 2017, June 2017, and July 2017, was your and your two youngest children's Social Security Benefits.

8) You testified you are under age 65, and eligible for and receiving Medicare Parts A and B. You were eligible for and enrolled in Medicare for the months of May 2017, June 2017, and July 2017.

9) You testified you attempted to complete an application for financial assistance on August 18, 2017, however a technical defect prevented you from completing that application.

10) You testified you intended to request retroactive Medicaid for the three months before your August 18, 2017 application but were prevented from doing so because a technical issue would not allow your application to be processed.

11) NYSOH representatives filed a defect notice on August 21, 2017 as

12) According to an entry in the Appeal Summary, dated "11/13/2017:"

    The appellant [ ] is requesting Retroactive Medicaid for self and child, [ ] , effective 5/1/2017. The appellant contacted the Marketplace on 8/18/2017 and completed the application. A technical issue prevented the application from being submitted in August. If so, the application would have given the option of help with medical bills from May-July 2017. Instead, the application was successfully completed on 11/1/2017, granting retroactive coverage for 8/1/2017-10/31/2017. System shows only the account holder has this Retro period. Child, [ ], has none. was submitted in an attempt to resolve the issue- the issue remains unresolved. The appellant has provided income documentation for requested months. The appellant, [ ], is requesting FFS Medicaid for self effective 5/1/2017.

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13) An appeal notice was issued on November 14, 2017, describing your appeal for you and your child as, "Consumer wants retroactive Medicaid for May June and July [

14) You and your family reside in Oneida County, NY.

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

Applicable Law and Regulations

Timely Appeal Requests

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)).

De Novo Review

The 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).

Household Composition

In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, the household consists of the individual and if living with them, their spouse, and any children under the age of 19.

For children under age 19, their household includes their parents and any siblings under age 19 (42 CFR § 435.603(f)(3)).

Medicaid Adult Parents

An individual is eligible for enrollment in Medicaid through NYSOH (called MAGI-based Medicaid) when he or she meets certain nonfinancial criteria and has a household income that is at or below the applicable Medicaid income standard (45 CFR § 155.305(c); N.Y. Soc. Serv. Law § 366(1)(b)).

In general, to qualify for MAGI-based Medicaid through NYSOH, you must also be one of the following:

• An adult aged 19-64 who is not eligible for Medicare Part A or Part B,
• A pregnant woman or infant,
• A child aged 1-18, or
• A parent or caretaker relative

(45 CFR § 155.305(c); N.Y. Soc. Serv. Law § 366(1)(b)).

A caretaker relative is a relative of a dependent child by blood, adoption, or marriage, who: Lives with the dependent child; Assumes primary responsibility for the child's care; and, is either the child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece (42 CFR § 435.4; N.Y. Soc. Serv. Law § 366(1)(a)(2)(i); NY Department of Health Administrative Directive 13ADM-03)

A dependent child is a child who:

• Is under 18 years old, or is 18 years old and a full-time high school student; and
• Is deprived of parental support by at least parent due to either death, absence, physical or mental incapacity, or unemployment (42 CFR § 435.4; N.Y. Soc. Serv. Law § 366(b)(1)(v); NY Department of Health Administrative Directive 13ADM-03).

Parents and caretaker relatives under age 65 and receiving Medicare remain in the MAGI category regardless of Medicare eligibility (GIS18 MA/001-2018 Medicaid Managed Care Transition for Enrollees Gaining Medicare at pg. 2).

In an analysis of Medicaid eligibility, the determination is based on the (Federal Poverty Level (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 $24,600.00 for a four-person household (82 Federal Register 8831).

<u>Medicaid for 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 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 2017 FPL, which is $28,780.00 for a five-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 you filed a timely appeal request of your and your youngest child's request for retroactive Medicaid coverage in the months of May 2017, June 2017, and July 2017.

The record supports that you first submitted a request for an appeal of your denial for help paying medical bills for the months of May 2017, June 2017, and July 2017 on November 13, 2017. You spoke with NYSOH's Account Review Unit that day and requested your and your youngest child's eligibility be redetermined for Medicaid for those three months. The record also shows that an application was initially started on August 18, 2017 and not completed until November 1, 2017.

The record does not contain a notice of eligibility determination or redetermination on the issue of your and your youngest child's eligibility for retroactive Medicaid for the months of May 2017, June 2017, and July 2017. It does contain an entry in the record that NYSOH filed a defect notice on August 21, 2017 as [redacted], which states in relevant part that, "[a] technical issue prevented the application from being submitted in August. If so, the application would have given the option of help with medical bills from May-July 2017" [redacted] You credibly testified that because of this defect you were unable to complete your application an unable to request retroactive Medicaid coverage for the three-month period prior to your August 18, 2017 initial application.

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their eligibility determination notice by NYSOH. The record reflects that, due to a technical issue, NYSOH was unable to process your August 18, 2017 application until November 1, 2017. You filed an appeal request on November 13, 2017 which was within twelve days of your November 1, 2017 completed application. Therefore, your appeal request may be considered timely filed as it was within 60 days of a determination made by NYSOH.

Additionally, the lack of a notice of eligibility determination on the issue of your and your child's eligibility for retroactive Medicaid coverage for the months of May 2017, June 2017, and July 2017, does not prevent the Appeals Unit from reaching the merits of this case or constitute material error. Under 45 CFR § 155.505(b), you are as entitled to appeal NYSOH's failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination. Here, Incident [redacted] along with the text of the November 14, 2017 appeal notice, indicates your request retroactive Medicaid coverage for yourself and your youngest child for the months of May 2017, June 2017, and July 2017, remains unresolved.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to the notice of eligibility determination had it been issued. Therefore, the remaining issue under review are whether you and your youngest child were eligible for retroactive Medicaid for the months of May 2017, June 2017, and July 2017.

As to your household size, in the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, the household consists of the individual and if living with them, their spouse, and any children under the age of 19. The record reflects that you do not plan on filing a Federal tax return for 2017, and live with your domestic partner and your three children, all of whom are under the age of 19.

Therefore, you are in a four-person household, which consists of yourself and your three children under age 19.

As to your youngest child's household size, in the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made for children under age 19, their household includes their parents and any siblings under age 19.

The record reflects that your youngest child resides with [redacted] parents and two siblings. Therefore, your youngest child, [redacted] in the months of May 2017, June 2017, and July 2017, is in a five-person household for purposes of this analysis.

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 first applied on August 18, 2017, but a technical issue prevented your application from being processed. NYSOH has conceded that, had your application been processed that day, your request for retroactive Medicaid for yourself and your youngest child for the three previous months could have been considered. Those months are May 2017, June 2017, and July 2017.

Generally, Medicaid through NYSOH (called MAGI-based Medicaid) is available to individuals who are between the ages of 19 and 64, who are not eligible for Medicare Parts A or B; pregnant women or infants; children between the ages of 1 and 18; and parent or caretaker relatives. However, parents and caretaker relatives under age 65 and receiving Medicare remain in the MAGI category regardless of Medicare eligibility. You are under age 65 and receiving Medicare benefits. Due to your status as a parent with children under the age of 19, you remain eligible for analysis for Medicaid under MAGI Budgeting Methodologies with NYSOH. Therefore, your eligibility may be determined for Medicaid fee for service purposes through NYSOH despite being eligible for and enrolled in Medicare.

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 May 2017, June 2017, and July 2017, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL for 2017, which is $2,829.00 per month for a four-person household.

To be eligible for Medicaid in May 2017, June 2017, and July 2017, your youngest child would have needed to meet the non-financial criteria and have an income no greater than 154% of the FPL for 2017, which is $3,694.00 per month for a five-person household.

There is no indication in the record that you or your youngest child would have been ineligible for Medicaid based on non-financial criteria during May 2017, June 2017, and July 2017.

You provided income documentation on November 9, 2017 and January 4, 2018, showing you receive monthly Social Security benefits of $1,072.00, and your two youngest children receive monthly benefits of $268.00 each (Documents [redacted] and [redacted] Appellant's Exhibit 1, p. 2). You testified that your only source of income for the months of May 2017, June 2017, and July 2017, was your and your two youngest children's Social Security Benefits.

Therefore, the record supports that in the months of May 2017, June 2017, and July 2017, you and your youngest child had a monthly household income of $1,608.00, at most, and $1,072.00 not counting your children's benefits, at least.

Since the record now contains a more accurate representation of what your and your youngest child's income was for the months of May 2017, June 2017, and July 2017, your case is RETURNED to NYSOH to consider your and your youngest child's request for retroactive coverage for May 2017, June 2017, and July 2017, based on a household size of four people for yourself, and five people for your youngest child, and a household income of $1,608.00 for the months of May 2017, June 2017, and July 2017, for individuals residing in Oneida County, NY.

Decision

Your appeal request was timely filed.

Your case is RETURNED to NYSOH to consider your and your youngest child's request for retroactive coverage for May 2017, June 2017, and July 2017, based on a household size of four people for yourself, and five people for your youngest child, and a household income of $1,608.00 for the months of May 2017, June 2017, and July 2017, for individuals residing in Oneida County, NY. NYSOH will notify you accordingly.

Effective Date of this Decision: January 25, 2018

How this Decision Affects Your Eligibility

This is not a final determination of your and your youngest child's eligibility for retroactive Medicaid for the months of May 2017, June 2017, and July 2017.

Your case is sent back to NYSOH to redetermine your and your youngest child's eligibility based on the evidence adduced 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

Your appeal request was timely filed.

Your case is RETURNED to NYSOH to consider your and your youngest child's request for retroactive coverage for May 2017, June 2017, and July 2017, based on a household size of four people for yourself, and five people for your youngest child, and a household income of $1,608.00 for the months of May 2017, June 2017, and July 2017, for individuals residing in Oneida County, NY. NYSOH will notify you accordingly.

This is not a final determination of your and your youngest child's eligibility for retroactive Medicaid for the months of May 2017, June 2017, and July 2017.

Your case is sent back to NYSOH to redetermine your and your youngest child's eligibility based on the evidence adduced 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)

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.

(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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