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

Notice of Decision

Decision Date: March 07, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025589

Dear [redacted],

On February 14, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 2, 2017 eligibility determination notice and the failure to determine your child eligible for Medicaid for the months of September and October 2017.

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: March 07, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000025589

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 child was not eligible for Medicaid for the months of August 2017, September 2017, and October 2017?

Procedural History

On September 21, 2017, NY State of Health (NYSOH) received your updated application for financial assistance with health insurance. You also uploaded a copy of your 2016 tax return on this date.

On September 22, 2017, NYSOH issued a notice stating that the income information you entered into your application did not match what NYSOH received from state and federal data sources. The notice directed you to submit proof of your current household income by October 6, 2017, in order to confirm your child's eligibility.

Also on September 22, 2017, NYSOH issued a notice stating that the income documentation that you submitted did not confirm the information in your application. The notice directed you to submit income documentation by October 21, 2017 to confirm your child's eligibility.

On November 2, 2017, NYSOH issued a denial notice stating that child did not qualify for health coverage through NYSOH because you did not provide the income documentation needed to verify the income listed in your application, and

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the date to send in this information had passed. It also stated that NYSOH was unable to determine whether your child was eligible for help paying for health coverage without this information.

Also on November 2, 2017, NYSOH issued an eligibility determination notice stating that NYSOH denied your child's request for Medicaid coverage for the month of August 2017, because you failed to provide your current household income to confirm your child's eligibility by the deadline.

On November 7, 2017, NYSOH received your updated application for financial assistance with health insurance.

On November 8, 2017, NYSOH issued an eligibility determination notice stating that your child was eligible for Medicaid, effective November 1, 2017.

Also on November 8, 2017, NYSOH issued a plan enrollment notice confirming your child's enrollment in a Medicaid Managed Care plan, effective December 1, 2017.

On December 11, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as it denied retroactive Medicaid for the month of August 2017.

On February 14, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, you clarified what you were seeking through the appeal. You testified that you are seeking retroactive Medicaid for your child for the months of August 2017, September 2017, and October 2017, The Hearing Officer agreed to amend the appeal to include your request for retroactive Medicaid for your child for the months of September 2017 and October 2017. The record was developed during the hearing and held open until March 1, 2018, to allow you to submit supporting documents.

As of the end of the business day on March 1, 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 for the months of August 2017, September 2017, and October 2017.

2) At all times relevant, your child was over one year of age and younger than nineteen years of age.

3) You testified that you expect to file your 2017 federal income tax return as single, and claim your one child as a dependent on that tax return.

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

5) According to your NYSOH account, an updated application for financial assistance was submitted on November 7, 2017.

6) Your application that was submitted on November 7, 2017 listed an annual expected income of $24,000.00. You testified that this was correct.

7) You testified that you work as a [redacted] employee for the [redacted] [redacted]

8) You testified that your monthly income varies based on how much you work and how many [redacted] during the month.

9) You testified that some months you earn a negative amount of income and you must pay back money to the company.

10) You testified that you do not know what your income was for the months of August 2017, September 2017, or October 2017.

11) The Hearing Officer left the record open until March 1, 2018, to allow you time to submit proof of your income for the months of August 2017, September 2017, and October 2017.

12) As of the close of business on March 1, 2018, no income documentation was received by the NYSOH's Appeals Unit, nor was any income documentation viewable in your NYSOH account regarding your income for the months of August 2017, September 2017, and October 2017.

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

Applicable Law and Regulations

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 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 issue under review is whether NYSOH properly determined that your child was not eligible for Medicaid for the month of August 2017, September 2017, and October 2017.

You testified that you are appealing the denial of retroactive Medicaid for your child for the months of August 2017, September 2017, and October 2017. However, the record only contains an eligibility determination regarding your request for retroactive Medicaid for your child for the month of August 2017.

Here, the lack of a notice of eligibility determination on the issue of retroactive Medicaid for the months of September 2017 and October 2017, 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.

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.

You testified that you are seeking Medicaid for your child from August 1, 2017 through October 31, 2017.

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. There is no indication in the record that your child would have been ineligible for Medicaid based on non-financial criteria during August 2017, September 2017, and October 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 in August 2017, September 2017, and October 2017, your child would have needed to meet the non-financial criteria and have an income no greater than 154% of the FPL, which is $2,085.00 per month.

You testified that your monthly income varies based on how much you work you have and how many [redacted] during the month. You further testified that you are unsure as to what your income was for the month of August 2017, September 2017, and October 2017.

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The Hearing Officer left the record open until March 1, 2017 to allow you time to submit proof of your income for the months of August 2017, September 2017, and October 2017. However, by the close of business on March 1, 2017, no documentation was received by the NYSOH's Appeals Unit nor was there any documentation viewable in your NYSOH account.

Since there is insufficient information in the record to verify your income information for the relevant months, the NYSOH's Appeals Unit is unable to provide a decision as to whether NYSOH properly determined that your child ineligible for Medicaid for the month of August 2017. Further, the NYSOH's Appeals Unit is unable is unable to determine whether your child was eligible for Medicaid for the months of September 2017 and October 2017.

Decision

The NYSOH's Appeals Unit is unable to provide a decision as to whether NYSOH properly determined that your child was ineligible for Medicaid for the month of August 2017, based on the record.

The record contains insufficient documentation to determine whether your child was eligible for Medicaid for the months of September 2017 and October 2017.

This Decision has no effect on any subsequent eligibility determinations made by NYSOH.

Effective Date of this Decision: March 07, 2018

How this Decision Affects Your Eligibility

The record does not contain enough information to determine whether your child was eligible for Medicaid for the months of August 2017, September 2017, and October 2017.

This Decision does not affect your child's current eligibility.

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

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).

The NYSOH’s Appeals Unit is unable to provide a decision as to whether NYSOH properly determined that your child was ineligible for Medicaid for the month of August 2017, based on the record.

The record contains insufficient documentation to determine whether your child was eligible for Medicaid for the months of September 2017 and October 2017.

This Decision has no effect on any subsequent eligibility determinations made by NYSOH.

The record does not contain enough information to determine whether your child was eligible for Medicaid for the months of August 2017, September 2017, and October 2017.

This Decision does not affect your child’s current eligibility.

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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