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

Notice of Decision

Decision Date: March 13, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026429

[redacted]

Dear [redacted],

On February 22, 2018 you appeared by telephone at a hearing on your appeal of NY State of Health's November 9, 2017 and February 13, 2017 eligibility determination notices.

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

Decision

Decision Date: March 13, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000026429

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly determine that you and your child were not eligible for Medicaid for September 1, 2017 through October 31, 2017?

Procedural History

On November 6, 2017, a certified application counselor (CAC) submitted an updated application for financial assistance with health insurance on your behalf and indicated that you were seeking help paying for medical bills for the past three months.

On November 7, 2017, NYSOH issued a noticed stating that you were ineligible for Medicaid for October 1, 2017 through October 31, 2017 because the program you are eligible for cannot pay for any care you received in the past. This notice did not address your eligibility for the month of September.

On November 8, 2017, a CAC submitted an updated application for financial assistance with health insurance adding your child to your account and indicated that you and your child were seeking help paying for medical bills for the past three months.

On November 9, 2017, NYSOH issued a notice of eligibility determination stating that you remain eligible for Medicaid. This eligibility was effective as of November

1, 2017. This notice also stated that your child remained conditionally eligible for Medicaid, effective November 1, 2017.

Also on November 9, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid for August 1, 2017 through August 31, 2017 because your monthly household income of $1,519.68 was at or below the allowable monthly income limit. This notice did not address your eligibility for the month of September 2017 nor did it address your child's eligibility for retroactive Medicaid.

Also on November 9, 2017, NYSOH issued a notice confirming that both you and your child were enrolled into a Medicaid Managed Care plan, effective December 1, 2017.

On December 21, 2017, NYSOH issued an eligibility determination notice stating that you remain eligible for Medicaid, effective December 1, 2017. This notice also stated that your child remained conditionally eligible for Medicaid, effective December 1, 2017. NYSOH requested that you provide proof of your child's Social Security number by February 6, 2018.

On December 28, 2017, a CAC spoke to NYSOH's Account Review Unit and appealed insofar as you and your child were not eligible for retroactive Medicaid for the months of September and October 2017.

On February 13, 2018, NYSOH issued an eligibility determination notice stating that your child was ineligible for Medicaid for September 1, 2017 through October 31, 2017 because you failed to provide her Social Security number. This notice did not address your eligibility for retroactive Medicaid.

On February 22, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. At that time, you clarified that the issue you were appealing was the denial of retroactive Medicaid for you and your child for the months of September and October. The record was developed during the hearing and held open up to March 9, 2017, to allow you to submit supporting documents.

On March 5, 2018 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 retroactive Medicaid for September and October 2017 for yourself and your child to cover medical bills.

2) Your application states that you expect to file your 2017 federal income tax return as single, and claim one dependent.

3) Your application states that you do not plan on taking any deductions on your tax return.

4) Your child is [redacted]

5) On October 26, 2017 your account reflects and you confirmed that proof of your income for September 2017 was uploaded. You testified that you submitted this documentation with the help of your Local Department of Social Services.

6) You testified that a CAC from [redacted] submitted an application for financial assistance on behalf of you and your child on November 8, 2017.

7) You testified that you believed that all of the necessary documentation for your NYSOH application was submitted.

8) Your account reflects that the birth certificates for your child were uploaded on your behalf by a CAC on December 18, 2017, however your child's Social Security number was not included.

9) On March 5, 2018, you faxed an hour and wage report for September, October, and November 2017 showing a gross pay amount of $1,191.96 for September 2017, $1,193.99 for October 2017, and $1,096.08 in gross pay for November 2017.

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

Applicable Law and Regulations

Medicaid for Adults between the Ages of 19 and 65

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for

Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

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).

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 you and your child were not eligible for Medicaid for September 1, 2017 through October 31, 2017.

You and your child are in a two-person household; you file your taxes with a tax filing status of single and claim your child as a dependent on your tax return.

An application for financial assistance was submitted on your and your child's behalf by a CAC on November 8, 2017 and requested help in paying for medical bills for the last 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 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 yourself and your child from September 1, 2017 to October 31, 2017 to cover medical bills.

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 September and October, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,868.00 per month. 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 and your account reflects that your income for the month of September was uploaded to your account on October 26, 2017. You testified that this was done with the assistance of your local Department of Social Services. Also on March 5, 2018, you faxed an hour and wage report for September and October showing a gross pay amount of $1,191.96 for September and $1,193.99 for October 2017.

Since the November 7, 2017 notice of eligibility determination found you were not eligible for Medicaid for October 1, 2017 to October 31, 2017, because the

program you were eligible for cannot pay for any care you received in the past, this notice is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage for September 2017 based on a household size of two people and household income of $1,191.96 and for October 2017 based on a household size of two people and household income of $1,193.99.

NYSOH issued an eligibility determination on February 13, 2018 stating that your child was ineligible for Medicaid for September 1, 2017 through October 31, 2017, because you failed to submit your child's Social Security number. Your account reflects that the birth certificates for your child was uploaded on your behalf by a CAC on December 18, 2017, however as of February 13, 2018, your child's Social Security number was not uploaded to your account.

Since, the February 13, 2018 notice of eligibility determination found that your child was not eligible for Medicaid for September 1, 2017 through October 31, 2017, because you failed to submit your child's Social Security number, this notice is AFFIRMED.

However, you testified that you received assistance with your application and submission of documents from a CAC. You testified that you believed all the required documentation was submitted. Your account reflects your child's birth certificate was uploaded by a CAC on December 18, 2017 however, your child's Social Security number was not included.

Therefore, your child's case is RETURNED to NYSOH so that you can resubmit your child's Social Security number and the NYSOH is to consider your request for retroactive Medicaid coverage for your child based on the updated income documentation listed above for September and October 2017.

Decision

The November 9, 2017 eligibility determination is RESCINDED.

The February 13, 2017 eligibility determination is AFFIRMED.

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage for yourself and your child for September and October 2017 based on a household size of two and household income of $1,196.96 and $1,193.99, respectively.

NYSOH is directed to reach out to you to assist you in updating your child's Social Security number.

Effective Date of this Decision: March 13, 2018

How this Decision Affects Your Eligibility

This is not a final determination of you and your child's eligibility. Your case is sent back to NYSOH to redetermine you and your child's eligibility for retroactive Medicaid based on the evidence you presented at the hearing. You will need to resubmit your child's Social Security number.

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 November 9, 2017 eligibility determination is RESCINDED.

The February 13, 2017 eligibility determination is AFFIRMED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for you and your child based on a household size of two people and household income of $1,196.96 for the month of September 2017 and $1,193.99 for the month of October 2017.

This is not a final determination of you and your child's eligibility. Your case is sent back to NYSOH to redetermine you and your child's eligibility based on the evidence presented at the hearing.

NYSOH is directed to reach out to you to assist you in updating your child's Social Security number.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

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 तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई नि:शुल्क 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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