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

Notice of Decision

Decision Date: April 21, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000013423

Dear ,

On February 23, 2017, appeared by telephone on your behalf as your authorized representative at a hearing on your appeal of NYS Department of Health's September 12, 2016 response to your request for retroactive Medicaid for the month of May 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: April 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013423

Issues

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

> Was your appeal of the NY State Department of Health's (NYSDOH) September 12, 2016 decision confirming NY State of Health's (NYSOH) May 25, 2016 eligibility determination timely?
>
> Did NYSDOH, on behalf of NYSOH, properly determine that you were not eligible for retroactive Medicaid during the month of May 2016?

Procedural History

On April 28, 2016, your NYSOH account was created.

On May 24, 2016, you updated your NYSOH account using the services of a certified application counselor (CAC).

On May 25, 2016, NYSOH issued an eligibility redetermination notice stating that you were eligible for the Essential Plan, effective July 1, 2016.

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Also on May 25, 2016, NYSOH issued an enrollment notice confirming your plan selection of May 24, 2016, stating that you were enrolled in an Essential Plan, and that your coverage in that plan would start July 1, 2016.

On June 24, 2016, your authorized representative, [redacted] submitted a request for retroactive Medicaid for the month of May 2016 directly to the NYSDOH via email to [redacted] utilizing the Retroactive Spreadsheet procedure.

On June 27, 2016, your authorized representative uploaded to your NYSOH account a letter from your employer regarding your total pay for the month of May 2016 (*see* Document [redacted]).

On September 12, 2016, NYSDOH, Office of Health Insurance Programs, Division of Eligibility and Marketplace Integration provided via the Retroactive Spreadsheet, a determination that the May 25, 2016, NYSOH eligibility redetermination notice was correct. That decision states;

> At the time of application, filled out by [redacted], it was asked that his income be considered on an annual basis. Based on that, the annual income was $17,680.00, making him EP eligible. The eligibility determination is correct.

On October 13, 2016, your authorized representative mailed a written request to NYSOH to appeal the September 12, 2016 NYSDOH denial of retroactive Medicaid for the month of May 2016.

On October 20, 2016, NYSOH Appeals Resolution Unit (ARU) spoke with your authorized representative. At that time, your authorized representative again requested an appeal of the denial of retroactive Medicaid for May 2016. Appeal AP000000012675 was established by NYSOH ARU (*see* Incident # [redacted].

Also on October 20, 2016, NYSOH ARU closed appeal AP000000012675 with the only explanation “filed in error” (*see* Incident #s [redacted] and [redacted].

On November 21, 2016, your authorized representative contacted NYSOH ARU to inquire about the status of the requested appeal on the denial of retroactive Medicaid for the month of May 2016. NYSOH ARU representative set up new appeal AP000000013423 (*see* Incident # [redacted]).

On December 6, 2016, NYSOH issued a Notice of Invalid Appeal Request stating your November 21, 2016 appeal was untimely because it was submitted more than 60 days after the date of your eligibility determination letter.

On January 3, 2017, your authorized representative submitted a letter to NYSOH in support of the appeal and requested that the Notice of Invalid Appeal Request be vacated.

On January 9, 2017, NYSOH issued a Notice of Dismissal-Failure to Submit a Valid Appeal Request.

On January 23, 2017, NYSOH vacated the Notice of Dismissal.

On January 27, 2017, NYSOH issued a Notice of Telephone Hearing for February 23, 2017 for appeal AP000000013423.

On February 23, 2017, [redacted] acting as your authorized representative, had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open until March 9, 2017 to allow your authorized representative time to submit documentation concerning the NYSDOH September 12, 2016 determination and the related documentation in support of your appeal.

On March 1, 2017, your authorized representative submitted to NYSOH Appeals Unit via secure facsimile, 31 pages of documents. Those documents included a four-page letter in support of the appeal together with documents marked as Exhibit's A through E. Those documents were made part of the record collectively as "Appellant's Exhibit 1." The record is now closed.

Findings of Fact

A review of the record supports the following findings of fact:

1) According to your NYSOH application, dated May 24, 2016, you will file your taxes as single and will claim no dependents.

2) According to your NYSOH application, your expected 2016 income was $17,680.00.

3) According to your NYSOH account, a letter dated June 15, 2016 from your employer was uploaded on June 27, 2016. That letter states that your gross payroll for May 2016 was $1,020.00. The letter stated the last day you worked was May 15, 2016 and you returned to work on June 4, 2016. (*see* Document [redacted]).

4) Your authorized representative testified that you were hospitalized on [redacted] and discharged that same day.

5) According to your NYSOH account, you were found eligible for the Essential Plan on May 25, 2016 and enrolled in a plan at that time with a start date of July 1, 2016.

6) According to your NYSOH account, on June 24, 2016, your authorized representative submitted directly to NYSDOH via email a request for retroactive Medicaid for the month of May 2016. (*see* Appellant's Exhibit # 1; Exhibit B).

7) On September 12, 2016, NYSDOH Office of Health Insurance Programs, Division of Eligibility and Marketplace Integration issued a determination via email to your authorized representative stating that the May 25, 2016 NYSOH eligibility determination notice finding you eligible for the Essential Plan based on an annual income of $17,680.00 was correct and denied your request for retroactive Medicaid for the month of May 2016.

8) According to your NYSOH account, your authorized representative filled a timely appeal to NYSOH of that September 12, 2016 NYSDOH decision by letter, dated October 13, 2016.

9) On October 20, 2016, NYSOH ARU initiated appeal AP000000012675. For unknown reasons, also on October 20, 2016, NYSOH ARU closed appeal AP000000012675.

10) According to your NYSOH account, on November 21, 2016, your authorized representative contacted NYSOH ARU regarding the status of appeal AP000000012675. At that time, a new appeal AP000000013423 was established on the issue of denial of retroactive Medicaid for May 2016.

11) According to your NYSOH account, appeal AP000000013423 was initially dismissed as untimely but then the dismissal was vacated by NYSOH and scheduled for a hearing on February 23, 2017.

12) You were initially found eligible for Essential Plan on May 25, 2016, effective July 1, 2016. Your authorized representative testified that you are seeking retroactive Medicaid coverage for the month of May 2016.

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 through NYSOH can be provided 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 federal poverty level (FPL) for the applicable family size (42 CFR §§ 435.119(b), 435.911(b)(1), 435.603(d)(4); N.Y. Soc. Serv. 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 2016 FPL, which is $11,880.00 for a one-person household (81 Fed. Reg. 4036).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of 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 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)).

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)).

Legal Analysis

The initial issue under review is whether your appeal of NYSDOH’s September 12, 2016 decision confirming NYSOH May 25, 2016 eligibility determination was timely.

The record reflects that on October 13, 2016, your authorized representative submitted to NYSOH a written request to appeal NYSDOH’s September 12, 2016 decision. On October 21, 2016, your authorized representative spoke with NYSOH ARU and requested appeal of NYS DOH’s denial of retroactive Medicaid for the month of May 2016. At that time, appeal AP000000012675 was established. Inexplicably, later that same day, NYSOH ARU closed appeal AP000000012675 with notation that it was set up in error. On November 21, 2016, your authorized representative contacted NYSOH ARU regarding status of the previously filed appeal. At that time, a new appeal AP000000013423 was established, with description of the appeal as denial of retroactive Medicaid coverage.

On December 6, 2016, NYSOH issued a Notice of Invalid Appeal Request stating your November 21, 2016 appeal was untimely because it was submitted more than 60 days after the date of your eligibility determination letter. This notice was based on the mistaken belief that you were appealing the May 25, 2016 NYSOH eligibility redetermination. This analysis did not consider the direct communications between your authorized representative and the NYSDOH and the resulting September 12, 2016 NYS DOH determination on NYSOH’s May 25, 2016 eligibility determination. Therefore, your authorized representative’s appeal filed October 13, 2016 was timely. The subsequent January 9, 2017 Notice of Dismissal – Failure to Submit a Valid Appeal Request issued by NYSOH was also in error and was correctly vacated by NYSOH.

Therefore, the appeal of NYS DOH’s September 12, 2016 decision confirming NYSOH’s May 25, 2016 eligibility redetermination was filed timely.

The second issue under review is whether NYSDOH, on behalf of NYSOH, properly determine that you were not eligible for retroactive Medicaid during the month of May 2016.

You are in a one-person household for purposes of this analysis because you file your taxes with a tax filing status of single and claim no dependents on your tax return.

You were initially found eligible for the Essential Plan in the May 25, 2016 NYSOH eligibility determination notice, effective July 1, 2016.

Your authorized representative testified that you are seeking to be found eligible for retroactive Medicaid for the month of May 2016.

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.

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 2016, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,366.20 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during May 2016.

Your authorized representative testified that you were hospitalized on [redacted] and discharged that same day. On June 27, 2016, your authorized representative uploaded to your NYSOH account a letter from your employer letter dated June 15, 2016 that stated that your gross payroll for May 2016 was $1,020.00. The letter stated the last day you worked was May 15, 2016 and you returned to work on June 4, 2016. (*see* Document [redacted]). For an individual, the monthly gross income limit to be eligible for Medicaid in 2016 was $1,366.20. Your gross wages for the month of May 2016 were $1,020.00, which is within the Medicaid limit for that month.

Therefore, your case is RETURNED to NYSOH to consider your request for retroactive coverage for the month of May 2016 based on a household size of one person with a monthly income of $1,020.00, for an individual living in [redacted] and to notify you accordingly.

Decision

The September 12, 2016, NYSDOH determination that you were not eligible for Medicaid for the month of May 2016 is RESCINDED.

Your case is RETURNED to NYSOH to determine your eligibility for Medicaid for a one-person household with a monthly income of $1,020.00 for the month of May 2016.

Effective Date of this Decision: April 21, 2017

How this Decision Affects Your Eligibility

Your eligibility for and enrollment in the Essential Plan is not changed by this decision and both remain effective July 1, 2016.

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).

This is not a final determination of your eligibility for retroactive Medicaid in the month of May 2016. Your case is sent back to NYSOH to redetermine your eligibility for the month of May 2016. NYSOH will notify you once your eligibility has been redetermined.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services. 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 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 September 12, 2016, NYSDOH determination that you were not eligible for Medicaid for the month of May 2016 is RESCINDED.

Your case is RETURNED to NYSOH to determine your eligibility for Medicaid for a one-person household with a monthly income of $1,020.00 for the month of May 2016.

Your eligibility for and enrollment in the Essential Plan is not changed by this decision and both remain effective July 1, 2016.

This is not a final determination of your eligibility for retroactive Medicaid in the month of May 2016. Your case is sent back to NYSOH to redetermine your eligibility for the month of May 2016. NYSOH will notify you once your eligibility has been redetermined.

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।

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).

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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