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

Notice of Decision

Decision Date: April 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013481

[redacted]

Dear [redacted],

On February 28, 2017, you and your authorized representative appeared by telephone at a hearing on your appeal of NY State of Health's July 13, 2016 eligibility determination notice.

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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Decision

Decision Date: April 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013481

[redacted]

Issues

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

> Was your appeal of the NY State of Health's (NYSOH) July 13, 2016 eligibility determination notice timely?
>
> Did NYSOH properly determine that you were not eligible for Medicaid for April 1, 2016 through April 30, 2016?

Procedural History

On March 24, 2016, NYSOH issued an eligibility redetermination notice stating that you were eligible for the Essential Plan effective May 1, 2016.

On March 29, 2016, NYSOH issued an enrollment confirmation notice, confirming your March 28, 2016 selection of an Essential Plan, with an enrollment start date of May 1, 2016.

On July 12, 2016, you submitted an updated application for financial assistance and indicated that you were seeking help paying for medical bills for April 2016.

On July 13, 2016, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid from April 1, 2016 through April 30, 2016 because the program you are eligible for cannot pay for any care you received in the past.

On November 22, 2016, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as you were denied retroactive Medicaid for the month of April 2016.

On February 28, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) According to your NYSOH account and your testimony, you file your income taxes as single and do not claim any dependents.

2) According to your NYSOH account and your testimony, you reside in [redacted], New York.

3) You testified that you are seeking Medicaid for the period of April 1, 2016 through April 30, 2016.

4) According to your NYSOH account, you were found eligible for the Essential Plan on March 23, 2016 and enrolled in a plan, effective May 1, 2016.

5) You testified that you required hospitalization and emergency surgery on [redacted]. You testified that you have over $10,000.00 in medical bills associated with that hospitalization that are unpaid.

6) According to your NYSOH account, on July 12, 2016, you submitted an updated application for financial assistance and requested help with paying medical bills for the three-month period prior to your application. Specifically, you asked for help with medical bills for the month of April 2016.

7) According to your NYSOH account, the July 12, 2016 eligibility redetermination used a system calculated monthly average income of $1,687.06. You testified that amount was incorrect for the month of April 2016.

8) You testified that you are paid $9.85 per hour and are paid weekly.

9) According to your NYSOH account, on July 14, 2016, July 28, 2016, and on August 18, 2016 you faxed various documents in regards to proof of income for the month of April 2016, which you testified

NYSOH told you were needed. These documents included four paystubs received in April 2016, as follows:

Pay date April 1, 2016 for a gross pay amount of $394.59;
Pay date April 8, 2016 for a gross pay amount of $392.03;
Pay date April 15, 2016 for a gross pay amount of $397.10;
Pay date April 22, 2016 for a gross pay amount of $152.87.

(*see* Documents [redacted], [redacted] and [redacted]).

10) You testified that you did not receive a pay check for April 29, 2016 because you were out of work from April 15, 2016 to May 2, 2016.

11) According to your NYSOH account and your testimony, after you submitted income documents showing your April 2016 income you contacted NYSOH customer service on August 25, 2016 and October 13, 2106, complaining about the July 13, 2016 denial of retroactive Medicaid for the month of April 2016 and on each occasion your complaint was closed without action.

12) You testified that you believed NYSOH was still reviewing your request for retroactive Medicaid for the month of April 2016 during this time frame.

13) According to your NYSOH account and your testimony, on November 22, 2016, you contacted NYSOH and were referred to the Account Review Unit. At that time, you requested an appeal of the July 13, 2016 eligibility determination denying your request for retroactive Medicaid for the month of April 2016.

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)).

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 July 12, 2016 application, that was the 2016 FPL, which is $11,880.00 for a one-person household (81 Fed. Reg. 4036).

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 they received the services if they 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 initial issue under review is whether your appeal of NYSOH's July 13, 2016 eligibility determination notice was timely.

The November 23, 2016 notice confirming your November 23, 2016 appeal states the reason for your appeal is "Other" and the description of your appeal is "Denial of Retroactive coverage".

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

For an appeal to have been valid on the issue of the denial of retroactive Medicaid coverage as stated in the July 13, 2016 eligibility determination, an appeal should have been filed by September 11, 2016. The record reflects that you filed your appeal on November 22, 2016, which is well beyond the 60-day deadline.

However, the record reflects and you testified that you submitted proof of income documents for the month of April 2016 on July 14, 2016, July 28, 2016, August 18, 2016, August 28, 2016 and September 22, 2016. Further, you spoke with NYSOH customer service representatives on August 25, 2016 and October 11, 2016 to complain about the denial of your request for retroactive Medicaid for the month of April 2016. According to your NYSOH account, on each occasion a complaint was filed, but then closed with no action. You credibly testified that you believed NYSOH was still reviewing your request for retroactive Medicaid for the month of April 2016. On November 22, 2016 when you contacted NYSOH to get another update on your complaints, you were referred to the Account Review Unit and filed an appeal at that time.

Since you initially complained about this issue on August 25, 2016, this would be within the 60-day period to file an appeal. Therefore, your appeal was filed timely.

The second issue under review is whether NYSOH properly determined that you were not eligible for Medicaid for April 1, 2016 through April 30, 2016.

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

You submitted an application for financial assistance on July 12, 2016 and requested help in paying for medical bills for the month of April 2016.

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 retroactive Medicaid coverage from April 1, 2016 to April 30, 2016.

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 April 2016, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,367.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during April 2016.

Therefore, this analysis turns to the financial criteria. You testified that you are paid weekly. You uploaded four paystubs for the month of April 2016 with a pay date of April 1, 2016 for a gross pay amount of $394.59; a pay date April 8, 2016 for a gross pay amount of $392.03; a pay date April 15, 2016 for a gross pay amount of $397.10; and a pay date April 22, 2016 for a gross pay amount of $152.87. You credibly testified that you did not receive a paycheck for April 29, 2016 because you were out of work from April 15, 2016 to May 2, 2016. due to your emergency surgery. Therefore, the total pay you received in the month of April 2016 was $1,336.59.

Since the July 13, 2016 eligibility determination notice incorrectly found you were not eligible for Medicaid for April 1, 2016 to April 30, 2016, because the program you were eligible for cannot pay for any care you received in the past, it is RESCINDED.

Since the record now contains a more accurate representation of what your income was for the month of April 2016, your case is RETURNED to NYSOH to consider your request for retroactive coverage for April 2016 based on a household size of one person and household income of $1,336.59 for the month of April 2016, and to notify you accordingly.

Decision

The July 13, 2016 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for April 2016 based on a household size of one person and household income of $1,336.59 for the month of April 2016, and to notify you accordingly.

Effective Date of this Decision: April 24, 2017

How this Decision Affects Your Eligibility

The plan enrollment start date of your Essential Plan remains as May 1, 2016.

Your case is being RETURNED to NYSOH to recalculate your eligibility for retroactive Medicaid coverage for April 2016 based on the evidence provided in this Decision. NYSOH will issue a separate notice regarding its determination.

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):

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).

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 July 13, 2016 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for April 2016 based on a household size of one person and household income of $1,336.59 for the month of April 2016, and to notify you accordingly.

The plan enrollment start date of your Essential Plan remains as May 1, 2016.

Your case is being RETURNED to NYSOH to recalculate your eligibility for retroactive Medicaid coverage for April 2016 based on the evidence provided in this Decision. NYSOH will issue a separate notice regarding its determination.

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 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.

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