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

Notice of Decision

Decision Date: May 9, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013785

[redacted]

Dear [redacted],

On February 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's May 1, 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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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).

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

Decision

Decision Date: May 9, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013785

[redacted]

Issues

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

> Was your appeal of the May 1, 2016 notice denying your oldest child retroactive Medicaid coverage from January 1, 2016 to March 31, 2016, timely?
>
> Did NY State of Health (NYSOH) properly determine your oldest child was not eligible for retroactive Medicaid coverage from January 1, 2016 to March 31, 2016?

Procedural History

On April 30, 2016, NYSOH received your updated application for financial assistance with health insurance indicating you were seeking help paying for medical bills for your oldest child (child) for the three months prior to the application.

On May 1, 2016, NYSOH issued an eligibility determination notice stating your child was eligible to receive advance payments of the premium tax credit (APTC), effective June 1, 2016.

Also on May 1, 2016, NYSOH issued a notice denying your request for help paying for your child's medical bills for the three-month period prior to the April 30, 2016 application, because the program she was eligible for could not pay for any care she received in the past.

On May 25, 2016, NYSOH received your updated application for financial assistance with health insurance indicating you were seeking help paying for medical bills for your child for the three months prior to the application.

On May 26, 2016, NYSOH issued a notice denying your request for help paying for your child's medical bills for the three-month period prior to the May 25, 2016 application, because the program she was eligible for could not pay for any care she received in the past.

On July 5, 2016, NYSOH received your updated application for financial assistance with health insurance indicating you were seeking help paying for medical bills for your child for the three months prior to the application.

On July 12, 2016, NYSOH issued an eligibility determination notice stating your child was eligible for Medicaid, effective August 1, 2016.

Also on July 12, 2016, NYSOH issued a notice stating additional information was required to determine whether your child was eligible for retroactive Medicaid coverage for the three-month period of April 1, 2016 to June 30, 2016. The notice directed you to submit proof of your household's income for that time-period by July 26, 2016.

On July 13, 2016, NYSOH issued an enrollment confirmation notice stating your child was enrolled in a Medicaid Managed Care plan, effective August 1, 2016.

On September 6, 2016, NYSOH received your updated application for financial assistance with health insurance indicating you were seeking help paying for medical bills for your child for May and June 2016.

On September 7, 2016, NYSOH issued a notice stating your child was eligible for retroactive Medicaid coverage for the period of May 1, 2016 to June 30, 2016, because your monthly household income of $0.00 was below the allowable monthly income limit.

On September 14, 2016, NYSOH issued a notice stating your child was eligible for retroactive Medicaid coverage for the period of July 1, 2016 to July 31, 2016, because your monthly household income of $0.00 was below the allowable monthly income limit.

On December 5, 2016, you spoke to NYSOH's Account Review Unit and appealed insofar as your child was not eligible for Medicaid coverage for the months of January, February, and March 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 held open to allow you to submit supporting documents.

On February 28, 2017, NYSOH received the requested documentation and it was incorporated into the record as Appellant's Exhibit #1, the record closed thereafter.

Findings of Fact

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

1) You testified that you are seeking retroactive Medicaid coverage for your child from January 1, 2016 to March 31, 2016.

2) Your account confirms your child was covered by your family's qualified health plan until she was disenrolled, effective October 31, 2015.

3) You testified your child began attending college in September of 2014 and that she received health coverage through an insurance plan issued by her school.

4) Your account indicates you updated your application on October 14, 2015, indicating your child no longer needed health insurance. As a result, her coverage through your qualified health plan was terminated on October 31, 2015. You testified this was inadvertent as you only intended to report her health coverage through her school and designate that policy as her primary insurance policy.

5) You testified your child has outstanding medical bills for the months of January 2016 to March 2016 that third-party health insurance policy is not covering.

6) You submitted an updated application for financial assistance on April 30, 2016 requesting assistance paying for medical bills for the previous three months for your child.

7) You testified, and the application indicates, that you would file your 2016 federal income tax return as married filing jointly and claim two dependents on that return.

8) Your account indicates that NYSOH calculated that for the months of January, February, and March 2016 your income was $1,666.67 in each month. Additionally, that application stated that your spouse's income for the months of January, February and March 2016 was $2,514.50 in each of those months. You testified this information is not correct and you do not know where it came from.

9) NYSOH denied your request to pay for your child's medical bills for the three months prior to the April 30, 2016 application because the program she was eligible for could not pay for any care she received in the past

10) You testified you were advised by a NYSOH representative that a glitch in your account was causing the application to indicate a monthly household income of $10,000.00 for the month of May which was the reason your child was denied retroactive Medicaid coverage.

11) Notes in your account confirm NYSOH identified a defect in your account on May 24, 2016 persisting to September 2016 concerning an inability to populate appropriate fields in the application pertaining to retroactive coverage.

12) You testified both you and your spouse are self-employed and you both earn income erratically and it is difficult to predict how much household income you will have.

13) You testified you and your spouse both made significantly less money in 2016 as you did in 2015 so your 2015 tax return was not sufficient evidence of your household's income in 2016.

14) On May 6, 2016, after the denial of your request for retroactive coverage was issued, you sent a letter to NYSOH asking for assistance in paying for your daughter's medical bills.

15) You uploaded many documents in May 2016 including bank statements and transaction reports showing transfers and deposits made to you and your spouse in January, February and March 2016. You also uploaded various bills, statements, and transaction reports purporting to be business expenses paid and/ or owed by you and your spouse.

16) On May 26, 2016, you uploaded a document you testified you created, listing income and business expenses for you for the months of January, February, and March 2016 [redacted].

17) Also on May 26, 2016, you uploaded a document you testified you created, listing income and business expenses for your spouse for the months of January, February, and March 2016 [redacted].

18) Additionally, on February 28, 2017, you uploaded spread sheets titled "Profit and Loss Standard" for the months of January, February, and March 2016. You testified these documents showed your total income for those months [redacted],

[redacted]. You also uploaded spread sheets you testified evidenced your spouse's total income during the same time frame [redacted]. According to these documents:

a. In the month of January 2016, you and your spouse had $20,187.56 in combined income and $14,979.05 in combined expenses for a net monthly household income of $5,208.51.

b. In the month of February 2016, you and your spouse had $23,707.30 in combined income and $17,946.00 in combined expenses for a net monthly household income of $5,761.30.

c. In the month of March 2016, you and your spouse had $450.00 in combined income and $17,878.58 in combined expenses for a net monthly household income of -$17,428.00.

19) Your child was determined eligible for Medicaid, effective August 1, 2016. Later she was determined eligible for retroactive Medicaid coverage for the period of May 1, 2016 to July 31, 2016.

20) You testified your child has outstanding medical bills from the months of January, February and March 2016.

21) You testified you are seeking retroactive Medicaid coverage for your child for the period of January 1, 2016 to March 31, 2016.

22) According to your NYSOH account, your oldest child is [redacted]. She was [redacted] at the time of the April 30, 2016 updated application.

23) On August 23, 2016, you contacted NYSOH and complaint [redacted] was generated pertaining to your request to backdate your child's Medicaid coverage for January, February and March 2016. Your request was denied by NYSOH on December 5, 2016.

24) A formal appeal was filed on your behalf on December 5, 2016.

25) On April 24, 2017, you uploaded a copy of your 2016 tax return, which indicated your household adjusted gross income was $6,455.00.

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 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 federal poverty level 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 2016 FPL, which is $24,300 for a four-person household (81 Federal Register 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 he received the services if he had applied (42 USCA § 1396A(34); 42 CFR § 435.915(a)). It is not necessary for the person to be found eligible for Medicaid going forward for the individual to be eligible for retroactive Medicaid. 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 is whether your appeal of the May 1, 2016 notice denying your oldest child (child) retroactive Medicaid coverage from January 1, 2016 to March 31, 2016 was timely.

You submitted an updated application for financial assistance on April 30, 2016 and requested help paying for medical bills for your child for the months of January, February, and March 2016. On May 1, 2016, NYSOH issued a notice

denying your request for help paying for your child's medical bills for the three-month period prior to the April 30, 2016 application, because the program she was eligible for could not pay for any care she received in the past. You have appealed this denial.

Pursuant to the above cited regulations, individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of NYSOH's denial of your request for retroactive Medicaid coverage for your child for the months of January, February, and March 2016, as stated in the May 1, 2016 notice, an appeal should have been filed by June 30, 2016.

On May 6, 2016, after the denial of your request for retroactive coverage was issued, you sent a letter to NYSOH asking for assistance in paying for your daughter's medical bills. The Appeals Unit of NYSOH finds that this was clearly intended to be an appeal of the denial of retroactive medical benefits.

Further, you submitted updated applications on May 25, 2016, July 5, 2016, and July 13, 2016, each requesting retroactive coverage for your child.

Accordingly, it is concluded that your appeal of the denial of retroactive benefits was timely.

The second issue under review is whether NYSOH properly determined your child was not eligible for retroactive Medicaid coverage from January 1, 2016 to March 31, 2016.

You are in a four-person household; you file your taxes with a tax filing status of married filing jointly and you will claim two dependents on your tax return.

As discussed above, you submitted an updated application for financial assistance on April 30, 2016 and requested help in paying for medical bills for your child for the months of January, February, and March 2016. On May 1, 2105, NYSOH issued a notice denying your request for help paying for your child's medical bills for the three-month period prior to the April 30, 2016 application, because the program she was eligible for could not pay for any care she received in the past.

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 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.

Therefore, the May 1, 2016 notice of eligibility determination that stated your child was not eligible for retroactive Medicaid benefits, because the program you were eligible for could not pay for any care she received in the past, was incorrect on that point and may be rescinded on that basis alone.

However, to also review the May 1, 2016 notice on a substantive basis, Medicaid coverage can be made effective retroactively for up to three months prior to an application if the individual received medical services that would have been covered under Medicaid and if the individual would have been eligible for Medicaid in those three months had he or she 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 January, February, and March 2016 your child would have needed to meet the non-financial criteria and have a household income no greater than 138% of the FPL, which is $2,795.00 per month. (There is no indication in the record that your child would have been ineligible for Medicaid based on non-financial criteria during any of the relevant months.)

Although NYSOH calculated that for the months of January, February, and March 2016 your income was $1,666.67 in each month and your spouse's income was $2,514.50 in each of those months, you testified this information was not correct and you do not know where it came from.

Notes in your account confirm NYSOH identified a defect in your account on May 24, 2016 persisting to September 2016 concerning an inability to appropriately populate fields in the application pertaining to retroactive coverage.

You testified that both you and your spouse are self-employed and you both earn income erratically and it is difficult to predict how much household income you will have. You further testified that you and your spouse both made significantly less money in 2016 than you did in 2015 so your 2015 tax return was not sufficient evidence of your household's income in 2016.

As evidence of your household's income, in May 2016 you uploaded many documents to your NYSOH account including bank statements and transaction reports showing transfers and deposits made to you and your spouse in January, February and March 2016. You also uploaded various bills, statements, and transaction reports purporting to be business expenses paid and/or owed by you and your spouse.

On February 28, 2017, you also uploaded several spreadsheets you testified showed the income earned and business expenses paid by you and your spouse in the months of January, February, and March 2016. According to these documents, your monthly household income for January 2016 was $5,208.51; for February 2016 it was $5,761.30; and in March 2016 the spreadsheets indicated

the income you and your spouse earned in that month was exceeded by the expenses paid resulting in a negative income for that month.

It is also noted that on April 24, 2017, you uploaded a copy of your 2016 tax return, which indicated your household annual adjusted gross income was $6,455.00.

Given the totality of the evidence including the documentation of income previously submitted corroborating the income amounts listed on the spreadsheets, it is concluded the spreadsheets submitted on February 28, 2016 are sufficient evidence of your household's income in the months of January, February, and March 2016, and the Appeals Unit finds that the denial of your request for retroactive Medicaid benefits must be RESCINDED.

Because the record now contains a more accurate representation of what your household's income was for the months of January, February, and March 2016, your case is RETURNED to NYSOH to consider your request for retroactive coverage for your child for the months of January, February, and March 2016 based on a household size of four people and a monthly household income of $5,208.51 in January 2016, $5,761.30 in February 2016, and $0.00 in March 2016.

Decision

Your appeal of the May 1, 2016 eligibility determination denying your request for retroactive Medicaid coverage for your oldest child for the months of January, February, and March 2016 was timely.

The May 1, 2016 eligibility determination stating your child was not eligible for retroactive Medicaid coverage from January 1, 2016 to March 31, 2016 is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for your child for the months of January, February, and March 2016 based on a household size of four people and a monthly household income of $5,208.51 in January 2016, $5,761.30 in February 2016, and $0.00 in March 2016.

Effective Date of this Decision: May 9, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your child's eligibility. Your case is being sent back to NYSOH to redetermine your child's eligibility for retroactive Medicaid coverage for the months of January, February, and March 2016 based on the record as developed 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 of the May 1, 2016 eligibility determination denying your request for retroactive Medicaid coverage for your oldest child for the months of January, February, and March 2016 is timely.

The May 1, 2016 eligibility determination stating your child was not eligible for retroactive Medicaid coverage from January 1, 2016 to March 31, 2016 is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for your child for the months of January, February, and March 2016 based on a household size of four people and a monthly household income of $5,208.51 in January 2016, $5,761.30 in February 2016, and $0.00 in March 2016.

This is not a final determination of your child's eligibility. Your case is being sent back to NYSOH to redetermine your child's eligibility for retroactive Medicaid coverage for the months of January, February, and March 2016 based on the record as developed 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:

[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।

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.

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.

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).