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

Notice of Decision

Decision Date: June 01, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013865

[redacted]

[redacted]

Dear [redacted],

On May 10, 2017, your authorized representative appeared by telephone on your behalf at a hearing on your appeal of a January 14, 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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DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: June 01, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013865

[redacted]

[redacted]

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 6, 2016 decision confirming NY State of Health's (NYSOH) January 14, 2016 eligibility determination timely?
>
> Did NYSOH properly determine that your spouse was not eligible for retroactive Medicaid during the month of December, 2015?

Procedural History

On January 13, 2016, you updated your NYSOH account using the services of a certified application counselor (CAC).

On January 14, 2016, an eligibility determination notice was issued finding you and your spouse eligible to enroll in the Essential Plan effective February 1, 2016. The notice stated your spouse had requested help with paying medical bills for the three-month period prior to your application.

On January 14, 2016, NYSOH issued an enrollment notice stating you and your spouse were enrolled in the Essential Plan 2, starting January 1, 2016

On January 14, 2016, NYSOH issued an eligibility determination notice stating that your spouse was not eligible for Medicaid for December 1, 2015 through December 31, 2015 because the program she was eligible for cannot pay for any care you received in the past.

On March 31, 2016, your authorized representative submitted a request for retroactive Medicaid for the month of December 2015 directly to NYSDOH.

Also on March 31, 2016, your authorized representative uploaded income verification documentation in the form of 3 months earnings and expenses from your personal business (see Appellant's Exhibit 1).

On August 25, 2016, a NYSDOH representative provided an e-mail response that your request for retroactive Medicaid for the month of December 2015 was denied because "Consumer is not eligible for retroactive coverage for the month of December 2015. She is currently EP eligible and that program cannot pay for any care received in the past. The consumer was sent a system generated notice on January 14, 2016 stating this [redacted])."

On September 6, 2016, in response to an e-mail from your authorized representative for more information on why there was a denial of your request, a NYSDOH representative responded that you were determined ineligible for retroactive Medicaid.

On November 2, 2016, your authorized representative mailed a written request to NYSOH to appeal the September 6, 2016 NYSDOH denial of retroactive Medicaid for the month of December, 2015.

On December 7, 2016, your authorized representative spoke to NYSOH's Account Review Unit and appealed insofar as it denied retroactive Medicaid for your spouse for the month of December 2015.

On December 20, 2016, NYSOH issued a Notice of Invalid Appeal Request stating your December 7, 2016 appeal was untimely because it was submitted more than 60 days after the date of your eligibility determination letter.

On February 22, 2017, your authorized representative submitted a letter to NYSOH and requested that the Notice of Dismissal be vacated. (See Documents [redacted], [redacted]).

On March 3, 2017, your authorized representatives request to vacate the dismissal was approved.

On May 10, 2017, [redacted] acting as your authorized representative appeared at a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing held open 15 days to allow her to submit supporting documents.

On May 18, 2017, NYSOH received the requested documentation and it was incorporated into the record as Appellant's Exhibit #2, the record was closed that day.

Findings of Fact

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

1) Your authorized representative testified that you are seeking Medicaid for your spouse from December 1, 2015 to December 30, 2015.

2) You submitted an application for financial assistance on January 13, 2016.

3) Your January 13, 2016 application attested to the fact you expect to file your 2016 federal income tax return as married filing jointly with your spouse, and will claim three dependents on that return.

4) Your application on January 13, 2016, stated your annual household income for 2016 was going to be $39,996.00.

5) You and your spouse were determined eligible for the Essential Plan 2 effective February 1, 2016.

6) Your January 13, 2016 application requested help paying for medical bills for your spouse for the three-month period prior to your application.

7) Your authorized representative provided documentation on March 31, 2016, showing your monthly income for the month of December 2015 was $ (-789.11). (See Appellant's Exhibit 1, pg. 1).

8) Your authorized representative in response to the Hearing Officer's request provided documentation stating you own your own [redacted] business and are the sole shareholder. Your tax filing status for your business is an S-Corporation which you are the sole shareholder of. See Appellant's Exhibit 2, pg. 3).

9) The record supports you reside in Suffolk County, NY.

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

Applicable Law and Regulations

Valid and Timely 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 application, that was the 2015 FPL, which was $28,410.00 for a five-person household (80 Fed. Reg. 3236, 3237).

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 first issue under review is whether your appeal of the NYSDOH September 6, 2016 decision confirming NYSOH's January 14, 2016 eligibility determination was timely.

On January 14, 2016, NYSOH issued an eligibility determination notice stating that your spouse was not eligible for Medicaid for December 1, 2015 through December 31, 2015 because the program she was eligible for cannot pay for any care you received in the past.

On March 31, 2016, your authorized representative, submitted a request for retroactive Medicaid for the month of December 2015 directly to NYSDOH. Income documentation was further uploaded that day to support you request.

On August 25, 2016, a NYSDOH representative provided a response that your request for retroactive Medicaid for the month of December 2015 was denied because "Consumer is not eligible for retroactive coverage for the month of December 2015. She is currently EP eligible and that program cannot pay for any care received in the past. The consumer was sent a system generated notice on January 14, 2016 stating this."

On September 6, 2016, your authorized representative inquired as to why there was a denial of your request, to which a NYSDOH representative responded again that you were determined ineligible for retroactive Medicaid.

On November 2, 2016, your authorized representative mailed a written request to NYSOH to appeal the September 6, 2016 NYSDOH denial of retroactive Medicaid for the month of December, 2015.

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

Since your authorized representative requested an appeal of the September 6, 2016 written communication with NYSDOH on November 2, 2016, or 57 days from that date, it was filed timely.

Therefore, the appeal of NYSDOH's September 6, 2016 decision confirming NYSOH's January 14, 2016 eligibility determination was filed timely.

The second issue under review is whether NYSOH properly determined that your spouse was not eligible for retroactive Medicaid during the month of December, 2015.

Your spouse is in a five-person household; she files her income tax return with a tax filing status of married filing jointly and claims 3 dependents on that tax return.

On January 13, 2016, you submitted an application for financial assistance on behalf of your spouse and requested help in paying for medical bills for December 1, 2015 through December 30, 2015.

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.

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 December, 2015, your spouse would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $3,268.00 per month for a five-person household. There is no indication in the record that your spouse would have been ineligible for Medicaid based on non-financial criteria during December 2015.

Your authorized representative provided documentation on March 31, 2016, showing your household's monthly income for the month of December 2015 was $ (-789.11). (See Appellant's Exhibit 1, pg. 1).

Since your household's income of $ (-789.11) was less than the $3,268.00 monthly Medicaid limit for December, 2015, NYSOH incorrectly determined that your spouse was not eligible for Medicaid coverage during that month based upon the fact that she was determined eligible for the Essential Plan effective February 1, 2016.

Therefore, the January 14, 2016 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your spouse's eligibility for retroactive Medicaid coverage for December, 2015 based on a household size of five people and household monthly income of $ (-789.11).

Decision

The January 14, 2016 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your spouse's eligibility for retroactive Medicaid coverage for December, 2015 based on a household size of five people and household monthly income of $ (-789.11).

Effective Date of this Decision: June 01, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your spouse's eligibility. Your case is being sent back to NYSOH to redetermine your spouse's eligibility for retroactive Medicaid for the month of December 2015.

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:

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).

- 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 January 14, 2016 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your spouse's eligibility for retroactive Medicaid coverage for December, 2015 based on a household size of five people and household monthly income of $ (-789.11).

This is not a final determination of your spouse's eligibility. Your case is being sent back to NYSOH to redetermine your spouse's eligibility for retroactive Medicaid for the month of December 2015.

Legal Authority

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).

We are issuing this determination in accordance with 45 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).

A Copy of this Decision Has Been Provided To:

[redacted]

[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.

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).

□□□□□ (Bengali)

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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 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.

(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)

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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.

(Yiddish) אידיש

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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