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

Notice of Decision

Decision Date: August 1, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014542

[redacted]

Dear [redacted]

On July 12, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's denial of your request for retroactive Medicaid for the months of September 2014 and October 2014.

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 Date: August 1, 2017

NY State of Health Account ID: [redacted]
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Issue

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

> Was your appeal of the NY State of Health's denial of your request for retroactive Medicaid for September 2014 and October 2014 timely?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid for September 1, 2014 through October 31, 2014?

Procedural History

On November 20, 2014, NY State of Health (NYSOH) received your application for financial assistance with health insurance and indicated that you were seeking help with paying for medical bills from the past three months.

On December 5, 2014, NYSOH issued a notice of eligibility determination stating that you were eligible for advanced premium tax credits of up to $322.00 per month, and cost-sharing reductions if you enrolled in a silver-level qualified health plan, for a limited time, effective January 1, 2015. This notice also directed you to submit proof of your citizenship by February 20, 2015.

On January 3, 2017, you spoke to NYSOH's Account Review Unit and filed an appeal, insofar as you had not been granted retroactive Medicaid coverage for September 2014 and October 2014.

On February 15, 2017, NYSOH issued a notice stating that the telephone hearing you requested as scheduled for March 14, 2017 at 2:00 p.m. However, this telephone hearing was postponed due to extreme weather.

On May 3, 2017, you were scheduled for a telephone hearing with a Hearing Office from the NYSOH's Appeals Unit. The Hearing Officer placed three phone calls to the number you provided NYSOH and was unable to reach you; therefore, your hearing was dismissed as a failure to appear.

On May 18, 2017, you submitted documentation requesting that the dismissal be vacated; which was granted.

On July 12, 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 until July 27, 2017 to allow you time to submit supporting documentation.

On July 21, 2017, NYSOH received documentation from you and it was incorporated into the record as "Appellant's Exhibit #1". The record was left open until July 27, 2017 to allow you time to submit additional income documentation.

As of July 27, 2017, the Appeals Unit did not receive any additional documents from you and none were viewable in your NYSOH account. Therefore, the record was closed the same day and the decision is based on the record as developed at the hearing and includes the income documentation that was received on July 21, 2017.

Findings of Fact

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

1) You testified that you are seeking Medicaid from September 1, 2014 to October 31, 2014.

2) You testified that you filed your 2014 federal income tax return as single, and claimed no dependents on that tax return.

3) The record indicates that you submitted an application for financial assistance on November 20, 2014.

4) Your application submitted on November 20, 2014, states that your expected annual income for 2014 was $16,640.00. You testified that amount sounded correct.

5) You testified that in 2014 you were paid bi-weekly.

6) You testified that in 2014 your income varied because you only worked part-time and only got paid for the hours that you worked.

7) You faxed a paystub dated September 30, 2014 for a gross pay amount of $285.27, a paystub dated October 15, 2014 for a gross pay amount of $1,189.98, and a paystub dated October 30, 2014 for a gross pay amount of $925.54.

8) The record only contains two weeks' worth of pay for the month of September 2014 and there is no indication in the record that you only worked for two weeks.

9) You testified that you did not take any deductions on your 2014 tax return.

10) You testified that you did not file an appeal until January 2017 because you were unsure as to what the process was, and you kept being informed by the NYSOH representatives that your Medicaid coverage would be backdated, so you thought this meant that you would have coverage for September 2014 and October 2014.

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)).

De Novo Review

NYSOH Appeals Unit must review each appeal de novo and "consider all relevant facts and evidence adduced during the appeals process" (45 CFR § 155.535(f)). "De novo review means a review of an appeal without deference to prior decisions in the case" (45 CFR § 155.500).

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)).

A person who meets certain nonfinancial criteria and has a household income that is at or below the applicable Medicaid income standard is eligible for Medicaid benefits (45 CFR § 155.305(c)). One of the non-financial criteria for Medicaid eligibility is the immigration status of the person applying for health insurance. Generally, no person except a United States citizen, naturalized citizen, qualified alien, or person permanently residing in the United States under color of law (PRUCOL) is eligible for full Medicaid benefits (NY Soc. Serv. Law § 122(1); 18 NYCRR § 360-3.2).

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 2014 FPL, which is $11,670.00 for a one-person household (79 Fed. Reg. 3593, 3593).

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 initial issue under review is whether your appeal of NYSOH's denial of retroactive Medicaid for September 2014 and October 2014 was timely.

The record reflects that you submitted an application for financial assistance with health insurance on November 20, 2014, and requested assistance with the past three months of medical bills. On January 6, 2017, the record indicates that you filed a formal complaint about being denied retroactive Medicaid for September 2014 and October 2014.

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 whether you were eligible for retroactive Medicaid for the month of September 2014 and October 2014, an appeal should have been filed on or around February 3, 2015. The record reflects that your appeal was filed on January 6, 2017, which is well beyond the 60-day deadline.

However, the record reflects that NYSOH never issued an eligibility determination notice regarding your eligibility for retroactive Medicaid for September 2014 and October 2014. You credibly testified that you were not sure how the process works, and that you kept being told that your coverage could be backdated by NYSOH representatives and you through this meant that you would have coverage for September 2014 and October 2014.

It is reasonable to infer that you filed your appeal within a reasonably short time of learning that you had been denied retroactive Medicaid for the months of September 2014 and October 2014. Therefore, your appeal was timely filed.

The second issue under review is whether NYSOH properly determined that you were not eligible for Medicaid for September 2014 and October 2014.

You testified that you are appealing the denial of a retroactive Medicaid for September 2014 to October 2014. However, the record does not contain a notice of eligibility determination or redetermination on the issue of retroactive coverage for September 2014 or October 2014.

Here, the lack of a notice of eligibility determination on the issue of retroactive Medicaid coverage for September 2014 and October 2014 does not prevent the Appeals Unit from reaching the merits of the case or constitute material error. Under 45 CFR § 155.505(b), you are as entitled to appeal NYSOH failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination.

Your credible testimony along with the January 7, 2017 appeal confirmation notice stating that the reason for your appeal was “eligibility determination”, permits an inference that NYSOH did deny your request for retroactive Medicaid coverage in September 2014 and October 2014.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to the eligibility determination notice had it been issued.

The financial criteria for Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the federal poverty level (FPL) for the applicable family size.

Your application states, and you confirmed that in September 2014 and October 2014, you were in a one-person household; you filed your 2014 taxes with a tax filing status of single and claimed no dependents on your tax return.

You submitted an application for financial assistance on November 20, 2014 and requested help with paying for medical bills from the past 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 from September 1, 2014 to October 31, 2014.

To be eligible for Medicaid in September 2014 and October 2014, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL for 2014, which was $1,343.00 per month.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

You testified that you were paid bi-weekly, and that your income varied depending on how many hours you are scheduled for during the month. You further testified that you only worked part time.

You faxed a paystub dated September 30, 2014 for a gross pay amount of $285.27. However, you testified that you are paid biweekly and you only submitted one paystub for September 2014. There is also no indication in the

record that you only worked for two weeks in September 2014.Therefore, the documentation you submitted is not sufficient to calculate the amount of gross income you made in the month of September 2014.

As such, NYSOH Appeals Unit is unable to determine whether you were eligible for Medicaid in the month of September 2014.

You also faxed a paystub dated October 15, 2014 for a gross pay amount of $1,189.98, and a paystub dated October 30, 2014 for a gross pay amount of $925.54. Therefore, the record indicates that in the month of October 2014, you had a monthly household income of $2,115.52.

To be eligible for Medicaid for the month of October 2014, you would have to meet the non-financial criteria and have an income no greater than 138% of the 2014 FPL, which was $1,343.00 per month. Since you submitted income documentation that shows that your monthly income in October 2014 was $2,115.52, you do not qualify for Medicaid based on your monthly income in October 2014.

Decision

The record contains insufficient documentation to determine whether you were eligible for Medicaid for the month of September 2014.

You are not eligible for Medicaid for the month of October 2014.

Effective Date of this Decision: August 1, 2017

How this Decision Affects Your Eligibility

You are not eligible for Medicaid for the month of October 2014.

The record does not contain enough information to determine whether you were eligible for Medicaid for the month of September 2014.

The Notice of Dismissal issued May 5, 2017 is superseded by this Decision

This Decision has no effect on any subsequent eligibility determinations made by NYSOH.

If You Disagree with this Decision (Appeal Rights)

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 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

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- By fax: 1-855-900-5557

Summary

The record contains insufficient documentation to determine whether you were eligible for Medicaid for the month of September 2014.

You are not eligible for Medicaid for the month of October 2014.

The Notice of Dismissal issued May 5, 2017 is superseded by this Decision.

This Decision has no effect on any subsequent eligibility determinations made by NYSOH.

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)

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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।

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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