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

Notice of Decision

Decision Date: September 5, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018215

[redacted]

Dear [redacted],

On August 3, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 21, 2017 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
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Decision

Decision Date: September 5, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018215

[redacted]

Issue

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

> Did NY State of Health (NYSOH) properly determine that you were not eligible for Medicaid from December 1, 2016 through December 31, 2016?

Procedural History

On October 9, 2016, NYSOH issued a renewal notice stating that, it did not have enough information from state and federal data sources to determine if you can get help paying for your insurance or what coverage you can have next year. The notice instructed you to return to your account between October 16, 2016 and November 15, 2016 to complete your renewal and, if you miss this deadline, the financial assistance you were currently getting might end.

No updates were made to your NYSOH account by November 15, 2016.

On November 17, 2016, NYSOH issued an eligibility determination notice stating that, effective December 1, 2016, you were not eligible for financial assistance through any of the insurance affordability programs and could not purchase a qualified health plan at full cost through NYSOH because you did not respond to the renewal notice and did not complete your renewal within the required timeframe.

On November 23, 2016, NYSOH issued a disenrollment notice stating that your coverage in your Medicaid Managed Care plan would end November 30, 2016,

because you were no longer eligible to enroll in health insurance through NYSOH.

On November 30, 2016, NYSOH issued an eligibility determination notice, based on your November 29, 2016 updated application, stating that you were eligible to enroll in the Essential Plan for a limited time, effective January 1, 2017. The notice also instructed you to submit additional information in the form of proof of income by February 27, 2017 and, if you missed the due date, you might lose your coverage in the Essential Plan.

Also on November 30, 2016, NYSOH issued a plan enrollment notice confirming your Essential Plan selection with no monthly premium and a start date of January 1, 2017.

On March 1, 2017, NYSOH issued an eligibility determination notice, based on your February 28, 2017 updated account, stating that you were eligible to receive up to $208.00 per month in advance payments of the premium tax credit (APTC) and eligible for cots sharing reductions if you enrolled in a silver-level qualified health plan, effective April 1, 2017.

Also on March 1, 2017, NYSOH issued a disenrollment notice stating that your Essential Plan coverage would end on March 31, 2017, because you were no longer eligible to enroll in that plan.

On March 21, 2017 NYSOH issued a plan enrollment notice confirming your March 20, 2017 selection of a platinum-level qualified health plan, with an enrollment start date of May 1, 2017.

On April 20, 2017, you spoke to NYSOH's Account Review Unit and appealed NYSOH's denial of backdate of coverage for December 2016.

On April 21, 2017, NYSOH issued an eligibility determination notice, based on your April 20, 2017 updated application, stating that you were eligible for Medicaid, effective April 1, 2017, and no longer qualified for APTC and cost sharing reductions as of March 31, 2017.

Also on April 21, 2017, NYSOH issued a plan enrollment notice confirming you were enrolled in a Medicaid Managed Care plan, effective June 1, 2017.

On August 3, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing held open to August 18, 2017, to allow you to submit supporting documents.

On August 16, 2017, NYSOH received the requested documentation and it was made part of the record as "Appellant's Exhibit A." The record was closed that same day.

Findings of Fact

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

1) You testified that you are seeking Medicaid from December 1, 2016 through December 31, 2016, because you incurred medical and hospital bills that month.

2) According to your NYSOH account, you submitted applications dated November 29, 2016, February 28, 2017 and April 20, 2017, but did not request help with medical bills for the three months prior to any of those applications.

3) You last submitted an updated application for financial assistance on April 20, 2017, and testified that you verbally requested retroactive Medicaid for the month of December 2016.

4) According to the April 21, 2017 appeal acknowledgement notice, you are appealing NYSOH's denial of backdating coverage for you; specifically, for Medicaid coverage retroactively for December 2016.

5) You testified that you expect to file your 2017 federal income tax return as single, and will claim one dependent on that tax return.

6) You faxed to NYSOH Appeals Unit your paystubs, dated December 2, 2016, showing gross pay of $1,150.08; December 9, 2016, showing gross pay of $697.06; December 16, 2016, showing gross pay of $490.75; December 23, 2016, showing gross pay of $110.17; and December 30, 2016, showing gross pay of $256.39 (see Appellant's Exhibit A).

7) Your gross pay received in December 2016 equals $2,715.35 (*id.*).

8) According to your NYSOH account, you do not plan on taking any deductions on your tax returns.

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

Applicable Law and Regulations

Timely Appeal

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

The Marketplace 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)).

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). In December 2016, that was the 2016 FPL, which is $11,880.00 for a one-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)). 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

Initially, it is noted that for an appeal to be valid on the issue of denial of retroactive Medicaid, an appeal should be filed within 60 days. According to the credible evidence in the record, you contacted NYSOH on April 20, 2017, were verbally denied retroactive Medicaid for December 2016, and filed a formal appeal that same day. Therefore, your formal appeal request was timely and the merits of the issue will be addressed.

The analysis turns to whether NYSOH properly determined that you were not eligible for Medicaid from December 1, 2016 through December 31, 2016.

Since you file your taxes with a tax filing status of single and claim one dependent on your tax return, you are in a two-person household for purposes of this analysis.

You submitted an application for financial assistance on April 20, 2017, and requested help in paying for medical bills for the month of December 2016.

On April 20, 2017, you also spoke with NYSOH's Account Review Unit and requested review on the basis that you were verbally denied retroactive Medicaid coverage for December 2016. The record does not contain an eligibility determination notice on this issue. It does contain an April 21, 2017 appeal acknowledgement notice in which NYSOH acknowledges receipt of an appeal request and identifies the issue on appeal as "Other: Denial of Backdate."

Here, the lack of an eligibility determination notice on the issue of retroactive Medicaid for the month of December 2016 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. The text of the April 21, 2017, which acknowledges the appeal on the issue of denial of retroactive Medicaid, along with your credible testimony, permits an inference that NYSOH did deny your request for retroactive Medicaid.

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

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 December 1, 2016 through December 31, 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 December 2016, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the 2016 FPL, which for a two-person household is $1,843.00 per month.

Since there is nothing in the record to indicate that you would have been ineligible for Medicaid based on non-financial criteria during December 2016, the analysis turns to the financial requirements to be eligible for Medicaid.

You uploaded your December 2016 paystubs which indicate you received gross income of $2,715.35 that month (*see* Appellant's Exhibit A). Since your December 2016 monthly income of $2,715.35 was more than the $1,843.00 monthly Medicaid limit for a two-person household in 2016, NYSOH properly determined that you were not eligible for Medicaid coverage during that month.

Decision

NYSOH properly determined that you were not eligible for Medicaid coverage retroactively during the month of December 2016.

Effective Date of this Decision: September 5, 2017

How this Decision Affects Your Eligibility

You are not eligible for Medicaid in the month of December 2016.

This decision does not change your current eligibility for Medicaid or enrollment in a Medicaid Managed Care plan.

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

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).

Albany, NY 12211

- By fax: 1-855-900-5557

Summary

NYSOH properly determined that you were not eligible for Medicaid coverage retroactively during the month of December 2016.

You are not eligible for Medicaid in the month of December 2016.

This decision does not change your current eligibility for Medicaid or enrollment in a Medicaid Managed Care plan.

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.

□□□□□ (Bengali)

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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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)

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).

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).