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

# Notice of Decision

Decision Date: October 17, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019186

[redacted]

Dear [redacted],

On September 6, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's denial of your request for retroactive Medicaid coverage.

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: October 17, 2017

NY State of Health Account ID: [redacted]
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[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 for September 2016 through October 2016?

## Procedural History

On October 20, 2016, an application for health insurance was run on your behalf. It indicated that you were seeking help for paying for medical bills for the prior three months.

On October 21, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan for a limited time, effective October 1, 2016. This notice did not direct you to provide documentation.

On November 4, 2016, an application was run on your behalf.

On November 5, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan for a limited time, effective November 1, 2016. You were directed to produce income documentation by January 18, 2017.

On November 13, 2016, NYSOH issued an enrollment confirmation notice, stating that you were enrolled in the Essential Plan, effective November 1, 2016.

On December 7, 2016, you submitted an application for financial assistance with health insurance. The application indicated that you were seeking help for paying for medical bills for September 2016 through November 2016.

On December 8, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan for a limited time, effective January 1, 2017.

Also on December 8, 2016, NYSOH issued an enrollment confirmation notice stating that you were enrolled in the Essential Plan, effective November 1, 2016.

Also on December 8, 2016, you uploaded income documentation.

On May 22, 2017, you spoke to NYSOH's Account Review Unit and filed an appeal insofar as you were denied retroactive Medicaid for the month September and October 2016.

On August 23, 2017, you uploaded additional income documentation.

On September 6, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing held open up to September 22, 2017, to allow you to submit supporting documents.

On September 20, 2017, NYSOH received the requested documentation and it was incorporated into the record as Appellant's Exhibit #1, the record was closed that day.

## Findings of Fact

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

1) You testified that you are seeking Medicaid from September 2016 to October 2016.

2) You testified that you file your federal income tax return as married filing jointly, and will claim one dependent on that tax return.

3) You submitted an application for financial assistance on October 20, 2016. You testified that you found out you were [redacted] pregnant [redacted], which means that you were also pregnant in September 2016. You testified that your pregnancy ended in [redacted]

4) You testified that the person assisting you with your testimony did not include that you were pregnant in the application, but that you were

told everything was fine. You first contacted NYSOH regarding your coverage in February 2017.

5) You submitted a copy of your I-766, which states that you are a category C08.

6) Your application submitted on October 20, 2016, states that for the month of September 2016 your household's gross income was $2,166.67.

7) You testified that you have no income, and have not worked since March or April 2015.

8) You uploaded a Self-Declaration of Income form, signed and dated by your spouse on December 7, 2016, which states that your spouse earns $500.00 per week. The form states that he earned $2,000.00 in September 2016 and $2,000.00 in October 2016. The form was certified by your application counselor, [redacted].

9) You uploaded your 2016 1040 form, which confirms that you and your spouse file your taxes as married filing jointly and claimed one dependent. You had a gross household income of $11,157.00 in 2016.

10) You testified that you do not plan on taking any deductions on your tax return.

11) NYSOH has not issued an eligibility determination notice regarding your request for retroactive Medicaid for September 2016 and October 2016.

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

## Applicable Law and Regulations

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-Pregnant Women

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)).

For purposes of Medicaid eligibility, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

Medicaid is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the FPL for the applicable family size (see 42 CFR § 435.116(c); New York State Department of Health 13 OHIP/ADM-03). Once eligible, a pregnant woman will remain eligible until the end of the month in which the sixtieth day following the end of the pregnancy occurs, regardless of any change in household income, even if such change would render her ineligible for financial assistance (NY Social Services Law § 366(4)(b)(1)).

On the date of your application, that was the 2016 FPL, which is $24,300.00 for a four-person household (81 Fed. Reg. 4036).

Presumptive Eligibility for Pregnant Women

In New York State, presumptive eligibility for Medicaid is a means of immediately providing Medicaid coverage for prenatal care services pending a full Medicaid eligibility determination. A pregnant woman does not need to provide documentation of income for the presumptive eligibility determination. Pregnant women are also not required to document citizenship/immigration status for presumptive eligibility or for ongoing Medicaid eligibility. Citizenship/immigration status is not an eligibility requirement for a pregnant woman throughout her pregnancy and for 2 months after the month in which the pregnancy ends (N.Y. Soc. Serv. Law § 366 (4)(b)). Medicaid pays providers during the presumptive eligibility period for care provided to pregnant women; however, as a matter of Medicaid Program policy, labor and delivery services are excluded from payment.

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)).

Immigration Status

Generally, no person except a United States citizen, a naturalized citizen, a qualified alien, and persons permanently residing in the United States under color of law (PRUCOL), is eligible for medical assistance from the state (NY Social Services Law § 122(1); 18 NYCRR § 360-3.2(j)).

A PRUCOL alien is a person who is residing in the United States with the knowledge and permission or acquiescence of the federal immigration agency and whose departure from the United States such agency does not contemplate enforcing (18 NYCRR § 360-3.2(j)). The New York Department of Health regards aliens who have been issued an Employment Authorization Document (I-688B or I-766), and have the requisite category code, to be PRUCOL (08 OHIP/INF-4, dated August 4, 2008)).

The guide, "'Key to I-766/I-688B, Employment Authorization Documents (EADs)', defines certain codes on the USCIS Employment Authorization Documents" (08 MA/033, dated December 1, 2008). It confirms that a person who has category code of "(c)(8)", reflecting asylum applicant, has PRUCOL status (i*d*.).

Qualified Immigrants

In NY State, qualified immigrants who were formerly eligible for Medicaid through the state, but not eligible for Medicaid under federal law, were transitioned to the Essential Plan as of January 1, 2016 (New York's Basic Health Plan Blueprint, p. 19, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html). This category of qualified immigrants includes individuals lawfully admitted for permanent residence in the United States who are still in their first five years of permanent residency. (18 NYCRR § 349.3, 8 USC § 1613).

## Legal Analysis

The issue under review is whether NYSOH properly determined that you were not eligible for Medicaid for September 2016 through October 2016.

You testified that you are appealing the denial of a retroactive Medicaid for September and October 2016. However, the record does not contain a notice of

eligibility determination or redetermination on the issue of retroactive coverage for September or October 2016.

Here, the lack of a notice of eligibility determination on the issue of retroactive Medicaid coverage for September or October 2016does 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 testimony along with the May 23, 2017 appeal confirmation notice stating that the reason for your appeal was “failure of the Exchange to provide timely notice of eligibility determination”, permits an inference that NYSOH did not find you eligible for retroactive Medicaid for September or October 2016.

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.

When calculating family size for Medicaid purposes, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman but also the number of children she expects to deliver. On the date of your NYSOH application, you were pregnant. Consequently, you were in a four-person household; you file your taxes with a tax filing status of married filing jointly and in addition to being pregnant, you and your spouse claim one dependent on your tax return.

You submitted an application for financial assistance on October 20, 2016 and requested help in paying for medical bills for the prior three months.

When an individual file, 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 for September and October 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 September and October 2016, you would have needed to meet the non-financial criteria and have an income no greater than 223% of the FPL, which is $4,516.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during September and October 2016.

You testified that you do not have an income. You testified that your spouse earns $500.00 per week, and uploaded a certified Self-Declaration of Income form, signed and dated by your spouse on December 7, 2016, which states that your spouse earns $500.00 per week. The form states that he earned $2,000.00 in September 2016 and $2,000.00 in October 2016. Therefore, the record indicates that in the months of September and October 2016, you had a monthly household income of $2,000.00.

You testified, and the record reflects, that at the time of your application, you were in the country with a C08 I-766, which confirms that you are an asylum applicant. You testified that you have had that status since July 2016. The guide for Employment Authorization Documents confirms that you have PRUCOL status with a category [redacted]. As of January 1, 2016, qualified immigrants who were receiving Medicaid through NY State, must now receive coverage through the Essential Plan. Therefore, because of your PRUCOL status, you would not meet the non-financial requirements for Medicaid. However, you credibly testified that at the time of your application, you were pregnant, and immigration status is not an eligibility requirement for Medicaid for a pregnant woman throughout her pregnancy. Therefore, at the time of your application, due to your pregnancy, you met the non-financial requirements for Medicaid.

Since the record now contains a more accurate representation of what your income and pregnancy status was for the months of September and October 2016, your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage as a pregnant woman for September and October 2016 based on a household size of four people and household income of $2,000.00 for the months of September and October 2016.

## Decision

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage as a pregnant woman for September and October 2016 based on a household size of four and household income of $2,000.00 for the months of September and October 2016.

## **Effective Date of this Decision:** October 17, 2017

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).

## How this Decision Affects Your Eligibility

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your eligibility based on the evidence you presented 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):

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

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage as a pregnant woman for September and October 2016 based on a household size of four and household income of $2,000.00 for the months of September and October 2016.

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your eligibility based on the evidence you presented 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।

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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.

**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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