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

Notice of Decision

Decision Date: January 19, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022974

[redacted]

[redacted]

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

This page intentionally left blank.

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: January 19, 2018

NY State of Health Account [redacted]
Appeal Identification Number: AP000000022974

[redacted]

Issue

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

> Did NYSOH properly determine that you were not eligible for Medicaid from October 1, 2016 through October 31, 2016?

Procedural History

On November 1, 2016, you submitted an initial application for financial assistance with health insurance.

On November 2, 2016, NYSOH issued a notice stating the income information in your application does not match what NYSOH received from state and federal data sources. The notice requested you provide proof of your income by November 16, 2016.

You submitted income documentation, which NYSOH deemed invalid on November 15, 2016.

NYSOH issued a notice on November 16, 2016, stating the income documentation reviewed did not confirm the information in your application and directed you to provide additional income documents.

On January 12, 2017 you submitted an updated application for financial assistance and indicated that you were seeking help for paying for medical bills for the prior three months.

On January 13, 2017, NYSOH issued a notice stating the income information in your application does not match what NYSOH received from state and federal data sources. The notice requested you provide additional proof of income by January 14, 2017.

Income documentation in the form of a letter from your employer and an explanation of disability payments was provided on March 23, 2017 (*see* Documents [redacted] Based on this documentation, NYSOH calculated your household income and submitted a new application on your behalf.

On March 24, 2017, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective March 1, 2017.

Also on March 24, 2017, NYSOH issued a notice stating you were eligible for Medicaid from January 1, 2017 through February 28, 2017 because your monthly income of $375.00 was at or below the allowable monthly income limit of $2,349.00 for Medicaid. The notice also stated you were eligible for Medicaid from December 1, 2016 through December 31, 2016, because your monthly household income of $375.00 was below the monthly income limit of $2,319.00 for Medicaid.

On April 3, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective May 1, 2017.

On September 29, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your Medicaid coverage requesting Medicaid for the month of October 2016. A notice was issued on September 30, 2017, confirming your appeal request.

On December 28, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the proceeding.

Findings of Fact

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

1) You testified that you are seeking Medicaid from October 1, 2016 to October 31, 2016.

2) You testified that you filed your 2016 federal income tax return as head of household with two qualifying individuals.

3) You testified you gave birth to your twins on [redacted].

4) You submitted an initial application for financial assistance on November 1, 2016.

5) According to your NYSOH account, you first submitted a request for help paying medical bills for the prior three months on January 12, 2017.

6) The record shows NYSOH did not issue a decision on your request for help paying medical bills for the prior three months from your January 12, 2017 application.

7) The three months before your January 12, 2017 application, include October, November, and December 2016.

8) The record shows your request for retro Medicaid coverage was denied by NYSOH only on April 21, 2017, as noted in internal notes [redacted]

9) There is no formal notice denying retroactive Medicaid in your NYSOH account.

10) According to the Appeal Summary in the Evidence Packet, an entry dated 11/22/2017, states:

I cannot see that NYSOH ever issued a denial to appellant's 1/12/17 update to [your] application, in which she requested retroactive Medicaid assistance for October 2016. Please refer this to the unit that issues decisions on such requests

[redacted]

11) According to the Appeal Summary in the Evidence Packet, an entry dated 11/29/2017, states:

There was a referral filed, due to [the] retro-coverage request, and the appellant was denied. Please refer to [redacted] several notes stating why the Appellant was not eligible for the retro coverage for the month of October 2016

[redacted]

12) You were determined eligible for Medicaid effective March 1, 2017.

13) You were determined eligible for retroactive Medicaid coverage for the months of December 2016, January 2017, and February 2017.

14) You submitted income documentation in the form of a November 16, 2017 letter from your employer stating your disability claim was received and processed and you were to receive an amount of $184.70 per week for eight weeks [redacted]

15) You provided pay records showing you received a lump sum payment amount of $1,477.60 for your disability period of 9/23/16-11/17/16 on November 18, 2016 [redacted]

16) You submitted a copy of your paystub from your employer with a pay date of October 13, 2016 showing you received $27.48 [redacted]

17) You testified that, during the month of October 2016, you received only the one paycheck in the amount of $27.48 on October 13, 2016, and received no other income from any sources, including none from disability or unemployment in that month.

18) You testified you did not have medical insurance coverage through your employer or any third party for the month of October 2016.

19) You reside in Kings County, NY.

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

Applicable Law and Regulations

De Novo Review

The 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)).

FPL for Pregnant Women

Medicaid is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the Federal Poverty Level (FPL) for the applicable family size (see 42 CFR § 435.116(c); NY Department of Health Administrative Directive 13ADM-03).

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 $20,160.00 for a three-person household (81 Fed. Reg. 4036).

For purposes of Medicaid eligibility, however, 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).

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, while you did not file an appeal until September 29, 2017 on the issue of retroactive Medicaid eligibility in the month of October 2016, it is noted that you did request retroactive Medicaid coverage in your January 12, 2017 application and an Incident related to your request was filed on April 21, 2017. According to the Appeal Summary prepared by NYSOH in contemplation of this hearing, that incident was not resolved as of the date of your appeal. Therefore, the incident remained outstanding such that your appeal is determined to be timely.

The first issue under review is whether NYSOH properly determined that you were not eligible for Medicaid for October 1, 2016 through October 31, 2016.

The record supports that you first submitted a request for help paying medical bills for the prior three months in your January 12, 2017 application. You then spoke with NYSOH's Account Review Unit on September 29, 2017 and requested your eligibility be redetermined for Medicaid for October 2016. The record does not contain a notice of eligibility determination or redetermination on the issue of your eligibility for retro Medicaid for the month of October 2016. It does contain an incident indicating that Medicaid coverage was denied by NYSOH representatives in NYSOH computer systems on April 21, 2017 [redacted]

Here, the lack of a notice of eligibility determination on the issue of your eligibility for retroactive Medicaid coverage for the month of October 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's failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination. The text of your September 30, 2017 appeal notice, and your filed Incident [redacted] acknowledging your request for retroactive Medicaid coverage permits an inference that NYSOH did deny your request for retro Medicaid coverage for 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 notice of eligibility determination had it been issued. Therefore, the issue under review is whether you were properly denied retroactive Medicaid for the month of October 2016.

According to your NYSOH account, you filed your 2016 taxes with a tax filing status of head of household and claimed two dependents on your tax return. The record reflects that you were also pregnant with twins in the month of October 2016. 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. Therefore, you were in a three-person household for purposes of the analysis of your eligibility for October 2016.

You submitted an application for financial assistance on January 12, 2017, and requested help in paying for medical bills for October 2016.

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.

Since you requested help with medical bills for the past three months in your January 12, 2017 application, a review of your eligibility for retroactive Medicaid relates back to October 1, 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 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 $3,747.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during October 2016. Therefore, the analysis turns to whether you met the fincial requirements to be eligible for Medicaid retroactively in October 2016.

The record reflects that you submitted a disability claim to your employer, which was processed for the period of 9/23/16-11/17/16. The results of your claim show you were to receive an amount of $184.70 per week for eight weeks [redacted] a lump sum payment amount of $1,477.60 for your disability period on November 18, 2016 [redacted]

You credibly testified and submitted documentary evidence to show that the only income you received in the month of October 2016 was a one-time payment of $27.48 received on October 13, 2016 from your employer [redacted] You also credibly testified that you had no other sources of income that month.

Since the record now contains a more accurate representation of what your income was for the month of October 2016, your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage for the month of October 2016 based on a three-person household with a household income of $27.48 that month.

Decision

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage for the month of October 2016 based on a three-person household with a household income of $27.48 that month, and to notify you accordingly.

Effective Date of this Decision: January 19, 2018

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility for financial assistance for the month of October 2016.

Your case is sent back to NYSOH to redetermine your eligibility based on the evidence adduced at hearing as noted above. NYSOH will notify you of its determination.

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 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).

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 case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage for the month of October 2016 based on a three-person household with a household income of $27.48 that month, and to notify you accordingly.

This is not a final determination of your eligibility for financial assistance for the month of October 2016.

Your case is sent back to NYSOH to redetermine your eligibility based on the evidence adduced at hearing as noted above. NYSOH will notify you of its determination.

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 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.

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).