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

Notice of Decision

Decision Date: February 05, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023887

[redacted]

[redacted],

On December 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 31, 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).

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: February 05, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023887

[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 assistance for July 2017?

Procedural History

On May 15, 2017, you applied for financial assistance with NYSOH.

On May 18, 2017, NYSOH Issued a notice stating that your May 15, 2017 application had been reviewed; however, the income information did not match information NYSOH received from state and federal data sources. You were requested to provide additional information regarding your household income by May 31, 2017. You were also requested to submit proof of immigration status by August 14, 2017 and proof of your New York State residency by August 15, 2017.

On July 24, 2017 you submitted a USICS I-20, Certificate of Eligibility for Nonimmigrant Student Status for the period of March 22, 2017 through March 21, 2019. You also submitted a letter from your employer indicating that your employment ended April 13, 2017.

On July 25, 2017, NYSOH issued a notice stating that you had submitted documentation to confirm your eligibility, however there was an application change in progress that needed to be completed. You were requested to

complete and submit your updated application by contacting NYSOH. No deadline was listed for completion of this request.

On October 30, 2017, you submitted an updated application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for July 2017.

On October 31, 2017, NYSOH issued an eligibility determination notice based on your October 30, 2017 updated application, stating that you were not eligible for Medicaid for July 1, 2017 through July 31, 2017 because the program you were eligible for could not pay for any care you received in the past.

On November 1, 2017, you spoke to NYSOH's Account Review Unit and appealed that October 31, 2017 eligibility determination notice insofar as it denied retroactive Medicaid for the month of July 2017.

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 hearing.

Findings of Fact

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

1) According to your NYSOH account and your testimony, you updated your account on May 15, 2017 and requested financial assistance with health insurance.

2) According to your NYSOH account, following this May 15, 2017 application, you were place in a pending Medicaid status. You were requested to submit proof of your household income by May 31, 2017, proof of your immigration status by August 14, 2017 and proof of New York State residency by August 15, 2017.

3) According to your NYSOH account, on May 19, 2017 an incident was filed in which a NYSOH representative indicated a "re-sequenced defect" arose on the account. A defect report was filed on that day as [redacted], requesting that the error be corrected.

4) According to your NYSOH account, on July 24, 2017 you submitted proof of your immigration status. Also on that date, you submitted a letter from your previous employer indicating that your employment ended effective April 13, 2017.

5) According to your NYSOH, your proof of no income and immigration status were validated on July 24, 2017. However, NYSOH could not submit an application on your behalf because there was still a pending defect on your account.

6) According to your NYSOH account, you submitted an updated application for health insurance on October 30, 2017 and requested assistance with medical bills for the month of July 2017.

7) According to your NYSOH account, on October 31, 2017, NYSOH denied your request for Medicaid for the month of July 2017 because the program you were eligible for could not pay for any medical care you received in the past.

8) You testified that you had been employed by a company out of state and that employment ended April 13, 2017.

9) You testified that after the termination of employment you returned to Orange County, New York to live with family.

10) You testified that the date of your return to New York would be around the same time of your May 15, 2017 application for health insurance to NYSOH.

11) According to your NYSOH account and your testimony, you were the [redacted] in the month of July 2017 and you have extensive medical and hospitalization bills that were incurred during that month amounting to over $5,000.00.

12) According to your NYSOH account, you have a citizenship/immigration status as a non-immigrant visa holder.

13) According to your NYSOH account you expect to file a 2017 federal income tax return as Head of Household (with qualifying individual) and claim one dependent.

14) According to you NYSOH account, the October 30, 2017 application stated that you resided in Orange County, New York.

15) You testified that during the month of July 2017 you had no income as you were unemployed.

16) You testified that you want to be determined eligible for Medicaid for the month of July 2017 because of the uncovered medical bills you incurred.

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

Applicable Law and Regulations

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 2017 FPL, which is $16,240.00 for a two-person household (82 Federal Register 8831).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved 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

The issue under review is whether NYSOH properly determined that you were not eligible for Medicaid for July 1, 2017 through July 31, 2017.

You are in a two-person household; you testified you intend to file your taxes with a tax filing status of head of household (with qualifying individual) and claim one

dependent on your tax return. Your citizenship/immigration status is non-immigrant visa holder.

You submitted an updated application for financial assistance on October 30, 2017 and requested help in paying for medical bills for the month of July 2017.

When an individual applies for Medicaid, his or her eligibility for retroactive Medicaid assistance depends on the date of application. To this end, it does not matter whether 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 July 2017, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,354.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during July 2017.

You testified and the record reflects that you lost employment on April 13, 2017. After losing employment, you returned to Orange County, New York and lived with your family. The record reflects that in the month of July 2017 you had $0.00 household income.

Since the October 31, 2017 eligibility determination notice found you were not eligible for Medicaid for July 1, 2017 to July 31, 2017, because the program you were eligible for cannot pay for any care you received in the past, this is RESCINDED.

Since the record now contains a more accurate representation of what your income was for the month of July 2017, your case is RETURNED to NYSOH to consider your request for retroactive coverage for July 2017 based on a household size of two people and household income of $0.00 for the month of July 2017.

Decision

The October 31, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for July 2017 based on a household size of two and household income of $0.00 for the month of July 2017.

Effective Date of this Decision: February 05, 2018

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 for Medicaid for the month of July 2017 based on the evidence in the record.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the 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

- By fax: 1-855-900-5557

Summary

The October 31, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for July 2017 based on a household size of two and household income of $0.00 for the month of July 2017.

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your eligibility for Medicaid for the month of July 2017 based on the evidence in the record.

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 तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई 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).