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

Notice of Decision

Decision Date: May 3, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027061

[redacted]

Dear [redacted]

On April 6, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's July 13, 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: May 3, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027061

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Was your appeal of NY State of Health's July 13, 2017 eligibility determination notice timely?
>
> Did NY State of Health properly decline to determine your eligibility for retroactive Medicaid from February 1, 2017 through March 31, 2017?

Procedural History

On May 25, 2017, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for February 2017, March 2017, and April 2017.

On May 26, 2017, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible for the Essential Plan for a limited time, effective July 1, 2017. This notice directed you to submit proof of your household income by August 23, 2017.

On May 26, 2017, you updated your application for financial assistance with health insurance.

On May 27, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH had received from state and federal data sources. This notice directed you to submit proof of your household income by June 10, 2017 in order to determine your eligibility for financial assistance.

On July 12, 2017, you uploaded income documentation to your NYSOH account.

Also on July 12, 2017, NYSOH verified the income documentation you submitted and submitted an application on your behalf.

On July 13, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective July 1, 2017.

Also on July 13, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid for April 1, 2017 through June 30, 2017 because your monthly household income of $0.00 was at or below the allowable monthly income limit of $2,349.00.

On January 10, 2018, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as you were not found eligible for retroactive Medicaid for the months of February 2017 and March 2017.

On April 6, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, Haitian Creole interpreter #[redacted] translated. The record was developed during the hearing held open until April 27, 2018, to allow you to submit supporting documents.

As of April 28, 2018, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day and this decision is based on the record as developed at the time of the hearing.

Findings of Fact

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

1) You testified that you are seeking Medicaid from February 1, 2017 to March 31, 2017.

2) You were found eligible for Medicaid through NYSOH effective July 1, 2017 and retroactive Medicaid was granted to you for the months of April 2017, May 2017, and June 2017.

3) You testified that filed your 2017 federal income tax return as head of household and claimed two dependents on that tax return.

4) You testified that you gave birth to your second child on [redacted]

5) You submitted applications for financial assistance on May 25, 2017 and May 26, 2017.

6) The application you submitted on May 25, 2017 listed annual expected income of $23,920.00 and monthly income of $1,993.33 for February 2017 and March 2017.

7) The application that was submitted on May 26, 2017 listed annual expected income of $1,500.00 and monthly income of $1,993.33 for February 2017 and March 2017.

8) On December 2, 2016, you uploaded two paystubs to your NYSOH account for pay dates October 21, 2016 and November 4, 2016.

9) You testified that you worked for [redacted] in 2017, that you went out of work in January 2017 and returned to work on [redacted] related to the birth of your child.

10) You testified that when you were working for [redacted] you were paid $700.00 per week each Friday. You testified that you had gross annual income between $28,000.00 and $30,000.00 for 2017.

11) On July 12, 2017 you uploaded a letter dated June 23, 2017 which states that you were not currently working for [redacted] that when you were working you received weekly gross pay of $460.00, and that your last day worked was [redacted].

12) You testified that you had no income for February 2017 or March 2017.

13) You also testified that while you were out of work you received $600.00 which you stated was the type of money you receive while out of work for a baby. You were not sure if this was from your employer or from a short-term disability carrier. You were not sure when you received this income.

14) During the hearing, the Hearing Officer directed you to submit your final paystub from your employer from when you went out of work due to your pregnancy and your first paystub from when you returned to work following your pregnancy, as well as proof of when you received the $600.00 related to your out of work status for your pregnancy. The record was left open until April 27, 2018 to allow you to submit this documentation.

15) As of April 28, 2018, no additional documentation has been uploaded to your NYSOH account.

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)).

However, where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe as determined by NYSOH that failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal (45 CFR §155.520(d)(2)(i)(D)).

Medicaid for Pregnant Women

Medicaid can be provided through the Marketplace 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)), N.Y. Soc. Serv. Law § 366(1)(b)).

In New York, a pregnant woman is eligible for Medicaid at a household income of 223% of the federal poverty level (FPL) for the applicable family size (42 CFR §435.116 (c)(2); NY Department of Social Services Administrative Directive 13ADM-03).

"Family size" means the number of persons counted as members of an individual's household. The household of a taxpayer who expects to file a return,

and does not expect to be claimed as a tax dependent by anyone else, consists of the taxpayer plus all people the taxpayer expects to claim as tax dependents (42 CFR § 435.603(f)(1)).

For purposes of Medicaid eligibility, the family size of a pregnant woman includes the pregnant woman and 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).

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 $20,420.00 for a three-person household (82 Fed. Reg. 8831).

Generally, Medicaid coverage begins on the first day of the month in which the applicant was found eligible (42 CFR § 435.915(b)).

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 first issue under review is whether your appeal of NYSOH's July 13, 2017 eligibility determination notice was timely.

The record reflects that you first contacted NYSOH to file a formal appeal regarding the failure of NYSOH to determine your eligibility for retroactive Medicaid for February 1, 2017 through March 31, 2017 on January 10, 2018.

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH.

However, NYSOH has never issued an eligibility determination as to whether you were eligible for retroactive Medicaid for February 1, 2017 through March 31, 2017.

As NYSOH has never issued a notice of eligibility determination addressing your eligibility for retroactive Medicaid for February 1, 2017 through March 31, 2017, the 60-day period from which an appeal should have been filed never began to run.

Therefore, your appeal is timely and will be addressed.

The second issue under review is whether NYSOH properly declined to determine your eligibility for Medicaid from February 1, 2017 through March 31, 2017.

You testified that you filed your 2017 tax return as head of household and claimed two dependents on that return. Additionally, the record reflects that you were pregnant in 2017 and gave birth on [redacted]

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.

Therefore, you were in a three-person household during February 2017 and March 2017.

You submitted an application for financial assistance on May 25, 2017 and requested help in paying for medical bills for February 2017, March 2017, and April 2017. You were subsequently found eligible for Medicaid for April 2017.

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 February 1, 2017 through March 31, 2017.

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 February 2017 you would have needed to meet the non-financial criteria and have an income no greater than 223% of the FPL, which was $3,795.00 per month.

To be eligible for Medicaid in March 2017 you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which was $2,349.00 per month.

There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during February 2017 and March 2017.

You testified that you had no income in February 2017 and March 2017 as you were out of work due to your pregnancy. However, you also testified that you received $600.00 in income associated with your out of work status. You could not recall what type of payment this was or when you received this payment.

Although you testified that you had no income in February 2017 and March 2017, you had submitted a letter dated June 12, 2017 indicating that you stopped working on [redacted]. In the May 25, 2017 and May 26, 2017 applications you indicated that you had income of $1,993.33 for February 2017 and March 2017.

The Hearing Officer directed you to submit proof of when you received the payment related to your out of work pregnancy status as well as the final paystub from when you went out of work for your pregnancy and your first paystub from when you returned to work following your pregnancy in order to resolve the discrepancies between your testimony, your application, and documentation you previously submitted. The record was left open until April 27, 2018 to allow you to submit this documentation. However, you have produced no additional documentation.

Therefore, there remains insufficient evidence in the record for NYSOH to determine your eligibility for retroactive Medicaid for the months of February 2017 and March 2017.

Therefore, the July 13, 2017 eligibility determination notice which declined to address your eligibility for retroactive Medicaid for February 1, 2017 through March 31, 2017 is AFFIRMED.

Decision

The July 13, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: May 3, 2018

How this Decision Affects Your Eligibility

Your eligibility for retroactive Medicaid for February 1, 2017 through March 31, 2017 has not been determined as you have failed to submit sufficient income documentation to confirm your income for those months.

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 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 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 July 13, 2017 eligibility determination notice is AFFIRMED.

Your eligibility for retroactive Medicaid for February 1, 2017 through March 31, 2017 has not been determined as you have failed to submit sufficient income documentation to confirm your income for those months.

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.

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).