nystateofhealth
The Official Health Plan Marketplace

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

Notice of Decision

Decision Date: April 13, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028660

[redacted]

[redacted]

On April 3, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's denial of retroactive Medicaid coverage for July 2017.

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: April 13, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028660

[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 the month of July 2017?

Procedural History

On September 14, 2017, you submitted an application for financial assistance with health insurance and indicated that you were seeking help with paying medical bills from the previous three months.

On September 15, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for the Essential Plan, effective October 1, 2017.

Also on September 15, 2017, NYSOH issued a notice of enrollment in the Essential Plan, with a coverage start date of September 1, 2017.

On September 19, 2017, you submitted an updated application for financial assistance and once again indicated that you were seeking help with paying medical bills from the previous three months.

On September 30, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for the Essential Plan for a limited time, effective October 1, 2017. That notice asked that you submit proof of income by December 18, 2017.

On October 18, 2017, NYSOH received by fax your signed attestation, dated September 21, 2017, that you had received no income for the month of July, 2017.

On November 4, 2017, you submitted an updated application which reflected a change in your attested household income. You again indicated that you were seeking help with paying medical bills from the previous three months.

On November 7, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid for October 1, 2017 through October 31, 2017, because your monthly income of $758.33 was below the allowable monthly income limit. That notice also asked you to submit proof of your income for the period from August 1, 2017 to September 30, 2017 by November 21, 2017.

On November 18, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid for September 1, 2017 through September 30, 2017, because your household monthly income of $550.00 was below the allowable monthly income limit. The notice also stated that you were eligible for Medicaid for August 1, 2017 through August 31, 2017, because your household monthly income of $200.00 was also below the allowable monthly income limit.

On February 8, 2018, you spoke to NYSOH's Account Review Unit and appealed your eligibility for Medicaid coverage for the month of July 2017.

On April 3, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed by your testimony 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) You testified that you are seeking Medicaid for July 2017 because you have outstanding medical bills from that month.

2) You testified that you expect to file your 2017 federal income tax return as single, and that you will claim no dependents.

3) On September 14, 2017, you submitted an application for financial assistance and indicated that you were seeking help with paying medical bills from the previous three months.

4) Your September 14, 2017 application states that, for the months of July and August 2017, your income was $433.33 per month.

5) You testified that in July 2017 you had no income.

6) On October 18, 2017 NYSOH received a letter from you, dated September 21, 2017, stating that you had no income in the month of July 2017 and that you were under your student visa (F1) at the time and your optional professional training card was pending, thereby not yet permitting you to work legally.

7) The copy of your Employment Authorization Card you submitted to NYSOH shows Category status of C03B, a temporary work authorization granted to persons who have been lawfully present in the United States under an F-1 student visa. Your authorization is valid from [redacted] through [redacted]

8) On December 23, 2017 a complaint was filed ([redacted]) in which you called in regarding your eligibility for retroactive fee for service Medicaid coverage for July 2017.

9) On February 8, 2018 a formal appeal was filed regarding your ineligibility for Medicaid for the month of July 2017.

10) No eligibility notices issued by NYSOH have addressed your eligibility for Medicaid for the month of July 2017.

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). Among the express grounds for a de novo appeal is "a failure by the Exchange to provide timely notice of an eligibility determination" (45 CFR § 155.505(b))."

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 Federal Poverty Level 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 $12,060.00 for a one-person household (82 Fed. Reg. 8831).

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 the month of July 2017.

You testified that you are appealing the denial of retroactive Medicaid coverage for yourself for July 2017. However, the record does not contain a notice of eligibility determination on the issue of retroactive Medicaid for July 2017.

Here, the lack of a notice of eligibility determination on the issue of retroactive Medicaid coverage for the month of July 2017does 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 credible testimony along with the December 23, 2017 complaint (#[redacted]) in which you called in regarding your eligibility for retroactive fee for service Medicaid coverage for July 2017, permits an inference that NYSOH did deny you retroactive Medicaid coverage for July 2017.

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.

You are in a one-person household; you file your taxes with a tax filing status of single and claim no dependents on that tax return.

You submitted an application for financial assistance to NYSOH on September 14, 2017. In that application, you requested help with paying your medical bills from the previous three months. On September 15, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan with an October 1, 2017 coverage start date.

When an individual file an initial application for financial assistance with NYSOH, his or her eligibility for retroactive Medicaid depends on the date of application. To this end, it does not matter whether that application resulted in Medicaid eligibility 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 prior to the month of his or her application submission date.

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 coverage for July 2017 because you have outstanding medical bills from that month.

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 need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which was $1,138700 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria in July of 2017.

You testified that you had no income for the month of July 2017 because you were lawfully present in the United States under an F-1 student visa and were not yet legally authorized to work. You submitted both a signed attestation of these facts and a copy of your Employment Authorization Card which shows that your work authorization began as of [redacted]. Therefore, the record contains sufficient evidence that in the month of July 2017, you had a monthly household income of $0.00 (zero dollars).

Since the record now contains a more accurate representation of your income for the month of July 2017, your case is RETURNED to NYSOH to reach a determination on your request for retroactive coverage for July 2017 based on a household size of one and household income of $0.00 (zero dollars) for that month.

Decision

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for July 2017 based on a household size of one and household income of $0.00 (zero dollars) for the month of May 2017.

Effective Date of this Decision: April 13, 2018

How this Decision Effects Your Eligibility

Your eligibility for retroactive Medicaid for the months of August, September and October 2017 remains unchanged.

This is not a final determination of your retroactive Medicaid eligibility for the month of July 2017. 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):

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 based on a household size of one and household income of $0.00 (zero dollars) for the month of July 2017.

This is not a final determination of your eligibility. Your case is being 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।

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).