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

Notice of Decision

Decision Date: April 3, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000012526

[redacted]

Dear [redacted],

On March 1, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 14, 2016 eligibility determination.

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
Albany, NY 12211

Decision

Decision Date: April 3, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000012526

[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 in October and November 2016?

Procedural History

On October 13, 2016, you submitted an updated application for financial assistance with health insurance. That same day, NYSOH prepared a preliminary eligibility determination stating that you were eligible to receive up to $101.00 in advance payments of the premium tax credit, effective November 1, 2016.

Also on October 13, 2016, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as you were looking for a higher level of financial assistance.

On October 14, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $101.00 in advance payments of the premium tax credit, effective November 1, 2016. The notice also stated that you were not eligible for cost-sharing reductions, Medicaid, or the Essential Plan because your income was over the allowable limits for these programs.

On November 17, 2016 and November 29, 2016, you updated your NYSOH application.

On December 6, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective December 1, 2016, and you subsequently enrolled in a Medicaid Managed Care plan, which began on January 1, 2017.

On March 1, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, the issue under appeal was amended, as you were now eligible for Medicaid, but wanted to be eligible in October and November 2016 as well. The record was developed during the hearing held open up to March 16, 2017, to allow you to submit proof of any Unemployment Insurance Benefits received in the month of October 2016.

On March 10, 2017, you uploaded the requested documentation to your NYSOH account. The record is now closed.

Findings of Fact

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

1) You testified that you are seeking Medicaid coverage from October 1, 2016 through November 30, 2016.

2) You testified that you expect to file your 2016 federal income tax return as single, and claim no dependents.

3) You submitted an application for financial assistance on November 29, 2016, and that application was processed by NYSOH on December 5, 2016.

4) You testified that the income listed on your October 13, 2016 application consisted of $30,500.00 that you earned [redacted] which ended as of August 31, 2016, and income that you anticipated receiving from Unemployment Insurance Benefits (UIB).

5) You testified that you applied for UIB in September 2016, and that you received some payments, but that you were then denied, and the payments stopped.

6) You testified that, as of the date of the hearing, you have not been asked to repay the UIB that you received.

7) You testified that, as of November 1, 2016, you had no income at all, and that you still have no income at this time.

8) On November 17, 2016, you uploaded a letter to your NYSOH account from the NYS Department of Labor, dated November 10, 2016, stating that you were disqualified from receiving UIB because you quit your job without good cause (Document [redacted]).

9) After the hearing, you uploaded a one-page document consisting of a UIB payment history. The document reflects that you received a total of five UIB payments, for gross amounts of $397.00 each. One of those payments was received in the month of September 2016, and four of them were received in the month of October 2016 (Document [redacted]). This document is marked and entered into the record as "Appellant's Exhibit One."

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

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 federal poverty level (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 2016 FPL, which is $11,880.00 for a one-person household (81 Federal Register 4036).

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 you were eligible for Medicaid in the months of October and November 2016.

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

You submitted an application for financial assistance on October 13, 2016, and then again on November 29, 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.

You testified that you are seeking Medicaid from October 1, 2016 through November 30, 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 and November 2016, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,366.20.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during October and November 2016.

You testified that the only income you received in October 2016 was from UIB, and that your UIB stopped at the end of October 2016 after you received a denial from the Department of Labor, which you provided to NYSOH (see document [redacted]). You testified that you had no income at all in November 2016.

After the hearing, you uploaded a UIB payment history showing that you received $397.00 a week for four weeks in October 2016. Therefore, the record indicates that in the month of October 2016, you had a monthly household income of $1,588.00, and a monthly income of $0.00 in November 2016 (see Appellant's Exhibit One).

Since your income of $1,588.00 was more than the $1,366.20 monthly Medicaid limit for October 2016, you would not have been eligible for Medicaid coverage during that month.

Since the record now contains a more accurate representation of what your income was for the month of November 2016, your case is RETURNED to NYSOH to consider your request for retroactive coverage for November 2016 based on a household size of one person, and household income of $0.00 for the month of November 2016.

Decision

You were not eligible for Medicaid in the month of October 2016.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for November 2016 based on a household size of one, and household income of $0.00 for the month of November 2016.

Effective Date of this Decision: April 3, 2017

How this Decision Affects Your Eligibility

You were not eligible for Medicaid in the month of October 2016.

You may be eligible for Medicaid in the month of November 2016. Your case is sent back to NYSOH to redetermine your eligibility for the month of November 2016, based on the evidence and testimony 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

You were not eligible for Medicaid in the month of October 2016.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for November 2016 based on a household size of one, and household income of $0.00 for the month of November 2016.

You were not eligible for Medicaid in the month of October 2016.

You may be eligible for Medicaid in the month of November 2016. Your case is sent back to NYSOH to redetermine your eligibility for the month of November 2016, based on the evidence and testimony 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 निःशुल्क 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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