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

Notice of Decision

Decision Date: May 9, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014570

[redacted]

Dear [redacted],

On April 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 4, 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: May 9, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014570

[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 retroactive Medicaid for the month of April 2016?

Procedural History

On May 7, 2016, NYSOH issued an eligibility determination notice, based on your May 6, 2016 application, stating that more information was needed to make an eligibility determination. That notice further stated that you needed to provide proof of income by May 22, 2016.

On May 13, 2016 and May 17, 2016, you submitted an end-of-year pay statement as proof of your 2016 gross household income. These documents were subsequently invalidated by NYSOH on May 17, 2016 and May 19, 2016 [redacted]

On May 18, 2016 and May 20, 2016, NYSOH issued notices stating that, although you have submitted proof of income, the documentation appears to be insufficient to resolve the request. That notice stated that additional proof of income was required to confirm your income.

On July 5, 2016, NYSOH issued an eligibility redetermination notice stating that you are eligible to purchase a qualified health plan at full cost through NYSOH, effective August 1, 2016. This was because NYSOH did not receive the income documentation needed to verify the income listed in your application.

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).

On January 3, 2017, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility insofar as you were not eligible for retroactive Medicaid for the month of April 2016.

On January 4, 2017, NYSOH issued an eligibility redetermination notice stating that you were ineligible for help with paying medical bills for October 1, 2016 through October 31, 2016.

Also on January 4, 2017, NYSOH issued a notice identifying you as the appellant and confirming your appeal of an "Eligibility Determination and Other: Requesting Retroactive Medicaid Coverage for April 2016."

On April 7, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was held open until April 22, 2017 for you to submit proof of income for April 2016.

On April 22, 2017, you submitted an attestation letter stating that you were unemployed from 2015 through May 16, 2016, an Unemployment Benefits Statement, a termination letter from your former employer and a hiring letter from your current employer. These documents were made part of the record as "Appellant's Exhibit A." No further documentation was received and the record is closed as of that day.

Findings of Fact

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

1) According to your NYSOH account, your tax filing status is single and you have no dependents.

2) According to your NYSOH account, although you requested help paying for medical bills in the last three months in your May 6, 2016 application, you were never issued an eligibility determination regarding that request. You were initially found eligible for full price qualified health plan as of August 1, 2016.

3) You testified that you were unemployed in the months of January 2016 through March 2016. You worked one day in the month of April 2016 as a [redacted] for the [redacted] and began a full-time job for the [redacted] in May 2016.

4) You testified that, because you were paid for your April 2016 [redacted] work in May 2016, you had no income in the month of April 2016. You were supported by family during the times you were unemployed.

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).

5) You submitted documentation that shows you were paid $200.00 for your April 2016 primary election work on May 12, 2016. NYSOH invalidated this document as insufficient [redacted].

6) You testified that you updated your account on January 3, 2017 because you were never issued an eligibility determination regarding your request for Retroactive Medicaid for the month of April 2016. You further stated that the January 4, 2017 eligibility determination notice regarding Retroactive Medicaid being denied for the period of October 1, 2016 through October 31, 2016 was incorrect and that it should have stated why you were denied for April 2016.

7) On April 22, 2016, you submitted a letter of attestation stating that you were unemployed from 2015 until May 16, 2016, an Unemployment Benefits Statement showing that your unemployment benefits ceased as of May 17, 2015, a termination letter from your former employer showing that you stopped working on May 5, 2014, and a hiring statement from your current employer showing that you began working on May 16, 2016 (*see* Appellant's Exhibit A).These documents indicate that you had no income in April 2016.

8) You testified that you currently have coverage through your employer, and are only seeking coverage for a hospital bill from April 2016.

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).

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 2016 FPL, which is $11,880.00 for a one-person household (81 Fed. Reg. 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 for Adults between the Ages of 19 and 65

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of 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 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 retroactive Medicaid for the month of April, 2016.

The record reflects that you updated your account and applied for Medicaid for yourself on May 6, 2016, and requested help [redacted] for medical bills form the last three months. You testified that you were seeking retroactive Medicaid for only the month of April 2016 because you had a hospital bill from that month. You were required to submit proof of income so that NYSOH could confirm your income as reported in your May 6, 2016 application and determine your eligibility for financial assistance.

Since the income documentation you provided was invalidated by NYSOH, on July 5, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for a qualified health plan at full cost, effective August 1, 2016.

Although the record contains a July 5, 2016 eligibility determination notice on the issue of eligibility for August 2016, it is silent as to your request for retroactive Medicaid coverage for the month of April 2016. The record does contain evidence of a January 4, 2017 notice in which NYSOH acknowledges receipt of

an appeal request, and identifies you as the appellant and the issue on appeal as "Eligibility Determination and Other: Requesting Retroactive Medicaid Coverage for April 2016" and a January 4, 2017 eligibility determination notice stating that you are not eligible for help paying medical bills for the period of October 1, 2016 through October 31, 2016.

Here, the lack of an eligibility determination notice on the issue of retroactive Medicaid for the month of April 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 failure to timely issue an eligibility determination notice as you are to appeal an adverse eligibility determination notice. The text of the January 4, 2017 appeal notice, which acknowledges the appeal on the issue of your denial of retroactive Medicaid and the January 4, 2017 eligibility determination which denies your request for retroactive Medicaid for the month of October 2016, along with your testimony, in which you stated you wanted help covering the medical expenses you have for the month of April 2016, permits an inference that the NYSOH did deny your request for retroactive Medicaid in the month of April 2016.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to an eligibility determination had it been issued. Therefore, the issue under review remains as whether you were properly denied retroactive Medicaid benefits for the month of April 2016.

You submitted an application for financial assistance on May 6, 2016 and requested help in paying for medical bills in April 2016. Subsequently, you were found eligible to enroll in a qualified health plan at full cost as indicated in the July 5, 2016 eligibility determination notice.

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 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 are in a one-person household for purposes of this analysis. This is because you expect to file your taxes with a tax filing status of single and will claim no dependents on your tax return.

You testified that you are seeking Medicaid for the month of April 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 April 2016, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,367.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during April 2016, therefore this matter turns to your financial eligibility that month.

You testified that you were unemployed from January 1, 2016 through March 30, 2016, but that you did work one day in April 2016. You received support from your family during this period. You further testified that you were paid for that one day of work in the month of May 2016; thus, you had no income for the month of April 2016.

To corroborate your testimony, you submitted your 2014, 2015 and 2016 year-end election income statement showing that you were paid $200.00 on May 12, 2016 for working [redacted] on April 19, 2016, a letter of attestation stating that you were unemployed from 2015 until May 16, 2016, an Unemployment Benefits Statement showing that your unemployment benefits ceased as of May 17, 2015, a termination letter from your former employer showing that your last day of employment was May 5, 2014, and a hiring statement from your current employer showing that you began working on May 16, 2016 [redacted] and Appellant's Exhibit A).

These documents indicate that you did not have any income in the month of April 2016.

Since your monthly income of $0.00 in April 2016 is less than the $1,367.00 monthly Medicaid allowable limit for that month, your eligibility for retroactive Medicaid coverage during April 2016 was not properly determined.

Therefore, your case is RETURNED to NYSOH to redetermine your eligibility for retroactive Medicaid coverage for April 2016 based on a one-person household, utilizing an FPL of 138%, and a household income of $0.00 for April 2016, and to notify you accordingly.

Decision

Your case is RETURNED to NYSOH to redetermine your eligibility for retroactive Medicaid coverage for April 2016 based on a one-person household, utilizing an FPL of 138%, and a household income of $0.00 for April 2016, and to notify you accordingly.

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).

Effective Date of this Decision: May 9, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility for financial assistance in April 2016. Your case is being sent back to NYSOH to redetermine your eligibility for retroactive Medicaid coverage for April 2016 based on a one-person household, utilizing an FPL of 138%, and a household income of $0.00 for April 2016. NYSOH will notify you once this has been done.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services. 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 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

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).

- By fax: 1-855-900-5557

Summary

Your case is RETURNED to NYSOH to redetermine your eligibility for retroactive Medicaid coverage for April 2016 based on a one-person household, utilizing an FPL of 138%, and a household income of $0.00 for April 2016, and to notify you accordingly.

This is not a final determination of your eligibility for financial assistance in April 2016. Your case is being sent back to NYSOH to redetermine your eligibility for retroactive Medicaid coverage for April 2016 based on a one-person household, utilizing an FPL of 138%, and a household income of $0.00 for April 2016. NYSOH will notify you once this has been done.

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.

□□□□□ (Bengali)

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).

□□□ □□ □□□□□□□□□□□□□ □□□□ □□□ □□□□□ □□□□□ □□□ □□□□□□□□□□ □□□□□□□□ □□ □□□□□, □□□□□□□ □□□ 1-855-355-5777 □□□□□□ □□ □□□□□ □□□□ □□ □□□□□□ □□□ □□□□ □□□□□□□□□□ □□□□ □□□□□□ □□□□ □□□□□□ □□□□ □□□□□

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)

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).

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).