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

Notice of Decision

Decision Date: June 7, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014845

[redacted]

Dear [redacted]

On April 11, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 26, 2016 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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nystateofhealth
The Official Health Plan Marketplace

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

Decision

Decision Date: June 7, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014845

[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 you were not eligible for retroactive Medicaid coverage from August 1, 2016 to September 30, 2016?

Procedural History

On November 3, 2016, NYSOH received your updated application for financial assistance with health insurance indicating you were seeking help paying for medical bills for the month of October 2016.

On November 4, 2016, NYSOH issued a notice stating the income information listed in your application did not match information received from state and federal data sources. The notice directed you to submit proof of your income by November 18, 2016, or NYSOH would not be able to determine your eligibility for health insurance.

On November 14, 2016, you updated your application and indicated you were seeking help paying for medical bills for the three months prior to the application.

On November 15, 2016, NYSOH issued a notice stating the income information listed in your application did not match information received from state and federal data sources. The notice directed you to submit proof of your income by November 29, 2016, or NYSOH would not be able to determine your eligibility for health insurance.

On November 25, 2016, NYSOH verified your income documentation and systematically redetermined your eligibility.

On November 26, 2016, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective November 1, 2016.

Also on November 26, 2016, NYSOH issued an eligibility determination notice stating you were not eligible for retroactive Medicaid coverage for the period of August 1, 2016 to October 31, 2016, because the household income you provided for each month was over the allowable monthly income limit.

On January 13, 2017, you spoke to NYSOH's Account Review Unit and appealed, insofar as you were not eligible for retroactive Medicaid coverage for the months of August, September, and October 2016.

On April 11, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to allow you to submit supporting documents.

On April 12, 2017, NYSOH received the requested documentation and it was incorporated into the record as Appellant's Exhibit #1. The record was then closed.

Findings of Fact

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

1) You submitted an updated application for financial assistance with health insurance on November 14, 2016. That application indicated you were seeking retroactive coverage for the months of August, September, and October 2016.

2) The November 14, 2016 application listed your income as $2,200.00 for August 2016, $1,437.42 for September 2016, and $1,437.42 for October 2016.

3) Income documentation you submitted was verified by NYSOH on November 25, 2016 and you were determined Medicaid eligible, effective November 1, 2016.

4) On November 26, 2016, NYSOH denied your request for retroactive Medicaid coverage for the months of August, September, and October 2016, because your household income was over the allowable income limit in each month, based on the information in the November 14, 2016 application.

5) You testified the monthly income amounts listed in the November 14, 2016 application were not accurate.

6) You testified you were employed until August 29, 2016, and your last paycheck received from this employment was only partial and was dated September 9, 2016. You testified you were paid weekly at this job.

7) You testified you applied for unemployment insurance benefits after losing your job, but you did not qualify.

8) You testified you have had no income since your last paycheck on September 9, 2016.

9) You testified that you are only seeking retroactive Medicaid coverage for the months of August and September 2016. You testified you are no longer seeking retroactive Medicaid coverage for the month of October 2016.

10) You were directed to submit a copy of all paystubs relating to paychecks received in the months of August and September 2016.

11) On April 12, 2017, you uploaded to your NYSOH the following documentation ([redacted]:

a. A paystub with pay date of August 19, 2016 for pay period of August 8, 2016 to August 14, 2016 in the gross amount of $830.96.

b. A paystub with pay date of August 26, 2016 for pay period of August 15, 2016 to August 21, 2016 in the gross amount of $852.04.

c. A paystub with pay date of September 2, 2016 for pay period of August 22, 2016 to August 28, 2016 in the gross amount of $884.51.

d. A paystub with pay date of September 9, 2016 for pay period of August 29, 2016 to September 4, 2016 in the gross amount of $206.20.

e. A letter from your former employer dated October 17, 2016 stating your last day of employment was August 29, 2016.

12) You testified, and your most recent application confirms, you will file your 2017 tax return with a tax filing status of single, and you will claim no dependents on that return.

13) You testified you started a small business in 2016, but you have derived no income from that business. You testified you may have a small amount of business deductions you will take on your 2017 tax return relating to this business, but you are not sure of the amount.

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).

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)). It is not necessary for the person to be found eligible for Medicaid going forward for the individual to be eligible for retroactive Medicaid. 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 you were not eligible for retroactive Medicaid coverage from August 1, 2016 to September 30, 2016.

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

You submitted an updated application for financial assistance on November 14, 2016. That application indicated you were seeking retroactive coverage for the months of August, September, and October 2016. This application listed your income as $2,200.00 for August 2016, $1,437.42 for September 2016, and $1,437.42 for October 2016.

Following a November 25, 2016 systematic eligibility redetermination, you were determined eligible for Medicaid, effective November 1, 2016. On November 26, 2016, NYSOH issued an eligibility determination stating you were not eligible for retroactive Medicaid coverage for the months of August, September, and October 2016, because your household income was over the allowable income limit in each month, based on the information in the November 14, 2016 application.

You testified the monthly income amounts listed in the November 14, 2016 application were not accurate compared with the actual income you received in those months. Additionally, you testified you are only seeking retroactive Medicaid coverage for the months of August and September 2016. You testified you are not seeking retroactive coverage for the month of October 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 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 for the period from August 1, 2016 to September 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 August and September 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 August or September 2016.

Although you testified you were paid weekly until you lost your job on August 29, 2016, you only submitted two paystubs with check dates in August 2016. As such, the record does not contain sufficient evidence to determine your total gross income in the month of August 2016. However, even based on the two weekly paystubs submitted, the total gross income of which equals $1,683.00, the evidence establishes your earnings were over the monthly income limit of $1,367.00 to qualify for Medicaid in the month of August 2016.

Therefore, the November 26, 2016 eligibility determination, insofar as it stated you were not eligible for retroactive Medicaid coverage for the month of August 2016 because you were over the allowable income limit, is correct and is AFFIRMED.

With regard to September 2016, you submitted two paychecks with check dates in September 2016 indicating total gross income of $1,090.00. You testified, and the evidence corroborates, you have had no additional income since your last paycheck dated September 9, 2016. Therefore, the evidence establishes your total gross income for the month of September 2016 was $1,090.00

Since the record now contains a more accurate representation of what your income was for the month of September 2016, your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage for September 2016, based on a household size of one person and household income of $1,090.00 for the month of September 2016.

Decision

The November 26, 2016 eligibility determination, insofar as it stated you were not eligible for retroactive Medicaid coverage for the month of August 2016, is AFFIRMED.

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage for September 2016, based on a household size of one person and household income of $1,090.00 for the month of September 2016.

Effective Date of this Decision: June 7, 2017

How this Decision Affects Your Eligibility

You were not eligible for retroactive Medicaid coverage for the month of August 2016.

This is not a final determination of your eligibility. Your case is being sent back to NYSOH to redetermine your eligibility for retroactive Medicaid coverage for the month of September 2016, based on the record as developed during and after 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

The November 26, 2016 eligibility determination, insofar as it stated you were not eligible for retroactive Medicaid coverage for the month of August 2016, is AFFIRMED.

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage for September 2016, based on a household size of one person and household income of $1,090.00 for the month of September 2016.

You were not eligible for retroactive Medicaid coverage for the month of August 2016.

This is not a final determination of your eligibility. Your case is being sent back to NYSOH to redetermine your eligibility for retroactive Medicaid coverage for the month of September 2016, based on the record as developed during and after 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)

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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।

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)

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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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