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

Notice of Decision

Decision Date: June 08, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015881

[redacted]

Dear [redacted]

On May 18, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 1, 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: June 08, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015881

[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 from December 1, 2016 through December 31, 2016?

Procedural History

On December 27, 2016, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills in December 2016.

On January 2, 2017, you faxed a self-attestation letter and a copy of two consecutive bi-weekly paystubs dated November 18, 2016 and December 2, 2016 (*see* Document [redacted]).

On February 1 ,2017, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid from September 1, 2016 through November 30, 2016, because your monthly household income of $2,100.00 was over the allowable monthly income limit of $1,367.00.

Also on February 1, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid as of January 1, 2017.

On February 15, 2017, you spoke to NYSOH's Account Review Unit and appealed the one February 1, 2017 eligibility determination notice that denied you retroactive Medicaid for the month of December 2016.

On February 16, 2017, NYSOH issued an appeal notice stating that you are appealing your “Eligibility determination.”

On May 18, 2017, you had a telephone hearing with a Hearing Officer from NYSOH’s Appeals Unit. The record was developed during the hearing held open to June 3, 2017, to allow you to submit supporting documents.

As of June 3, 2017, 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. 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 for the month of December 2016.

2) You testified that you expect to file your 2017 federal income tax return as head of household and claim one dependent.

3) You submitted an application for financial assistance on December 27, 2016.

4) Your application submitted on December 27, 2016, states that you file as head of household and have no dependents. It further states that for the month of December 2016 your income was $0.00.

5) On January 2, 2017, you faxed a copy of two consecutive bi-weekly paystubs dated November 18, 2016 and December 2, 2016. These documents show that your gross household earnings for December 2016 were at least $1,760.00 (*see* Document [redacted]).

6) You testified that the December 2, 2016 paystub was the only paystub you received in December 2016.

7) According to your NYSOH account and your testimony, on February 15, 2017, you contacted NYSOH to request retroactive Medicaid coverage for December 2016 and filed an appeal on this issue.

8) You testified that you are requesting Medicaid for the month of December 2016 because you have medical bills for that month.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

De Novo Review

The 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).

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 from December 1, 2016 through December 31, 2016.

The record reflects that you updated your account and applied for Medicaid for yourself on December 27, 2016. On February 1, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective January 1, 2017. That same day, NYSOH issued a second eligibility determination notice denying you retroactive Medicaid coverage for the months of September 1, 2016 through November 30, 2016.

Although the record contains two February 1, 2017 eligibility determination notices on the issue of Medicaid eligibility for January 2017 and September 1, 2016 through November 30, 2016, those notices are silent as to your request for retroactive Medicaid coverage for the month of December 2016. The record does contain evidence of a February 15, 2017 telephone call record to NYSOH in which you request retroactive Medicaid for December 2016 and a February 16, 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.”

Here, the lack of a notice of eligibility determination on the issue of retroactive Medicaid for you for the month of February 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 a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination. The record of the February 15, 2017 telephone call along with the text of the February 16, 2017 notice, which acknowledges the appeal on the issue of your denial of retroactive Medicaid, and your testimony, in which you stated you wanted help covering the medical expenses you have for the month of December 2016, permits an inference that the NYSOH did deny your request for retroactive Medicaid in the month of December 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 is whether you were properly denied retroactive Medicaid benefits for the month of December 2016.

You were initially found eligible for Medicaid in the February 1, 2017 eligibility determination notice. According to this notice, your coverage with Medicaid began January 1, 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 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 your Medicaid coverage retroactively applied solely for the month of December 2016.

Although you testified that you claim one dependent on your income tax return, you failed to submit any documentation to prove this. Therefore, for purposes of this analyses, as stated in your application, you are in a one-person household based on the information in your NYSOH that you file your taxes with a tax filing status of head of household and claim no dependents on your tax return.

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 December 2016, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the applicable FPL, which is $1,367.00 per month for a one-person household. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during December 2016.

You testified that you are paid bi-weekly. You faxed a paystub dated December 2, 2016 with a gross pay amount of $1,760.00. You testified that this was your only paystub for household income you received in December 2016 (*see* Document [redacted]).

Therefore, the record indicates that in the month of December 2016, you had a monthly household income of at least $1,760.00.

Since your income of at least $1,760.00 is more than the allowable maximum monthly Medicaid limit of $1,367.00 for a one-person household in December 2016, NYSOH properly determined that you were not eligible for Medicaid coverage during that month. Therefore, by this Decision, it is determined that you were not eligible for retroactive Medicaid in the month of December 2016.

Decision

By this Decision, it is determined that you were not eligible for retroactive Medicaid in the month of December 2016.

Effective Date of this Decision: June 08, 2017

How this Decision Affects Your Eligibility

You are not eligible for retroactive Medicaid in the month of December 2016.

Your eligibility for Medicaid was effective as of January 1, 2017.

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

By this Decision, it is determined that you were not eligible for retroactive Medicaid in the month of December 2016.

You are not eligible for retroactive Medicaid in the month of December 2016.

Your eligibility for Medicaid was effective as of January 1, 2017.

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 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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