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

Notice of Decision

Decision Date: July 19, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016235

[redacted]

Dear [redacted]

On July 6, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's denial of Retroactive Medicaid coverage for the months of June 2016 and October 2016.

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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NY State of Health Account ID: [redacted]
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Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health (NYSOH) properly determine that you were not eligible for Retroactive Medicaid coverage for June 1, 2016 through June 30, 2016?
>
> Did NYSOH properly determine that you were not eligible for eligible for Retroactive Medicaid coverage for October 1, 2016 through October 31, 2016?

Procedural History

On October 11, 2016, you submitted an application for financial assistance with health insurance to NYSOH and indicated that you were seeking help for paying for medical bills for July 2016 through September 2016.

Also on October 11, 2016, you uploaded income documentation.

On October 12, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for the Essential Plan for a limited time, effective November 1, 2016. You were directed to submit proof of income by January 9, 2017.

Also on October 12, 2016, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in an Essential Plan with a start date of November 1, 2016.

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On October 19, 2016, NYSOH determined that your income documentation was valid.

On October 20, 2016, NYSOH issued an eligibility determination stating that you were eligible for the Essential Plan, effective December 1, 2016.

Also, on October 20, 2016, NYSOH issued a notice of enrollment confirmation stating that you remained enrolled in an Essential Plan, effective November 1, 2016.

Also, on October 20, 2016, NYSOH issued a notice stating that it received your request dated October 11, 2016 for help paying for medical bills for the three months prior to your October 11, 2016 application. The notice directed you to provide proof of income for July 1, 2016 through July 31, 2016 by November 3, 2016.

On January 24, 2017, you uploaded proof of income to your NYSOH account.

On February 13, 2017, your income documentation was verified and NYSOH redetermined your eligibility.

On February 14, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid from July 1, 2016 through July 31, 2016 because your monthly household income of $0.00 was below the allowable monthly income limit of $1,367.00.

On February 24, 2017, you spoke to NYSOH's Account Review Unit and appealed the verbal denial of Retroactive Medicaid coverage for the month of June 2016 and October 2016.

On May 12, 2017, you spoke to NYSOH's Account Review Unit and appealed the verbal denial of Retroactive Medicaid coverage for the month October 2016 and that your gross income for eligibility determination purposes was not reduced by the deductions taken by the IRS from your Social Security disability payments for a tax lien.

On July 6, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed 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 beginning in October 2016, the IRS began deducting $215.70 per month from your Social Security disability payments based on a tax lien you owed in the amount of $33,000.00. You appealed the fact that your gross income for eligibility determination purposes was not reduced by the deductions taken by the IRS. You testified that you were withdrawing and no longer appealing that issue.

2) You testified that you are seeking Retroactive Medicaid coverage from June 1, 2016 to June 30, 2016.

3) You testified that you have outstanding medical bills from June 2016 for which you are seeking insurance coverage.

4) You testified that you are also seeking Retroactive Medicaid coverage from October 1, 2016 to October 31, 2016.

5) You testified that you have outstanding medical bills from October 2016 for which you are seeking insurance coverage.

6) You testified that you have not filed a federal income tax return in several years because your income is below the threshold level where the filing of a tax return is required.

7) You submitted an application for financial assistance on October 11, 2016.

8) Your application submitted on October 11, 2016 stated that your expected yearly income was $17,196.00.

9) You testified that your sole source of income is your Social Security disability benefits which are $1,433.00 per month ($17,196.00 annually).

10) You testified that you first began receiving Social Security disability benefits on October 8, 2016.

11) You testified that you had no other income in 2016 except for your Social Security disability benefits which you first received in October 2016 and subsequently in November 2016 and December 2016.

12) You uploaded a Social Security statement of benefits on October 11, 2016 which was verified on October 19, 2016.

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13) On January 24, 2017, you uploaded proof of income to your NYSOH account consisting of a letter attesting to you having no income during July 2016. This proof of income was verified February 13, 2017.

14) You testified that in February 2017 you were verbally denied Retroactive Medicaid coverage by NYSOH for June 2016.

15) You testified that in March 2017 you were verbally denied Retroactive Medicaid coverage by NYSOH for October 2016.

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 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)). 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 first issue under review is whether NYSOH properly determined that you were not eligible for Medicaid for June 1, 2016 through June 30, 2016.

You testified that you are appealing the denial of Retroactive Medicaid coverage for June 2016. However, the record does not contain a notice of eligibility determination or redetermination on the issue of Retroactive Medicaid coverage for June 2016.

You submitted an application for financial assistance on October 11, 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 June 1, 2016 through June 30, 2016. The three months before the month of your application (October 11, 2016) were July 2016 through September 2016. As such, you are not eligible to be considered for Retroactive Medicaid coverage for the month of June 2016 because it is beyond the three-month period.

Therefore, NYSOH's February 2017 verbal denial of your request for Retroactive Medicaid coverage for the month of June 2016 was correct and is AFFIRMED.

The second issue under review is whether NYSOH properly determined that you were not eligible for Medicaid coverage for October 1, 2016 through October 31, 2016.

You testified that you are appealing the denial of Medicaid coverage for October 2016.

You are in a one-person household.

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 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 October 2016.

You testified that your sole source of income is your Social Security disability benefits which are $1,433.00 per month. You uploaded a Social Security statement of benefits dated October 6, 2016 which indicated that for the month of October 2016 you received $1,433.00. Therefore, in the month of October 2016, you had a monthly household income of $1,433.00.

Since your income of $1,433.00 was more than the $1,367.00 monthly Medicaid limit for October 2016, NYSOH properly determined that you were not eligible for Medicaid coverage during that month. Therefore, the March 2017 verbal denial of Medicaid coverage for October 2016, is correct and is AFFIRMED.

Decision

The February 2017 verbal denial of Medicaid coverage for June 2016 is AFFIRMED.

The March 2017 verbal denial of Medicaid coverage for October 2016 is AFFIRMED.

Effective Date of this Decision: July 19, 2017

How this Decision Affects Your Eligibility

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

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

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.

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).

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 February 2017 verbal denial of Medicaid coverage for June 2016 is AFFIRMED.

The March 2017 verbal denial of Medicaid coverage for October 2016 is AFFIRMED.

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

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

Legal Authority

We are issuing this determination in accordance with 45 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).

A Copy of this Decision Has Been Provided To:

[redacted]

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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 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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