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

Notice of Decision

Decision Date: July 10, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000016356

[redacted]

[redacted]

Dear [redacted]

On June 15, 2017, your authorized representative, [redacted] appeared on your behalf by telephone at a hearing on your appeal of NY State of Health's January 31, 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.

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).

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: July 10, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016356

[redacted]

[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 August 1, 2016 through August 31, 2016?

Procedural History

According to your NYSOH account, you were determined eligible to receive up to $187 per month in advance payments of the premium tax credit and, if you selected a silver-level qualified health plan, newly eligible for cost-sharing reductions, effective May 1, 2016. However, you did not enroll in a qualified health plan for coverage to start.

On October 28, 2016, your NYSOH account was updated and earning statements were submitted. You also listed an expected yearly income of $700.00, which put you in pending Medicaid status.

On October 29, 2016, NYSOH issued a notice stating that the income information in your application did not match the information received from state and federal data sources. The notice instructed you to provide documentation to prove your

household income and confirm your eligibility for financial assistance by November 12, 2016.

On November 10, 2016, NYSOH issued a notice stating that the documentation you submitted was reviewed and did not confirm the information in your application. The notice instructed you to submit additional income documentation by February 2, 2017, so that your eligibility could be confirmed.

Also on November 10, 2016, NYSOH issued an eligibility determination notice stating you were eligible for the Essential Plan for a limited time, effective December 1, 2016. The notice further stated that you had to provide documentation to prove your income and continue your eligibility by February 7, 2017.

On November, 29, 2016, NYSOH issued e plan enrollment notice confirming you selected an Essential Plan 1 on November 28, 2016, and had a $20.00 monthly premium and an effective start date of December 1, 2016.

On December 17, 2016, NYSOH issued another eligibility determination notice stating that you were fully eligible for the Essential Plan, effective January 1, 2017.

Also on December 17, 2016, NYSOH issued a notice acknowledging your November 9, 2016 request for help with paying medical bills for the three-month period prior to your application for health insurance, dated November 9, 2016. The notice stated that you needed to provide proof of income for the period of August 1, 2016 through September 30, 2016 by December 31, 2016.

Also on December 17, 2016, NYSOH issued a plan enrollment notice confirming your enrollment in an Essential Plan 1, with a $20.00 monthly premium and an effective start date of December 1, 2016.

On December 20, 2016, NYSOH issued a disenrollment notice stating that your coverage in your Essential Plan 1 ended, effective December 1, 2016, because you did not pay your insurance bill by the payment deadline.

On December 21, 2016, NYSOH issued a notice stating that the documentation you submitted was reviewed and did not confirm the information in your application. The notice instructed you to submit additional documentation by January 15, 2017, so that your eligibility could be confirmed.

On December 21, 2016, NYSOH issued an eligibility determination notice stating that you did not qualify for retroactive Medicaid from September 1, 2016 through September 30, 2016, because your income of $3,216.84 that month was over the allowable monthly income limit of $1,367.00

On January 31, 2017, NYSOH issued an eligibility determination notice stating that you did not qualify for retroactive Medicaid from August 1, 2016 through August 31, 2016, because your income of $1,552.38 that month was over the allowable monthly income limit of $1,367.00.

On March 1, 2017, NYSOH issued a notice acknowledging your February 28, 2017 request for an appeal to have the denial of retroactive Medicaid for August 2016 reviewed.

A hearing scheduled for June 13, 2017, was adjourned to June 15, 2017 at the request of your authorized representative. On June 15, 2017, a telephone hearing was conducted by a Hearing Officer with NYSOH's Appeals Unit. Through sworn testimony and acting on your behalf, your authorized representative agreed to waive formal notice of the adjourned hearing and agreed to have your right to be present waived. The record was developed during the hearing and closed at the end of the proceeding.

Findings of Fact

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

1) According to your NYSOH account, in your November 9, 2016 application, you requested help with paying medical bills for the three previous months. Your authorized representative testified that her office submitted the application and income documents on your behalf that day.

2) According to your NYSOH account and your authorized representative's testimony, you are seeking retroactive Medicaid for the month of August 2016.

3) Your authorized representative testified that you were hospitalized on [redacted], and were out of work most of the month.

4) According to the income documentation you/your authorized representative submitted, you received an earnings statement, dated August 12, 2016, for the pay period of July 25, 2016 through August 7, 2016, showing gross earnings of $1,076.76. The corresponding pay period detail, dated November 13, 2016, also shows gross earnings received on August 12, 2016, in that same amount. There were no other earnings reported as received in August 2016 and the next earnings statement was dated September 9, 2016, as also documented on the pay period detail.

5) According to your NYSOH account, the income calculated by the system showed you received gross earnings of $1,552.38 in the month of August 2016. Your authorized representative testified that she was not sure how NYSOH came up with this amount.

6) According to your NYSOH account, you expect to file your 2016 federal tax return using a tax filing status of single and will not claim any dependents on that 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 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 retroactively from August 1, 2016 through August 31, 2016

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

You submitted an updated application for financial assistance on November 9, 2016, and requested help with paying for medical bills for the past three months; specifically, for the month of August 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.

Your authorized representative confirmed through sworn testimony that you are seeking Medicaid retroactively for the month of August 2016, which is the third month before your November 9, 2016 application.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

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 2016, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the 2016 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 2016.

The credible evidence of record indicates that you are paid once every two weeks, and the income documentation your authorized representative uploaded supports that the only earnings you received during the month of August 2016, were on August 12, 2016 in the gross amount of $1,076.76. The record further supports that your next pay was received on September 9, 2016. Therefore, the

record indicates that in the month of August 2016, you had a monthly household income of $1,076.76.

The January 31, 2017 eligibility determination notice stated you were not eligible for Medicaid from August 1, 2016 through August 31, 2016, because your household income of $1,552.38 that month was over the allowable monthly income limit of $1,367.00. Since the income amount for August 2016 calculated by NYSOH is incorrect and not supported by the record, the notice is RESCINDED.

Since the record now contains a more accurate representation of what your income was for the month of August 2016, your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage from August 1, 2016 through August 31, 2016 based on a household size of one person and household income of $1,076.76 for the month of August 2016.

Decision

The January 31, 2017 eligibility determination notice regarding your eligibility for retroactive Medicaid during the month of August 2016 is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage from August 1, 2016 through August 31, 2016, based on a household size of one person and household income of $1,076.76 for the month of August 2016, and to notify you accordingly.

Effective Date of this Decision: July 10, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility for retroactive Medicaid for the month of August 2016. Your case is sent back to NYSOH to redetermine your eligibility based on the evidence you presented at the hearing. NYSOH will notify you once a redetermination is made.

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 January 31, 2017 eligibility determination notice regarding your eligibility for retroactive Medicaid during the month of August 2016 is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage from August 1, 2016 through August 31, 2016 based on a household size of one person and household income of $1,076.76 for the month of August 2016, and to notify you accordingly.

This is not a final determination of your eligibility for retroactive Medicaid for the month of August 2016. Your case is sent back to NYSOH to redetermine your eligibility based on the evidence you presented at the hearing. NYSOH will notify you once a redetermination is made.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

[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)

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).

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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