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

Notice of Decision

Decision Date: June 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016504

[redacted]

Dear [redacted]

On June 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 15, 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: June 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016504

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Was your appeal of the NY State of Health's December 15, 2016 eligibility determination notice timely?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid for September 1, 2016 through September 31, 2016?

Procedural History

On November 23, 2016, NY State of Health (NYSOH) received your application for financial assistance with health insurance. This application indicated that you were seeking help for paying for medical bills for August 2016, September 2016 and October 2016.

Also on November 23, 2016, you uploaded four documents to your NYSOH account.

On November 24, 2016, NYSOH issued a notice stating that the information in your application did not match what NYSOH received from state and federal data sources. This notice further stated that more information was needed to confirm the information in your application, and directed you to submit additional income documentation by December 7, 2016.

On December 15, 2016, NYSOH verified and partially validated the documents that you uploaded to your NYSOH account on November 23, 2016. Subsequently, a new application was run on your behalf.

On December 15, 2016, NYSOH issued an eligibility determination stating that you were eligible for Medicaid, effective December 1, 2016.

Also on December 15, 2016, NYSOH issued an eligibility determination stating that you were not eligible for Medicaid for Medicaid for August 1, 2016 through August 31, 2016 because your monthly household income of $1,465.41 is over the allowable monthly income limit of $1,367.00 and that you were not eligible for Medicaid for September 1, 2016 through September 20, 2016 because your monthly household income of $1,618.87 is over the allowable month income of $1,367.00. This notice further directed you to submit income documentation for October 1, 2016 to October 30, 2016 by December 29, 2016 in order for NYSOH to determine eligibility for Medicaid coverage for October 2016.

On December 16, 2016, NYSOH issued a notice stating that the documentation you submitted did not confirm the information in your account. This notice further directed you to submit additional income documentation by January 13, 2017.

On March 3, 2017, you spoke to NYSOH's Account Review Unit and appealed the December 15, 2016 eligibility determination notice insofar as it denied you retroactive Medicaid for the month of September 2016.

On June 14, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and the record was 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 you are seeking Medicaid for the month of September 2016.

1) You testified that you filed your 2016 federal income tax return as single, and claimed no dependents. You further testified that you did not take any deductions on your tax return

2) You submitted an application for financial assistance on November 23, 2016. In this application, you requested help with medical bills for the months of August 2016, September 2016 and October 2016.

3) Your application submitted on November 23, 2016, states that for the month of September 2016 your income was $1,618.87. You testified that amount was correct.

4) You testified that you are paid weekly.

5) You further testified that you made more in September 2016 than you normally make because you worked overtime that month.

6) You uploaded four paystubs; dated September 2, 2016 for a gross pay amount of $500.69, September 9, 2016 for a gross pay of $341.23, September 16, 2016 for a gross pay of $509.86, and September 23, 2016 for a gross pay amount of $400.26.

7) You testified that you are seeking retroactive Medicaid for the month of September 2016 because you have unpaid medical bills from that month.

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

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by NYSOH to provide timely notice of an eligibility determination; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505, 45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH (45 CFR § 155.520(b)(2); 18 NYCRR § 358-3.5(b)(1)).

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 initial issue under review is whether your appeal of NYSOH's December 15, 2016 eligibility determination was timely.

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of your denial of retroactive Medicaid for the month of September 2016 as stated in the December 15, 2016 preliminary eligibility determination, an appeal should have been filed on or around February 13, 2017. The record reflects that your appeal was filed on March 3, 2017, which is well beyond the 60-day deadline.

However, the record indicates that you were in contact with NYSOH multiple times prior to filing your appeal asking NYSOH to re-determine your eligibility for Medicaid for the month of September 2016. The record further reflects that you first contacted NYSOH and requested to be re-determined eligible for retroactive Medicaid for September 2016 on January 3, 2017 after receiving the December 15, 2016 eligibility determination finding you not eligible for retroactive Medicaid for the month of September 2016.

Therefore, it is reasonable to infer that you filed your appeal within a reasonably short time of learning that you were not eligible for Medicaid for the month of

September 2016 after requesting to be re-determined eligible. Therefore, your appeal was timely filed.

The second issue under review is whether NYSOH properly determined that you were not eligible for Medicaid for September 1, 2016 through September 30, 2016.

You are in a one-person household; you filed your 2016 taxes with a tax filing status of single and claimed no dependents on your tax return.

You submitted an application for financial assistance on November 23, 2016 and requested help in paying for medical bills for August 2016, September 2016 and 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 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.

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 September 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 September 2016.

You testified that you are paid weekly. You uploaded four paystubs; dated September 2, 2016 for a gross pay amount of $500.69, dated September 9, 2016 for a gross pay amount of $341.23, dated September 16, 2016 for a gross pay of $509.86, and dated September 23, 2016 for a gross pay of $400.26. Therefore, the record indicates that in the month of September 2016, you had a monthly household income of $1,752.04.

Since your income of $1,752.04 was more than the $1,367.00 monthly Medicaid limit for September 2016, NYSOH properly determined that you were not eligible for Medicaid coverage during that month.

Therefore, the December 15, 2016 eligibility determination stating that you were not eligible for Medicaid in the month of September 2016, is correct and is AFFIRMED.

Decision

The December 15, 2016 eligibility determination is AFFIRMED.

Effective Date of this Decision: June 28, 2017

How this Decision Affects Your Eligibility

You are not eligible for Medicaid in the month of September.

Your eligibility for Medicaid was effective as of December 1, 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.

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 December 15, 2016 eligibility determination is AFFIRMED.

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

Your eligibility for Medicaid was effective as of December 1, 2016.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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)

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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)

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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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