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

Notice of Decision

Decision Date: July 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017243

[redacted]

Dear [redacted]

On June 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's denial of retroactive Medicaid for the month of April 2017.

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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Decision

Decision Date: July 26, 2017

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000017243

[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 retroactive Medicaid from April 1, 2017 through April 30, 2017?

Procedural History

On March 24, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan, effective May 1, 2017.

Also on March 24, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as it began your Essential Plan enrollment on May 1, 2017, and not April 1, 2017.

On March 25, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in an Essential Plan 1 with a $20.00 monthly premium and an enrollment start date of May 1, 2017.

On April 18, 2017, you updated your NYSOH application and requested help paying for medical bills from the last three months.

On May 6, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid because your household income of $15,360.00 was at or below the allowable income limit. This eligibility was effective as of May 1, 2017.

On May 9, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid from February 1, 2017 through February 28, 2017 because the monthly household income you provided of $1,739.93 was over the allowable monthly income limit of $1,387.00.

On June 28, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Your request to amend the appeal to have a redetermination of your eligibility for Retroactive Medicaid for the month of April 2017 was granted and testimony was received.

The record was held open to July 13, 2017 for you to submit proof of your income for April 2017. As of July 13, 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 and 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 were found eligible for Medicaid on May 6, 2017 with an effective date of May 1, 2017. You testified that you are seeking retroactive Medicaid coverage for the month of April 2017.

2) According to your NYSOH account, and your testimony, you expect to file your 2017 federal income tax return as single and claim no dependents.

3) In your applications for financial assistance on April 18, 2017 and May 8, 2017, you requested help paying for medical bills for the past three months.

4) You testified that you started a new job on April 10, 2017 and only received one or two paystubs that month. You were unsure how much income you received during that month.

5) According to your NYSOH account, you do not plan on taking any deductions on your tax return.

6) You testified that you had an urgent medical need in April 2017 that you had to pay for out of pocket.

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

Applicable Law and Regulations

De Novo Review

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).

Retroactive Medicaid for Adults between the Ages of 19 and 65

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of 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 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

Initially and per your NYSOH account, it is noted that your appeal related to your Essential Plan enrollment start date. However, you testified at hearing that you are appealing to be redetermined eligible for retroactive Medicaid for the month of April 2017. The Hearing Officer agreed to receive testimony on this issue.

Therefore, the issue under review is refined to whether NYSOH properly determined that you were not eligible for retroactive Medicaid from April 1, 2017 through April 30, 2017.

The record reflects that you updated your account and applied for retroactive Medicaid on April 18, 2017. On May 6, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective May 1, 2017. On May 8, 2017, you again applied for retroactive Medicaid to help pay for medical bills from the three prior months. On May 9, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid from February 1, 2017 through February 28, 2017, because your monthly income was over the allowable monthly income limit to qualify for retroactive Medicaid that month.

Although the record contains evidence in the May 9, 2017 eligibility determination notice on the issue of Medicaid eligibility for February 2017, it is silent as to your May 8, 2017 request for retroactive Medicaid coverage for the month of April 2017. By this notice, NYSOH acknowledged receipt of your request for

retroactive Medicaid for the three months before May 2017; that is, for April 2017, March 2017, and February 2017.

Here, the lack of an eligibility determination notice on the issue of retroactive Medicaid for the three months prior to May 2017 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 text of the May 9, 2017 notice, which acknowledged receipt of your request for retroactive Medicaid for the three months before May 2017 along with your testimony, in which you stated you wanted help covering the medical expenses for the month of April 2017, permits an inference that the NYSOH did deny your request for retroactive Medicaid in the month of April 2017.

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 notice had it been issued.

You were initially found eligible for Medicaid in the May 6, 2017 eligibility determination notice. According to this notice, your coverage with Medicaid began May 1, 2017.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's 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 April 2017.

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

You testified that you began working a new job in April 2017 and, therefore, only received one or two paystubs in that month. The record was held open to July 13, 2017 for you to submit proof of your income for the month of April 2017. However, as of July 13, 2017, no documentation was received to prove your income for that month. Since you failed to submit proof of your April 2017 income, the merits on the issue of your eligibility for retroactive Medicaid for the month of April 2017 cannot be addressed.

Therefore, no further action is required of NYSOH at this time.

Decision

Since you failed to submit proof of your April 2017 income, the merits on the issue of your eligibility for retroactive Medicaid for the month of April 2017 cannot be addressed.

Therefore, no further action is required of NYSOH at this time.

Effective Date of this Decision: July 26, 2017

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

The effective date of your Medicaid is May 1, 2017.

Your eligibility for retroactive Medicaid in the month of April 2017 cannot be addressed since you failed to submit proof of income for that month.

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

Since you failed to submit proof of your April 2017 income, the merits on the issue of your eligibility for retroactive Medicaid for the month of April 2017 cannot be addressed.

No further action is required of NYSOH at this time.

This decision does not change your eligibility.

The effective date of your Medicaid is May 1, 2017.

Your eligibility for retroactive Medicaid in the month of April 2017 cannot be addressed since you failed to submit proof of income for that month.

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 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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