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

Notice of Decision

Decision Date: August 8, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017648

[redacted]

Dear [redacted]

On July 17, 2017, you both appeared by telephone at a hearing on your appeal of NY State of Health's March 21, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: August 8, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017648

[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 December 1, 2016 through January 31, 2017?

Procedural History

On March 20, 2017, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills from December 2016 through February 2017.

On March 21, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost, effective May 1, 2017.

Also on March 21, 2017, NYSOH issued another eligibility determination notice stating that you were not eligible for Medicaid from December 1, 2016 through February 28, 2017, because the program you are eligible for cannot pay for any care you received in the past.

On April 3, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as you were denied retroactive Medicaid for the months of December 2016 through February 2017.

On July 17, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, you were represented by Attorney [redacted] Your request to amend the appeal to a redetermination of retroactive Medicaid for the months of December 2016 and January 2017 was granted and testimony was received. The record was developed during the hearing and held open to August 9, 2017, to allow you to submit supporting documents.

On July 21, 2017 and July 31, 2017, NYSOH received the requested documentation, which was made part of the record as "Appellant's Exhibit A" and "Appellant's Exhibit B" respectively. The record was closed on July 31, 2017.

Findings of Fact

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

1) You testified that you are seeking Medicaid from December 1, 2016 through January 31, 2017.

2) According to your NYSOH account and your testimony, you filed your 2016 and expect to file your 2017 federal income tax returns as single, and will claim no dependents on those tax returns. You had not filed your 2016 income tax return as of the date of the hearing, but testified you had filed an extension.

3) You applied for financial assistance on March 20, 2017.

4) Your application submitted on March 20, 2017, states that for the month of December 2016 your income was $0.00 and for the month of January 2017 your income was $4,333.33. You testified that the amount for December 2016 was correct, but you were unsure of your income for January 2017.

5) You testified that your employment income was your only source of income in January 2017, you started a new job in January 2017, and are paid bi-weekly.

6) On July 21, 2017, you submitted an attestation stating that you did not have any income in the month of December 2016 and a paystub dated January 20, 2017, showing a gross bi-weekly pay amount of $865.39. This paystub did not include your year-to-date income (*see* Appellant's Exhibit [redacted]

7) On July 31, 2017, you submitted an attestation stating that you did not have any income other than your employment income during January

2017. You also submitted a copy of a complete paystub dated January 20, 2017, showing you received a gross year-to-date income in the amount of $865.39 (*see* Appellant's Exhibit [redacted]

8) You testified that you do not plan on taking any deductions on your tax returns.

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, and the 2017 FPL, which is $12,060.00 for a one-person household (81 Fed. Reg. 4036, 82 Fed. Reg. 8831).

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 January 31, 2017.

According to your NYSOH account and your testimony, you expect to file your 2016 and 2017 taxes with a tax filing status of single and will claim no dependents on those tax returns. Therefore, for purposes of these analyses, you are in a one-person household.

You submitted an application for financial assistance on March 20, 2017, and requested help paying for medical bills for the months of December 2016 through February 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 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.

During the hearing, you requested to amend your appeal to a redetermination of your eligibility for retroactive Medicaid from December 1, 2016 to January 31, 2017. That request was granted and testimony was received.

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 and January 2017, 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 in 2016 and $1,387.00 per month in 2017. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during the months of December 2016 and January 2017.

You testified, and submitted documentation, that you are paid bi-weekly. You uploaded an attestation stating that you did not have any income in December 2016, and you credibly testified to the same. In addition, you submitted an attestation that your only source of income in January 2017 was your employment income. The bi-weekly paystub, dated January 20, 2017, you submitted shows that during January 2017, you received one paycheck in a gross pay amount of $865.39. Further, since you are paid every two weeks, it is reasonable to conclude that your next pay stub would be issued on February 3, 2017. Therefore, the credible evidence of record indicates that in the month of

December 2016, you had $0.00 gross household income, and in January 2017, you had a gross household income of $865.39.

Since the March 21, 2017 eligibility determination notice found you were not eligible for Medicaid in December 2016 and January 2017, because the program you were eligible for cannot pay for any care you received in the past, this notice is RESCINDED, insofar as it concerns your eligibility for the months of December 2016 and January 2017.

Since the record now contains a more accurate representation of what your income was for the month of December 2016 and January 2017, your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage for December 2016 through January 2017, based on a one-person household, utilizing 138% of the FPL for an individual, and a gross household income of $0.00 for the month of December 2016 and $865.39 for January 2017.

Decision

The March 21, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage for December 2016 and January 2017, based on a one-person household, utilizing 138% of the applicable FPL for an individual with a gross household income of $0.00 in the month of December 2016 and $865.39 in January 2017, and to notify you accordingly.

Effective Date of this Decision: August 8, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to redetermine your eligibility for retroactive Medicaid coverage for the months of December 2016 and January 2017, based on the information stated above. NYSOH will notify you once this has been done.

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.

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).

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

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Summary

The March 21, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage for December 2016 and January 2017, based on a one-person household, utilizing 138% of the applicable FPL for an individual with a gross household income of $0.00 in the month of December 2016 and $865.39 in January 2017, and to notify you accordingly.

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to redetermine your eligibility for retroactive Medicaid coverage for the months of December 2016 and January 2017, based on the information stated above. NYSOH will notify you once this has been done.

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)

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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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)

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).

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.

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).