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

Notice of Decision

Decision Date: October 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019416

[redacted]

Dear [redacted]

On September 6, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: October 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019416

[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 retroactively from December 1, 2016 through December 31, 2016?

Procedural History

On February 23, 2017, you submitted an updated application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills from the last 3 months.

On April 21, 2017, based on a systematic update, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid from January 1, 2017 through March 31, 2017 because the program you are eligible for cannot pay for any care you received in the past, which was determined to be the Essential Plan at the time.

On May 31, 2017, you spoke to NYSOH's Account Review Unit and appealed the April 21, 2017 eligibility determination notice insofar as you were not eligible for Medicaid for the month of December 2016.

On August 31, 2017, you had a scheduled telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. At the hearing, you stated you had not received notice of the hearing and requested an adjournment, which the Hearing

Officer granted. You agreed to waive your right to written notice for the rescheduled hearing.

On September 6, 2017, you had the rescheduled telephone hearing with the Hearing Officer and waived your right to written notice of the hearing. The record was developed during the hearing held open to September 21, 2017, to allow you to submit supporting documents.

On September 8, 2017, NYSOH received the requested documentation via facsimile consisting of two bi-weekly pay statements dated December 14, 2016 and December 28, 2016. Those documents have been made part of the record as Appellant's Exhibit #1. The record was closed that day.

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 to December 31, 2016 only, because you had [redacted] that month and have unpaid medical bills related to that [redacted].

2) According to your NYSOH account and your testimony, you filed your 2016 federal income tax return as single and claimed no dependents.

3) According to your NYSOH account, you took no deductions on that tax return.

4) According to your NYSOH account and your testimony, you submitted an updated application for financial assistance on February 23, 2017 and, in that application, requested help paying for medical bills for the last three months.

5) You testified that your work hours vary because you are a part time [redacted] and only work when called in by your employer. You are paid $11.50 per hour and are paid bi-weekly.

6) You submitted two bi-weekly pay statements for the month of December 2016 indicating you received a total of $1,408.76 in gross pay as follows:

    a. Pay date 12-14-2016 for period 11-21-16 to 12-04-16, gross pay $721.63,
    b. Pay date 12-28-2016 for period 12-05-16 to 12-18-16, gross pay $687.13.

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's 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).

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

You testified that you had [redacted] in December 2016, and that the medical bills you incurred in December 2016 remain unpaid.

In your updated application on February 23, 2017 you requested help in paying for medical bills for the three-month period prior to your application.

On April 21, 2017, based on a systematic update on April 20, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid for January 1, 2017 through March 31, 2017 because the program you are eligible for cannot pay for any care you received in the past.

On May 31, 2017, you spoke with NYSOH's Account Review Unit and requested review on the basis that you were not eligible for retroactive Medicaid for the month of December 2016. The record does not contain a notice of eligibility determination or redetermination on this issue. It does contain a June 1, 2017 notice in which NYSOH acknowledges receipt of your May 31, 2017 appeal request and identifies the relevant issue on appeal as "Other."

Here, the lack of a notice of eligibility determination on the issue of your eligibility for retroactive Medicaid for the month of December 2016 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 Marketplace failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination. The record reflects that you requested that NYSOH help paying your medical bills for the three months prior to your February 23, 2017 application, which since it was not addressed in the April 21, 2017 notice permits an inference that NYSOH denied or did not consider your request for retroactive Medicaid to cover medical bills incurred in December 2016.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to the notice of eligibility determination had it been issued.

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 hat 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 eligibility for retroactive Medicaid depends on the date of the initial application, which was February 23, 2017. The record reflects that you requested assistance with medical bills for the previous three-month period. December 2016 is within the previous three-month period of February 2017.

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, 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.

Since there is nothing in the record to indicate that you would have been ineligible for Medicaid based on non-financial criteria during December 2016, the analysis turns to the financial requirements to be eligible for Medicaid for that period.

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

You testified that you are paid bi-weekly. You submitted two pay statements that you received in December 2016. Pay statement dated December 14, 2016 had a gross pay amount of $721.63 and the pay statement dated December 28, 2016 had a gross pay amount of $687.13. Therefore, the record indicates that in the month of December 2016, you had a monthly household income of $1,408.76.

Based on your December 2016 income, as documented in the pay statements you provided, the income you received in December 2016 of $1,408.76 exceeds the maximum allowable monthly income limit of $1,367.00 for you to be eligible for retroactive Medicaid that month. Therefore, you do not qualify for retroactive Medicaid in the month of December 2016 because you were over-income. As such, no further action is required of NYSOH at this time.

Decision

By this Decision, you were not eligible for retroactive Medicaid during the month of December 2016.

This Decision does not affect any subsequent eligibility determinations or enrollments made nor corresponding notices issued by NYSOH.

Effective Date of this Decision: October 11, 2017

How this Decision Affects Your Eligibility

Because the income you received in December 2016 of $1,408.76 exceeds the maximum allowable monthly income limit of $1,367.00, you were not eligible for retroactive Medicaid that month.

This Decision does not affect your current eligibility or enrollment.

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 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).

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

By this Decision, you were not eligible for retroactive Medicaid during the month of December 2016.

This Decision does not affect any subsequent eligibility determinations or enrollments made nor corresponding notices issued by NYSOH.

Because the income you received in December 2016 of $1,408.76 exceeds the maximum allowable monthly income limit of $1,367.00, you were not eligible for retroactive Medicaid that month.

This Decision does not affect your current eligibility or enrollment.

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)

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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