nystateofhealth
The Official Health Plan Marketplace

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

Notice of Decision

Decision Date: October 5, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019762

[redacted]

Dear [redacted],

On September 11, 2017, your son, [redacted], appeared by telephone at a hearing on your appeal of NY State of Health's May 28, 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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Decision

Decision Date: October 5, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019762

[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 in the months of December 2016 and January 2017?

Procedural History

On January 23, 2017, you submitted an application for financial assistance with health insurance.

On January 24, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, for a limited time, effective March 1, 2017. The notice directed you to provide documentation of your income by April 23, 2017.

Also on January 24, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in an Essential Plan, beginning March 1, 2017.

On February 4, 2017, documentation was uploaded to your NYSOH account on your behalf.

On February 15, 2017, NYSOH redetermined your eligibility.

On February 16, 2017, NYSOH issued notice of eligibility determination stating that you were eligible for the Essential Plan with a $20.00 monthly premium, effective March 1, 2017.

On February 21, 2017, you updated your NYSOH application and indicated that you wanted help paying for medical bills in the months of December 2016 and January 2017.

On February 22, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, for a limited time, effective April 1, 2017. The notice directed you to submit documentation of your income by May 22, 2017.

On May 28, 2017, NYSOH issued a notice of eligibility determination stating that your request for Medicaid coverage for the months of December 2016 and January 2017 was denied because you did not provide proof of your household income to NYSOH.

On June 14, 2017, documentation was uploaded to your NYSOH account on your behalf.

Also on June 14, 2017, your son, [redacted], spoke to NYSOH's Account Review Unit and appealed the May 28, 2017 eligibility determination notice that denied retroactive Medicaid for the months of December 2016 and January 2017.

On September 11, 2017, your son, [redacted] appeared on your behalf as your Authorized Representative (AR) at a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing held open to allow you to submit supporting documents.

On September 28, 2017, your AR faxed a four-page document to NYSOH on your behalf. The record was closed that day.

Findings of Fact

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

1) Your AR testified that you are seeking Medicaid for December 2016 and January 2017 because you have over $2,000.00 in medical bills for those months.

2) Your NYSOH application indicates that you expect to file your 2017 federal income tax return as single, and claim no dependents, and your AR confirmed this.

3) You submitted an application for financial assistance, that requested help paying for bills in December 2016 and January 2017, on February 21, 2017.

4) Your application submitted on February 21, 2017, states that, for the months of December 2016 and January 2017, your income was $1,603.33 for each month.

5) Your AR testified that you earn $9.25 an hour, and that you work full-time.

6) On June 14, 2017, paystubs were uploaded to your NYSOH account on your behalf for the following dates and gross pay:

   a. 12/29/2016: $417.50;
   b. 1/5/2017: $431.67;
   c. 1/12/2017: $406.75;
   d. 1/19/2017: $437.42;

   (Documents [redacted] and [redacted]).

7) After the hearing, a four-page document was faxed to NYSOH consisting of paystub information, including the following pay dates and gross pay amounts:

   a. 12/1/2016: $407.15;
   b. 12/8/2016: $419.42;
   c. 12/15/2016: $425.17;
   d. 12/22/2016: $517.50;
   e. 1/26/2017: $441.25.

   Together, these documents are collectively marked and entered into the record as “Appellant’s Exhibit One.”

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 federal poverty level (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). In December 2016, that was the 2016 FPL, which is $11,880.00 for a one-person household (81 Fed. Reg. 4036). In January 2017, that was the 2017 FPL, which is $12,060.00 for a one-person household (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 for the months of December 2016 and January 2017.

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

You submitted an updated application for financial assistance on February 21, 2017, and requested help with paying for medical bills for December 2016 and January 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 that initial application resulted in Medicaid going forward or not. 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 the individual would have been eligible for Medicaid in those three months had he or she applied.

Your AR confirmed that you are seeking Medicaid for the months of December 2016 and January 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 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 was $1,366.00 per month in December 2016, and $1,387.00 per month in January 2017. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during December 2016 and January 2017.

You provided paystubs for the months of December 2016 and January 2017, both prior to the hearing, and after the hearing, as outlined above. Your total gross pay for December 2016 was $2,186.74, and your total gross pay for January 2017 was $1,717.09.

Because your December 2016 income of $2,186.74 was more than the $1,366.00 monthly Medicaid limit for December 2016, you were not eligible for Medicaid coverage during that month. Likewise, since your January 2017 income of $1,717.09 was more than the $1,387.00 monthly Medicaid income limit for January 2017, you were not eligible for Medicaid coverage during that month.

Since the record now contains a more accurate representation of what your income was for the months of December 2016 and January 2017, the May 28, 2017 eligibility determination stating that you were not eligible for Medicaid for those months is MODIFIED to state that you were not eligible for Medicaid in the months of December 2016 and January 2017 because your income was over the monthly Medicaid income limit.

Decision

The May 28, 2017 eligibility determination is MODIFIED to state that you were not eligible for Medicaid in the months of December 2016 and January 2017 because your income in those months was above the monthly Medicaid income limit.

Effective Date of this Decision: October 5, 2017

How this Decision Affects Your Eligibility

You were not eligible for Medicaid in the months of December 2016 and January 2017.

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

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).

Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The May 28, 2017 eligibility determination is MODIFIED to state that you were not eligible for Medicaid in the months of December 2016 and January 2017 because your income in those months was above the monthly Medicaid income limit.

You were not eligible for Medicaid in the months of December 2016 and January 2017.

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.

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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