



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

Notice of Decision

Decision Date: October 4, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000019824

[REDACTED]

Dear [REDACTED],

On September 15, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 27, 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: October 4, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000019824

[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 January 1, 2017 through January 31, 2017?

Procedural History

On December 31, 2016, NYSOH issued an eligibility determination notice, based on your December 30, 2016 application, stating that you were eligible to enroll in the Essential Plan with no monthly premium for a limited time, effective February 1, 2017.

On April 25, 2017, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills from January 1, 2017 through January 31, 2017.

On April 27, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid from January 1, 2017 through January 31, 2017, because the monthly household income you provided of \$3,549.00 is over the allowable monthly income limit of \$3,310.00.

On June 16, 2017, you spoke to NYSOH's Account Review Unit and appealed the December 31, 2016 eligibility determination notice insofar as it began your Essential Plan coverage on February 1, 2017, and not January 1, 2017.

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On September 15, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Your request to amend your appeal to a redetermination of retroactive Medicaid for you solely from January 1, 2017 to January 31, 2017 was granted and testimony was received. The record was developed during the hearing and held open to September 30, 2017, to allow you to submit supporting documents.

On September 26, 2017, NYSOH received the requested documentation and it was made part of the record as "Appellant's Exhibit A." 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 for yourself from January 1, 2017 through January 31, 2017.
- 2) According to your NYSOH account and your testimony, you expect to file your 2017 federal income tax return as married filing jointly, and will claim three dependents on that tax return.
- 3) You applied for financial assistance on April 25, 2017, and requested help with paying your medical bills for the month of January 2017.
- 4) Your application submitted on April 25, 2017, states that for the month of January 2017 your spouse's income was \$3,549.00. You testified that the amount for January 2017 is lower because your spouse's gross earnings from employment are \$725.00 per week.
- 5) You testified that your spouse's employment income was your only source of household income in January 2017 because you do not work.
- 6) On September 26, 2017, you submitted your spouse's four consecutive weekly paystubs dated January 4, 2017 through January 25, 2017. The paystub dated January 25, 2017 shows that your spouse's gross year-to-date income as of that date was \$3,276.00 (see Appellant's Exhibit A, p. 5).
- 7) According to your NYSOH account and your testimony, you and your spouse will not be taking any deductions on your tax return.

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 2017 FPL, which is \$28,780.00 for a five-person household, respectively (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 retroactively from January 1, 2017 through January 31, 2017.

According to your NYSOH account and your testimony, you expect to file your 2017 taxes with a tax filing status of married filing jointly and will claim three dependents on that tax return. Therefore, for purposes of this analysis, you are in a five-person household.

You submitted an updated application for financial assistance on April 25, 2017 and requested help in paying for medical bills for the month of January 2017.

When an individual files an initial application for Medicaid, his or her eligibility for retroactive Medicaid depends on the date of application. Medicaid coverage can

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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 retroactive Medicaid for you solely from January 1, 2017 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.

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 January 2017, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is \$3,310.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during the month of January 2017.

You testified, and submitted documentation, to support that your spouse is your only source of household income and he is paid weekly. On September 26, 2017, you submitted your spouse's four consecutive weekly paystubs dated January 4, 2017 through January 25, 2017. The record reflects that the last pay check he received in January 2017 was January 25, 2017. The paystub dated January 25, 2017 shows that your spouse's gross year-to-date income was \$3,276.00. Since your spouse is paid weekly, he would not have received his next paycheck until February 1, 2017. Therefore, the record indicates that in the month of January 2017, you had a monthly gross household income of \$3,276.00.

Since the record now contains a more accurate representation of what your household's income was for the month of January 2017, your case is RETURNED to NYSOH to redetermine your eligibility for retroactive Medicaid coverage solely for yourself in the month of January 2017, based on a five-person household, utilizing 138% of the FPL for an individual, and a household income of \$3,276.00 for the month of January 2017.

Decision

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage solely for yourself in the month of January 2017, based on a five-person household, utilizing 138% of the FPL for an individual, and a household income of \$3,276.00 for the month of January 2017, and to notify you accordingly.

Effective Date of this Decision: October 4, 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 January 2017, based on the information noted above. NYSOH will notify you of its redetermination.

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 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 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):

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- By calling the Customer Service Center at 1-855-355-5777
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NY State of Health Appeals
P.O. Box 11729
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- By fax: 1-855-900-5557

Summary

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage solely for yourself in the month of January 2017, based on a five-person household, utilizing 138% of the FPL for an individual, and a household income of \$3,276.00 for the month of 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 January 2017, based on the information noted above. NYSOH will notify you of its redetermination.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



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 مجاناً.

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বাংলা (Bengali)

এই নথি গুরুত্বপূর্ণ। আপনি যদি এটি বুঝতে সাহায্যের প্রয়োজন হয়, তবে দয়া করে 1-855-355-5777-এ কল করুন। আমরা আপনার ভাষায় একটি ব্যক্তিগত অনুবাদকর্মীকে আপনার জন্য নি:শুল্ক উপলব্ধ করতে 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 नि:शुल्क 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 महत्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क 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.

Twí (Twi)

Krataa yi ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&etumi ama wo obi a okyerE kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 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.