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

Notice of Decision

Decision Date: October 20, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020133

Dear [redacted],

On September 25, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's denial of retroactive Medicaid coverage for March 2017 and 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: October 20, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000020133

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health (NYSOH) properly determine that you were not eligible for Medicaid for March 1, 2017 through March 31, 2017?
>
> Did NYSOH properly determine that you were not eligible for Medicaid for April 1, 2017 through April 30, 2017?

Procedural History

On March 28, 2017, you submitted an application for financial assistance with health insurance.

On March 29, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH had received from state and federal data sources. This notice directed you to submit proof of your income by April 12, 2017 in order to determine your eligibility for financial assistance.

On March 30, 2017, you submitted an updated application for financial assistance with health insurance. Specifically, you updated the income information in your application.

Also on March 30, 2017, you uploaded income documentation to your NYSOH account.

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On March 31, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH had received from state and federal data sources. This notice directed you to submit proof of your income by April 12, 2017 in order to determine your eligibility for financial assistance.
On April 6, 2017, NYSOH verified the income documentation you submitted and submitted a new application on your behalf.

On April 7, 2017, NYSOH issued a notice of eligibility determination stating that you were conditionally eligible to purchase a qualified health plan at full cost through NYSOH, effective May 1, 2017. This notice directed you to submit proof of termination of your Medicare Part A or Part B by May 21, 2017 in order to confirm your eligibility for health insurance.

On April 24, 2017, you uploaded information regarding your Medicare to your NYSOH account.

Also on April 24, 2017, you submitted an application for financial assistance with health insurance.

On April 25, 2017, NYSOH issued a notice of eligibility determination stating that you were conditionally eligible to purchase a qualified health plan at full cost through NYSOH, effective June 1, 2017. This notice directed you to submit proof of termination of your Medicare Part A or Part B by May 21, 2017 in order to confirm your eligibility for health insurance.

Also on April 25, 2017, NYSOH reviewed the documentation regarding your Medicare and determined that this was insufficient proof that your Medicare had ended.

On April 26, 2017, NYSOH issued a notice stating that the documentation you submitted did not confirm the information that was in your application and that additional proof of termination of your Medicare Part A or Medicare Part B was required by June 5, 2017.

On May 23, 2017, you uploaded information regarding your Medicare to your NYSOH account.

Also on May 23, 2017, NYSOH reviewed the documentation regarding your Medicare and determined that this was insufficient proof that your Medicare had ended.

On May 24, 2017, NYSOH issued a notice stating that the documentation you submitted did not confirm the information that was in your application and that additional proof of termination of your Medicare Part A or Medicare Part B was required by June 5, 2017.

On June 23, 2017, you uploaded information regarding your Medicare to your NYSOH account.

Also on June 23, 2017, NYSOH reviewed the documentation you submitted and determined that this was sufficient proof of your Medicare status, and submitted a new application on your behalf.

On June 24, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for advance payments of the premium tax credit of up to $431.00 per month as well as cost-sharing reductions if you enrolled in a silver level qualified health plan, effective August 1, 2017.

On June 29, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were not found eligible for retroactive Medicaid for the month of March 2017 and April 2017.

On September 25, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing left open for twenty-one days to allow you the opportunity to submit proof of when your pension payments began.

On September 26, 2017, the Appeals Unit received via fax a letter from your pension plan notifying you of the start date and amount of your pension payments.

Findings of Fact

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

1) You testified that you are seeking Medicaid from March 1, 2017 to April 30, 2017.

2) You testified that you expect to file your 2017 federal income tax return as single and will claim no dependents on that return.

3) You submitted applications for financial assistance on March 28, 2017, March 30, 2017, and April 24, 2017. NYSOH submitted applications for financial assistance on your behalf on April 6, 2017 and June 23, 2017.

4) You testified that in March 2017 you began receiving Social Security benefits. You further testified that you began receiving pension benefits of around $400.00 per month in June 2017. You testified that you were advised that your pension benefit will decrease to $300.00 per month in October 2017.

5) You testified that your only income in March 2017 and April 2017 was your Social Security benefit.

6) You testified that your Medicare began in May 2017, when you ██████ ██.

7) You testified that you turned ██ on ██████████.

8) You submitted a letter from the Social Security Administration which indicates that you would begin receiving $1,259.00 in February 2017. This letter also indicates that your Medicare Part A will begin in April 2017.

9) You testified that your Medicare Part B began in May 2017.

10) You submitted a letter from your pension which indicates that you began receiving $444.37 per month on July 1, 2017.

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 (called MAGI-based Medicaid) 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)).

If an individual does not fall into one of these categories, he or she may still be eligible for non-MAGI-based Medicaid coverage through their Local Department of Social Services or the New York City Human Resources Administration (*see* N.Y. Soc. Serv. Law § 366(1)(c)).

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 $12,060.00 for a one-person household (82 Fed. Reg. 8831).

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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 first issue under review is whether NYSOH properly determined that you were not eligible for Medicaid for March 1, 2017 through March 31, 2017.

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

You filed applications for financial assistance on March 28, 2017, March 30, 2017, and April 24, 2017, and NYSOH filed applications on your behalf on April 6, 2017 and June 23, 2017.

You were ultimately found eligible for advance payments of the premium tax credit and cost-sharing reductions, effective August 1, 2017.

On June 29, 2017, when you filed your appeal, you requested that your eligibility for retroactive Medicaid for March 2017 and April 2017 be determined.

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.

You testified that you are seeking Medicaid from March 1, 2017 through April 30, 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 March 2017, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,387.00 per month. There is no indication in the record that you would

have been ineligible for Medicaid based on non-financial criteria during March 2017.

You testified that your only source of income in March 2017 was your Social Security benefit. You submitted a Social Security Award letter stating that as of February 2017 you would receive $1,259.00. This letter also indicated that your Medicare Part A would not begin until April 2017.

Since you have submitted documentation that your monthly income was $1,259.00 and that you did not have Medicare in March 2017, your case is RETURNED to NYSOH to consider your request for retroactive coverage for March 2017 based on a household of one person with a monthly household income of $1,259.00 for an individual who is not receiving Medicare for the month of March 2017.

The second issue under review is whether NYSOH properly determine that you were not eligible for Medicaid for April 1, 2017 through April 30, 2017.

Medicaid through NYSOH (called MAGI-based Medicaid) is available to individuals who are between the ages of 19 and 64, who are not eligible for Medicare Parts A or B; pregnant women or infants; children between the ages of 1 and 18; and parent or caretaker relatives.

According to your testimony and the information in your NYSOH application, you are single with no dependents and, therefore, not a parent or a caretaker relative of a dependent child.

The record reflects that, in April 2017 you were [redacted] old and receiving Medicare Part A.

Since you were receiving Medicare Part A in April 2017, and not a parent or caretaker relative, NYSOH properly determined that you are not eligible for Medicaid through NYSOH from April 1, 2017 through April 30, 2017. Therefore, the eligibility determination that you are not eligible for Medicaid through NYSOH from April 1, 2017 to April 30, 2017 is AFFIRMED.

NYSOH does not have the authority to determine whether or not you qualify for non-MAGI-based Medicaid. That authority lies with the New York City Human Resources Administration

The record reflects that you have not applied for non-MAGI-based Medicaid through the New York City Human Resources Administration. Since you may be eligible for Medicaid on a non-MAGI basis, NYSOH will refer your case to the New York City Human Resources Administration for consideration.

Your case is RETURNED to NYSOH to refer your case to the New York City Human Resources Administration for consideration.

Decision

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for March 2017 based on a household of one person with a monthly household income of $1,259.00 for an individual who is not receiving Medicare for the month of March 2017.

The determination that you are not eligible for Medicaid through NYSOH from April 1, 2017 to April 30, 2017 is AFFIRMED.

Your case is RETURNED to NYSOH to refer your case to the New York City Human Resources Administration for consideration.

Effective Date of this Decision: October 20, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility for March 2017. Your case is sent back to NYSOH to redetermine your eligibility based on the evidence you presented at the hearing.

You do not qualify for MAGI-based Medicaid through NYSOH for April 2017.

NYSOH does not have the authority to decide if you qualify for non-MAGI Medicaid.

Your case is being referred to the New York City Human Resources Administration for consideration of your eligibility for non-MAGI-based Medicaid.

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.

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).

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

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for March 2017 based on a household of one person with a monthly household income of $1,259.00 for an individual who is not receiving Medicare for the month of March 2017.

This is not a final determination of your eligibility for March 2017. Your case is sent back to NYSOH to redetermine your eligibility based on the evidence you presented at the hearing.

The eligibility determination that you are not eligible for Medicaid through NYSOH from April 1, 2017 to April 30, 2017 is AFFIRMED.

Your case is RETURNED to NYSOH to refer your case to the New York City Human Resources Administration for consideration.

You do not qualify for MAGI-based Medicaid through NYSOH for April 2017.

NYSOH does not have the authority to decide if you qualify for non-MAGI Medicaid.

Your case is being referred to the New York City Human Resources Administration for consideration of your eligibility for non-MAGI-based Medicaid.

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)

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।

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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 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.

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.

(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.

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