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

Notice of Decision

Decision Date: November 9, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020271

[redacted]

[redacted],

On October 24, 2017, you appeared by telephone, with your attorney representing you, at a hearing regarding your request for Retroactive Medicaid coverage for the months of November 2016 and December 2016.

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 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: November 9, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020271

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Are you eligible for retroactive Medicaid assistance for the months of November 2016 and December 2016?

Procedural History

On December 2, 2016, you applied through NYSOH for financial assistance with health insurance.

On December 3, 2016, NYSOH issued a notice stating that the income information in your application did not match the information NYSOH received from state and federal sources. The notice directed you to provide proof of income by December 17, 2016.

On December 7, December 16, December 17, and December 23, 2016, you uploaded income documentation.

On December 29, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible to purchase a full cost qualified health plan because NYSOH did not receive the income documentation needed to verify the income listed in your application. The eligibility was effective February 1, 2017.

On January 9, 2017, you updated your application, including requesting assistance paying for medical bills for the last three months and uploading income documentation.

On January 10, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal sources. The notice directed you to provide proof of income by January 24, 2017.

On January 17, 2017, NYSOH determined your income documentation was invalid.

On January 18, 2017, NYSOH issued a notice stating that the documentation that you provided did not confirm the information in your application. The notice directed you to provide income information by February 8, 2017.

On February 22, 2017, you uploaded income information.

On March 2, 2017, NYSOH determined your income documentation was invalid.

On March 3, 2017, NYSOH issued a notice stating that the documentation that you provided did not confirm the information in your application. The notice directed you to provide income information by March 25, 2017.

On May 8, 2017, NYSOH determined your income documentation valid.

On May 9, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to purchase a full cost qualified health plan. The notice stated that you did not qualify for Medicaid because you are [redacted]
The eligibility was effective June 1, 2017.

On July 6, 2017, you spoke to NYSOH's Account Review Unit and appealed your eligibility for Retroactive Medicaid.

On October 24, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, your attorney [redacted], assisted you with your testimony. The record was developed during the hearing and closed at the end of the hearing

Findings of Fact

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

1) Your attorney testified that you submitted an application for financial assistance on December 2, 2016.

2) On December 3, 2016, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal sources. The notice directed you to provide proof of income by December 17, 2016.

3) On December 29, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible to purchase a full cost qualified health plan because NYSOH did not receive the income documentation needed to verify the income listed in your application.

4) On January 9, 2017, you updated your application including requesting assistance paying for medical bills for the last three months, specifically November 2016 and December 2016.

5) Your attorney testified that you are seeking Retroactive Medicaid coverage for the months of November 2016 and December 2016.

6) You testified that you did not file a federal tax return in 2016 and that you will not do so in 2017.

7) You testified that you are married and that your spouse lives with you.

8) You testified that you are a [redacted] and get paid in cash. You live in [redacted].

9) Your January 9, 2017 application states that your spouse is unemployed and receives $0.00 income.

10) You testified that you had $1,493.00 in household income in November 2016.

11) You testified that that you had $0.00 household income in December 2016.

12) NYSOH records do not reflect that a determination was rendered with respect to your request for Retroactive Medicaid for the months of November 2016 and December 2016.

13) On February 22, 2017, you uploaded to your NYSOH account income information consisting of your gross earnings for the months of November 2016 ($1,493.00) and December 2016 ($0.00). Also on that date, you uploaded a letter stating your income for December 2016 ($0.00).

14) You uploaded a letter dated May 6, 2017 stating that you had [redacted] in November 2016 resulting in you being unable to work in December 2016. The letter indicated that you received $0.00 household income for the month of December 2016.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Medicaid

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 $16,020.00 for a two-person household (81 Federal Register 4036).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

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 is whether you were eligible for retroactive Medicaid assistance for the months of November 2016 and December 2016.

On January 9, 2017, you updated your application including requesting assistance paying for medical bills for the months of November 2016 and December 2016. To date, NYSOH has not responded to this request.

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. 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.

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 November 2016 and December 2016, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the relevant FPL, which is $1,843.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on any non-financial criteria during November 2016 and December 2016.

You testified that you had $1,493.00 in household income in November 2016. On February 22, 2017, you uploaded income information consisting 3 months of earnings and expenses indicating that your gross earnings for the month of November 2016 was $1,493.00. You are in a two-person household in [redacted]

You testified that that you had $0.00 household income in December 2016. On February 22, 2017, you uploaded income information consisting of your gross earnings for the month of December 2016 which was $0.00. You also uploaded a letter dated May 6, 2017 stating that you had [redacted] in November 2016 resulting in you being unable to work for the month of December 2016. You stated in the letter that you had $0.00 income for the month of December 2016. Therefore, in the month of December 2016, you had a monthly household income of $0.00.

Therefore, your case is being RETURNED to NYSOH to determine your eligibility for retroactive Medicaid assistance for November and December 2016, based on a two-person household living in [redacted], with gross monthly incomes of $1,493.00 and $0 for November and December 2016, respectively. NYSOH is directed to immediately notify you in writing of your new eligibility.

Decision

Your case is being RETURNED to NYSOH to determine your eligibility for retroactive Medicaid assistance for November and December 2016, based on a two-person household living in [redacted], with gross monthly incomes of $1,493.00 and $0 for November and December 2016, respectively.

Effective Date of this Decision: November 9, 2017

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).

How this Decision Affects Your Eligibility

Your case is being RETURNED to NYSOH to determine your eligibility for retroactive Medicaid assistance for the months of November 2016 and December 2016.

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your eligibility based on the income documentation you provided to NYSOH.

NYSOH will notify you in writing of your eligibility.

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
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

Your case is being RETURNED to NYSOH to determine your eligibility for retroactive Medicaid assistance for November and December 2016, based on a two-person household living in [redacted], with gross monthly incomes of $1,493.00 and $0 for November and December 2016, respectively.

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your eligibility based on the income documentation you provided to NYSOH.

NYSOH will notify you in writing of your eligibility.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

[redacted]

[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)

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.

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).

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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