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

Notice of Decision

Decision Date: November 29, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022494

[redacted]

[redacted]

On November 20, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 16, 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
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Decision

Decision Date: November 29, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022494

[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 you were not eligible for retroactive Medicaid assistance for the month of August 2017?

Procedural History

On September 12, 2017, an application for financial assistance with health insurance was submitted on your behalf requesting help paying for medical bills in the month of August 2017.

On September 14, 2017, NYSOH issued a notice of eligibility determination stating you were eligible for Medicaid, effective September 1, 2017.

On September 16, 2017, NYSOH issued an eligibility determination notice stating you were not eligible for retroactive Medicaid assistance for the month of August 2017, because the monthly household income you provided of $1,581.25 was over the allowable monthly income limit of $1,387.00.

On September 18, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as it denied you Medicaid coverage for the month of August 2017.

On November 20, 2017, you had a rescheduled telephone hearing with a Hearing Officer from NYSOH's Appeals Unit wherein you waived your right to

written notice of the hearing under oath. The record was developed during the hearing and closed thereafter.

Findings of Fact

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

1) You testified you are seeking retroactive Medicaid assistance for the month of August 2017, because you have outstanding medical bills from that time.

2) An updated application for financial assistance was submitted on your behalf on September 12, 2017. That application listed your annual expected income for 2017 as $18,750.00. You testified that amount is accurate.

3) The September 12, 2017 application requested retroactive coverage for the month of August 2017 and indicated your income for that month was $800.00. You testified you are unsure of where that monthly income amount came from, because an application counselor completed your application and entered that information.

4) You testified, and your application indicates, you will file your 2017 tax return with a tax filing status of single and you will claim no dependents.

5) NYSOH requested proof of your income for the month of August 2017 prior to issuing a determination of your eligibility for retroactive coverage for that month.

6) On September 13, 2017, NYSOH received the following documentation:

    a. An August 17, 2017 letter from your employer indicating your last date of employment was August 7, 2017 and your final paycheck was issued August 10, 2017.

    b. The following three paystubs:

        i. Pay date of August 3, 2017 for pay period of July 28, 2017 to August 3, 2017 in the gross amount of $900.00.

        ii. Pay date of August 10, 2017 for pay period of August 4, 2017 to August 10, 2017 in the gross amount of $200.00.

iii. Pay date of August 10, 2017 in the gross amount of $481.25 for vacation payout of 38.50 hours.

7) You testified that your job ended in August 2017.

8) You testified that the paystubs submitted represents all the income you earned in August 2017.

9) According to your account, NYSOH recalculated your monthly income for the month of August 2017 as $1,581.25, based on the paystubs submitted.

10) NYSOH denied your request for retroactive Medicaid coverage for the month of August 2017 on the grounds you were over the monthly income limit.

11) You appealed NYSOH's denial of retroactive coverage for the month of August 2017. You testified that the August 3, 2017 paycheck was for income mostly earned in July 2017.

12) Your application indicates you do not plan on 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 $12,060.00 for a one-person household (82 Federal Register 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 you were not eligible for retroactive Medicaid coverage for the month of August 2017.

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

You submitted an application for financial assistance on September 12, 2017 and requested help paying for medical bills for the month of August 2017.

When an individual applies for Medicaid, his or her eligibility for retroactive Medicaid assistance 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.

You testified that you are seeking retroactive Medicaid coverage for the month of August 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 August 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 August 2017.

The record establishes that you had a monthly gross income of $1,581.25 in August 2017. Although you testified that the August 3, 2017 paystub represented income you mostly earned in July 2017, that paystub confirms that the paycheck for that pay period was actually issued on August 3, 2017. Therefore, you would have received that income in the month of August. Thus, that income was properly included in the calculation of your monthly income for August 2017.

Since your income of $1,581.25 for the month of August 2017 was more than the $1,387.00 monthly Medicaid limit, NYSOH properly determined you were not eligible for retroactive Medicaid coverage during that month. Therefore, the September 16, 2017 eligibility determination stating you were not eligible for Medicaid in the month of August 2017, is correct and is AFFIRMED.

Decision

The September 16, 2017 eligibility determination is AFFIRMED.

Effective Date of this Decision: November 29, 2017

How this Decision Affects Your Eligibility

You are not eligible for Medicaid assistance in the month of August 2017.

Your eligibility for Medicaid was effective as of September 1, 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
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The September 16, 2017 eligibility determination is AFFIRMED.

You are not eligible for Medicaid in the month of August 2017.

Your eligibility for Medicaid was effective as of September 1, 2017.

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 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.

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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