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

Notice of Decision

Decision Date: December 14, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022892

[redacted]

[redacted]

On November 17, 2017, you appeared by telephone at a hearing on your request for retroactive Medicaid for 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: December 14, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022892

[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 April 2017?

Procedural History

On April 25, 2017, in a NY State of Health (NYSOH) account of which you are no longer a member, an application for financial assistance with health insurance was filed on your behalf, and assistance with medical bills for the preceding three months was requested. Your previous coverage through NYSOH ended effective March 31, 2017.

On April 26, 2017, in the NYSOH account of which you are no longer a member, NYSOH issued a notice stating that the income information in your application did not match information NYSOH received from state and federal sources. You were directed to provide proof of income by May 10, 2017 and proof of citizenship status by July 24, 2017.

On July 20, 2017, in the NYSOH account of which you are no longer a member, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective June 1, 2017. You were subsequently enrolled in a Medicaid Managed Care plan, UnitedHealthcare of New York, effective September 1, 2017. You were subsequently disenrolled effective October 31, 2017, because you were no longer eligible to enroll in health insurance through NYSOH.

However, before you were enrolled in, then disenrolled from, that Medicaid Managed Care plan, on July 24, 2017, you created your own account, [redacted], and applied for financial assistance with your health insurance. In your application, you stated you were single, with no dependents. You did not provide any information regarding special enrollment periods. You did not request assistance with medical bills from the preceding three months.

On July 25, 2017, NYSOH issued a notice of eligibility determination, stating that you were conditionally eligible to enroll in a qualified health plan (QHP) at full cost, but only if you qualified to enroll in a plan outside of the open enrollment period.

On September 7, 2017, in the NYSOH account of which you are no longer a member, an individual identified as your spouse attested to being married.

On September 28, 2017, you updated your application for financial assistance with your health insurance twice; you did not request assistance for any months preceding your application.

On September 28, 2017, you spoke to NYSOH's Account Review Unit and requested retroactive Medicaid coverage for April 2017.

On October 2, 2017, you applied for financial assistance in which you attested to being married; however, no information regarding your spouse or your spouse's income was included on your application.

On November 17, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open until November 27, 2017, to allow you to submit supporting documents.

As of November 27, 2017, the NYSOH's Appeals Unit did not receive any additional documents from you and none were viewable in your NYSOH account. Therefore, the record was closed the same day and this Decision is based on the record as it was developed at the hearing.

Findings of Fact

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

1) You testified that you are seeking Medicaid assistance for April 2017.

2) You testified that you expect to file your 2017 federal income tax return as single, and claim one dependent.

3) An application for financial assistance with your health insurance was filed on your behalf, in the account on which you are no longer a member, in April 2017, but you were not found eligible for coverage at that time.

4) An application for financial assistance with your health insurance was again filed on your behalf, in the account on which you are no longer a member, on June 7, 2017. No retroactive Medicaid assistance was requested. NYSOH records reflect that you were determined eligible for Medicaid, effective June 1, 2017.

5) On July 24, 2017, you applied for financial assistance with your health insurance, on your own account, and attested you were single.

6) On September 7, 2017, on the NYSOH account of which you are no longer a member, your spouse attested to still being married to you, and you were still included on that account.

7) On October 2, 2017, you applied for financial assistance with health insurance in your current account, and you attested to being married; however, no spouse was included on your application, nor was any income earned by that spouse.

8) You testified that you are married but in the process of a divorce.

9) You testified that you are self-employed as [redacted].

10) You testified that you had [redacted] surgery on [redacted].

11) You testified that you did not work and had no income during the month of April 2017.

12) You testified that you have medical bills which you incurred during April 2017.

13) You testified that you do not plan on taking any deductions on your tax return.

14) NYSOH records reflect that you requested help paying for bills for the previous three months in your application date April 25, 2017.

15) NYSOH records reflect that you also requested help paying for bills for the previous three months in your application date September 7, 2017.

16) NYSOH records reflect that there has been no determination issued regarding any request for retroactive benefits for April 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 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). On the date of your application, that was the 2017 FPL, which is $12, 060.00 for a one-person household or $16,240.00 for a two-person household (82 Federal Register 8831).

Retroactive Medicaid

The Department of Health must make Medicaid assistance available retroactively for up to three months preceding the month of an 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 are you eligible for retroactive Medicaid assistance for April 2017.

You testified that you are seeking help in paying for medical bills from April 2017.

When an individual applies for Medicaid, his or her eligibility for retroactive Medicaid assistance depends on the date of application, and it does not matter whether that application resulted in Medicaid going forward. Instead, an individual who has filed an application for Medicaid through NYSOH has the right

to be evaluated for Medicaid assistance for the three months preceding the month of any application.

Medicaid coverage can be made effective retroactively for up to three months prior to the month an individual filed an application if the individual applying for such assistance 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 they applied.

NYSOH's records show that you previously were covered by the Essential Plan until March 31, 2017, in an account on which you are no longer an authorized member.

Although you applied for health coverage in that old account on April 25, 2017, you were not found eligible to enroll in coverage at that time. No appeals were filed regarding that decision. No application was filed in that old account which would have resulted in April 2017 begin a month that could be considered for retroactive Medicaid assistance.

You did not create your own account with NYSOH until July 24, 2017, and you applied for insurance that same day. However, you did not request retroactive Medicaid assistance for the three months preceding this application.

Because there was no application that could have resulted in retroactive Medicaid assistance for April 2017, NYSOH properly did not come to a substantive determination on any eligibility for April 2017 to which you might otherwise have been entitled to had such assistance been timely requested.

It is also noted that the Hearing Officer directed you to provide a letter on your business letterhead stating that you are self-employed and indicating your gross pay amount for April 2017. The Hearing Officer left the record open until November 27, 2017 to allow you time to submit income documentation for the month of April 2017. However, by the end of the business day on November 27, 2017, you had not submitted any income documentation.

Your applications are also inconsistent regarding your marital and tax filing status. Given the inconsistencies in your applications and your failure to timely provide proof of income, your testimony is found to be unreliable.

Since there is no reliable income documentation of your correct marital status, tax filing status, or household monthly income in April 2017 in the record, there would be no basis for the Appeals Unit to determine any eligibility for retroactive assistance in April 2017 even if you had timely and appropriately applied for such assistance.

Decision

You are ineligible for retroactive Medicaid assistance for April 2017.

Effective Date of this Decision: December 14, 2017

How this Decision Affects Your Eligibility

You are ineligible for Medicaid in the month of April 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

You are ineligible for Medicaid for the month of April 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)

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 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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