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

# Notice of Decision

Decision Date: January 5, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023505

[redacted]

[redacted]

On December 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 23, 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).

This page intentionally left blank.

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).

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

# Decision

Decision Date: January 5, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023505

[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 Medicaid for July 1, 2017 through July 31, 2017?

## Procedural History

On August 26, 2017, you submitted an updated application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for July 2017. You also uploaded documentation to your NYSOH account on that same day.

On August 27, 2017, NYSOH issued a notice stating that the income information provided in your application did not match information NYSOH received from state and federal data sources. The notice advised you to submit documentation of your household income by September 16, 2017.

On August 28, 2017, NYSOH reviewed your documentation and determined your eligibility.

On August 29, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective August 1, 2017.

Also on August 29, 2017, NYSOH issued a notice stating that they had received your request for help paying medical bills for the three-month period prior to your August 2017 application, and that more information was needed to determine

your eligibility. The notice directed you to submit documentation of your household income for the period of July 1, 2017 through July 31, 2017 by September 12, 2017.

On August 29, 2017, you uploaded documentation to your NYSOH account.

On August 30, 2017, NYSOH issued a notice stating that the documentation you provided was not sufficient, and that you needed to provide documentation of your income for the month of July 2017 for your eligibility for Medicaid in that month to be determined.

On September 7, 2017, you again uploaded documentation to your NYSOH account.

That same day, NYSOH reviewed the documentation you uploaded and updated your application. NYSOH again determined that you were eligible for Medicaid in a notice dated September 8, 2017.

Also on September 8, 2017, NYSOH issued a notice stating that more information was needed to determine your eligibility for Medicaid in the month of July 2017. The notice directed you to provide documentation of your income by September 22, 2017.

On September 9, 2017, NYSOH issued a notice stating that the documentation you provided was not sufficient, and that you needed to provide documentation of your income for the month of July 2017 for your eligibility for Medicaid in that month to be determined.

On September 21, 2017, you uploaded documentation to your NYSOH account.

On September 23, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid for July 1, 2017 through July 31, 2017 because the monthly household income of $2,671.80 was over the allowable monthly income limit of $2,349.00.

On October 19, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice, insofar as it denied retroactive Medicaid for the month of July 2017.

On December 14, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing closed at the end of the hearing.

## Findings of Fact

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

1) You testified that you are seeking Medicaid in the month of July 2017.

2) You testified that you began the process of trying to renew your eligibility in April 2017.

3) You testified that, every time you submitted paperwork, you had to wait for it to be reviewed, and you would then receive a notice saying that you needed to submit more paperwork.

4) You testified that you saw the attachments on the notices listing the type of income documentation you could submit, and that you would call NYSOH to ask what they wanted from you.

5) You testified that you called NYSOH multiple times to ask what you needed to submit, but that after you submitted the requested documentation, you again received notices saying that more was needed.

6) You testified that NYSOH wanted a letter from one of your daughter's former employers and, since your daughter would not speak to that employer, you had to go yourself to request the letter.

7) You testified that, because of all of this, months went by while you tried to get recertified for insurance.

8) You testified that you began working with a Navigator in late August or early September 2017 because you were not getting anywhere with your application.

9) Your NYSOH account reflects that, between April 18, 2017 and August 20, 2017, your application was updated four times, and that NYSOH repeatedly requested income documentation from you.

10) Your NYSOH account reflects that income documentation you submitted on August 26, 2017 was validated by NYSOH, and you and your children were found eligible for Medicaid as of August 1, 2017.

11) You testified that you had to go to the [redacted] for a medical emergency in July 2017, and have incurred a $500.00 medical bill as a result.

12) Your NYSOH application indicates that you expect to file your 2017 tax return with a tax filing status of head of household, and that you will claim two dependents on that tax return. You testified that this is correct.

13) You testified that both of your children are full-time students, but that they also work part-time jobs.

14) You testified that your daughter did not work in the month of July 2017, and documentation you submitted to NYSOH confirms that her employment as a [redacted] ended on June 23, 2017, and her second job at [redacted] ended on May 25, 2017 (Documents [redacted]).

15) You testified that your son worked in the month of July 2017 and earned $1,672.00; documentation in your NYSOH account confirms this [redacted]).

16) You testified that you earned $999.80 in the month of July 2017, and documentation in your NYSOH account confirms this (Document [redacted]).

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

18) You testified that you do not think it is right that your eligibility for Medicaid in the month of July is based on your total household income in that month because, if NYSOH had approved your application for Medicaid earlier, your eligibility would not have been based on monthly income.

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

## Applicable Law and Regulations

Timely Appeal

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR § 155.520(b)(2); 18 NYCRR § 358-3.5(b)(1)).

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 $20,420.00 for a three-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 that you were not eligible for Medicaid for July 1, 2017 through July 31, 2017.

You testified during the hearing, and your account confirms, that you first applied for financial assistance in April 2017. You testified that you spent months trying to submit the correct income documentation and that, if NYSOH had found you eligible for Medicaid earlier, your eligibility for Medicaid in July 2017 would not have been determined based on your income in that month, but on your annual income instead.

For an appeal of an eligibility determination to be timely, an individual must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH. According to the credible evidence in the record, you contacted NYSOH on October 19, 2017 to file a formal appeal. Therefore, the oldest application update that your appeal could include was the application update of August 26, 2017. Since, by that point, your request for Medicaid in July

2017 was already a request for retroactive coverage, the Appeals Unit can only review your eligibility for Medicaid in July 2017 based on your income in the month of July 2017, and not based on your annual income.

You are in a three-person household; you file your taxes with a tax filing status of head of household and expect to claim three dependents on your tax return.

You submitted an updated application for financial assistance on August 26, 2017, and requested help in paying for medical bills for July 1, 2017 through July 31, 2017.

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 July 2017, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $2,348.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on any non-financial criteria during July 2017.

You submitted documentation indicating that your income in the month of July 2017 was $999.80, and you confirmed this in your testimony (Document [redacted]). You testified that your daughter did not earn any income in the month of July 2017, and documentation in your NYSOH account confirms this. Lastly, you testified that your son earned $1,672.00 in July 2017, and documentation in your NYSOH account confirms this (Document [redacted] Therefore, the record indicates that in the month of July 2017, you had a monthly household income of $2,671.80.

Since your income of $2,671.80 was more than the $2,348.00 monthly Medicaid limit for July 2017, NYSOH properly determined that you were not eligible for Medicaid coverage during that month. Therefore, the September 23, 2017 eligibility determination stating that you were not eligible for Medicaid in the month of July 2017, is correct and is AFFIRMED.

## Decision

The September 23, 2017 eligibility determination is AFFIRMED.

## **Effective Date of this Decision:** January 5, 2018

## How this Decision Affects Your Eligibility

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

## If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your appeal was decided, the 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 23, 2017 eligibility determination is AFFIRMED.

You are not eligible for Medicaid in the month of July 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)**

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।

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).

**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.

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).