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

Notice of Decision

Decision Date: January 09, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023816

[redacted]

[redacted]

On December 21, 2017, you and your Authorized Representative appeared by telephone at a hearing on an appeal that you filed regarding your request for Medicaid for the month of January 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
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Decision

Decision Date: January 09, 2018

NY State of Health Account ID [redacted]
Appeal Identification Number: AP0000000023816

[redacted]

Issue

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

> Were you eligible for retroactive Medicaid assistance through NY State of Health (NYSOH) for the period of January 1, 2017 through January 31, 2017?

Procedural History

On January 6, 2017, you applied for financial assistance with health insurance through NYSOH.

On January 7, 2017, NYSOH issued a notice stating that the income information in your application did not match information NYSOH received from state and federal data sources. The notice directed you to submit documentation of your income by January 21, 2017, and included an attachment detailing the type of documentation NYSOH would accept as proof of income.

On January 13, 2017, your NYSOH account was updated again.

On January 14, 2017, NYSOH again issued a notice stating that the income information in your application did not match information NYSOH received from state and federal data sources. The notice again directed you to submit documentation of your household income by January 21, 2017.

On February 1, 2017, NYSOH determined your eligibility.

On February 2, 2017, NYSOH issued a notice stating that you were eligible to enroll in a qualified health plan at full cost, effective March 1, 2017. The notice further stated that you were not eligible for Medicaid, the Essential Plan, or to receive tax credits or cost-sharing reductions. This was because NYSOH did not receive the documentation requested to verify your income.

On March 29, 2017, your NYSOH application was updated. In that application, you requested help paying for medical bills in the months of January and February 2017.

On March 30, 2017, NYSOH issued a notice stating that the income information in your application did not match information NYSOH received from state and federal data sources. The notice again directed you to submit documentation of your household income by April 13, 2017.

On April 19, 2017, documentation was uploaded to your account.

On April 21, 2017, NYSOH issued a notice stating that the documentation you submitted was reviewed, but that it did not confirm the information in your application. The notice directed you to submit documentation of your household income by April 28, 2017.

On May 23, 2017, documentation was uploaded to your NYSOH account.

That same day, NYSOH reviewed that documentation and determined your eligibility.

On May 24, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective March 1, 2017.

Also on May 24, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid for the period of February 1, 2017 through April 30, 2017 because your monthly household income of $1,097.42 was at or below the allowable monthly income limit of $1,387.00.

On June 13, 2017, you uploaded documentation of your business expenses for the month of January 2017.

On September 25, 2017, you faxed income documentation for January 2017 to NYSOH. NYSOH uploaded this documentation to your account on October 11, 2017 and October 16, 2017.

On October 30, 2017, you spoke to NYSOH's Account Review Unit and appealed, insofar as you had not been found eligible for Medicaid for the month of January 2017.

On December 21, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, [redacted], was sworn in as your Authorized Representative. 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) You testified that you are seeking Medicaid assistance for the month of January 2017.

2) You testified, and your NYSOH account confirms, that you first filed an application for health insurance in January 2017.

3) You testified that you filed this application with the assistance of an application counselor from the hospital where you were admitted.

4) You testified that your application counselor made you aware that you needed to submit income documentation.

5) Your Authorized Representative testified that you provided income documentation to your application counselor sometime around the end of January 2017, and that you also gave her documentation in February 2017.

6) You testified that you believed your application counselor was submitting your documentation to NYSOH.

7) Your NYSOH account does not indicate that NYSOH received any income documentation in the months of January or February 2017.

8) Your Authorized Representative testified that, at some point, you realized that the application counselor was not doing what she was supposed to be doing, so you started submitting documentation on your own.

9) Your NYSOH account reflects that a copy of your 2016 income tax return was uploaded to your NYSOH account on April 19, 2017 [redacted] and again on May 23, 2017 (Document [redacted].

10) Your NYSOH account reflects that NYSOH found you eligible for Medicaid in a notice dated May 24, 2017, based on an expected annual income of $13,169.00.

11) Your NYSOH account reflects that you requested retroactive Medicaid for the month of January 2017 when your March 29, 2017 application update was filed.

12) Your NYSOH account reflects that NYSOH found you eligible for retroactive Medicaid for the months of February, March, and April 2017, but never issued an eligibility determination for the month of January 2017.

13) Your NYSOH account reflects that NYSOH based your eligibility for retroactive Medicaid in the months of February, March, and April 2017 on a monthly income of $1,097.42.

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

15) You testified that you have unpaid medical bills for the month of January 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 (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 you were eligible for Medicaid through NYSOH in the month of January 2017.

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

You applied for financial assistance with health insurance on March 29, 2017 and requested help in paying for medical bills for January 2017.

When an individual applies 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 January 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 January 2017.

You applied for retroactive Medicaid assistance in your March 29, 2017 application; you were potentially eligible for retroactive assistance for each of the three months preceding March 2017, which would include January 2017.

Therefore, NYSOH erred when it failed to consider your eligibility for retroactive assistance for January 2017.

You were found eligible for Medicaid by NYSOH based on an expected annual household income of $13,169.00. NYSOH utilized that annual income amount to determine that you were eligible for retroactive Medicaid for the months of February, March, and April, by dividing the annual amount by twelve, and arriving at a monthly income figure of $1,097.42.

As NYSOH based your eligibility for Medicaid on a monthly income amount of $1,097.42 for February, March, and April 2017, that figure can also be used to determine your eligibility for Medicaid in January 2017, as it is derived from your annual 2017 income.

Therefore, since $1,097.42 is less than the Medicaid income limit of $1,387.00, your monthly income for January 2017 was below the monthly income limit for Medicaid.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for January 2017 based on a household size of one person and a household income of $1,097.42 for the month of January 2017.

NYSOH is directed to promptly notify you in writing of your eligibility.

Decision

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage for January 2017 based on a household size of one, and household income of $1,097.42 for the month of January 2017.

NYSOH is directed to promptly notify you in writing of your eligibility for Medicaid in the month of January 2017.

Effective Date of this Decision: January 09, 2018

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your eligibility based on the evidence in the record.

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

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).

Albany, NY 12211

- By fax: 1-855-900-5557

Summary

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage for January 2017 based on a household size of one, and household income of $1,097.42 for the month of January 2017.

NYSOH is directed to promptly notify you in writing of your eligibility for Medicaid in the month of January 2017.

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your eligibility based on the evidence in the record.

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]

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.

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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