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

Notice of Decision

Decision Date: March 2, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023912

Dear [redacted],

On January 29, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's denial of retroactive 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
Albany, NY 12211

Decision

Decision Date: March 2, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023912

[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 retroactive Medicaid from January 1, 2017 through January 31, 2017?

Procedural History

On January 21, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid effective as of February 1, 2017.

On July 19, 2017, August 3, 2017, and October 2, 2017, NYSOH issued notices stating that NYSOH had received your request for help with paying medical bills for the three-month period prior to your application, dated June 14, 2017. These notices directed you to provide additional proof of income for the period of January 1, 2017 through January 31, 2017 by August 2, 2017, August 2, 2017, and October 16, 2017, respectively.

On September 22, 2017 and October 11, 2017, you submitted form [redacted] dated September 22, 2017, entitled Self-Declaration of Income, which was invalidated by NYSOH on October 13, 2017 and October 17, 2017 (*see* Documents [redacted] and [redacted]).

On October 13, 2017 and December 4, 2017, NYSOH issued notices stating that NYSOH had received your request for help with paying medical bills for the three-month period prior to your June 14, 2017 application. These notices

directed you to provide additional proof of income for the period of January 1, 2017 through January 31, 2017 by October 27, 2017 and December 18, 2017, respectively.

On November 1, 2017, you spoke to NYSOH's Account Review Unit and appealed the denial of retroactive Medicaid for the month of January 2017.

On November 2, 2017, NYSOH issued a notice confirming your appeal of an "Eligibility Determination."

On January 29, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during that hearing and held open to February 13, 2018 for you to submit proof of your income for January 2017.

As of February 13, 2018, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day and this decision is based on the record as developed at the time of the hearing.

Findings of Fact

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

1) According to your NYSOH account, you were found eligible for Medicaid on January 21, 2017 with an effective date of February 1, 2017. You testified that you are seeking retroactive Medicaid coverage for the month of January 2017.

2) According to your NYSOH account and testimony, you expect to file your 2017 federal income tax return as single and will claim no dependents on that return.

3) In the June 14, 2017 application for financial assistance, you requested help paying for medical bills for the past three months. You made the same request on your updated applications.

4) Your June 14, 2017 application states that your income for January 2017 was $576.00. You testified that you were unsure how much income you received in the month of January 2017. You believe it to be about $200.00 per week before taxes.

5) You submitted a form DOH-4444, dated September 22, 2017, entitled Self-Declaration of Income, which states that you currently work for your employer and earn a cash income of $300.00 per week from that

employer. This document further states that you were unable to obtain a letter from your employer [with your January 2017 income] because they are “out of business” (*see* Documents [redacted] and [redacted].

6) You testified that you worked for your employer until June 2017. You further testified that you cannot obtain any documentation regarding your January 2017 income because you called your manager’s cell phone he did not respond to you when you left a message for him.

7) Your October 11, 2017 application states that you still work for your employer.

8) According to your NYSOH account, 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

De Novo Review

NYSOH Appeals Unit must review each appeal de novo and “consider all relevant facts and evidence adduced during the appeals process” (45 CFR § 155.535(f)). “De novo review means a review of an appeal without deference to prior decisions in the case” (45 CFR § 155.500).

Retroactive Medicaid for Adults between the Ages of 19 and 65

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of 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 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 retroactive Medicaid from January 1, 2017 through January 30, 2017.

The record reflects that you updated your account and applied for Medicaid for yourself on January 20, 2017. On January 21, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective February 1, 2017.

Although the record contains a January 21, 2017 eligibility determination notice on the issue of Medicaid eligibility for February 2017, it is silent as to your request for retroactive Medicaid coverage for the month of January 2017. The record does contain evidence of numerous notices, dated July 19, 2017 through December 4, 2017, requesting additional income information for the month of January 2017; and a November 2, 2017 notice in which NYSOH acknowledges receipt of an appeal request, and identifies you as the appellant and the issue on appeal as “Eligibility Determination.”

Here, the lack of a notice of eligibility determination on the issue of retroactive Medicaid for you for the month of January 2017 does not prevent the Appeals Unit from reaching the merits of the case or constitute material error. Under 45 CFR § 155.505(b), you are as entitled to appeal NYSOH failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination. The text of the July 19, 2017 through December 4, 2017 notices, and the November 2, 2017 notice, which acknowledges the appeal on the issue of your eligibility determination, along with your testimony, in which you stated you wanted help covering the medical expenses you have for the month of January 2017, permits an inference that the NYSOH did deny your request for retroactive Medicaid in the month of January 2017.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to an eligibility determination had it been issued. Therefore, the issue under review is refined to whether you were properly denied retroactive Medicaid benefits for the month of January 2017.

You were initially found eligible for Medicaid in the January 21, 2017 eligibility determination notice. According to this notice, your coverage with Medicaid began February 1, 2017.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual’s 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 to have your Medicaid coverage applied for the month of January 2017.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

You testified that you continued to work for your employer until on or about June 2017. You were unsure how much income you received from that employer in the month of January 2017. You testified you believe it to be about $200.00 per week. However, your testimony is inconsistent with the form [redacted], dated September 22, 2017, entitled Self-Declaration of Income, in which you stated that you earned a cash income of $300.00 per week from that employer, as well as the June 14, 2017 application, which states that you received $576.00 in the month of January 2017.

Nonetheless, the Self-Declaration of Income form also states that you are unable to get a letter from that employer regarding your January 2017 income because they are “out of business.” You also testified that you called your manager’s cell phone and he did not respond to you when you left a message for him.

However, these statements are not convincing since you testified that you worked for this employer until June 2017, which is the time you first applied for January 2017 retroactive Medicaid coverage. As such, it is concluded that had you requested the income information at the time you applied for January 2017 coverage, you would have been able to obtain proof of your January 2017 income. Moreover, your statements with respect to the amount of income you received in January 2017 are inconsistent. For these reasons, the record was held open to February 13, 2018 for you to submit proof of your income for the month of January 2017.

As of February 13, 2018, no further documentation was received to prove your income for the month of January 2017 and, therefore, the record is devoid of any documentary evidence of your income that month. As such, the issue of denial of retroactive Medicaid for the month of January 2017 cannot be addressed and no further action is required of NYSOH.

Decision

The issue of denial of retroactive Medicaid for the month of January 2017 will not be addressed. No further action is required of NYSOH.

Effective Date of this Decision: March 2, 2018

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

The effective date of your Medicaid is February 1, 2017.

You are not eligible for retroactive Medicaid in the month of January 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 issue of denial of retroactive Medicaid for the month of January 2017 will not be addressed. No further action is required of NYSOH.

This decision does not change your eligibility.

The effective date of your Medicaid is February 1, 2017.

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

Legal Authority

We are issuing this determination in accordance with 45 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).

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.

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).

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.

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.

(Urdu)اردو

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.

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(Yiddish) אידיש

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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