STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: February 27, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025644

[redacted]

Dear [redacted],

On February 20, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 29, 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
  PO 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 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(b).

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: February 27, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025644

[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 assistance for September 2017?

Procedural History

On October 25, 2017, NYSOH received an update to your application for financial assistance with health insurance.

Also on October 25, 2017, NYSOH received four earnings statements issued to you by your employer, [redacted]., between August 31, 2017 and September 28, 2017.

On October 26, 2017, NYSOH issued a notice stating that the information contained in your October 25, 2017 application did not match information NYSOH received from state and federal data sources. You were requested to provide documentation to prove your household income by November 9, 2017, so that an appropriate eligibility determination could be issued.

On November 11, 2017, NYSOH received a letter issued by your employer, dated November 10, 2017, confirming the date and amounts you were paid during the month of September 2017.

On November 27, 2017, NYSOH received (1) a letter issue to you by your former employer, [redacted]), stating that you had been laid off on

August 26, 2017, and (2) four additional earnings statements issued to you by your employer, [redacted]., between November 2, 2017 and November 24, 2017.

On November 28, 2017, NYSOH redetermined your eligibility for financial assistance with health insurance.

On November 29, 2017, NYSOH issued an eligibility determination notice stating that you had been found eligible for Medicaid, effective October 1, 2017.

Also on November 29, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid for September 1, 2017 through September 30, 2017 since your monthly household income of $2,833.33 was over the allowable income limit for that program.

On December 12, 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 September 2017.

On February 20, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. At your request, [redacted] also attended the hearing. The record was developed during the hearing and remained open as the Hearing Officer directed you to provide as additional evidence to corroborate your testimony: the final earnings statement issued to you by your former employer [redacted] after your lay-off on August 26, 2017. The record was to be closed on February 22, 2018, or upon the receipt of the above referenced documents, whichever occurred earlier.

On February 21, 2018, you provided to NYSOH Appeal Unit the above-reference document through facsimile.

Accordingly, the record was closed on February 21, 2018.

Findings of Fact

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

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

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

3) You submitted your application for financial assistance on October 25, 2017.

4) Your eligibility was redetermined by NSYOH on November 28, 2017 This redetermination reflected that for the month of September 2017 your income was $2,833.33. You testified that amount was incorrect.

5) You testified that you are currently employed by [redacted] are paid on a weekly basis in the range of $133.00 to $140.00 per week; however, you clarified that you are paid on a per diem basis.

6) On October 25, 2017, you provided to NYSOH both earnings statements and a letter from your employer, [redacted] confirming that you received (1) $133.00 on September 7, 2017, (2) $140.00 on September 14, 2017, (3) $126.50 on September 21, 2017, and (4) $133.00 on September 28, 2017.

7) On November 11, 2017, you provided a letter from your former employer, [redacted] stating that you were laid off on August 26, 2017.

8) On February 21, 2017, you provided to NYSOH an earnings statement issued to you by [redacted], reflecting that you last payment was on August 30, 2017 in the amount of $539.00.

9) Your NYSOH account reflects that you do not plan on taking any deductions on your tax return.

10) You testified that you were seeking retroactive Medicaid during the month of September 2017 because you incurred medical expenses during that month that were not covered.

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 that you were not eligible for Medicaid for September 1, 2017 through September 30, 2017.

You are in a one-person household; you file your taxes with a tax filing status of single and claim no dependent on your tax return.

You applied for financial assistance on October 25, 2017 and requested help in paying for medical bills for September 1, 2017 through September 30, 2017. Your eligibility was ultimately redetermined on November 28, 2017 based on the information contained in your NYSOH account at that time.

When an individual file an application for Medicaid, his or her eligibility for retroactive Medicaid depends on the date of application. To this end, it does not matter if 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 Medicaid from September 1, 2017 through September 30, 2017.

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

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 September 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 any non-financial criteria during September 2017.

You testified, and provided documentation reflecting, that you were paid weekly by your current employer, [redacted] and received a total of $532.50 during September 2017. You further provided documentation confirming that you did not receive any income from your former employer, [redacted] during September 2017.

Since the November 29, 2017 notice of eligibility determination found you were not eligible for Medicaid for September 1, 2017 to September 30, 2017 because your gross income during that month was $2,833.33, it is no longer supported by the now developed record, and is RESCINDED.

Since the record now contains a more accurate representation of what your income was for the month of September 2017, your case is RETURNED to NYSOH to consider your request for retroactive coverage for the month of September 2017 based on a one-person household with a household income of $532.50 during the month of September 2017.

Decision

The November 29, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for the month of September 2017 based on a one-person household with a household income of $532.50 during the month of September 2017.

Effective Date of this Decision: February 27, 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 you presented at the hearing.

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 case 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
  PO Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The November 29, 2017 eligibility determination notice is RESCINDED.

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your eligibility based on the evidence you presented at the hearing.

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।

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 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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