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

Notice of Decision

Decision Date: April 18, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026745

[redacted]

[redacted]

On March 26, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's failure to find you eligible for retroactive Medicaid assistance for the month of July 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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Decision

Decision Date: April 18, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026745

[redacted]

Issue

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

> Did NY State of Health (NYSOH) fail to determine your eligibility for retroactive Medicaid assistance for the month of July 2017?

Procedural History

On October 24, 2017, NYSOH received an updated application for financial assistance with health insurance submitted on your behalf. That application requested help paying for medical bills in July, August, and September 2017.

On October 25, 2017, NYSOH issued a notice stating the income information listed in your application did not match the information received from state and federal data sources. The notice directed you to submit proof of your income by November 8, 2017 or NYSOH would not be able to determine your eligibility for health coverage.

On November 17, 2017, NYSOH received your updated application. That application requested help paying for medical bills for the prior three months.

On November 18, 2017, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective October 1, 2017.

Also on November 18, 2017, NYSOH issued a notice stating you were eligible for retroactive Medicaid assistance for the months of August, September, and

October 2017, because the monthly income amount you provided was below income limit for Medicaid.

On January 4, 2018, you spoke to NYSOH's Account Review Unit and appealed insofar you were not eligible for retroactive Medicaid coverage for the month of July 2017.

On March 26, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to allow you to submit supporting documentation. On March 26, 2018 and April 11, 2018, documentation was uploaded to your NYSOH account. That documentation was incorporated into the record and collectively marked as Appellant's Exhibit # 1. The record closed thereafter.

Findings of Fact

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

1) An updated application was received on your behalf on October 24, 2017 listing your annual income for 2017 as $3,995.00.

2) The October 24, 2017 application requested help paying for medical bills for the prior three months, July through September 2017, and listed your monthly income as $332.92 for each of those months.

3) According to your account, NYSOH was unable to verify the income information in your application and you were placed in a pending Medicaid status with income documentation requested prior to NYSOH determining your eligibility for health coverage.

4) On November 17, 2017, you submitted an updated application online indicating that your income for 2017 would be the same as the last tax year, $16,000.00.

5) Your November 17, 2017 application requested help paying for medical bills for the prior three months, August through October 2017, and listed your monthly income as $1,333.33 for each of those months.

6) Based on the information in your updated application, NYSOH determined you eligible for Medicaid, effective October 1, 2017, and found you eligible for retroactive Medicaid assistance for the months of August, September, and October 2017.

7) You testified you are seeking retroactive Medicaid coverage for the month of July 2017, because you have outstanding medical bills from that time.

8) There is no record of NYSOH determining your eligibility for retroactive Medicaid assistance for the month of July 2017.

9) You testified that you were employed in the month of July 2017 at your current employer, but you were unsure of the amount of income you earned in that month. You testified that you are paid weekly on Fridays and that your weekly paycheck varies with the number of hours that you work.

10) You were directed to submit proof of your income for the month of July 2017.

11) On March 26, 2018 the following documentation was uploaded to your NYSOH account:

    a. Weekly paystub for check date of July 13, 2017 showing gross taxable income of $299.70

    b. Weekly paystub for check date of July 20, 2017 showing gross taxable income of $433.25

    c. Weekly paystub for check date of July 27, 2017 showing gross taxable income of $363.98

12) On April 11, 2018 a screenshot of a paystub detail was uploaded to your NYSOH account for your July 6, 2017 pay check showing gross weekly taxable income of $355.94.

13) You testified, and your applications indicated, you would file your 2017 tax return with a tax filing status of single and claim no dependents.

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 failed to determine your eligibility for retroactive Medicaid assistance for the month of July 2017.

An application for financial assistance was submitted on your behalf on October 24, 2017 requesting help paying for medical bills for the month of July 2017. According to your account, NYSOH was unable to verify the income information in your application and you were placed in a pending Medicaid status with income documentation requested prior to NYSOH determining your eligibility for health coverage.

On November 17, 2017, you updated your application. Following that application, NYSOH determined you eligible for Medicaid, effective October 1, 2017, and additionally found you eligible for retroactive Medicaid assistance for the months of August, September, and October 2017, as requested in the November 17, 2017 application. However, the record confirms that NYSOH has not issued a determination of your eligibility for retroactive coverage for the month of July 2017, as requested in your October 24, 2017 application, and you have appealed NYSOH's failure to determine you eligible for retroactive Medicaid assistance for that month.

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 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 retroactive Medicaid coverage for the month of July 2017 only.

Pursuant to the regulations, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size. The evidence establishes that you are in a one-person household, because you file your taxes with a tax filing status of single and claim no dependents.

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 $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 July 2017.

Your October 24, 2017 application listed your monthly income for the month of July 2017 as $332.92; however, according to your account, NYSOH was unable to verify the income information in that application. At the hearing, you were directed to submit proof of your income for the month of July 2017. Subsequently, you uploaded evidence to your NYSOH account of the four weekly paychecks you received in that month. That evidence established that your gross monthly income for July 2017 was $1,452.87.

Because the record now contains sufficient evidence that your monthly income for July 2017 was $1,452.87, which is over the allowable limit, you were not eligible for retroactive Medicaid assistance for July 2017.

Decision

You were not eligible for retroactive Medicaid assistance for July 2017

Effective Date of this Decision: April 18, 2018

How this Decision Affects Your Eligibility

Your eligibility has not changed.

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 were not eligible for retroactive Medicaid assistance for July 2017

Your eligibility has not changed.

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 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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