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

Notice of Decision

Decision Date: April 25, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027132

[redacted]

[redacted],

On March 12, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 26, 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).

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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: April 25, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000027132

[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 assistance for August 2017 and September 2017?

Procedural History

On November 15, 2017, you submitted an application for financial assistance to NYSOH with health insurance and indicated that you were seeking help for paying for medical bills for August 2017, September 2017, and October 2017.

Also on November 15, 2017, you uploaded to your NYSOH account proof of income documentation.

On November 16, 2017, NYSOH issued a notice stating that your November 15, 2017 application had been reviewed and the income information in your application did not match information NYSOH received from state and federal data sources. The notice requested additional proof of household income by November 30, 2017 in order to confirm your eligibility.

Also on November 16, 2017, NYSOH reviewed and invalidated the income documentation you submitted on November 15, 2017.

On November 17, 2017, NYSOH issued a notice stating that the documentation you submitted had been reviewed but did not confirm the information in your

application. You were requested to submit additional proof of household income and referred you to an attached list of acceptable documents. The notice stated that the proof of income documentation was needed by December 15, 2017.

On December 26, 2017, NYSOH issued an eligibility determination notice stating that you did not qualify for health coverage because you did not provide the income documentation needed to verify the income listed in your application by the due date.

Also on December 26, 2017, NYSOH issued an eligibility determination notice stating you were not eligible for Medicaid for August 1, 2017 through October 31, 2017 because you failed to provide proof of household income required to decide if you were eligible for Medicaid.

On January 1, 2018, you uploaded additional proof of income documentation.

On January 2, 2018, NYSOH reviewed the documentation you submitted and updated the income in your application and your eligibility was redetermined.

On January 3, 2018, NYSOH issued an eligibility determination notice based on the January 2, 2018 updated application, stating that you were eligible for Medicaid. This eligibility was effective as of January 1, 2018.

On January 11, 2018, you spoke to NYSOH's Account Review Unit and appealed the December 26, 2017 eligibility determination notice insofar as it denied retroactive Medicaid for the months of August 2017 and September 2017.

On March 12, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing held open up to March 19, 2018, to allow you to submit supporting documents.

On March 15, 2018, you uploaded to your NYSOH account income documentation for the months of August 2017 and September 2017. This documentation was collectively marked as Appellant's Exhibit #1 and incorporated into the record. The record was closed that day.

Findings of Fact

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

1) You testified that you are seeking Medicaid from August 1, 2017 to September 30, 2017.

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

3) You submitted an application for financial assistance on November 15, 2017 and requested help paying medical bills for the months of August 2017, September 2017, and October 2017.

4) According to your NYSOH account, NYSOH did not request proof of income for the months of August 2017, September 2017, and October 2017.

5) On November 15, 2017 you submitted two earning statements you received for employment in the month of August 2017. The first statement is for pay date of August 10, 2017 with gross pay of $1,271.89. The second statement is for pay date August 24, 2017 with gross pay of $1,123.16.

6) You testified that your employer terminated your employment as of [redacted] and has refused to provide you with a letter of termination.

7) You testified that you had [redacted] in August 2017 and you did not have health insurance at that time.

8) On December 26, 2017, NYSOH issued an eligibility determination notice stating that you did not qualify for retroactive Medicaid for the period of August 1, 2017 through October 31, 2017 because you did not provide proof of income for that period.

9) On March 15, 2018, you submitted the following proof of income for your spouse;

a. [redacted]: pay date August 4, 2017, gross pay $800.00,
b. [redacted]: pay date August 11, 2017, gross pay $800.00,
c. [redacted]: pay date August 20, 2017, gross pay $800.00,
d. [redacted]: pay date August 27, 2017, gross pay $800.00,
e. [redacted]: pay date August 31, 2017, gross pay of $156.00,
f. [redacted]: pay date September 3, 2017, gross pay $800.00,
g. [redacted]: pay date September 28, 2017, gross pay of $176.00,

10) You testified that you have not worked since [redacted] in August 2017. You testified that your spouse was laid off from [redacted] job in early September 2017.

11) According to your NYSOH account, you do not plan on taking any deductions on your tax return.

12) According to your NYSOH account you reside in Nassau County.

13) You testified that you want retroactive Medicaid for August 2017 because you had [redacted] and also for the month of September 2017 because you had follow up treatment with doctors that month.

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 $16,240.00 for a two-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 the months of August 2017 and September 2017.

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

You submitted an application for financial assistance on November 15, 2017 and requested help in paying for medical bills for the months of August 2017, September 2017 and October 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.

On December 26, 2017, NYSOH issued a notice denying your request for retroactive Medicaid assistance for the period of August 1, 2017 through October 31, 2017 because you did not provide proof of income for those months. However, the record reflects that NYSOH did not issue any notice specifically requesting that you provide proof of income documentation for the months of August 2017, September 2017, and October 2017.

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 August 2017 and 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 $1,868.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on any non-financial criteria during August 2017 and September 2017.

You testified that you were terminated from employment on [redacted] and that your employer has refused to provide you with a termination letter. You submitted two earning statements for pay you received in August 2017. The first statement is for pay date of August 10, 2017 with gross pay of $1,271.89. The second statement is for pay date August 24, 2017 with gross pay of $1,123.16. You testified that you have not worked since [redacted] in August 2017. Following the hearing, you submitted pay statements for your spouse for earnings he received in August 2017 and September 2017. He received $800.00 on August 4, 2017, August 11, 2017, August 20, 2017 and August 27, 2017 from employment at [redacted]. He also received $156.00 from [redacted] on August 31, 2017. In September 2107 he received $800.00 from [redacted] and was laid off. He also received $176.00 on September 28, 2017 from [redacted].

Therefore, the record indicates that in the month of August 2017, your household income was $5,751.05 ($1,271.89 + $1,123.16 + $800.00 + $800.00 + $800.00 +

$800.00 + $156.00). The record indicates that in the month of September 2017 your household income was $976.00 ($800.00 + $176.00).

Since the record now contains a more accurate representation of what your income was for the months of August 2017 and September 2017, your case is RETURNED to NYSOH to consider your request for retroactive coverage for August 2017 and September 2017 based on a two-person household and a household income of $5,751.05 for the month of August 2017 and $976.00 for the month of September 2017.

Decision

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for August 2017 and September 2017 based on a two-person household and a household income of $5,751.05 for August 2017 and $976.00 for September 2017

Effective Date of this Decision: April 25, 2018

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility. Your case is returned to NYSOH to reconsider your request for retroactive Medicaid assistance for August 2017 and September 2017 based on the evidence in the record.

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 a portion of 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
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for August 2017 and September 2017 based on a two-person household and a household income of $5,751.05 for August 2017 and $976.00 for September 2017

This is not a final determination of your eligibility. Your case is returned to NYSOH to reconsider your request for retroactive Medicaid assistance for August 2017 and September 2017 based on the evidence in the record.

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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