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: AP000000028303

[redacted]

[redacted]

On April 3, 2018 you appeared by telephone at a hearing on your appeal of NY State of Health's January 26, 2018 and January 31, 2018 eligibility determination notices.

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
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Decision

Decision Date: April 25, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028303

[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 for October, November, and December 2017?

Procedural History

On December 4, 2017, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for the past three months.

On January 26, 2018, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid for November 1, 2017 through November 30, 2017 because the monthly household income you provided of $2,581.16 was over the allowable monthly limit of $2,349.00.

On January 29, 2018, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for the past three months.

On January 31, 2018, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid for October 1, 2017 through October 31, 2017 because the monthly household income you provided of $2,581.16 was over the allowable monthly limit of $2,349.00. The notice also stated that you were not eligible for Medicaid for December 1, 2017 through December 31, 2017

because the monthly household income you provided of $2,581.16 was over the allowable monthly limit of $2,349.00.

On February 2, 2018, you spoke to NYSOH's Account Review Unit and appealed those eligibility determination notices insofar as they denied retroactive Medicaid for the months of October, November, and December 2017.

On April 3, 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 until April 18, 2018, to allow you time to submit documentation of your monthly income and expenses for October, November, and December 2017 as well as your 2017 income tax return, and proof of your rental income.

On April 16, 2018 NYSOH Appeal's Unit received a copy of your 2017 income tax return, profit and loss statements for September, October, December 2017, and January 2018, and rental income statements for September 2017 through January 2018 by upload in your NYSOH account and it was incorporated into the record as Appellant's Exhibit #1, the record remained open until April 18, 2018.

On April 20, 2018, a representative from NYSOH Appeals Unit reached out to you on behalf of the Hearing Officer and requested that you submit a profit and loss statement for November 2017. The record was left open until April 27, 2018 to allow you additional time to upload the requested documentation. On April 22, 2018, you uploaded your profit and loss statement for November 2017. The document was incorporated into the record as Appellant's Exhibit #2. The record was closed that day since all requested documentation had been received.

Findings of Fact

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

1) You testified that you are seeking Medicaid for the months of October, November, and December 2017.

2) You testified that you expect to file your 2017 federal income tax return as head of household with qualifying individual, and claim one dependent.

3) In the applications you submitted to NYSOH on December 4, 2017 and January 29, 2018 you indicated that you will be claiming two dependents on your income tax return.

4) On April 16, 2018, you uploaded a copy of your 2017 income tax return which shows that you filed as head of household with qualifying individual and claimed only one dependent.

5) Your application submitted on January 29, 2018, states that for the month of months of October, November, and December 2017 your income was $740.15.

6) You testified that you own a business and that your monthly income varies.

7) You testified that in addition to income that you receive from your business, you receive rental income.

8) On April 16, 2018 you provided documentation of your income for the month of October 2017 in [redacted]

9) On April 16, 2018 you provided documentation of your income for the month of November 2017 in [redacted].

10) On April 16, 2018 you provided documentation of your income for the month of December 2017 in [redacted]

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 Fed. Reg. 8831).

Household Composition

"Family size" means the number of persons counted as members of an individual's household. The household of a taxpayer who expects to file a return, and does not expect to be claimed as a tax dependent by anyone else, consists of the taxpayer plus all people the taxpayer expects to claim as tax dependents (42 CFR § 435.603(f)(1)).

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 October, November, and December 2017.

You submitted applications for financial assistance on December 4, 2017 and January 29, 2018 requesting help to pay for medical bills in the prior three months.

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 or not 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 for October, November, and December 2017.

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

Family size, for purposes of this analysis, means the number of persons counted as members of an individual's household. The household of a taxpayer who expects to file a return, and does not expect to be claimed as a tax dependent by anyone else, consists of the taxpayer plus all people the taxpayer expects to claim as tax dependents.

In the applications you submitted to NYSOH on December 4, 2017 and January 29, 2018 you indicated that you will be claiming two dependents on your income tax return.

In the eligibility determinations issued on January 26, 2018 and January 31, 2018, NYSOH determined that the monthly income threshold for Medicaid for your household was $2,349.00, which is the monthly income level for a three-person household.

However, you testified that you expected to file your 2017 federal income tax return as head of household with qualifying individual, and claim one dependent. You also uploaded a copy of your 2017 income tax return which shows that you filed as head of household with qualifying individual and claimed only one dependent.

Therefore, you are in a two-person household whose monthly allowable income limit is $1,868.00.

Since the January 26, 2018 and January 31, 2018 eligibility determination notices relied on an incorrect household size, they are RESCINDED.

Since the record now contains a more accurate representation of what your income and household size was for the months of October, November, and December 2017, your case is RETURNED to NYSOH to consider your request for retroactive coverage for those months.

NYSOH is directed to redetermine your eligibility for the month of October 2017 based on a two-person household with a monthly household income as calculated from the information in [redacted].

NYSOH is directed to redetermine your eligibility for the month of November 2017 based on a two-person household with a monthly household income as calculated from the information in [redacted]

NYSOH is directed to redetermine your eligibility for the month of December 2017 based on a two-person household with a monthly household income as calculated from the information in [redacted]

Decision

The January 26, 2018 and January 31, 2018 eligibility determination notices are RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for October, November, and December 2017.

NYSOH is directed to redetermine your eligibility for the month of October 2017 based on a two-person household with a monthly household income as calculated from the information in [redacted]

NYSOH is directed to redetermine your eligibility for the month of November 2017 based on a two-person household with a monthly household income as calculated from the information in [redacted].

NYSOH is directed to redetermine your eligibility for the month of December 2017 based on a two-person household with a monthly household income as calculated from the information in [redacted]

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 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)

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 January 26, 2018 and January 31, 2018 eligibility determination notices are RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for October, November, and December 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 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:

[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.

(Bengali)

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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1-855-355-5777

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)

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).

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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