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

Notice of Decision

Decision Date: May 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028692

[redacted]

Dear [redacted]

On April 18, 2018, you appeared by telephone at a hearing on your appeal to be found eligible for retroactive Medicaid in the month of November 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
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Decision

Decision Date: May 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028692

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Issue

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

Were you eligible for Medicaid in the month of November 2017?

Procedural History

On November 23, 2016, NYSOH issued a notice of eligibility determination stating you were eligible for Medicaid, effective November 1, 2016. You were subsequently enrolled into a Medicaid Managed Care (MMC) plan, beginning January 1, 2017.

On September 3, 2017, NYSOH issued a renewal notice stating it was time to renew your application for health insurance through NYSOH. The notice stated, based on information available from state and federal data sources, NYSOH could not determine whether you were eligible for financial assistance with the cost of health insurance. The notice directed you to update your application between September 16, 2017 and October 15, 2017, or you would be in danger of losing your coverage and financial assistance.

On October 17, 2017, NYSOH issued a discontinuance notice stating you were no longer eligible to enroll in coverage through NYSOH, effective November 1, 2017. This was because you did not respond to the renewal notice and did not complete your renewal within the required timeframe.

On October 17, 2017, NYSOH issued a notice stating you were disenrolled from your MMC plan, effective October 31, 2017, because you were no longer eligible to enroll in coverage through NYSOH.

On November 30, 2017, you updated your NYSOH application. In that application, you requested help paying for medical bills for the three months prior to your application for your three children and two cousins, but not for yourself.

On December 1, 2017, NYSOH issued a notice stating the income information in your application did not match the information NYSOH received from state and federal data sources. The notice advised you to submit documentation of your income by December 15, 2017.

On December 25, 2017, NYSOH redetermined your household's eligibility.

On December 26, 2017, NYSOH issued a notice of eligibility determination stating your two cousins were eligible for Medicaid, effective November 1, 2017.

Also on December 26, 2017, NYSOH issued a denial notice stating you and your three children were not eligible to enroll in coverage through NYSOH because you did not provide the income documentation needed to verify the information in your application.

That same day, NYSOH issued a notice stating your three children and two cousins were not eligible for Medicaid for the period of August 1, 2017 through October 31, 2017 because you did not provide income documentation needed to confirm their eligibility.

On February 8, 2018, you updated your NYSOH application and requested assistance with medical bills for the three months prior to your application on behalf of yourself and your three children.

Also on February 8, 2018, you spoke to NYSOH's Account Review Unit and appealed, insofar as you wanted to be eligible for retroactive Medicaid in the months of October, November, and December 2017, and NYSOH did not find you eligible on that day.

On February 9, 2018, NYSOH issued a notice stating the income information in your application did not match the information NYSOH received from state and federal data sources. The notice advised you to submit documentation of your household income by February 23, 2018.

On February 28, 2018, you faxed documentation to NYSOH.

On March 1, 2018, you updated your NYSOH application.

On March 2, 2018, NYSOH issued a notice of eligibility determination stating you and your three children were eligible for Medicaid, effective March 1, 2018.

Also on March 2, 2018, NYSOH issued a notice of eligibility determination stating you and your three children were eligible for Medicaid in the months of December 2017 and January and February 2018.

On April 18, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, the issue under review was amended to reflect that you were appealing on behalf of yourself only, and that you were appealing for the month of November 2017 only, as you were eligible for, and enrolled in, Medicaid and MMC coverage in the month of October 2017. The record was developed during the hearing and held open through May 3, 2018, to allow you to submit supporting documents.

As of May 4, 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) You testified that you are seeking Medicaid for yourself for the month of November 2017.

2) You testified that you expect to file your 2017 federal income tax return as married, but filing separately.

3) You testified you expect to claim four dependents on your tax return: your three children and one of your cousins.

4) You testified there were five people in your household in November 2017.

5) You applied for financial assistance on February 8, 2018, and requested assistance with medical bills from the months of November 2017, December 2017, and January 2018.

6) Your application submitted on February 8, 2018, states that for the month of November 2017, your income was $2,253.33.

7) You testified you are paid weekly, and you earned approximately $575.00 a week in the month of November 2017.

8) You testified you had to go to regular treatment in the month of November 2017, and have delinquent bills that could prevent you from remaining in that treatment.

9) After the hearing the record was kept open for fifteen days so that you could provide documentation of your income for the month of November 2017.

10) No documentation was received by the Appeals Unit or visible in your NYSOH account by the end of the 15-day period, and the record was closed.

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). In the month of November 2017, that was the 2017 FPL, which is $29,420.00 for a five-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 you were eligible for Medicaid in the month of November 2017.

You testified you were in a five-person household in the month of November 2017. You testified you will file your 2017 taxes with a tax filing status of married, filing separately, and claim four dependents on your tax return.

You APplied for financial assistance on February 8, 2018 and requested help in paying for medical bills for November 1, 2017 through January 31, 2018.

When an individual file 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 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.

In this case, NYSOH did not issue a determination on your eligibility for Medicaid in the month of November 2017, even though you requested coverage for November in your February 8, 2018 application. This appears to be because, by the time NYSOH issued an eligibility determination, it was March 2018, so the three-month period covered by your retroactive Medicaid was December 2017, January 2018, and February 2018. Nevertheless, as you applied for retroactive Medicaid for November 2017 in your February 8, 2018 application, you were entitled to have your eligibility for that coverage determined, and the Appeals Unit may review your request, even in the absence of a determination by NYSOH.

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 November 2017, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $3,383.00 per month for a household of five. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during November 2017.

You testified that you are paid weekly, and earn approximately $575.00 per week. The record was kept open so that you could submit documentation to provide proof of your total income of the month of November 2017. However, you did not submit any documentation after the hearing.

Since there is insufficient income information in the record to prove your income for the month of November 2017, there is no reason to return your case to NYSOH for a determination of your eligibility for Medicaid in that month.

You request for Medicaid in the month of November 2017 is DENIED as you have not submitted documentation to prove your income in that month.

Decision

You request for retroactive Medicaid in the month of November 2017 is DENIED.

The March 2, 2018 Eligibility determination is AFFIRMED. You and your three children were eligible for Medicaid in the months of December 2017 and January and February 2018.

Effective Date of this Decision: May 10, 2018

How this Decision Affects Your Eligibility

You are not eligible for Medicaid in the month of November 2017 because you did not submit the income documentation necessary for a determination of your eligibility to be made.

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 request for retroactive Medicaid in the month of November 2017 is DENIED.

You are not eligible for Medicaid in the month of November 2017 because you did not submit the income documentation necessary for a determination of your eligibility to be made.

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:

[redacted]

[redacted]

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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 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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