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

Notice of Decision

Decision Date: May 8, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028893

[redacted]

Dear [redacted]

On April 16, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 24, 2018 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
Albany, NY 12211

Decision

Decision Date: May 8, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028893

[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 December 2017?

Procedural History

On January 18 and 19, 2018, you submitted applications for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for October, November, and December 2017.

On January 19 and 20, 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 notices directed you to submit documentation of your income by February 2, 2018.

On January 29, 2018, you uploaded income documentation to your account and submitted two more applications for financial assistance.

Also on January 29, 2018, NYSOH redetermined your eligibility.

On January 30, 2018, NYSOH issued a notice of eligibility determination stating you were eligible to receive up to $266.00 per month in advance payments of the premium tax credit, effective March 1, 2018. The notice also stated you would be sent a separate notice advising you if you were eligible for Medicaid in the three-

month period prior to your application, or if additional information was needed to determine your eligibility.

Also on January 30, 2018, NYSOH issued a notice stating you were not eligible for Medicaid in the month of October 2017 because your income in that month was over the allowable income limit. The notice directed you to submit documentation of your income for the months of November and December 2017 by February 13, 2018.

On January 31, 2018, NYSOH issued a notice stating the documentation you provided was not sufficient to confirm the income information in your application. The notice advised you to submit income documentation for the month of December 2017 by February 28, 2018.

On February 2, 2018, you updated your NYSOH application.

On February 3, 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 notices directed you to submit documentation of your income by February 17, 2018.

On February 13, 2018, you uploaded additional documentation to your NYSOH account.

Also on February 13, 2018, you spoke with NYSOH's Account Review Unit and appealed, insofar as you had not been found eligible for Medicaid in the months of October, November, and December 2017.

On February 15, 2018, NYSOH issued a notice stating the documentation you provided was not sufficient to confirm the income information in your application. The notice advised you to submit income documentation by March 4, 2018.

On February 20, 2018, you uploaded documentation to your NYSOH account and updated your NYSOH application.

That same day, your eligibility was redetermined by NYSOH's system.

On February 21, 2018, NYSOH issued a notice of eligibility determination stating you were eligible for Medicaid, effective February 1, 2018.

Also on February 21, 2018, NYSOH issued a notice of eligibility determination stating you were ineligible for Medicaid in the month of January 2018 because your income was over the allowable monthly income limit for that month. The notice directed you to submit documentation of your income for the months of November and December 2017 by March 7, 2018.

On February 23, 2018, NYSOH's system redetermined your eligibility.

On February 24, 2018, NYSOH issued a notice of eligibility determination stating you remained eligible for Medicaid, effective February 1, 2018.

Also on February 24, 2018, NYSOH issued a notice of eligibility determination stating you were eligible for Medicaid in the month of November 2017, but ineligible for Medicaid for the month of December 2017 because your income was over the allowable monthly income limit in that month.

On March 20, 2018, NYSOH issued a notice stating you were eligible for Medicaid for the month of October 2017.

On April 16, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, you clarified that you were now seeking retroactive Medicaid for the month of December 2017 only, as you had been approved for retroactive Medicaid for the months of October and November 2017. The record was developed during the hearing held open through May 1, 2018 to allow you to submit supporting documents.

On April 16, 2018, you uploaded documentation to your NYSOH account. NO further documentation was submitted. The record is now closed.

Findings of Fact

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

1) You testified that you are seeking Medicaid for the month of December 2017.

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

3) You first submitted an application for financial assistance on January 18, 2018.

4) Your application submitted on January 18, 2018, states that for the month of December 2017, your income was $1,213.20.

5) NYSOH issued a notice on February 24, 2018 stating you were not eligible for Medicaid in the month of December 2017 because your income of $1,685.00 in that month was over the monthly income limit of $1,387.00.

6) You testified your only income in the month of December 2017 was Unemployment Insurance Benefits (UIB).

7) You testified you believe your income in the month of December 2017 was the same as it was in October 2017, so you do not understand why you were approved for retroactive Medicaid in October, and not December 2017.

8) On February 20, 2018, you submitted an Official Record of Benefit Payment History showing the UIB payments you received in the period of August 24, 2017 through January 9, 2018 (Document [redacted]

9) The Payment history shows you received payments in December 2017 on the following dates, and for the following gross amounts:

a. December 4, 2017: $337.00;
b. December 8, 2017 $337.00;
c. December 14, 2017: $337.00;
d. December 21, 2017: $337.00;
e. December 28, 2017: $337.00.

10) You testified you do not think you received the five payments on the days listed in the payment history, and that your bank statement proves this.

11) After the hearing, the record was left open so you could submit a copy of your bank statement showing the UIB payments you received in December 2017.

12) On April 16, 2018, you uploaded a copy of the same UIB Payment History that you uploaded on February 20, 2018 (Document [redacted]

13) You testified you have one medical bill from the month of December 2017 that you had to pay out of pocket, and for which you are looking to be reimbursed.

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 in the month of December 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 submitted an application for financial assistance on January 18, 2018, and requested help in paying for medical bills for October through December 2017. You were subsequently approved for retroactive Medicaid for the months of October and November 2017, but were denied coverage for December 2017.

When an individual files an 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.

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 December 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 non-financial criteria during December 2017.

You testified your only income in the month of December 2017 was UIB. You uploaded an official UIB payment history showing you received five UIB payments of $337.00 each in the month of December 2017, for a total of $1,685.00. You testified at the hearing that you did not believe you actually received five payments in the month of December 2017, and that your bank statement would show this. The record was kept open so that you could submit a copy of your bank statement, but the only documentation you submitted after the hearing was a second copy of the UIB payment history you had already provided. Therefore, the record indicates that in the month of December 2017, you had a monthly household income of $1,685.00.

Since your income of $1,685.00 was more than the $1,387.00 monthly Medicaid limit for December 2017, NYSOH properly determined that you were not eligible for Medicaid coverage during that month. Therefore, the February 24, 2018 eligibility determination stating that you were not eligible for Medicaid in the month of December 2017, is correct and is AFFIRMED.

Decision

The February 24, 2018 eligibility determination is AFFIRMED.

Effective Date of this Decision: May 8, 2018

How this Decision Affects Your Eligibility

You are not eligible for Medicaid in the month of December 2017.

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 February 24, 2018 eligibility determination is AFFIRMED.

You are not eligible for Medicaid in the month of December 2017.

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।

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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