



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

Notice of Decision

Decision Date: April 19, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000029777



On April 4, 2018, you appeared by telephone at an expedited hearing on your appeal of NY State of Health's August 3, 2017 denial of your request for retroactive Medicaid.

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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DEPARTMENT OF HEALTH
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Decision

Decision Date: April 19, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000029777



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 assistance for the period from April 1, 2017 through July 31, 2017?

Procedural History

On April 26, 2017, you submitted an application for financial assistance with health insurance.

On April 27, 2017, NYSOH issued a notice stating the income information in your application did not match information NYSOH received from state and federal data sources. The notice directed you to submit documentation of your income by May 11, 2017 to confirm your eligibility.

On May 22, 2017, NYSOH redetermined your eligibility.

On May 23, 2017, NYSOH issued a notice of eligibility determination stating you were eligible to enroll in a qualified health plan at full cost through NYSOH, effective July 1, 2017. The notice further stated you were not eligible for Medicaid, the Essential Plan, or to receive advance payments of the premium tax credit, because NYSOH did not receive income documentation needed to verify the income in your application.

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On June 19, 2017, you updated your NYSOH account and uploaded documentation. In your application, you requested help paying for medical bills from March, April, and May 2017.

On June 20, 2017, NYSOH issued a notice stating the income information in your application did not match what NYSOH received from state and federal data sources. The notice directed you to submit documentation of your income by July 4, 2017 to confirm your eligibility.

Also on June 20, 2017, you uploaded documentation to your NYSOH account.

On June 21 and 22, 2017, NYSOH issued notices stating that the documentation you submitted did not confirm the information in your application, and that you needed to supply documentation of your income by July 4 and July 19, 2017 respectively.

On July 10 and 11, 2017, you uploaded documentation to you NYSOH account.

On July 12, 2017, NYSOH issued a notice stating the documentation you submitted did not confirm the information in your application, and that you needed to supply documentation of your income by August 3, 2017.

On August 2, 2017, you uploaded documentation to your NYSOH account. That same day, NYSOH redetermined your eligibility.

On August 3, 2017, NYSOH issued a notice of eligibility determination stating you were eligible to receive up to \$239.00 per month in advance payments of premium tax credit, effective September 1, 2017.

Also on August 3, 2017, NYSOH issued a notice stating you were not eligible for Medicaid for the period of May 1, 2017 through July 31, 2017 because the monthly household income of \$2,563.83 you provided in your application was over the allowable monthly income limit of \$1,387.00.

That same day, NYSOH uploaded a copy of the July 12, 2017 notice, which was returned to NYSOH as undeliverable on July 27, 2017, to your NYSOH account, and marked your mailing address "invalid."

On August 4, 2017, NYSOH issued a notice of eligibility determination stating you were eligible to enroll in a qualified health plan at full cost, effective September 1, 2017.

On August 21, 2017, you updated your NYSOH application and uploaded documentation to your NYSOH account.

On August 22, 2017, NYSOH issued a notice stating the income information in your application did not match what NYSOH received from state and federal data sources. The notice directed you to submit documentation of your income by September 5, 2017 to confirm your eligibility.

On August 22, 2017, NYSOH redetermined your eligibility.

On August 23, 2017, NYSOH issued a notice of eligibility determination stating you were eligible for Medicaid, effective August 1, 2017.

On September 2, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in a Medicaid Managed Care plan, beginning October 1, 2017.

On March 5, 2018, you updated your NYSOH account and changed your address to [REDACTED]. That same day, you spoke to NYSOH's Account Review Unit and requested an expedited appeal of the August 3, 2017 eligibility determination notice that denied you retroactive Medicaid for the months of May, June, and July 2017. You also appealed to be eligible for Medicaid in the month of April 2017.

On March 6, 2018, NYSOH issued a discontinuance notice stating you were no longer eligible to enroll in coverage through NYSOH, effective April 1, 2018, because you were not a resident of NY State. You were also disenrolled from your Medicaid Managed Care plan, effective March 31, 2018.

On March 28, 2018, your request for an expedited appeal was approved in Incident # [REDACTED].

On April 4, 2018, you had an expedited telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing held open through April 19, 2018 to allow you to submit supporting documents.

On April 9 and April 13, 2018, you faxed documentation to NYSOH's Appeals Unit. 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 from April 1, 2017 through July 31, 2017.
- 2) You testified you have not worked in the last couple of years, and you lost your employer-sponsored health insurance in April 2017.

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- 3) You testified you believe you were found eligible for Medicaid in August 2017.
- 4) Your NYSOH account reflects you filed an application for financial assistance on April 26, 2017, and were subsequently found eligible to enroll in a full cost qualified health plan, effective July 1, 2017, because you did not submit income documentation.
- 5) Your NYSOH account reflects you updated your application again on June 19, 2017, and were found eligible to receive advance payments of the premium tax credit, effective September 1, 2017, based on the income information from your 2016 federal income tax return, which you provided to NYSOH on August 2, 2017.
- 6) Your NYSOH account reflects your mailing address was then marked "invalid" on August 3, 2017, after mail sent to you at the address listed in your NYSOH account was returned to NYSOH as undeliverable.
- 7) Your NYSOH account reflects you updated your application again on August 21, 2017, and were found eligible for Medicaid, effective August 1, 2017.
- 8) You testified you do not recall receiving the August 3, 2017 notice stating your request for retroactive Medicaid for the months of May, June and July 2017 was denied.
- 9) You testified you moved out of your residence in June 2017 and put in a change of address with the Post Office at that time; however, you were in [REDACTED] for [REDACTED], and did not actually reside in your new address until August 2017.
- 10) Your NYSOH account reflects the address in your account was changed on August 3, 2017, and you testified you believe your daughter completed this change.
- 11) You testified your daughter and sister were trying to assist you with the process of getting insurance and updating your NYSOH account while you were [REDACTED].
- 12) You testified you moved to [REDACTED] at the end of August 2017. Your NYSOH account reflects you reported this move to NYSOH on March 5, 2018.
- 13) You testified that you expect to file your 2017 federal income tax return as single, and claim no dependents.

- 14) On July 11, 2017, you uploaded a copy of a direct deposit summary from [REDACTED] showing a deposit of \$1,353.90 on July 1, 2017 (Document [REDACTED]).
- 15) You testified this is a pension you receive on behalf of your late husband, and that you receive \$1,353.90 every month.
- 16) You testified you have no other income.
- 17) You testified you were receiving short-term disability, but that this ended in April 2017.
- 18) You testified you sold your house in June 2017, but were not sure how much, if any, of the proceeds would be reported on your tax return.
- 19) You testified you need Medicaid coverage for May and June 2017, especially, because you have thousands of dollars of medical bills from [REDACTED] and [REDACTED].
- 20) After the hearing, on April 9, 2018, you faxed a three-page document to the Appeals Unit consisting of:
 - a. A cover sheet explaining you sold your house on [REDACTED] and not in June;
 - b. A copy of a title insurance invoice showing a closing date of [REDACTED];
 - c. A copy of a letter from an attorney stating that your closing took place on [REDACTED].

These documents are collectively marked and entered into the record as "Appellant's Exhibit One."

- 21) On April 13, 2018, you faxed a 27-page document to the Appeals Unit consisting of:
 - a. A one-page cover sheet;
 - b. A copy of electronic filing authorizations for your 2017 income tax return for [REDACTED], and the IRS, all dated April 12, 2018;
 - c. A copy of your 2017 IRS Form 1040 Individual Income Tax Return reflecting the following:
 - i. \$12,710.00 in W-2 earnings;
 - ii. \$16,247.00 in taxable pension and annuities;
 - iii. An adjusted gross income of \$28,957.00 for 2017;

- iv. A Schedule D showing a net capital gain of "\$0.00" from the sale of your house;
- d. A copy of your NY State Non-Resident and Part-Year Resident Income Tax Return, Form IT-203 and IT-203-B, along with IT-360.1, "Change of City Resident Status;"
- e. An IT-1099-R Summary of Federal Form 1099-R Statements showing retirement income of \$16,247.00;
- f. An IT-2 Summary of W-2 Statements showing \$12,710.00 in wages from "[REDACTED]," for 2017;
- g. A copy of your [REDACTED] 2017 Individual Income Tax Return;
- h. A letter from your CPA regarding the preparation of your 2017 tax returns.

Together, these documents are marked and entered into the record as "Appellant's Exhibit Two."

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 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 or she had applied then (42 USCA § 1396A(34); 42 CFR § 435.915(a)). The Department of Health may make eligibility effective for fee-for-

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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 assistance for the period from April 1, 2017 through July 31, 2017.

You are in a one-person household; you file your taxes with a tax filing status of single and claim no dependents on your tax return.

You submitted an application for financial assistance on June 19, 2017 and requested help in paying for medical bills for March 1, 2017 through May 1, 2017. On August 2, 2017, your application was updated by NYSOH, and that application reflected a request for help paying for medical bills in the months of May, June, and July 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 application resulted in Medicaid eligibility going forward; 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, regardless of current eligibility.

Therefore, although you were not found eligible for Medicaid until August 2017, because you requested help paying for medical bills in the three months prior to your June 2017 application, the Appeals Unit is able to review your eligibility for retroactive Medicaid assistance for April 2017, as well as the months addressed in the August 3, 2017 denial notice (May, June, and July 2017).

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 assistance in April, May, June, and July, 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 the period from April 1, 2017 through July 31, 2017.

You testified that you have not worked in the last "couple of years," and that your income consists of \$1,353.90 in a monthly pension payment from your late

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husband. You submitted documentation confirming this amount (See Document [REDACTED]). You testified you were receiving short-term disability as of April 2016, but that this income ended in April 2017. You also testified you sold your house in 2017.

After the hearing, you provided a copy of your 2017 federal income tax return, which confirmed that you received \$16,247.00 in pension payments in 2017, which equates to twelve payments of \$1,353.90. The tax return also reflected you had no gains to report from the sale of your house in 2017. However, the tax return reflected additional W-2 income of \$12,710.00 for 2017. You did not provide any testimony regarding this income. Additionally, as it was W-2 income, it cannot be assumed that this is the short-term disability income you referred to in your testimony.

Since the record contains insufficient information to determine your income in the months of April, May, June, and July 2017, the August 3, 2017 eligibility determination stating that you were not eligible for Medicaid for the period of May 1, 2017 through July 31, 2017 must be AFFIRMED. Additionally, there is insufficient information in the record to return your case to NYSOH for a determination of your Medicaid eligibility in the month of April 2017.

Decision

The August 3, 2017 eligibility determination is AFFIRMED.

There is insufficient information in the record to determine your eligibility for Medicaid in the month of April 2017.

Effective Date of this Decision: April 23, 2018

How this Decision Affects Your Eligibility

You are not eligible for Medicaid in the months of April, May, June, and July 2017, as there is not enough information in the record to determine your monthly income for those months.

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.

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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

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The August 3, 2017 eligibility determination is AFFIRMED.

There is insufficient information in the record to determine your eligibility for Medicaid in the month of April 2017.

You are not eligible for Medicaid in the months of April, May, June, and July 2017, as there is not enough information in the record to determine your monthly income for those months.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:



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 مجاناً.

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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&etumi ama wo obi a okyerε kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 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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