



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

## Notice of Decision

Decision Date: June 2, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000014640

[REDACTED]

Dear [REDACTED]

On May 2, 2017, your spouse appeared by telephone at a hearing on the appeal of NY State of Health's January 5, 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.

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## Decision

Decision Date: June 2, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000014640



## Issue

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

Did NY State of Health properly determine that your spouse was not eligible for Medicaid in the month of December 2016?

## Procedural History

On May 12, 2016, NY State of Health (NYSOH) issued an eligibility determination notice stating that your spouse was eligible for Medicaid. This eligibility was effective as of May 1, 2016.

On June 10, 2016, NYSOH issued a disenrollment notice stating that your spouse's Medicaid fee-for-service coverage through NYSOH would be discontinued as of June 30, 2016 and also that her Medicaid fee-for-service coverage through NYSOH would be discontinued as of March 31, 2017.

On October 19, 2016, NYSOH issued a renewal notice stating that there was no action needed for your spouse, and that you would get sent more information in April 2017 in regards to renewing her coverage. It also indicated that the coverage your spouse was receiving now would end on May 31, 2017.

On December 27, 2016, NYSOH issued a letter stating that an incorrect Health Insurance Premium Reimbursement payment was made on your spouse's behalf. It further stated that the reason for the overpayment was that your spouse received a Medicaid premium reimbursement for the month of December 2016

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that she was not entitled to due to your spouse's Medicaid coverage ending November 30, 2016.

On January 4, 2017, NYSOH ran an application for financial assistance with health insurance on your family's behalf. A preliminary eligibility determination found your spouse eligible for Medicaid, effective January 1, 2017. This preliminary determination further found that your spouse also was eligible for Medicaid for December 2014 and November 2014.

On January 5, 2017, you spoke to NYSOH's Accounts Review Unit and appealed the preliminary eligibility determination insofar as you were denied a backdate of Medicaid coverage for your spouse to December 1, 2016.

On January 6, 2017, NYSOH issued an eligibility determination notice stating that your spouse was eligible for Medicaid, effective January 1, 2017.

Also on January 6, 2017, NYSOH issued an eligibility determination notice stating that your spouse was eligible for Medicaid for November 1, 2014 through December 31, 2014.

On May 2, 2017, your spouse had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open until May 17, 2017 to allow you time to submit the letter from NYSOH which indicated that there was an incorrect Health Insurance Premium Reimbursement payment made on your spouse's behalf.

On May 2, 2017, NYSOH's Appeals Unit received a four-page fax which contained this letter. The letter was made part of the record as "Appellant's Exhibit #1" and the record was closed the same day.

## **Findings of Fact**

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

- 1) According to your NYSOH account, your spouse was found eligible for Medicaid coverage, effective May 1, 2016, as reflected in the May 12, 2016 eligibility determination notice.
- 2) Your spouse testified that she was told that she did not have any Medicaid coverage when she went to the doctor's office and was told that her Medicaid coverage ended November 30, 2016.
- 3) Your spouse testified that she received no documentation that she had been found ineligible for Medicaid in December 2016.

- 4) Your spouse testified that she was told by NYSOH's Account Review Unit that they could not find a notice that her Medicaid coverage ended November 30, 2016.
- 5) Your spouse further testified that she was told that her coverage for Medicaid started January 1, 2017, resulting in a gap of coverage for the month of December 2016.
- 6) According to your NYSOH account, your spouse resided in New York State at all times relevant.
- 7) According to your NYSOH account, your spouse has a valid Social Security number.
- 8) Your spouse testified that she is seeking to be reinstated her Medicaid fee-for-service for the month of December 2016 because she received a letter from NYSOH stating that an incorrect Health Insurance Premium Reimbursement payment in the amount of \$104.90 was made on her behalf, which NYSOH is stating that she must repay.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

## **Applicable Law and Regulations**

### De Novo Review

NYSOH's Appeals Unit must review each appeal de novo and "consider all relevant facts and evidence adduced during the appeals process" (45 CFR § 155.535(f)). "*De novo review* means a review of an appeal without deference to prior decisions in the case" (45 CFR § 155.500).

### 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)).

Most adults determined eligible for Medicaid are guaranteed twelve months of Medicaid coverage even if they lose Medicaid eligibility because of any changes

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or updates they make to their NYSOH account. For example, even if income increases above the Medicaid limit allowed for the household size, the insured will remain covered under Medicaid for a twelve-month period. This twelve-month period is referred to as “continuous coverage” and is set based on the start date of the original Medicaid eligibility determination or the date of a subsequent Medicaid eligibility determination based on modified adjusted gross income (N.Y. Soc. Serv. Law § 366(4)(c)).

An individual will be enrolled or remain in their Medicaid coverage with limited exceptions, including lack of state residence or failing to provide a valid social security number. (N.Y. Soc. Serv. Law § 366(4)(c)).

## **Legal Analysis**

The issue under review is whether NYSOH properly determined that your spouse was not eligible for Medicaid in December 2016.

On January 5, 2017, you spoke with NYSOH’s Account Review Unit and requested review of your spouse’s eligibility on the basis that your spouse was not eligible for Medicaid; specifically, that your request for a backdate of your spouse’s Medicaid coverage to December 1, 2016 was denied. The January 5, 2017 eligibility determination notice does not address your spouse’s eligibility for Medicaid in the month of December 2016 and, after review of the record, there is no other indication that you spouse was denied coverage for Medicaid for the month of December 2016. However, the record does contain a January 6, 2017 appeal notice in which NYSOH acknowledges receipt of an appeal request and identifies the issue on appeal as “Other, Appealing the denial of a backdate request for Medicaid in the month of December.”

Here, the lack of a notice of eligibility determination on the issue of your eligibility for Medicaid coverage for December 2016 does not prevent the Appeals Unit from reaching the merits of the case or constitute material error. Under 45 CFR § 155.505(b), you are as entitled to appeal NYSOH’s failure to timely issue an eligibility determination notice as you are to appeal an adverse notice of eligibility determination. The text of the January 21, 2017 notice, which acknowledges the appeal on the issue of denying you a backdate of your spouse’s Medicaid coverage for the month of December 2016, permits an inference that NYSOH did deny that request.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to the eligibility determination notice had it addressed this issue. Therefore, the issue under review remains as whether your spouse was eligible for Medicaid in the month of December 2016.

Your spouse was found eligible for Medicaid in an eligibility determination notice dated May 12, 2016, with her Medicaid coverage starting on May 1, 2016.

Under New York State law, once a person is eligible for Medicaid, that eligibility continues for twelve months, even if the household income rises above 138% of the FPL. This provision is called “continuous coverage.”

The record indicates that your spouse has been a continuous resident of NY State and your account contains a valid Social Security number. Therefore, there is nothing in the record which would have taken your spouse out of continuous coverage for Medicaid. As a result, your spouse’s Medicaid coverage started on May 1, 2016 and should have continued until April 30, 2017.

Therefore, the January 5, 2017 eligibility determination is MODIFIED to state that your spouse was eligible for Medicaid fee-for-service as of May 1, 2016.

Your case is RETURNED to NYSOH to re-enroll your spouse in Medicaid fee-for-service for the period of December 1, 2016 through December 31, 2016 and to facilitate the withdrawal of the letter dated December 27, 2016, which states that an incorrect Health Insurance Premium Reimbursement payment in the amount of \$104.90 was paid in error on your spouse’s behalf.

## **Decision**

The January 5, 2017 eligibility determination is MODIFIED to state that your spouse was eligible for Medicaid fee-for-service as of May 1, 2016.

Your case is RETURNED to NYSOH to re-enroll your spouse in Medicaid fee-for-service for the period of December 1, 2016 through December 31, 2016 and to facilitate the withdrawal of the letter dated December 27, 2016, which states that an incorrect Health Insurance Premium Reimbursement payment in the amount of \$104.90 was paid in error on your spouse’s behalf.

**Effective Date of this Decision:** June 2, 2017

## **How this Decision Affects Your Eligibility**

Your spouse’s Medicaid fee-for-service coverage, which began on May 1, 2016, should have continued until April 30, 2017.

Your case is being sent back to NYSOH to re-enroll your spouse in Medicaid fee-for-service for the period of December 1, 2016 through December 31, 2016 and to facilitate the withdrawal of the letter dated December 27, 2016, which states

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that an incorrect Health Insurance Premium Reimbursement payment in the amount of \$104.90 was paid in error on your spouse's behalf. NYSOH will notify you once this has been achieved.

### **If You Disagree with this Decision (Appeal Rights)**

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services. 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 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

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## **Summary**

The January 5, 2017 eligibility determination is MODIFIED to state that your spouse was eligible for Medicaid fee-for-service as of May 1, 2016. Your spouse's Medicaid fee-for-service coverage, which began on May 1, 2016, should have continued until April 30, 2017.

Your case is RETURNED to NYSOH to re-enroll your spouse in Medicaid fee-for-service for the period of December 1, 2016 through December 31, 2016 and to facilitate the withdrawal of the letter dated December 27, 2016 which states that an incorrect Health Insurance Premium Reimbursement payment in the amount of \$104.90 was paid in error on your spouse's behalf. NYSOH will notify you once this has been achieved.

Your spouse's Medicaid fee-for-service coverage, which began on May 1, 2016, should have continued until April 30, 2017.

Your case is being sent back to NYSOH to re-enroll your spouse in Medicaid fee-for-service for the period of December 1, 2016 through December 31, 2016 and to facilitate the withdrawal of the letter dated December 27, 2016, which states that an incorrect Health Insurance Premium Reimbursement payment in the amount of \$104.90 was paid in error on your spouse's behalf. NYSOH will notify you once this has been achieved.

## **Legal Authority**

We are sending you this notice 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 مجاناً.

### বাংলা (Bengali)

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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।

### **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 okyerE 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.

### **שׂוּדִישׁ (Yiddish)**

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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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