



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

## Notice of Decision

Decision Date: September 15, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000017512

[REDACTED]

Dear [REDACTED],

On July 13, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's denial of your request for retroactive Medicaid for the month of June 2016.

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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## Decision

Decision Date: September 15, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000017512

[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 June 2016?

## Procedural History

On August 5, 2016, you submitted an application for financial assistance with health insurance. That day, you also submitted paystubs to NYSOH.

On August 6, 2016, NYSOH issued a notice of eligibility determination stating that you were conditionally eligible for Medicaid, effective August 1, 2016. You were directed to submit income documentation by August 20, 2016.

On August 10, 2016, the paystubs you submitted were reviewed and an application was submitted on your behalf.

On August 11, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective August 1, 2016.

On August 13, 2016, NYSOH issued an enrollment confirmation notice stating that your enrollment in a Medicaid Managed Care plan was effective September 1, 2016.

On March 30, 2017, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for June 2016.

Also on March 30, 2017, you spoke to NYSOH's Account Review Unit and a complaint was created ( [REDACTED] ) which indicated that you were denied retro coverage for June 2016. You filed a formal appeal that day based on the verbal denial of retro Medicaid.

On March 31, 2017, NYSOH issued an appeal confirmation notice stating that the reason for your appeal was "denial of retro coverage for June 2016",

On July 13, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing held and open up to August 30, 2017, to allow you to submit supporting documents.

As of August 30, 2017, 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 expect to file your 2017 federal income tax return as single, and claim no dependents.
- 2) You submitted an application for financial assistance on August 5, 2016. That application indicates that you were pregnant with one child and that your due date was [REDACTED].
- 3) You submitted an application on March 30, 2017 in which you requested help paying for medical bills for the month of June 2016.
- 4) You testified that you do not plan on taking any deductions on your tax return.
- 5) The record reflects that while you were working, you were paid weekly.
- 6) You testified that you have an outstanding bill for an [REDACTED]. You testified that you do not have a copy of the bill, but that at some point, you had received letters regarding the bill.
- 7) You testified that you were no longer working when you had [REDACTED].

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- 8) You testified that you are seeking to have the bill paid by Medicaid. You also testified that the issue may have been resolved, because you have had subsequent studies without any billing issues.
- 9) You did not submit a copy of your outstanding bill or income documentation for June 2016.

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 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)).

For purposes of Medicaid eligibility the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

Medicaid is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the FPL for the applicable family size (see 42 CFR § 435.116(c); NY Department of Health Administrative Directive 13ADM-03).

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 2016 FPL, which is \$16,020.00 for a two-person household (81 Fed. Reg. 4036).

### 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 June 2016.

You testified that you are appealing the denial of retroactive Medicaid for June 2016. However, the record does not contain a notice of eligibility determination or redetermination on the issue of retroactive coverage for June 2016.

Here, the lack of a notice of eligibility determination on the issue of retroactive Medicaid coverage for June 2016 does not prevent the Appeals Unit from reaching the merits of the case or constitute material error.

Your testimony along with the March 31, 2017 appeal confirmation notice stating that the reason for your appeal was “denial of retro coverage for June 2016”, permits an inference that NYSOH did not find you eligible for retroactive Medicaid for June 2016.

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 been issued.

You submitted an application for financial assistance on August 5, 2016. That application indicates that you were pregnant with one child and that your due date was [REDACTED]

When calculating family size for Medicaid purposes, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman but also the number of children she expects to deliver. Therefore, in June 2016 you were in a two-person household.

You submitted an application for financial assistance on July 16, 2016. On March 30, 2017, you submitted an updated application for financial assistance and requested help in paying for medical bills for June 2016.

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 June 2016 because you have an outstanding medical bill. Because you submitted an application for financial assistance on August 5, 2016, a determination can be made regarding your eligibility for Medicaid for up to three months prior to August 2016, including June 2016.

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 June 2016, you would have needed to meet the non-financial criteria and have an income no greater than 223% of the FPL, which is \$2,978.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during June 2016.

The Hearing Officer left the record open for you to submit income documentation to prove your income in June 2016 so that a determination could be made on your eligibility. No documentation was received within the required time frame. Therefore, your income for the month of June 2016 cannot be verified and is not ascertainable based on the information contained in your NYSOH account.

Since your income could not be verified for June 2016, NYSOH properly determined that you were not eligible for Medicaid coverage during that month.

## **Decision**

NYSOH properly determined that you were not eligible for Medicaid in June 2016.

**Effective Date of this Decision:** September 15, 2017

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).

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

NYSOH properly determined that you were not eligible for Medicaid in June 2016.

## **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 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).



## **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**

NYSOH properly determined that you were not eligible for Medicaid in June 2016.

## **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)

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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 bɛtumi ama wo obi a okyerɛ 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 איר געבן א דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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