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

Notice of Decision

Decision Date: August 1, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018001

[redacted]

Dear [redacted]

On July 27, 2017, your spouse appeared by telephone on your behalf at a hearing on your appeal of NY State of Health's February 28, 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.

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: August 1, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018001

[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 and your spouse were not eligible for Medicaid retroactively from November 1, 2016 through November 30, 2016?

Procedural History

On February 27, 2017, you submitted an application for financial assistance with health insurance and indicated that you and your spouse were seeking help for paying for medical bills from November 1, 2016 through January 31, 2017.

On February 28, 2017, NYSOH issued an eligibility determination notice, based on your February 27, 2017 updated application, stating that you and your spouse were eligible to enroll in the Essential Plan, effective April 1, 2017.

Also on February 28, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were not eligible for Medicaid from November 1, 2016 through January 31, 2017, because the program you were found eligible for cannot pay for any care you received in the past.

On April 13, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as it denied Medicaid for you and your spouse for the months of October 2016 through December 2016.

On May 7, 2017, you submitted paystubs, including four of your consecutive weekly paystubs, dated November 4, 2016 through November 25, 2016, and four out of five of your spouse's consecutive paystubs, dated November 3, 2016 through December 1, 2016 (*see* Documents [redacted]).

On July 27, 2017, your spouse appeared on your behalf at a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Your spouse's request to amend the appeal to have a redetermination solely of your and your spouse's eligibility for retroactive Medicaid for the month of November 2016 was granted and testimony was received. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) Your spouse testified that you and your spouse are seeking Medicaid from November 1, 2016 to November 30, 2016, to cover medical expenses incurred that month. You and your spouse do not need insurance for October 2016 and December 2016 because there are no medical bills for those months.

2) Your spouse mentioned a tax penalty on your 2016 income taxes, but stated that this issue was resolved.

3) Your spouse testified that you and your spouse filed your 2016 federal income tax return as married filing jointly, and claimed no dependents.

4) You submitted an updated application for financial assistance for yourself and your spouse on February 27, 2017.

5) Your application submitted on February 27, 2017, states that for the month of November 2016 your gross household income was $1,875.99. Your spouse testified this amount was incorrect. He estimated your gross household income based on the hours you and he had worked in the month of November 2016 and not the dates you both received payment in November 2016.

6) You submitted four consecutive weekly paystubs dated November 4, 2016 through November 25, 2016 that show you received $497.25 in gross employment income in November 2016, calculated as follows:

November 4, 2016 weekly Gross Income(GI):	$112.50
November 10, 2016 weekly GI:	114.75

November 18, 2016 weekly GI:	155.25
November 25, 2016 weekly GI:	114.75
Your Total November 2016 GI:	$497.25

7) You also submitted three of your spouse's four weekly paystubs for the month of November 2016, dated November 3, 2016 through November 23, 2016, that show he received $954.10 in gross employment income in November 2016, calculated as follows:

November 17, 2016 Year to Date (YTD) GI:	$12,680.27
Less November 3, 2016 YTD GI:	($12,214.97)
	$ 465.30
Less November 17, 2016 weekly GI:	($ 218.55)
Total November 10, 2016 weekly GI:	$ 246.75

November 3, 2016 Gross Income(GI):	$246.75
November 10, 2016 GI:	246.75
November 17, 2016 GI:	218.55
November 23, 2016 GI:	242.05
Spouse's Total November 2016 GI:	$954.10

8) You also submitted your spouse's weekly paystub dated December 1, 2016, which shows that your spouse's paystub dated November 23, 2016, was his last payment in November 2016.

9) Your gross employment income of $497.25 plus your spouse's gross employment income of $954.10 received in November 2016, equals a gross total household income of $1,451.35 for the month of November 2016 (*see* Documents [redacted]).

10) Your spouse testified that you and your spouse do not plan on taking any deductions on your tax return.

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 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 and your spouse were not eligible for retroactive Medicaid from November 1, 2016 through November 30, 2016.

You and your spouse file your taxes with a tax filing status of married filing jointly and claim no dependents. Therefore, for purposes of these analyses, you and your spouse are in a two-person household.

You submitted an application for financial assistance for yourself and your spouse on February 27, 2017 and requested help in paying for medical bills for November 2016 through January 2017.

On February 28, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were not eligible for Medicaid for November 1, 2016

through January 31, 2017 because the program you and your spouse were eligible for cannot pay for any care you received in the past. At the hearing, your spouse amended your appeal and requested that your and your spouse's eligibility for retroactive Medicaid be redetermined solely for the month of November 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 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.

Your spouse testified that you are seeking Medicaid for you and your spouse in the month of November 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 November 2016, you and your spouse would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,843.00 per month. There is no indication in the record that you or your spouse would have been ineligible for Medicaid based on non-financial criteria during November 2016.

You submitted documentation that shows you and your spouse received a gross total household income of $1,451.35 in November 2016. This was calculated by adding your gross employment income of $497.25 to your spouse's November 2016 gross employment income of $954.10.

Since the February 28, 2017 eligibility determination notice found you and your spouse were not eligible for Medicaid for the month of November 2016, because the program you and your spouse were eligible for cannot pay for any care you received in the past, it is RESCINDED in part, only as it concerns your and your spouse's eligibility for retroactive Medicaid in the month of November 2016.

Since the record now contains a more accurate representation of what your household income was for the month of November 2016, your case is RETURNED to NYSOH to consider your and your spouse's request for retroactive coverage for November 2016 based on a household size of two people and household income of $1,451.35 for the month of November 2016. NYSOH is directed to notify you of its redetermination in this regard.

Decision

The February 28, 2017 eligibility determination is RESCINDED in part, only as it concerns your and your spouse's eligibility for Medicaid in the month of November 2016.

Your case is RETURNED to NYSOH to reconsider your and your spouse's request for retroactive coverage for November 2016 based on a household size of two and household income of $1,451.35 for the month of November 2016. NYSOH is directed to notify you of its redetermination in this regard.

Effective Date of this Decision: August 1, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your and your spouse's eligibility for retroactive Medicaid for the month of November 2016.

Your case is being sent back to NYSOH to redetermine your and your spouse's eligibility based on the evidence your spouse presented at the hearing and as noted above.

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 28, 2017 eligibility determination is RESCINDED in part, only as it concerns your and your spouse's eligibility for Medicaid in the month of November 2016.

Your case is RETURNED to NYSOH to reconsider your and your spouse's request for retroactive coverage for November 2016 based on a household size of two and household income of $1,451.35 for the month of November 2016. NYSOH is directed to notify you of its redetermination in this regard.

This is not a final determination of your and your spouse's eligibility for retroactive Medicaid for the month of November 2016.

Your case is being sent back to NYSOH to redetermine your and your spouse's eligibility based on the evidence your spouse presented at the hearing and as noted above.

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:

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.

□□□□□ (Bengali)

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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 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 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)

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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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