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

Notice of Decision

Decision Date: September 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019638

[redacted]

[redacted]

On September 11, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's retroactive Medicaid coverage regarding your spouse for the months of December 2016, January 2017, and February 2017.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of the 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 the NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification Number at the top of this letter.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(b).

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
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Decision

Decision Date: September 26, 2017

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000019638

[redacted]

Issue

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

> Did NY State of Health (NYSOH) fail to determine your spouse eligible for retroactive Medicaid coverage for the months of December 2016, January 2017, and February 2017?

Procedural History

On January 26, 2017, an application for financial assistance was submitted through NYSOH.

On January 27, 2017, NYSOH issued a notice stating that the income information in your application did not match what NSYOH received from state and federal data sources. The notice directed you to submit proof of income and third-party health insurance by February 10, 2017, to confirm your spouse's eligibility.

On February 3, 2017, additional documentation was faxed to NYSOH [redacted]

On March 9, 2017, NYSOH issued an eligibility determination notice stating that your spouse was eligible to purchase a qualified health plan at full cost, effective as of April 1, 2017.

On March 10, 2017, your account was systemically updated.

On March 11, 2017, NYSOH issued an eligibility determination notice stating that your spouse was conditionally eligible for Medicaid, effective as of March 1, 2017. The notice directed you to submit proof of your spouse's third-party health insurance by March 25, 2017, to confirm their eligibility.

On March 20, 2017, your NYSOH was updated.

On March 21, 2017, NYSOH issued a notice stating that the income information in your application did not match what NSYOH received from state and federal data sources. The notice directed you to submit proof of income and third-party health insurance by April 4, 2017 and April 9, 2017, to confirm your spouse's eligibility.

On April 13, 2017, NYSOH issued a notice stating that the income information in your application does not match what NSYOH received from state and federal data sources. The notice directed you to submit proof of income by May 4, 2017, to confirm your spouse's eligibility.

On April 28, 2017, additional documentation was faxed to NYSOH [redacted]

On May 11, 2017, May 20, 2017, and May 25, 2017, NYSOH issued notices stating that the income information in your application did not match what NSYOH received from state and federal data sources. The notice directed you to submit proof of income by May 19, 2017, to confirm your spouse's eligibility.

On June 8, 2017, NYSOH issued an eligibility determination notice stating that your spouse was eligible to purchase a qualified health plan at full cost, effective as of July 1, 2017.

Also on June 8, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as your spouse's eligibility for Medicaid for the months of December 2016, January 2017, and February 2017 had not been determined.

On September 11, 2017, you had a scheduled telephone hearing with a Hearing Officer from the Appeals Unit of NYSOH. Your testimony was taken during the hearing, and the record was left open until September 18, 2017, to allow you to submit: (1) your unemployment insurance benefit history and (2) your spouse's earnings statements from December 2016.

On September 15, 2017, you faxed ten-pages of documentation to NYSOH's Appeals Unit. That documentation has been made part of the record as "Appellant Exhibit A." The record is now complete and closed.

Findings of Fact

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

1) According to your NYSOH account and testimony, you are applying for health insurance for your spouse.

2) You testified that you filed a 2016 federal income tax return with the tax status of married filing jointly and did not claim any dependents on that tax return.

3) You testified that you expect to file a 2017 federal income tax return with the tax status of married filing jointly and do not expect to claim any dependents on that tax return.

4) On March 20, 2017, your NYSOH account was updated to reflect that your spouse was requesting help paying for medical bills for the last three months.

5) According to your NYSOH account, you did not claim any deductions on your federal income tax return.

6) On September 15, 2017, you submitted your unemployment insurance benefit (UIB) payment history from NYS Department of Labor. You were issued a gross amount of $430.00 on: December 5, 2016; December 12, 2016; December 19, 2016; December 27, 2016; January 3, 2017; January 9, 2017; January 17, 2017; January 23, 2017; January 30, 2017; February 6, 2017; February 13, 2017; February 21, 2017, and February 27, 2017 (Appellant Exhibit A, p. 1).

7) On September 15, 2017, you submitted your spouse's earnings statements from [redacted]. Your spouse was issued federal taxable wages of:

   (a) $849.97 on 12/09/2016;
   (b) $953.63 on 12/16/2016;
   (c) $575.20 on 12/23/2016;

   (Appellant Exhibit A, pp. 2-5).

8) On February 3, 2017, you faxed a letter from [redacted] December 14, 2016 [redacted]).

9) On February 3, 2017 and April 28, 2017, you submitted letters of explanation of benefits for your spouse's disability payments. The

letters state that your spouse's benefits are 100 percent taxable. Your spouse was issued:

(a) $850.00 on January 23, 2017. That payment was for five weeks and five weeks had been paid to date.
(b) $170.00 on March 20, 2017. That payment was for one week and thirteen weeks had been paid to date.

(c) [redacted]

10) You testified that your spouse was consistently issued $170.00 on a weekly basis between January 23, 2017, and March 20, 2017.

11) You testified that your spouse incurred medical expenses in the months of December 2016, January 2017, and February 2017, and you want Medicaid to cover those medical expenses.

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:

Medicaid can be provided through the Marketplace 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 that is at or below 138% of the federal poverty for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.603(d)(4)), N.Y. Soc. Serv. Law § 366(1)(b)).

In the case of an individual who expects to file a tax return and does not expect to be claimed by another taxpayer, the household consists of the taxpayer and all persons whom such individual expects to claim as a tax dependent (42 CFR § 435.603(f)(1)).

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). For the month of December 2016, that was the 2016 FPL, which is $16,020.00 for a two-person household (81 Fed. Reg. 4036).

For the months of January 2017 and February 2017, that was the 2017 FPL, which is $16,240.00 for a two-person household (82 Federal Register 8831).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

Medicaid Retroactive Coverage:

NYSOH must make Medicaid eligibility effective no later than the third month before the month of application if the individual received medical services that would have been covered under Medicaid and would have been eligible for Medicaid at the time he received the services if they had applied (42 CFR 435.915(a)). NYSOH 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 failed to determine that your spouse was eligible for Medicaid coverage for the months of December 2016, January 2017, and February 2017.

You testified that you are seeking retroactive Medicaid coverage for your spouse for the months of December 2016, January 2017, and February 2017. However, the record does not contain any notice of eligibility determination regarding the issue of retroactive Medicaid coverage for the months in question.

Here, the lack of a notice of eligibility determination on the issue 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 failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination. On June 9, 2017, NYSOH issued a notice confirming that you requested an appeal insofar as, "Consumer wanted FFS for [spouse] from Dec-Feb due to medical expenses" [redacted] That notice is sufficient to deduce that NYSOH denied your request for retroactive Medicaid coverage for your spouse.

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.

The record reflects that you filed your 2016 federal income tax return with the tax status of married filing jointly and did not claim any dependents on that tax return. Additionally, you expect to file your 2017 federal income tax return with the tax status of married filing jointly and claim no dependents on that return. Therefore, your spouse is in a two-person household for purposes of this analysis.

The record supports that it was indicated in your March 20, 2017, application that you were seeking help paying for medical bills, for your spouse, for the months of December 2016, January 2017, and February 2017.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's application, if they would have been found eligible for Medicaid in any of the three months had an application been submitted.

Medicaid can be provided through the NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size.

The 2016 FPL was $16,020.00 for a two-person household. Financial eligibility for Medicaid applicants who are not currently receiving Medicaid benefits may be based on current monthly household income and family size. For an adult to be eligible for Medicaid in a household of two in 2016, their monthly income must not exceed $1,843.00.

You testified that were issued UIB from NYS Depart of Labor in December 2016. Based on the documentation submitted, you were issued ($430.00 X 4) $1,720.00 in that month. Furthermore, your spouse was issued ($849.97 + $953.63 + $575.20) $2,378.80 from their employer. Your household income in December 2016 was $4,098.80.

The 2017 FPL was $16,240.00 for a two-person household. Financial eligibility for Medicaid applicants who are not currently receiving Medicaid benefits may be based on current monthly household income and family size. For an adult to be eligible for Medicaid in a household of two in 2017, their monthly income must not exceed $1,868.00.

You testified that were issued UIB from NYS Depart of Labor in January 2017 and February 2017. Based on the documentation submitted, you were issued ($430.00 X 5) $2,150.00 in January 2017 and ($430.00 X 4) $1,720.00 in February 2017.

Based on the available record, your spouse went out on disability on December 14, 2016 (see Document [redacted]). Your spouse was issued taxable disability benefits of $850.00 on January 23, 2017, and $170.00 on March 20, 2017. Furthermore, you testified that your spouse was consistently issued $170.00 in disability benefits on a weekly basis between January 23, 2017, and March 20, 2017.

Based on the available record, your household income was at least ($2,150.00 + $850.00) $3,000.00 in January 2017, and at least ($1,720.00 + four payments of $170.00) $2,400.00 in February 2017.

Based on the foregoing calculations, your household income exceeded the maximum allowable monthly household income limits for your spouse to be found eligible retroactively for Medicaid in the months of December 2016, January 2017, and February 2017. Therefore, NYSOH did not fail to determine your spouse eligible for retroactive Medicaid for the months of December 2016, January 2017, and February 2017.

Decision

NYSOH did not fail to determine your spouse eligible for retroactive Medicaid for the months of December 2016, January 2017, and February 2017.

Effective Date of this Decision: September 26, 2017

How this Decision Affects Your Eligibility

Your spouse was ineligible for Medicaid coverage from December 1, 2016 through February 28, 2017, because your monthly income in each of those months exceeded the maximum allowable monthly income limit for a two-person household.

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

NYSOH did not fail to determine your spouse eligible for retroactive Medicaid for the months of December 2016, January 2017, and February 2017.

Your spouse was ineligible for Medicaid coverage from December 1, 2016 through February 28, 2017, because your monthly income in each of those months exceeded the maximum allowable monthly income limit for a two-person household.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(a).

A Copy of this Decision Has Been Provided To:

[redacted]

Getting Help in a Language Other than English

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).

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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