



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

Notice of Decision

Decision Date: November 8, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000019787

[REDACTED]

[REDACTED]

On September 19, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's denial of retroactive Medicaid for the month of December 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: November 8, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000019787



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 your spouse was not eligible for supplemental retroactive Medicaid for December 1, 2016 through December 31, 2016?

Procedural History

On February 2, 2017, NYSOH issued an eligibility determination notice stating that your spouse was eligible for Medicaid, effective January 1, 2017.

On March 4, 2017, NYSOH issued an eligibility determination notice stating that your spouse remained eligible for Medicaid, effective March 1, 2017.

On June 15, 2017, NYSOH issued an eligibility determination notice stating that your spouse was no longer eligible for Medicaid, effective June 1, 2017, but would have Medicaid coverage continue until December 31, 2017.

Also on June 15, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as your spouse was denied retroactive Medicaid for the month of December 2016.

On June 16, 2017, NYSOH issued a notice confirming your appeal of an "Eligibility Determination."

On September 19, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was held open to October 4, 2017 for you to submit supporting documentation.

On September 29, 2017, you submitted a letter from your spouse's disability insurance company, a letter from your spouse's employer-sponsored insurance (ESI) company, a copy of your spouse's last paystub dated December 7, 2016, a copy of four of your paystubs dated December 1, 2016 through January 5, 2017, and copies of past due medical bills, dated March 10, 2017 through June 9, 2017. These documents were made part of the record as "Appellant's Exhibit A." No further documentation was received by October 4, 2017 and the record closed that day.

Findings of Fact

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

- 1) You testified that you are seeking supplemental Medicaid benefits for your spouse from December 1, 2016 to December 31, 2016.
- 2) According to your NYSOH account and your testimony, you and your spouse filed your 2016 federal income tax return as married filing jointly, and claimed one dependent on that tax return.
- 3) You submitted an application for financial assistance on behalf of your spouse on January 24, 2017.
- 4) Your submitted documentation shows that, in the month of December 2016, your spouse had a gross household income of \$1,987.92, consisting of \$670.00 you received in employment income, \$1,115.00 you received in [REDACTED], and \$202.92 your spouse received in employment income.
- 5) You testified, and submitted documentation to show, that your spouse did not begin receiving income from disability benefits until January 2017, due to an elimination period on the policy.
- 6) You testified, and submitted documentation to show, that although your spouse was covered by ESI in December 2016, he had reached his maximum health benefit for the year, which resulted in a significant amount of medical bills not being covered for that month.
- 7) You testified that you called NYSOH numerous times to request help covering the medical expenses your spouse has for the month of December 2016, to no avail.

- 8) There is evidence of fourteen telephone calls made by you to NYSOH made between January 24, 2017 and June 15, 2017,
- 9) According to your NYSOH account and your testimony, you and your spouse did not take any deductions on your 2016 tax return

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)).

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 a, which is \$20,160.00 for a three-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 your spouse was not eligible for supplemental retroactive Medicaid from December 1, 2016 through December 31, 2016.

The record reflects that you updated your spouse's account and applied for Medicaid on January 24, 2017. On February 2, 2017, NYSOH issued an eligibility determination notice stating that your spouse was eligible for Medicaid, effective January 1, 2017.

Although the record contains a February 2, 2017 eligibility determination notice on the issue of Medicaid eligibility as of January 1, 2017, it is silent as to your request for supplemental retroactive Medicaid coverage for the month of December 2016. The record does contain evidence of fourteen telephone calls made by you to NYSOH made between January 24, 2017 and June 15, 2017, and a June 16, 2017 notice in which NYSOH acknowledges receipt of an appeal request, and identifies you as the appellant and the issue on appeal as "Eligibility Determination."

Here, the lack of a notice of eligibility determination on the issue of supplemental retroactive Medicaid for your spouse for the month of 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 a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination. The text of the June 16, 2017 notice, which identifies your spouse as the appellant and acknowledges the appeal on the issue of his eligibility determination, along with your testimony, in which you stated you called NYSOH numerous times to request help covering the medical expenses your spouse has for the month of December 2016, permits an inference that the NYSOH did deny your request for supplemental retroactive Medicaid for your spouse in the month of December 2016.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to an eligibility determination had it been issued.

According to your NYSOH account and your testimony, you and your spouse filed your 2016 federal income tax return as married filing jointly, and claimed one dependent on that tax return. Therefore, for purposes of these analyses, your spouse is in a three-person household.

You submitted an application for financial assistance on behalf of your spouse on January 24, 2017 and requested help in paying for his medical bills for December 1, 2016 through December 31, 2016.

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).

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.

You testified that your spouse is seeking supplemental Medicaid from December 1, 2016 to December 31, 2016.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

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 December 2016, your spouse would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is \$2,319.00 per month. There is no indication in the record that your spouse would have been ineligible for supplemental Medicaid benefits based on non-financial criteria during the months of December 2016.

Your submitted documentation shows that in the month of December 2016, you received \$670.00 in employment income and \$1,115.00 in [REDACTED]. Your spouse received \$202.92 in employment income. Additionally, the letter from the disability insurance company confirms that your spouse did not receive any disability benefits in December 2016. Therefore, the credible evidence of record, along with your credible testimony, indicates that in the month of December 2016, your spouse had a monthly household gross income of \$1,987.92.

Since the record now contains a more accurate representation of what your spouse's income was for the month of December 2016, your case is RETURNED to NYSOH to consider your request for supplemental retroactive Medicaid coverage for your spouse, based on a three-person household, utilizing 138% of the FPL for an individual, and a household income of \$1,987.92 for the month of December 2016.

Decision

Your spouse's case is RETURNED to NYSOH to consider your request for supplemental retroactive Medicaid coverage for your spouse based on a three-person household, utilizing 138% of the FPL for an individual, and a household income of \$1,987.92 for the month of December 2016.

Effective Date of this Decision: November 8, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your spouse's eligibility. Your spouse's case is sent back to NYSOH to redetermine his eligibility based on the evidence you presented at the hearing. NYSOH will notify you when this has been done.

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

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).

- 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

Your spouse's case is RETURNED to NYSOH to consider your request for supplemental retroactive Medicaid coverage for your spouse based on a three-person household, utilizing 138% of the FPL for an individual, and a household income of \$1,987.92 for the month of December 2016.

This is not a final determination of your spouse's eligibility. Your spouse's case is sent back to NYSOH to redetermine his eligibility based on the evidence you presented at the hearing. NYSOH will notify you when this has been done.

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।

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 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&btumi 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.

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).