



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

## Notice of Decision

Decision Date: September 29, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000020354

[REDACTED]

Dear [REDACTED],

On September 26, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 10, 2017 verbal denial of your request for retroactive Medicaid coverage for the month of May 2017.

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 29, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000020354

[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 retroactively from May 1, 2017 through May 31, 2017?

## Procedural History

On June 29, 2017, you submitted an application for financial assistance with health insurance and indicated that you were seeking help paying for medical bills incurred in May 2017.

On June 30, 2017, NYSOH issued an eligibility determination notice stating that you remained eligible for Medicaid. This eligibility was effective as of June 1, 2017. You were subsequently enrolled in a Medicaid Managed Care plan with an enrollment start date of August 1, 2017.

On July 10, 2017, you spoke to NYSOH's Account Review Unit and were informed that you were not eligible for retroactive Medicaid Fee-For-Service coverage for the month of May 2017. You appealed that verbal notification denying you retroactive Medicaid for the month of May 2017.

On July 11, 2017, NYSOH issued a notice to confirm your appeal request from the previous day. That notice stated that the reason for your appeal was "eligibility determination".

On September 26, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. 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) You testified that you are appealing the verbal denial of your request for Medicaid from May 1, 2017 through May 31, 2017.
- 2) You testified that you expect to file your 2017 federal income tax return as single and do not expect to claim any dependents.
- 3) You submitted an application for financial assistance on June 29, 2017, and requested help paying for medical bills for month of May 2017.
- 4) On June 29, 2017, you submitted a copy of your Official Record of Benefit Payment History from the New York State Department of Labor. That document shows that in the month of May 2017, there were five unemployment insurance benefit payments released to your debit card as follows;
  - a. 05/03/2017 \$ 430.00
  - b. 05/08/2017 \$ 430.00
  - c. 5/15/2017 \$ 430.00
  - d. 5/22/2017 \$ 430.00
  - e. 5/30/2017 \$ 430.00
- 5) You testified that your unemployment insurance benefits were the only source of income you had in the month of May 2017.
- 6) You testified that you were [REDACTED] starting on [REDACTED] through [REDACTED]
- 7) You testified that your hospital bills incurred starting June 1, 2017 have been covered by Medicaid, but you need Medicaid coverage for the month of May 2017 because you were admitted on May 31, 2017.

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 2017 FPL, which is \$1,387.00 for a one-person household (82 Fed. Reg. 8831).

### 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 from May 1, 2017 through May 31, 2017.

You testified that you are appealing the denial of a retroactive Medicaid coverage for the month of May 2017. However, the record does not contain a notice of eligibility determination or redetermination on the issue of retro Medicaid coverage for that month.

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).



Here, the lack of a notice of eligibility determination on the issue of your eligibility for retroactive Medicaid coverage for the month of May 2017 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.

Your credible testimony, along with the July 11, 2017 appeal confirmation notice stating that the reason for your appeal was “eligibility determination”, permits an inference that NYSOH did deny your request for retro Medicaid coverage for the month of May 2017.

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 are in a one-person household for purposes of this analysis because you file your taxes with a tax filing status of single and claim no dependents on your tax return.

You submitted an application for financial assistance on June 29, 2017 and requested help in paying for medical bills for May 1, 2017 to May 31, 2017.

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 the month of May 2017, because you were [REDACTED] on [REDACTED] through [REDACTED]. Although your [REDACTED] bills from [REDACTED] to [REDACTED] are covered by Medicaid, the [REDACTED] bill for [REDACTED] is unpaid.

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 May 2017, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is \$1,387.00 per month. There is no indication in the record that you would

have been ineligible for Medicaid based on non-financial criteria during May 2017.

You testified that your only source of income in May 2017 was unemployment insurance benefit payments in the amount of \$430.00 per week. The record reflects that five unemployment insurance benefit payments of \$430.00 each were released to your debit card account on May 3, 2017, May 8, 2017, May 15, 2017, May 22, 2017 and May 30, 2017. Therefore, the record indicates that in the month of May 2017, you had a monthly household income of \$2,150.00.

Since your income of \$2,150.00 was more than the \$1,387.00 monthly Medicaid limit for May 2017, NYSOH properly determined that you were not eligible for Medicaid coverage during that month. Therefore, the credible evidence of record indicates that you were not eligible for Medicaid in the month of May 2017, and NYSOH's verbal denial on July 11, 2017 of retroactive Medicaid for the month of May 2017 is correct and is AFFIRMED.

## **Decision**

The July 11, 2017 verbal denial by NYSOH of retroactive Medicaid for the month of May 2017 is AFFIRMED.

**Effective Date of this Decision:** September 29, 2017

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

You are not eligible for Medicaid in the month of May 2017.

Your eligibility for Medicaid was effective as of June 1, 2017.

## **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.

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).

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 July 11, 2017 verbal denial by NYSOH of retroactive Medicaid for the month of May 2017 is AFFIRMED.

You are not eligible for Medicaid in the month of May 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).



Your eligibility for Medicaid was effective as of June 1, 2017.

**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 אייך געבן א דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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