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

Notice of Decision

Decision Date: November 9, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000020369

On September 29, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's denial of retroactive Medicaid for your spouse for the month of April 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

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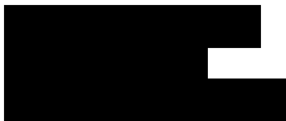
Appeal Identification Number: AP000000020369



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 Medicaid for the month of April 2017?

Procedural History

According to your NYSOH account, your spouse was initially found eligible for Medicaid as of May 1, 2017. On June 5, 2017, you updated your spouse's application for health insurance and requested help paying for medical bills for the last three months.

On June 6, 2017, NYSOH issued an eligibility determination notice stating that your spouse was eligible for Medicaid from March 1, 2017 through March 31, 2017 because his household monthly income of $1,993.33 was at or below the allowable monthly income limit of $2,829.00.

On July 10, 2017, you spoke to NYSOH's Account Review Unit and appealed your spouse not being eligible for retroactive Medicaid for the month of April 2017.

On July 11, 2017, NYSOH issued a notice confirming your spouse as the appellant and your appeal of an "Eligibility Determination."

On August 7, 2017 and August 21, 2017, you submitted proof of your spouse's April 2017 household income, including three of your consecutive weekly

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paystubs, dated April 14, 2017 through April 28, 2017 [redacted]

On September 29, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to October 14, 2017, to allow you time to submit supporting documents.

On October 11, 2017, NYSOH received your April 7, 2017 paystub and it was made part of the record as "Appellant's Exhibit A." Since this was the only document required, the record was closed that day.

Findings of Fact

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

1) According to your NYSOH account and your testimony, your spouse's tax filing status is married filing jointly and you will claim two dependents on your 2017 tac return.

2) Your spouse was initially found eligible for Medicaid as of May 1, 2017.

3) According to your NYSOH account, although you requested help paying for your spouse's medical bills in the last three months in your spouse's June 5, 2017 application, your spouse was never issued an eligibility determination regarding the month of April 2017.

4) You testified that you were the only one in your household that was employed in the month of April 2017. Your spouse has been unemployed since January 2017 and has not received any unemployment benefits or income this year.

5) Your submitted documentation shows you received $1,873.13 in the month of April 2017, calculated by adding your four consecutive weekly paystubs dated April 7, 2017 through April 28, 2017 in the amount of $368.00, $549.13, $460.00 and $460.00, respectively (*see* Documents [redacted], and Appellant's Exhibit A, p. 1).

6) You testified that you are seeking Medicaid coverage for your spouse for the month of April 2017.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

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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 spouse's application, that was the 2017 FPL, which is $24,600.00 for a four-person household (82 Fed. Reg. 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 March 19, 2014).

Retroactive Medicaid for Adults between the Ages of 19 and 65

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of 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 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 Medicaid for the month of April 2017.

The record reflects that you updated your spouse's account and applied for retroactive Medicaid for him on June 5, 2017. On June 6, 2017, NYSOH issued an eligibility determination notice stating that your spouse was eligible for retroactive Medicaid from March 1, 2017 through March 31, 2017.

Although the record contains a June 6, 2017 eligibility determination notice on the issue of retroactive Medicaid eligibility for March 2017, it is silent as to your request for retroactive Medicaid coverage for your spouse for the month of April 2017. The record does contain evidence of your request for help paying for your spouse's medical bills for the last three months prior to his June 5, 2017 application and a July 11, 2017 notice in which NYSOH acknowledges receipt of an appeal request, and identifies your spouse as the appellant and the issue on appeal as "Eligibility Determination."

Here, the lack of a notice of eligibility determination on the issue of retroactive Medicaid for your spouse for the month of April 2017 does not prevent the Appeals Unit from reaching the merits of the case or constitute material error. Under 45 CFR § 155.505(b), your spouse is as entitled to appeal NYSOH's failure to timely issue an eligibility determination notice as he is to appeal an adverse eligibility determination notice. The text of the July 11, 2017 notice, which acknowledges the appeal on the issue of your spouse's eligibility determination and your spouse's June 5, 2017 application requesting for help paying his medical bills for the last three months, along with your testimony in which you stated you wanted help covering your spouse's medical expenses for the month of April 2017, permits an inference that the NYSOH did deny your spouse's request for retroactive Medicaid in the month of April 2017.

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.

You submitted an application on behalf of your spouse for financial assistance on June 5, 2017 and requested help in paying for your spouse's medical bills for the last three months.

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.

According to your NYSOH account, and your testimony, your spouse's tax filing status is married filing jointly and you will claim two dependents on your 2017 federal tax return. Therefore, for purposes of these analyses, your spouse is in a four-person household.

You testified that you are seeking Medicaid for your spouse for the month of April 2017.

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 April 2017, your spouse would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $2,829.00 per month. There is no indication in the record that your spouse would have been ineligible for Medicaid based on non-financial criteria during April 2017.

You credibly testified that you were the only one in your household that received income in the month of April 2017. Further, you submitted four consecutive weekly paystubs dated April 7, 2017 through April 28, 2017 in the amounts of $368.00, $549.13, $460.00 and $460.00, respectively. Therefore, the record indicates that in the month of April 2017, your spouse had a monthly household income of $1,873.13

Since your spouse's monthly household income of $1,873.13 in April 2017 is less than the $2,829.00 monthly Medicaid allowable limit for that month, your spouse's eligibility for retroactive Medicaid coverage during April 2017 is being sent back to NYSOH to redetermine.

Therefore, your spouse's case is RETURNED to NYSOH to redetermine your spouse's eligibility for retroactive Medicaid coverage for April 2017 based on a four-person household, utilizing 138% of the applicable FPL, and a household income of $1,873.13 for April 2017, and to notify you accordingly.

Decision

Your spouse's case is RETURNED to NYSOH to redetermine your spouse's eligibility for retroactive Medicaid coverage for April 2017 based on a four-person household, utilizing an FPL of 138%, and a household income of $1,873.13 for April 2017, and to notify you accordingly.

Effective Date of this Decision: November 9, 2017

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How this Decision Affects Your Eligibility

This is not a final determination of your spouse's eligibility for financial assistance in April 2017.

Your spouse's case is being sent back to NYSOH to redetermine your spouse's eligibility for retroactive Medicaid coverage for April 2017 based on the information noticed above. NYSOH will notify you once 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

- 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 redetermine your spouse's eligibility for retroactive Medicaid coverage for April 2017 based on a four-person household, utilizing an FPL of 138%, and a household income of $1,873.13 for April 2017, and to notify you accordingly.

This is not a final determination of your spouse's eligibility for financial assistance in April 2017.

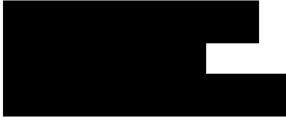
Your spouse's case is being sent back to NYSOH to redetermine your spouse's eligibility for retroactive Medicaid coverage for April 2017 based on the information noticed above. NYSOH will notify you once this has been done.

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:



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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)

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.

(Urdu)اردو

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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