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

Notice of Decision

Decision Date: January 8, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023379

[redacted]

Dear [redacted],

On November 30, 2017, you appeared by telephone at a hearing concerning your and your spouse's Medicaid eligibility for the month of June 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

Decision Date: January 8, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023379

[redacted]

Issue

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

> Were you and your spouse eligible for Medicaid for the month of June 2017?

Procedural History

On June 22, 2017, you submitted an application for financial assistance with health insurance.

On June 23, 2017, NY State of Health (NYSOH) issued a letter stating that the income information in your application does not match what NYSOH received from state and federal data sources. You were asked to submit income documentation for you and your spouse.

On July 14, 2017, you uploaded income documentation into your account. That same day, NYSOH verified that documentation and determined it was sufficient to validate your income, NYSOH recalculated your household income based on the information you provided, and submitted an application on your and your spouse's behalf.

On July 15, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective July 1, 2017, and your spouse was eligible to enroll in the Essential Plan, also effective July 1, 2017.

On August 31, 2017, NYSOH issued a notice stating that you and your spouse were eligible for Medicaid for March 1, 2017 through May 31, 2017.

On October 16, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal because you and your spouse did not receive retroactive Medicaid for the month of June 2017.

On November 30, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing held open until December 15, 2017, to allow you to submit income documentation for you and your spouse for June 2017.

On December 11, 2017 NYSOH received the requested documentation and it was incorporated into the record as Appellant's Exhibit #1, the record was closed that day.

Findings of Fact

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

1) You testified that you are seeking Medicaid coverage for you and your spouse for the month of June 2017.

2) The application submitted on July 14, 2017, states that you and your spouse's expected yearly income for 2017 is $10,619.00. You testified that amount was correct.

3) You uploaded a letter from your employer stating that you have been on medical leave from your job since [redacted] due to an injury, and that you have not received employment income from your employer since that date. This letter is contained in your NYSOH account as Document Number [redacted].

4) You testified that your spouse is an [redacted], employed as a driver for a [redacted]. You testified that he is paid on a weekly basis if he works that week. You testified that your spouse's income varies weekly depending on the number of shifts he works, and that the shifts he works per week is inconsistent. You testified that he does not receive tips.

5) You provided documentation in the form of six paystubs from your spouse's employer to your NYSOH account, which are collectively labeled Document Number [redacted]

6) You submitted a paystub for your spouse dated June 9, 2017 that shows he received a gross pay amount of $262.36.

7) You submitted a paystub for your spouse dated June 12, 2017 that shows he received a gross pay amount of $800.90.

8) You submitted a paystub for your spouse dated June 16, 2017 that shows he received a gross pay amount of $297.00.

9) You submitted a paystub for your spouse dated June 17, 2017 that shows he received a gross pay amount of $465.21.

10) You submitted a paystub for your spouse dated June 21, 2017 that shows he received a gross pay amount of $134.18.

11) You submitted a paystub for your spouse dated June 30, 2017 that shows he received a gross pay amount of $49.76.

12) You provided documentation in the form of a profit and loss statement for your spouse for the month of June 2017, which shows your spouse's total monthly deductions for June 2017 were $2,220.00.

13) You testified that you expect to file your 2017 federal income tax return as married filing jointly, and that you will not claim any dependents.

14) You testified that your spouse plans on taking business deductions on your 2017 tax return for his EZ Pass, car insurance, car loan payments, and car maintenance and upkeep.

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

Applicable Law and Regulations

De Novo Review

The 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 $16,240.00 for a two-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 is whether you and your spouse were eligible for Medicaid for the month of June 2017.

To date, NYSOH has not made a determination as to you and your spouse's eligibility for Medicaid for the month of June 2017, the month in which you initially requested a determination be made.

Here, the lack of a notice of eligibility determination on the issue of you and your spouse's eligibility for Medicaid for the month of June 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 and your spouse 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.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to the notice of eligibility determination had it been issued. Therefore, the issue under review is whether you and your spouse were eligible for Medicaid for the month of June 2017.

You and your spouse are in a two-person household; you and your spouse file your taxes together with a tax filing status of married filing jointly, and neither of you will claim any dependents on your tax return.

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 and your spouse are seeking Medicaid for the month of June 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 June 2017, 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 $1,868.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during June 2017.

You testified and provided corroborating documentation that you did not receive income in June 2017 because you have been on medical leave from your job as of [redacted] and that you have not received employment income since that date.

You provided six paystubs that show that your spouse's total gross pay for June 2017 was $2,009.41. You also provided a profit and loss sheet that shows that your spouse's total expenses that he will be claiming as deductions on his 2017 tax return for June 2017 was $2,220.00. Therefore, the record indicates that in the month of June 2017, you and your spouse had a monthly income of $0.00.

Since the record now contains a more accurate representation of you and your spouse's income for the month of June 2017, your case is RETURNED to NYSOH to consider your request for retroactive coverage for June 2017 based on a household size of two people and household income of $0.00 for the month of June 2017.

Decision

Your case is RETURNED to NYSOH to consider you and your spouse's request for retroactive coverage for June 2017 based on a household size of two people and household income of $0.00 for the month of June 2017.

Effective Date of this Decision: January 8, 2018

How this Decision Affects Your Eligibility

This is not a final determination of your and your spouse's eligibility for the month of June 2017.

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

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 case is RETURNED to NYSOH to consider your and your spouse's request for retroactive coverage for June 2017 based on a household size of two people and household income of $0.00 for the month of June 2017.

This is not a final determination of your and your spouse's eligibility for the month of June 2017.

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

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

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.

বাংলা (Bengali)

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).

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 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)

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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