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

Notice of Decision

Decision Date: August 8, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017641

[redacted]

Dear [redacted]

On July 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 1, 2017 eligibility determination notice.

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: August 8, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017641

[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 from February 1, 2017 through February 28, 2017?

Procedural History

On March 4, 2017, you submitted an application for financial assistance with health insurance and indicated that you were seeking help paying for medical bills for February 2017.

On March 4, 2017, NYSOH issued a notice that the income information in your application did not match what it received from state and federal data sources. You were directed to provide proof of your household income by March 18, 2017.

On March 12, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective March 1, 2017.

Also on March 12, 2017, NYSOH issued a notice acknowledging that you had requested help paying for medical bills for the three-month period prior to your March 3, 2017 application. You were directed to provide proof of income for the period of February 1, 2017 to February 28, 2017 by March 26, 2017.

On March 16, 2017, NYSOH issued a plan enrollment notice confirming that your Medicaid Managed Care plan would start effective April 1, 2017.

On March 18, 2017, NYSOH issued a notice stating that the documentation you provided had been reviewed but did not confirm the information in your application. You were directed to send in more proof of income by April 10, 2017.

On April 1, 2017, NYSOH issued an eligibility determination notice stating that you remained eligible for Medicaid, effective March 1, 2017.

Also on April 1, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid from February 1, 2017 through February 28, 2017, because your monthly household income of $1,840.58 was over the allowable monthly income limit of $1,387.00.

On April 3, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as you were denied retroactive Medicaid for the month of February 2017.

On July 14, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing 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 seeking Medicaid from February 1, 2017 through February 28, 2017.

2) According to your NYSOH account and your testimony, you expect to file your 2017 federal income tax return as single, and claim no dependents.

3) You testified that you do not plan on taking any deductions on your tax return.

4) You submitted an application for financial assistance on March 3, 2017.

5) According to your NYSOH account, your application submitted on March 3, 2017, states that for the month of February 2017 your income was $770.00.

6) You testified that you were paid weekly.

7) According to your NYSOH account, on March 3, 2017 you submitted a letter from your employer, dated February 17, 2017, stating that your last day of work was January 27, 2017 [redacted]. Also submitted at that time were four paystubs as follows:

   a. Pay date 1/20/2017, pay period 1/09/17 to 1/15/17, gross pay $633.50,
   b. Pay date 1/27/2017, pay period 1/16/17 to 1/22/17, gross pay $707.00,
   c. Pay date 2/03/2017, pay period 1/23/17 to 1/29/17, gross pay $581.00,
   d. Pay date 2/10/2017, pay period 1/30/17 to 02/5/17, gross pay $189.00.

8) According to your NYSOH account, on March 13, 2017, you submitted a letter from your employer, dated March 13, 2017, and included a check and payment advice from [redacted]. The payment advice indicates the check was issued on 02/28/2017 with a description that it was for policy # [redacted], paid from 02/04/2017 to 02/28/2017. The gross benefit and taxable amount was $1,070.58, and the net amount of $988.68. You testified that this payment was for NYS short term disability.

9) You testified that, in February 2017, you became ill and [redacted]. You testified that you did not have any health insurance in February 2017 and therefore need retro Medicaid coverage for that month.

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

Applicable Law and Regulations

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 $12,060 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)).

Modified Adjusted Gross Income

The NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term "modified adjusted gross income" means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (*see* 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

In general, Internal Revenue Code Section 105 indicates that long-term disability and short-term disability benefits, as sick pay, are to be included in the gross income of employees if the employer pays all or part of the premium for the coverage. In these situations, the disability benefits received by the employee are subject to federal taxation and count as income.

Legal Analysis

The issue under review is whether NYSOH properly determined that you were not eligible for Medicaid from February 1, 2017 through February 28, 2017.

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

You submitted an application for financial assistance on March 3, 2017, and requested help in paying for medical bills for February 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 from February 1, 2017 to February 28, 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 February 2017, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the applicable FPL, which is $16,643.00 per annum and $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 February 2017.

You testified that you are paid weekly. You submitted a paystub dated 2/03/2017, for pay period 1/23/17 to 1/29/17, gross pay $581.00 and a pay stub dated 2/10/2017, for pay period 1/30/17 to 02/5/17, gross pay $189.00. You also submitted a short-term disability check dated February 28, 2017 for the period 02/04/2017 to 02/28/2017. The payment advice that went with this short-term disability payment stated that the gross benefit and taxable amount was $1,070.58.

Therefore, the record indicates that in the month of February 2017, you had a monthly household income of $1,840.58.

Since your income of $1,840.58 was more than the $1,387.00 monthly Medicaid limit for February 2017, NYSOH properly determined that you were not eligible for Medicaid coverage during that month. Therefore, the April 1, 2017 eligibility determination notice stating that you were not eligible for Medicaid in the month of February 2017, is correct and is AFFIRMED.

Decision

The April 1, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: August 8, 2017

How this Decision Affects Your Eligibility

You were not eligible for Medicaid in the month of February 2017.

Your eligibility for Medicaid was effective as of March 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.

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 April 1, 2017 eligibility determination notice is AFFIRMED.

You were not eligible for Medicaid in the month of February 2017.

Your eligibility for Medicaid was effective as of March 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:

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.

□□□□□ (Bengali)

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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)

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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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