



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

Notice of Decision

Decision Date: October 18, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000020993

[REDACTED]

Dear [REDACTED],

On October 12, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 20, 2017 eligibility determination notice.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of the 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 the NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification Number at the top of this letter.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(b).

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: October 18, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000020993



Issue

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

Did New York State of Health (NYSOH) properly determine that you were ineligible for Medicaid coverage from April 1, 2017 through June 30, 2017?

Procedural History

On July 12, 2017, you submitted an application for financial assistance through NYSOH.

On July 13, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan with a \$20.00 premium per month for a limited time, effective August 1, 2017.

Also on July 13, 2017, NYSOH issued a plan enrollment notice confirming that, as of July 12, 2017, you were enrolled in an Essential Plan with an enrollment start date of June 1, 2017.

On July 19, 2017, your account was systemically updated.

On July 20, 2017, NYSOH issued an eligibility determination notice stating that you were ineligible for Medicaid from April 1, 2017 through June 30, 2017, because your monthly household income was over the allowable monthly income limit for that program.

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On July 31, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as you were ineligible for Medicaid for the months of April 2017, May 2017, and June 2017.

On October 12, 2017, you had a scheduled telephone hearing with a Hearing Officer from the Appeals Unit of NYSOH. 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) According to your NYSOH account and testimony, you are applying for health insurance for yourself.
- 2) According to your NYSOH account and testimony, you expect to file a 2017 federal income tax return with the tax status of single, and do not expect to claim any dependents on that tax return.
- 3) According to your July 12, 2017 application, you were requesting help paying for medical bills for the last three months.
- 4) According to your July 12, 2017 application, you attested that your monthly income was \$1,666.67 in each of the months of April 2017, May 2017, and June 2017.
- 5) You testified that you are issued \$400.00 on a weekly basis, and your monthly income in April 2017, May 2017, and June 2017 was \$1,600.00.
- 6) According to your NYSOH account and testimony, you do not expect to claim any deductions on your 2017 federal income tax return.

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

Applicable Law and Regulations

Medicaid:

Medicaid can be provided through the Marketplace 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

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Medicaid State plan in accordance with subpart B of this part; and (5) have a household modified adjusted gross income that is at or below 138% of the federal poverty for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.603(d)(4)), N.Y. Soc. Serv. Law § 366(1)(b)).

In the case of an individual who expects to file a tax return and does not expect to be claimed by another taxpayer, the household consists of the taxpayer and all persons whom such individual expects to claim as a tax dependent (42 CFR § 435.603(f)(1)).

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 \$12,060.00 for a one-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 by the US Department of Health and Human Services, March 19, 2014).

Medicaid Retroactive Coverage:

NYSOH must make Medicaid eligibility effective no later than the third month before the month of application if the individual received medical services that would have been covered under Medicaid and would have been eligible for Medicaid at the time he received the services if they had applied (42 CFR 435.915(a)). NYSOH 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 ineligible for Medicaid coverage from April 1, 2017 through June 30, 2017.

The record reflects that you expect to file your 2017 federal income tax return with the tax status of single, and do not expect to claim any dependents on that return. Therefore, you are in a one-person household.

The record supports that it was indicated in your July 12, 2017 application that you were seeking help paying for medical bills for the months of April 2017, May 2017, and June 2017.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's application if they would have been eligible for Medicaid in those three months had they applied.

Medicaid can be provided through the NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size.

On the date of your application, the FPL was \$12,060.00 for a one-person household. Financial eligibility for Medicaid applicants who are not currently receiving Medicaid benefits may be based on current monthly household income and family size. For an adult to be eligible for Medicaid in a household of one, their monthly must not exceed \$1,387.00.

According to your July 12, 2017, application, you attested that you were issued \$1,667.67 on a month basis. During the hearing, you testified that you are issued \$400.00 per week and was issued \$1,600.00 in April 2017, May 2017, and June 2017.

Based on the available record, your household income exceeded the income threshold for you to be eligible for Medicaid in April 2017, May 2017, and June 2017.

Therefore, the July 20, 2017, eligibility determination notice stating that you were ineligible for Medicaid from April 1, 2017 through June 30, 2017, is **AFFIRMED**.

Decision

The July 20, 2017 eligibility determination notice is **AFFIRMED**.

Effective Date of this Decision: October 18, 2017

How this Decision Affects Your Eligibility

You were ineligible for Medicaid coverage from April 1, 2017 through June 30, 2017 because your household income in each of those months exceeded the maximum allowable monthly income to be eligible for Medicaid retroactively.

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):

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- By calling the Customer Service Center at 1-855-355-5777
- By mail at:
NY State of Health Appeals
P.O. Box 11729

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Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The July 20, 2017, eligibility determination notice is AFFIRMED.

You were ineligible for Medicaid coverage from April 1, 2017, through June 30, 2017.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(a).

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 مجاناً.

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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।

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.

Twí (Twi)

Krataa yi ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&etumi ama wo obi a okyerE 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.