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

Notice of Decision

Decision Date: January 4, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023108

[redacted]

[redacted]

[redacted] 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 25, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: January 4, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023108

[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 for the month of June 2017?

Procedural History

On August 21, 2017, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for May 1, 2017 through June 30, 2017.

On August 25, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective as of August 1, 2017.

Also on August 25, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid for May 1, 2017 through June 30, 2017 because the monthly household income of $1,400.00 is over the allowable monthly income limit of $1,387.00.

On October 4, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as it denied retroactive Medicaid for the month of June 2017.

On December 21, 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 that hearing.

Findings of Fact

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

1) You testified that you are seeking Medicaid for June 2017 because you have unpaid medical bills from that month. You testified that you are not seeking Medicaid for the month of May 2017.

2) You submitted an application for financial assistance on August 24, 2017.

3) Your application submitted on August 24, 2017, states that for the month of June 2017 your income was $1,400.00. You testified that this amount was incorrect.

4) You testified that in June 2017 you were employed with [redacted] You testified that this was your only employer in the month of June, and that you had no other sources of income.

5) You testified that you were paid weekly, but that you did not receive a paycheck for every week in June 2017 because you were hospitalized for part of the month so you did not work during that time and therefore did not receive a paycheck.

6) You uploaded a Paycheck History Detail from [redacted] reflecting that you were paid three times in June 2017. The Paycheck History Detail reflects you received a gross pay of $422.24 on June 7, 2017, $370.89 on June 14, 2017, and $406.64 on June 21, 2017. The Paycheck History Detail reflects that your next paycheck was issued on July 5, 2017.

7) You testified that you expect to file your 2017 federal income tax return as single, and will not claim any dependents.

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

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

Applicable Law and Regulations

<u>Medicaid for Adults between the Ages of 19 and 65</u>

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 $12,060.00 for a one-person household (82 Fed. Reg. 8831).

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

Medicaid Managed Care plan enrollments received on or before the fifteenth day of the month are effective the first day of the following month. Enrollments received after the fifteenth day of the month are effective the first day of the second following month (Medicaid Managed Care Model Contract (Appendix H-6(b)(ii) & (iii), effective 3/1/2014 – 2/28/2019; see 42 USC § 1315; § 364-j(1)(c); 18 NYCRR § 360-10.3(h), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

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 for June 2017.

You are in a one-person household; you file your taxes with a tax filing status of single and will not claim any dependents on your tax return.

You submitted an application for financial assistance on August 24, 2017 and requested help in paying for medical bills for June 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 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 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.

In your August 24, 2017 application, your gross income for the month of June 2017 is listed as $1,400.00. NYSOH relied upon the income listed in your application in determining your Medicaid eligibility for that month. Since $1,400.00 is greater than the allowable monthly income limit of $1,387.00, NYSOH properly found you to be ineligible for Medicaid based on the information provided in your application.

Accordingly, the August 25, 2017 eligibility determination notice is AFFIRMED because it properly found you to be ineligible for Medicaid for the month of June 2017. Your ineligibility for Medicaid was properly based on the gross monthly income listed on your application as being over the limit for that program.

However, you testified and the record reflects that although you are normally paid weekly, you were not paid every week in June 2017 because you missed work. You uploaded a Paycheck History Detail from your employer reflecting that you were paid three times in June 2017. The Paycheck History Detail reflects you received a gross pay of $422.24 on June 7, 2017, $370.89 on June 14, 2017, and $406.64 on June 21, 2017. Therefore, the record indicates that in the month of June 2017, you had a monthly household income of $1,199.77.

Since the record now contains a more accurate representation of what your income was 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 one and household income of $1,199.77 for the month of June 2017.

Decision

The August 25, 2017 eligibility determination is AFFIRMED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for June 2017 based on a household size of one and household income of $1,199.77 for the month of June 2017.

Effective Date of this Decision: January 4, 2018

How this Decision Affects Your Eligibility

This decision is not a final determination of your eligibility for Medicaid for the month of June 2017.

Your case is being sent back to NYSOH to determine your eligibility for Medicaid for June 2017 based on the evidence 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

The August 25, 2017 eligibility determination is AFFIRMED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for June 2017 based on a household size of one and household income of $1,199.77 for the month of June 2017.

This decision is not a final determination of your eligibility for Medicaid for the month of June 2017.

Your case is being sent back to NYSOH to determine your eligibility for Medicaid for June 2017 based on the evidence presented at the hearing.

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:

[redacted]

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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)

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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 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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