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

# Notice of Decision

Decision Date: February 14, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024915

[redacted]

[redacted]

On February 8, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's failure to determine you eligible for retroactive Medicaid for the month of September 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: February 14, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024915

[redacted]

## Issue

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

> Did NY State of Health (NYSOH) fail to determine you eligible for retroactive Medicaid for the month of September 2017?

## Procedural History

On October 17, 2017, NYSOH issued an eligibility determination notice stating, in relevant part, that you were eligible for Medicaid, effective as of October 1, 2017.

On November 5, 2017, NYSOH issued a plan enrollment notice confirming that as of November 4, 2017, you were enrolled in a Medicaid Managed Care (MMC) plan with an enrollment start date of December 1, 2017.

On November 28, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal relative to your eligibility for retroactive Medicaid coverage for the month of September 2017.

On February 8, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was given during the hearing, and the record was left open until to allow you to upload additional income documentation to your NYSOH account.

On February 8, 2018, you uploaded additional income documentation to your NYSOH account. That documentation has been made part of the record collectively as "Appellant Exhibit A." The record is now complete and closed.

## Findings of Fact

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

1) You testified that you are seeking retroactive Medicaid coverage for the month of September 2017.

2) According to your NYSOH account, you were determined eligible for Medicaid, effective October 1, 2017.

3) On September 12, 2017, you submitted a letter from the [redacted] The letter states you were enrolled in the company medical plan as a dependent of [redacted] The medical coverage would terminate effective October 31, 2017, because you were turning [redacted].

4) You testified that your primary health insurance plan did not cover all your medical expenses in September 2017 and you want Medicaid to cover those expenses.

5) 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 return.

6) On September 12, 2017, you submitted a letter from [redacted] stating that your position was eliminated effective August 30, 2017 [redacted]

7) On October 3, 2017, you submitted weekly paystubs from your employment with [redacted] You were issued gross earnings of $900.00 on September 1, 2017, and September 8, 2017 each [redacted]

8) On October 3, 2017, and October 9, 2017, you submitted biweekly paystubs from your employment with [redacted]. You were issued gross pay of $472.50 on September 15, 2017, and $525.00 on September 29, 2017 [redacted].

9) According to your NYSOH account, you expect to claim a business expense deduction of $1,500.00 and a student loan interest deduction of $3,000.00 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

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).

Modified Adjusted Gross Income

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)).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions (26 USC § 62(a)).

Subject to limitations, deductions that are attributable to a trade or business may be deductions from a taxpayer's adjusted gross income (26 USC § 62 (a)(1); IRS Publication 535 (2017)).

Subject to limitations, there shall be allowed as a deduction from the adjusted gross income, an amount not to exceed $2,500.00, equal to the interest paid by the taxpayer during the taxable year on any qualified education loan (26 USC § 221; IRS Publication 970 (2017)).

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)).

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 March 19, 2014).

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 failed to determine that you were eligible for Medicaid for the month of September 2017.

You testified that you are appealing the fact that you were not determined eligible for Medicaid coverage for the month of September 2017. The record does not contain a notice of eligibility determination regarding the issue of your eligibility for retroactive Medicaid coverage for the month of September 2017.

The lack of a notice of eligibility determination on the issue of retroactive Medicaid coverage for September 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 are as entitled to appeal NYSOH's failure to timely issue a notice of eligibility determination.

Your testimony regarding the relief that you are seeking permits an inference that NYSOH denied your request or failed to determine your eligibility for retroactive Medicaid coverage for the month of September 2017. Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to the eligibility determination notice had it been issued.

The record reflects that you were determined eligible for Medicaid, effective October 1, 2017.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's application, if they would have been found eligible for Medicaid in any of the three months had an application been submitted.

You testified 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 for purposes of this analysis.

Medicaid can be provided through 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.

The 2017 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.

On October 3, 2017, you submitted weekly paystubs from your employment with [redacted] stating that you were issued gross earnings of $900.00 on September 1, 2017, and September 8, 2017 [redacted]; [redacted]Therefore, you were issued gross income of $1,800.00 from that employer during September 2017.

On October 3, 2017, and October 9, 2017, you submitted biweekly paystubs from your employment with [redacted] stating that you were issued gross pay of $472.50 on September 15, 2017, and $525.00 on September 29, 2017 ([redacted]. Therefore, you were issued $997.50 from that employer during September 2017.

Your NYSOH account reflects that you attested that you would be claiming a $1,500.00 business expense deduction and a $3,000.00 student loan interest deduction on your 2017 federal income tax return. The maximum student loan interest deduction that a taxpayer can claim on their federal income tax return is $2,500.00. Therefore, you expect to claim ($2,500.00 + $1,500.00) $4,000.00 in deductions on your 2017 federal income tax return.

Based on the available record, your September 2017 monthly income was ($1,800.00 + $997.50) – ($4,000.00 / 12 months = $333.33 per month) $2,464.17.

Therefore, your household income in September 2017 exceeded the income threshold of $1,387.00 per month for you to be eligible for Medicaid that month. As such, NYSOH did not fail to determine you were eligible for retroactive Medicaid for the month of September 2017.

## Decision

NYSOH did not fail to determine you were eligible for retroactive Medicaid for the month of September 2017.

## Effective Date of this Decision: February 14, 2018

## How this Decision Affects Your Eligibility

You were ineligible for retroactive Medicaid coverage for the month of September 2017, because your monthly income exceeded the maximum allowable monthly income limit.

## 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 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).

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

NYSOH did not fail to determine you were eligible for retroactive Medicaid for the month of September 2017.

You were ineligible for retroactive Medicaid coverage for the month of September 2017, because your monthly income exceeded the maximum allowable monthly income limit.

## 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)**

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।

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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 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.

**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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