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

Notice of Decision

Decision Date: March 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026396

[redacted]

Dear [redacted],

On March 13, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 18, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: March 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026396

[redacted]

Issue

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

> Did NY State of Health (NYSOH) properly deny your request for retroactive Medicaid coverage from June 1, 2017, through June 30, 2017?

Procedural History

On September 13, 2017, you submitted an application for financial assistance through NYSOH.

On September 14, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan with a $0.00 monthly premium for a limited time, effective October 1, 2017. The notice instructed you to submit proof of income by December 12, 2017, to confirm your eligibility.

Also on September 14, 2017, NYSOH issued a plan enrollment notice confirming that as of September 13, 2017, you were enrolled in an Essential Plan with an enrollment start date of October 1, 2017.

On December 17, 2017, your NYSOH account was systematically updated.

On December 18, 2017, NYSOH issued an eligibility determination notice stating that your request for Medicaid coverage for June 1, 2017 through June 30, 2017, had been denied. The notice stated that you did not provide sufficient proof of your household income to confirm your eligibility.

On December 27, 2017, your NYSOH account was updated.

Also on December 27, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as your eligibility for retroactive Medicaid for the month of June 2017 had been denied.

On December 28, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective as of December 1, 2017.

Also on December 28, 2017, NYSOH issued an enrollment notice confirming that as of December 27, 2017, you were enrolled in a Medicaid Managed Care (MMC) plan with an enrollment start date of February 1, 2018.

On March 13, 2018, you had a scheduled telephone hearing with a Hearing Officer from the Appeals Unit of NYSOH. Your testimony was taken during the hearing, and the record was left open until March 14, 2018, to allow you to submit your Unemployment Benefit Payment History to NYSOH's Appeals Unit.

On March 13, 2018, you uploaded six-pages of documentation to your NYSOH account (Document [redacted]). That documentation was made part of the record 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 want to be determined eligible for retroactive Medicaid coverage from June 1, 2017, through June 30, 2017.

2) According to your September 13, 2017 application, you indicated that you requested help paying medical bills for the month of June 2017.

3) According to your September 13, 2017 application, you attested to a June 2017 household income of $0.00.

4) You testified that you filed a 2017 federal income tax return, with the tax status of single, and did not claim any dependents on that tax return.

5) According to your September 13, 2017 application and testimony, your employment at [redacted]. ended on March 26, 2017.

6) You testified that you immediately applied for unemployment insurance benefits (UIB) after your employment ended; however, your benefits were not approved until July 2017.

7) On March 13, 2018, you submitted your Official Record of Benefit Payment History from the Department of Labor. The documentation states that you were determined eligible for a weekly benefit amount of $356.00 with an effective date of March 27, 2017. Further, your "Payment History," states that your first payment of $356.00 was released on July 7, 2017 (Appellant A [redacted]).

8) You testified that you have outstanding medical expenses from the month of June 2017, and you want Medicaid to cover those expenses.

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

Applicable Law and Regulations

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, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)).

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 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). For the month of June 2017, that was the 2017 FPL, which is $12,060.00 for a one-person household (82 Federal Register 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 denied your request for Medicaid coverage from June 1, 2017, through June 30, 2017.

The record supports that on September 13, 2017, you submitted an application for financial assistance. In that application you attested that you were seeking help paying for medical bills for the month of 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 found eligible for Medicaid in any of the three months had an application been submitted.

You testified that you filed your 2017 federal income tax return, with the tax status of single, and did not claim any dependents on that return. Therefore, you are in a one-person household.

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.

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.

You testified that your employment at [redacted] ended on March 26, 2017. After your employment ended, you immediately applied for UIB; however, your benefits were not approved until July 2017.

On March 13, 2018, you submitted your Official Record of Benefit Payment History from the Department of Labor. The documentation states that you were determined eligible for a weekly benefit amount of $356.00; however, your "Payment History," reflects that your first payment of $356.00 was not released until July 7, 2017 (Appellant A [redacted]). Based on the available record, your household income in June 2017 was $0.00.

Therefore, the December 18, 2017 eligibility determination notice stating that your request for Medicaid coverage for June 1, 2017 through June 30, 2017, had been denied on the basis that you did not provide sufficient proof of your household income is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for retroactive Medicaid, for the month of June 2017, based on a one-person household with a monthly income of $0.00.

Decision

The December 18, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for retroactive Medicaid, for the month of June 2017, based on a one-person household with a monthly income of $0.00.

Effective Date of this Decision: March 16, 2018

How this Decision Affects Your Eligibility

Your case is being sent back to NYSOH to redetermine your eligibility for retroactive Medicaid, for the month of June 2017, based on the parameters noted above.

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 December 18, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for retroactive Medicaid, for the month of June 2017, based on a one-person household with a monthly income of $0.00.

Your case is being sent back to NYSOH to redetermine your eligibility for retroactive Medicaid, for the month of June 2017, based on the parameters noted above.

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:

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।

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).

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.

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).