



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

Notice of Decision

Decision Date: October 28, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000008259



Dear [REDACTED],

On September 29, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's January 23, 2016 eligibility determination.

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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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 not eligible for retroactive Medicaid coverage from November 1, 2014 through November 30, 2014?

Procedural History

On January 7, 2015, you submitted a financial assistance application through NYSOH.

On January 8, 2015, NYSOH issued an eligibility determination notice that you were eligible for Medicaid as of January 1, 2015.

Also on January 8, 2015, NYSOH issued an enrollment notice confirming that as of January 7, 2015, you were enrolled in MetroPlus Health Plan, Inc. with a plan enrollment start date of February 1, 2015.

On February 8, 2015, you faxed income documentation to NYSOH



On June 28, 2015, you faxed income documentation to NYSOH



On June 29, 2015, NYSOH issued a notice stating that you have submitted documentation to resolve an inconsistency, but the documentation appear to be insufficient to resolve the request. The notice directed you to submit additional

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income information for the month of November 2014 to confirm your eligibility for Medicaid.

On November 26, 2015, you faxed income documentation to NYSOH

On January 23, 2016, NYSOH issued an eligibility determination notice stating that you are not eligible for Medicaid for the period of November 1, 2014 through November 30, 2014.

On March 24, 2016, you spoke to NYSOH Account Review Unit and requested an appeal insofar as your eligibility for Medicaid for the period of November 1, 2014 through November 30, 2014.

On September 29, 2016, 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 October 3, 2016, to allow you to fax your 2014 Form 1040, U.S. Individual Income Tax Return to NYSOH Appeals Unit.

On October 4, 2016, a two-page fax was received by NYSOH Appeals Unit. That fax has been marked as "Appellant Exhibit A" and has been incorporated into the record. The record is now complete and closed.

Findings of Fact

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

1. You indicated on your January 7, 2015 NYSOH application that you were applying for yourself.
2. You testified that you filed a 2014 federal income tax return with the tax status of single and claimed no dependents on that tax return.
3. On January 8, 2015, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective January 1, 2015.
4. You indicated on your February 12, 2015, NYSOH application that you wanted help paying for medical bills for the last 3 months.
5. You testified and your NYSOH account reflects that you were employed at [REDACTED] in November 2014.
6. On November 26, 2015, you faxed income documentation to NYSOH. You were issued \$403.88 from [REDACTED] on November 7, 2014 [REDACTED]

7. On June 28, 2015, you faxed income documentation to NYSOH. You were issued from [REDACTED]: \$459.25 on November 14, 2014; \$357.32 on November 21, 2014, and \$356.77 on November 26, 2014 [REDACTED]
8. On January 23, 2016, NYSOH issued an eligibility determination notice stating that you are not eligible for Medicaid for the period of November 1, 2014 through November 30, 2014.
9. You testified that you want to be found eligible for retroactive Medicaid for November 2014 to cover the medical expenses that you incurred in that month.
10. On October 4, 2016, you faxed your 2014 Form 8879 to NYSOH Appeals Unit (Appellant Exhibit A p. 2).

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 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)).

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).

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 2014 FPL, which is \$11,670.00 for a one-person household (79 Fed. Reg. 3593, 3593).

Medicaid Retroactive Coverage:

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).

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

Currently at issue is whether NYSOH properly determined that you were not eligible for retroactive Medicaid from November 1, 2014 through November 30, 2014.

The record reflects that you filed your 2014 federal income tax return with a tax status of single and did not claim any dependents on that return. Therefore, your household size for Medicaid purposes was one.

Since you were determined Medicaid eligible on January 8, 2015, you were entitled to begin your Medicaid coverage on January 1, 2015. However, you indicated in your February 12, 2015 application that you wanted help paying for medical bills for the last three months. An individual may be entitled to receive retroactive coverage, provided that you would have been eligible for Medicaid had an application been completed in November 2014.

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.

For the month of November 2014, the FPL was \$11,670.00 for a one-person household. Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits may be based on current monthly household income and family size. In order to be eligible for Medicaid a household of one must not exceed a monthly income limit of \$1,343.00.

You credibly testified that [REDACTED] was your only source of income in November 2014. Furthermore, you faxed your November 2014 earnings statements from that employer to NYSOH. Your earnings statements show that you were issued: \$403.88 on November 7, 2014; \$459.25 on November 14, 2014; \$357.32 on November 21, 2014, and \$356.77 on November 26, 2014.

According to the available record, you were issued \$1,577.22 in the month of November 2014. NYSOH properly determined that you were not eligible for Medicaid coverage for the period of November 1, 2014, to November 30, 2014.

Therefore, the January 23, 2016 eligibility determination is AFFIRMED.

Decision

The January 23, 2016 eligibility determination is AFFIRMED.

Effective Date of this Decision: October 28, 2016

How this Decision Affects Your Eligibility

You were not eligible for Medicaid November 1, 2014 through November 30, 2014.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 after the date 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 U.S. Department of Health and Human Services. This must be done within 30 days of the date of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c))

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:

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Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The January 23, 2016 eligibility determination is AFFIRMED.

You were not eligible for Medicaid November 1, 2014 through November 30, 2014.

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:

