



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

Notice of Decision

Decision Date: November 21, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000009730

[REDACTED]

Dear [REDACTED],

On November 8, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's May 4, 2016 eligibility determination.

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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Decision

Decision Date: November 21, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000009730

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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 April 1, 2016 through April 30, 2016?

Procedural History

On May 3, 2016, NYSOH received your application for health insurance as well as your request for help with paying for medical bills for April 2016.

On May 4, 2016, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid for April 1, 2016 through April 30, 2016 because the monthly household income of \$1,894.13 was over the allowable monthly income limit of \$1,367.00.

On May 19, 2016, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as it denied retroactive Medicaid for the month of April 2016.

On November 8, 2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open for 15 days to allow you time to submit proof of your income from April 2016, specifically the Hearing Officer directed you to submit a letter from your former employer indicating whether you had earned any income during April 2016. In addition, the letter was to include your last date of employment. On November 10, 2016 you faxed a letter from your former employer to the Appeals

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Unit. Since the documentation was sufficient, the record closed and the letter was marked as Appellant's Exhibit #1 and was incorporated into the record. The record is now closed.

Findings of Fact

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

- 1) The record indicates that the May 3, 2016 application listed an expected annual household income of \$22,734.40. The application also stated that your average monthly income was the same as the current month.
- 2) The income details of your NYSOH account indicate that the "system calculated" monthly income in your May 3, 2016 application was determined to be \$1,894.53.
- 3) You testified that you expect to file your 2016 federal income tax return as single, and claim no dependents.
- 4) You testified that in March 2016 you entered the hospital and stopped working.
- 5) You testified that you received no income during April 2016.
- 6) You provided supporting documentation dated November 11, 2016 from your former employer indicating that you had no income during April 2016 and that your last date of employment was March 9, 2016.
- 7) You testified that you have since started a new job.
- 8) You testified that you are seeking Medicaid coverage for the month of April 2016 because you incurred medical bills during the month of April 2016.

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

Applicable Law and Regulations

Medicaid for Adults between the Ages of 19 and 65

Medicaid through NYSOH can be provided 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

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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 federal poverty level (FPL) for the applicable family size (42 CFR §§ 435.119(b), 435.911(b)(1), 435.603(d)(4); N.Y. Soc. Serv. 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 2016 FPL, which is \$11,770.00 for a one-person household (81 Fed. Reg. 4036).

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).

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of 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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were not eligible for Medicaid from April 1, 2016 through April 30, 2016.

You are in a one-person household; you file your taxes with a tax filing status of single and claim no dependents on your tax return.

You testified that you are seeking to have Medicaid coverage retroactively for the month of April 2016.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's 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.

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 April 2016, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is \$1,367.00 per month. There is no indication in the record that you would

have been ineligible for Medicaid based on non-financial criteria during April 2016.

The May 3, 2016 application listed an expected annual household income of \$22,734.40 and stated that your average monthly income was the same as the current month. As a result, the income details of your NYSOH account state that the “system calculated” monthly income in your May 3, 2016 application was determined to be \$1,894.53. On May 4, 2016, NYSOH issued a notice stating that you were not eligible for Medicaid in April 2016 because the monthly household income of \$1,894.13 was over the allowable monthly income limit of \$1,367.00.

However, you credibly testified that in March 2016 you entered the hospital and stopped working. As such, you had no income during the month of April 2016. You provided a letter in support of your testimony dated November 11, 2016 from your former employer indicating that you had no income during April 2016 and that your last date of employment was March 9, 2016. Therefore, the record indicates that in the month of April 2016, you had a monthly household income of \$00.00.

Accordingly, the May 4, 2016 eligibility determination denying you retroactive Medicaid for the month of April 2016 is **RESCINDED** because it improperly stated that your monthly income for April 2016 was \$1,894.13.

Since the record now contains a more accurate representation of what your income was for the month of April 2016, your case is **RETURNED** to NYSOH to redetermine your eligibility for retroactive Medicaid coverage for April 2016 based on a household size of one person and household income of \$00.00.

Decision

The May 4, 2016 eligibility determination notice is **RESCINDED**.

Your case is **RETURNED** to NYSOH to consider your request for retroactive coverage for April 2016 based on a household size of one person and household income of \$00.00 for the month of April 2016.

Effective Date of this Decision: November 21, 2016

How this Decision Affects Your Eligibility

NYSOH improperly determined the amount of income you received in the month of April 2016.

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).

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your eligibility based on the evidence you presented at the hearing.

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 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 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:
NY State of Health Appeals
P.O. Box 11729
Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The May 4, 2016 eligibility determination notice is **RESCINDED**.

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NYSOH improperly determined the amount of income you received in the month of April 2016.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for April 2016 based on a household size of one person and household income of \$00.00 for the month of April 2016.

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your eligibility based on the evidence you presented at the hearing.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

