



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

### Notice of Decision

Decision Date: December 12, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000011631

[REDACTED]

[REDACTED]

Dear [REDACTED],

On December 6, 2016, your brother appeared on your behalf as your authorized representative by telephone at a hearing on your appeal of NY State of Health's August 24, 2016 denial of your request for retroactive Medicaid for the month of July 2016.

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 Account ID at the top of this notice.

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).

## **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: December 12, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000011631

[REDACTED]

[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 retroactive Medicaid coverage for the month of July 2016?

## Procedural History

On August 23, 2016, NYSOH received your updated application for health insurance.

Also on August 23, 2016, NYSOH issued a preliminary eligibility determination, based on your August 23, 2016 application, stating that you were not eligible for retroactive Medicaid from July 1, 2016 through July 31, 2016.

Also on August 23, 2016, you and/or your authorized representative spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as you were not determined eligible for retroactive Medicaid benefits during the month of July 2016.

On August 24, 2016, NYSOH issued an eligibility determination notice, based on your August 23, 2016 update, stating that you were eligible to enroll in the Essential Plan with no premium, effective October 1, 2016.

Also on August 24, 2016, NYSOH issued an eligibility determination notice, based on your August 23, 2016 application, stating that you were not eligible for retroactive Medicaid from July 1, 2016 through July 31, 2016. The reason stated was because the program you were found eligible for cannot pay for any care you received in the past.

On December 2, 2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit and your brother appeared on your behalf. The navigator that helped with your application testified. The hearing was held and the record closed.

## **Findings of Fact**

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

- 1) According to your NYSOH account, your account was updated on August 23, 2016 and a request was submitted requesting help paying for medical bills incurred in the month of July 2016. You were denied.
- 2) Your authorized representative testified, and according to your NYSOH account, you expect to file your 2016 taxes with a tax filing status of single and will claim no dependents on that tax return.
- 3) According to your NYSOH account, you were determined eligible for and enrolled in an Essential Plan, effective October 1, 2016. Your authorized representative testified that you are seeking retroactive Medicaid coverage for the month of July 2016.
- 4) On August 10, 2016, your authorized representative submitted a profit and loss statement from your two businesses for the months of May 2016, June 2016, and July, 2016, along with a letter from your accountant. The profit and loss statement from [REDACTED], shows a profit of \$1,163.00 for July 2016. The profit and loss statement from [REDACTED], shows a loss of \$1,116.00 for July 2016. The letter from your accountant stated that you had a dividend income from [REDACTED] investments in the amount of \$205.51 for July 2016.
- 5) Your total income for July 2016 was \$252.51. Your authorized representative testified that this was accurate.

- 6) Your authorized representative testified that you were hospitalized and had medical bills from July 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 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 \$11,880.00 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 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 retroactive Medicaid coverage for the month of July 2016.

On August 24, 2016, NYSOH issued an eligibility determination notice, based on your August 23, 2016 application, stating that you were not eligible for retroactive

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Medicaid from July 1, 2016 through July 31, 2016. That was because the program you were found eligible for cannot pay for any care you received in the past.

However, the Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of application if the medical services would have been covered under Medicaid and the individual would have been eligible for Medicaid at the time he or she received the services had he or she applied.

The record reflects that, on August 23, 2016, your authorized representative, with the assistance of a Navigator, submitted your updated application and requested in the application that you be considered for help paying for medical bills for July 2016.

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 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.

To be eligible for Medicaid in July 2016, you would have to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is \$1,367.00 per month for a one-person household.

There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during July 2016.

Financial eligibility for retroactive Medicaid for applicants who are not currently receiving Medicaid benefits is based on monthly household income and family size for the months they are requesting retroactive Medicaid.

According to your NYSOH account and your authorized representative's testimony, you will file your 2016 taxes with a tax filing status of single and claim no dependents on your tax return.

On August 10, 2016, you submitted a profit and loss statement from your two businesses for the months of May 2016, June 2016, and July, 2016 along with a letter from your accountant. The profit and loss statement from [REDACTED], [REDACTED] reflects a profit of \$1,163.00 for July 2016. The profit and loss statement from [REDACTED], reflects a loss of \$1,116.00 for July 2016. The letter from your accountant stated that you had a dividend income from [REDACTED] investments in the amount of \$205.51 for July 2016. When you combine your profits and losses for July 2016 (\$1,163.00 (profit) - \$1,116.00

(loss) + \$205.51 (dividends), your total income for July 2016 was \$252.51. Your authorized representative testified that this was accurate.

Since your eligibility in the Essential Plan going forward has no bearing on your right to apply for Medicaid for the three months prior to your August 23, 2016 application and the record now contains a more accurate representation of what your household income was for the month of July 2016, your case is RETURNED to NYSOH to consider your request for retroactive coverage in Medicaid during that month, based on a one-person household, utilizing 138% of the FPL on a monthly basis, and a monthly household income of \$252.51.

## **Decision**

Your case is RETURNED to NYSOH to consider your request for retroactive coverage in Medicaid during the month of July 2016, based on a one-person household, utilizing 138% of the FPL on a monthly basis, and a monthly household income of \$252.51.

**Effective Date of this Decision:** December 12, 2016

## **How this Decision Affects Your Eligibility**

This is not a final determination of your eligibility for financial assistance.

Your case is being sent back to NYSOH to redetermine your eligibility for retroactive Medicaid coverage to cover the cost of uncovered medical expenses for July 2016 based on a one-person household, utilizing 138% of the FPL on a monthly basis, and a monthly household income of \$252.51.

## **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.

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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**

Your case is RETURNED to NYSOH to consider your request for retroactive coverage in Medicaid during the month of July 2016, based on a one-person household, utilizing 138% of the FPL on a monthly basis, and a monthly household income of \$252.51.

This is not a final determination of your eligibility for financial assistance.

Your case is being sent back to NYSOH to redetermine your eligibility for retroactive Medicaid coverage to cover the cost of uncovered medical expenses for July 2016 based on a one-person household, utilizing 138% of the FPL on a monthly basis, and a monthly household income of \$252.51.

### **Legal Authority**

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

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**A Copy of this Decision Has Been Provided To:**

[REDACTED]

[REDACTED]