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

Notice of Decision

Decision Date: March 14, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013168

[redacted]

Dear [redacted] and [redacted],

On March 9, 2017, your appeared by telephone at a hearing on your appeal of NY State of Health's October 5, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: March 14, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013168

[redacted]

Issue

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

> Did NY State of Health properly determine that you were not eligible for Medicaid for August 1, 2016 through August 31, 2016?

Procedural History

On September 1, 2016, you updated your application for financial assistance with health insurance and indicated that you were seeking help paying for medical bills for August 2016.

On September 2, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible for the Essential Plan for a limited time, effective October 1, 2016. This notice further requested that you submit income documentation by November 30, 2016.

On October 5, 2016, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid for August 1, 2016 through August 31, 2016 because the program you are eligible for cannot pay for any care you received in the past.

On November 9, 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 August 2016.

On March 2, 2017, you were scheduled for a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Your authorized representative requested that day that the hearing be adjourned to a later date.

On March 9, 2017, you had an adjourned hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, [redacted] acted as your Authorized Representative. Under oath, your authorized representative waived the right to formal notice of the hearing. The record was developed during the hearing and left open for 7 days to allow you time to submit proof of your income, specifically the Hearing Officer directed you to submit a copy of your August 4, 2016 paystub. On March 9, 2017 the Appeals Unit received via fax a copy of your August 4, 2016 paystub, which was marked as Appellant's Exhibit #1 and incorporated into the record. The record is now closed.

Findings of Fact

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

1) Your authorized representative testified that you are seeking Medicaid from August 1, 2016 to August 31, 2016. She advised that you have outstanding medical bills for that time period.

2) Your authorized representative testified that you expect to file your 2016 income tax return as single, and claim no dependents.

3) Your authorized representative testified that in 2016 you have had three separate employers. She further testified that you worked for [redacted] throughout 2016, for [redacted] School during the spring, fall, and winter of 2016, and for [redacted] beginning in December of 2016.

4) Your authorized representative further explained that you are hired on for a semester with [redacted], and that your employment continues throughout a semester, and then ends, until such time as you are hired again.

5) You submitted an employment offer letter from [redacted] dated December 18, 2015 which indicates that this was a temporary position for which you will receive $1,615.00 for the semester payable in five lump sums. The letter further indicates that the program began on January 11, 2016 and extended through June 14, 2016.

6) You submitted an employment offer letter from [redacted] dated August 16, 2016 which indicates that this was a

temporary position for which you will receive $1,105.00 for the semester payable in five lump sums. The letter further indicates the program began on September 12, 2016 and extended through December 16, 2016.

7) Your authorized representative testified that your only source of income in August 2016 was your wages from the [redacted], for which you are paid on a biweekly basis.

8) You submitted a paystub dated August 4, 2016 for a gross pay amount of $500.00 and a paystub dated August 18, 2016 for a gross pay amount of $500.00.

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).

Retroactive Medicaid

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 Medicaid for August 1, 2016 through August 31, 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.

The record reflects that you submitted an application for financial assistance with health insurance on September 1, 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 initial 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.

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

Your authorized representative testified that you are seeking to have Medicaid for August 2016.

To be eligible for Medicaid in August 2016, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the 2016 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 August 2016.

Your authorized representative testified that you are paid bi-weekly by the [redacted], and that you had no other source of income in August 2016. You submitted a paystub dated August 4, 2016 for a gross pay amount of $500.00 and a paystub dated August 18, 2016 for a gross pay amount of $500.00. Therefore, the record indicates that in the month of August 2016, you had a monthly household income of $1000.00.

Since the October 5, 2016 notice of eligibility determination found you were not eligible for Medicaid for August 1, 2016 to August 31, 2016, because the program you were eligible for cannot pay for any care you received in the past, this is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for August 1, 2016 through August 31, 2016 based on a household size of one and household income of $1,000.00 for the month of August 2016.

Decision

The October 5, 2016 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for August 1, 2016 through August 31, 2016 based on a household size of one and household income of $1,000.00 for the month of August 2016.

Effective Date of this Decision: March 14, 2017

How this Decision Affects Your Eligibility

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:

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

Summary

The October 5, 2016 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for August 1, 2016 through August 31, 2016 based on a household size of one and household income of $1,000.00 for the month of August 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:

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