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

Notice of Decision

Decision Date: March 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013831

[redacted]

Dear [redacted],

On February 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 7, 2016 eligibility determination notice.

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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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 November 1, 2016 through November 30, 2016?

Procedural History

On November 2, 2016, NYSOH received your updated application for health insurance.

On November 3, 2016 NYSOH issued an eligibility determination notice, based on your November 2, 2016 application, stating that you were eligible for the Essential Plan. This eligibility was effective as of December 1, 2016.

Also on November 3, 2016, NYSOH issued an enrollment notice confirming your enrollment in the Essential Plan effective December 1, 2016.

On December 6, 2016, you submitted an updated application seeking financial assistance with health insurance and indicated that you were seeking help paying for medical bills from the month of November 2016.

Also on n December 6, 2016, you spoke to NYSOH's Account Review Unit and appealed insofar as you were not eligible for Medicaid for the month of November 2016.

On December 7, 2016, NYSOH issued an eligibility determination notice, based on your December 6, 2016 application and request, stating that you were not eligible for Medicaid for November 1, 2016 through November 30, 2016 because the program you are eligible for cannot pay for any care you received in the past.

On February 28, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open until March 15, 2017, to allow you time to submit proof of your income for November 2016.

As of the close of the business day on March 15, 2017, the Appeals Unit did not receive any documents from you. Therefore, the record was closed that same day and this decision is based on the record as developed at the time of the hearing.

Findings of Fact

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

1) You were initially found eligible for the Essential Plan as of December 1, 2016.

2) You testified that you are seeking retroactive Medicaid for the month of November 2016.

3) You testified that during November 2016 you were residing only with your child.

4) Your December 6, 2016 application states you had an expected annual income of $29,464.44. The system calculated your monthly income to be $2,453.75.

5) You testified that the annual income amount of $29,464.44 was accurate.

6) You testified that you are paid bi-weekly and on average receive $850.00 per paycheck before taxes. You further testified that the amount you are paid per paycheck varies.

7) The Hearing Officer directed you to submit proof of your income for the month of November 2016.

8) No income documents for the month of November 2016 were received by the Appeals Unit.

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 can be provided through NYSOH 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 FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services 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 $16,020.00 for a two-person household (81 Fed. Reg. 4036).

Retroactive Medicaid

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of an initial 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)). 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 November 1, 2016 through November 30, 2016.

For the month of November 2016, you were in a two-person household; you testified that during the month of November 2016 your child was the only one living with you.

You submitted an application for financial assistance on December 6, 2016 and requested help in paying for medical bills for the month of November 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 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.

You testified that you are seeking Medicaid for the month of November 2016.

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 November 2016, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,843.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during November 2016.

On December 6, 2016 application your reported an expected annual income of $29,464.44 and during the hearing you testified that this amount was accurate. On your December 6, 2016 application, the system calculated your monthly household income based on your annual salary of $29,464.44. This amounts to a monthly household income of $2,453.75. However, you testified that you are paid bi-weekly and on average receive $850.00 per paycheck before taxes.

The record was kept open until March 15, 2017 for you to provide income documentation to support your testimony of your monthly income for the month of November 2016. As of the close of the record, no documentation was received by the NYSOH Appeals Unit.

Therefore, absent evidence to the contrary, the credible evidence of the record indicates that in the month of November 2016, you had a monthly household income of $2,453.75.

Since your income of $2,453.75 was more than the $1,843.00 monthly Medicaid limit for November 2016, NYSOH properly determined that you were not eligible for Medicaid coverage during that month. Therefore, the December 7, 2016 eligibility determination stating that you were not eligible for Medicaid in the month of November 2016, is correct and is AFFIRMED.

Decision

The December 7, 2016 eligibility determination is AFFIRMED.

Effective Date of this Decision: March 21, 2017

How this Decision Affects Your Eligibility

You are not eligible for Medicaid in the month of November 2016.

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 December 7, 2016 eligibility determination is AFFIRMED.

You are not eligible for Medicaid in the month of November 2016.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

[redacted]

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).