nystateofhealth
The Official Health Plan Marketplace

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

Notice of Decision

Decision Date: March 30, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026025

[redacted]

[redacted]

Dear [redacted],

On February 23, 2018, you and [redacted] appeared by telephone at a hearing on [redacted] appeal of NY State of Health's November 11, 2017 eligibility determination notice and the November 11, 2017 eligibility determination regarding your request for retroactive Medicaid coverage.

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

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).

- 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.

This page intentionally left blank.

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

Decision

Decision Date: March 30, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026025

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health (NYSOH) provide a timely determination of your Medicaid eligibility as of November 11, 2017?
>
> Did NYSOH properly determine that you were eligible for Medicaid no earlier than November 1, 2017.
>
> Did NYSOH properly determine that you were eligible for retroactive Medicaid no earlier than August 1, 2017 through October 31, 2017?

Procedural History

Twice on July 25, 2017 and three times in August 2017, attempts to prove identity on this account failed.

On November 10, 2017, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for August 2017, September 2017, and October 2017.

On November 11, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid. This eligibility was effective as of November 1, 2017.

Also on November 11, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for retroactive Medicaid assistance for August 1, 2017 through October 31, 2017. This was because the monthly household income of $0.00 was at or below the allowable monthly income limit.

On December 19, 2017, you or your authorized representative spoke to NYSOH's Account Review Unit and appealed those eligibility determination notices insofar as you were not eligible for retroactive Medicaid assistance for May 2017, June 2017 and July 2017.

On February 23, 2018, you and your authorized representative had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing held open until March 9, 2018, to allow you to submit supporting documents.

On March 8, 2018, NYSOH received via secure facsimile, your 18 pages of supporting documentation and this material was incorporated into the record as Appellant's Exhibit #1. The record was closed that day.

Findings of Fact

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

1) On July 25, 2017, August 17, 2017, August 24, 2017 and August 31, 2017 your agent attempted to submit applications for financial assistance with health insurance with NYOSH account on your behalf. The "Events" tab in your NYSOH account indicates that on these dates, an application could not be submitted due to "Identity Proofing Fail."

2) On November 9, 2017 your agent submitted to NYSOH by facsimile, a copy of your NYS driver license and a signed attestation form for manual identify proofing.

3) On November 10, 2017, your agent submitted an application for financial assistance with health insurance on your behalf. The attested yearly household income on that application was $0.00.

4) On November 11, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid effective November 1, 2017.

5) Also on November 11, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid for the period of August 1, 2017 through October 31, 2017.

6) According to your NYSOH account, you were enrolled in a Medicaid Managed Care plan with a plan start date of December 1, 2017.

7) You authorized representative testified that you are seeking to be found eligible for Medicaid effective July 1, 2017 and to be eligible for retroactive Medicaid for the months of April 2017, May 2017 and June 2017.

8) According to the November 10, 2017 application, you do not intend to file a tax return and that your expected annual income is $0.00. Your application indicates that you rely on financial support from your family.

9) According to your authorized representative, you required medical services in the months of April 2017, May 2017, June 2017 and July 2017.

10) According to your application you reside in Oswego County.

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 2017 FPL, which is $12,060.00 for a one-person household (82 Fed. Reg. 8831).

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month (42 CFR §

435.915(b), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

Timely Notice of Medicaid Eligibility

When an individual applies for insurance through NYSOH, NYSOH must determine that person's eligibility promptly and without undue delay (45 CFR § 155.310(e)(1); 42 CFR § 435.1200(b)(3)(iii)).

To assess whether an eligibility determination was untimely, NYSOH must base the time period from the date of application to the date NYSOH notifies the applicant of its decision (45 CFR § 155.310(e)(2)). However, if the applicant submits an incomplete application or there is not sufficient information for NYSOH to make an eligibility determination, then NYSOH must notify that applicant that more information is needed to complete the application (45 CFR § 155.310(k)(1)).

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the application (42 CFR § 435.912).

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 first issue is whether NYSOH's provided you with timely determination of your Medicaid eligibility as of November 11, 2017.

Your NYSOH account reflects that on July 25, 2017, August 17, 2017, August 24, 2017 and August 31, 2017 your agent accessed your account and was not able to submit an application on your behalf due to identity proofing failure. The record is devoid of what, if any, attempts your agent made to address this identity proof failure.

On November 9, 2017 your agent submitted to NYSOH by facsimile, a copy of your NYS driver license and a signed attestation form for manual identify proofing. The record reflects that on November 10, 2017, your agent submitted a

completed application for financial assistance for health insurance on your behalf. That application also requested help with paying medical bills for the months of August 2017, September 2017 and October 2017.

According to your NYSOH account, on November 10, 2017 you were determined eligible for Medicaid effective November 1, 2017 and were also determined eligible for Medicaid for the period of August 1, 2017 through October 31, 2017.

The record does not contain any evidence as to why your agent did not submit your NYS driver license and the manual identity proofing attestation form prior to November 9, 2017. As such, the record indicates that an initial completed application was submitted to NYSOH on November 10, 2017 and an eligibility determination based on that initial application was issued one day later, on November 11, 2017.

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the completed application. To assess whether an eligibility determination was untimely, NYSOH must base the time period from the date of the completed application to the date NYSOH notifies the applicant of its decision.

NYSOH issued an eligibility determination notice on November 11, 2017 that stated you were eligible for Medicaid effective November 1, 2017. Also on November 11, 2017 NYSOH issued an eligibility determination stating that you were eligible for retroactive Medicaid for the three-month period of August 1, 2017 through October 31, 2017. Since NYSOH issued eligibility determination notices one day from the date of your initial application was considered complete, the November 11, 2017 eligibility determination notices were timely.

The second issue is whether NYSOH properly determined that you were eligible for Medicaid no earlier than November 1, 2017.

An individual is eligible for Medicaid fee-for-service effective on the first day of the month if an individual was eligible any time during that month. As you were determined eligible for Medicaid on November 10, 2017, your Medicaid fee-for-service properly started on November 1, 2017.

Therefore, the November 11, 2017 eligibility determination notice stating that you were eligible for Medicaid effective November 1, 2017 is AFFIRMED

The third issue under review is whether NYSOH properly determine that you were eligible for retroactive Medicaid no earlier than August 1, 2017 through October 31, 2017.

Your completed application for financial assistance was submitted on November 10, 2017 and in that application, you requested help in paying for medical bills for August 2017, September 2017 and October 2017.

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 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.

Your authorized representative testified that you are seeking to be found eligible for Medicaid effective July 1, 2017 and to be eligible for retroactive Medicaid for the months of April 2017, May 2017 and June 2017 because you had medical services during those months.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size. The record reflects that you have attested to no yearly income and that you rely on family for financial support. Therefore, you would meet the financial eligibility for Medicaid for the months which your authorized representative has requested. However, as noted above, the record reflects that your initial application for financial assistance was submitted on November 10, 2017 and you were found eligible for Medicaid effective November 1, 2017. The record reflects that based on non-financial criteria you could only be considered for Medicaid for the previous three-months prior to November 2017, that is for August 2017, September 2017 and October 2017. Your request for Medicaid coverage for the months of April 2017, May 2017, June 2017 and July 2017 are outside of the three-month period for consideration for retroactive Medicaid based on a November 10, 2017 application.

Therefore, the November 11, 2017 eligibility determination notice that stated you were eligible for retroactive Medicaid for the period of August 1, 2017 through October 31, 2017 is AFFIRMED.

Decision

The November 11, 2017 eligibility determination notices were timely and are AFFIRMED.

Effective Date of this Decision: March 30, 2018

How this Decision Affects Your Eligibility

Your eligibility for Medicaid was effective as of November 1, 2017.

You were eligible for retroactive Medicaid fee-for-service for the months of August 2017, September 2017 and October 2017.

You are not eligible for Medicaid for the months of April 2017, May 2017, June 2017 and July 2017.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the Decision is final unless you submit an appeal request to the Federal Marketplace 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 Federal Marketplace. 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 have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:

Health Insurance Marketplace
Attn: Appeals
465 Industrial Blvd.
London, KY 40750-0061

- By fax: 1-877-369-0129

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 November 11, 2017 eligibility determination notices were timely and are AFFIRMED.

Your eligibility for Medicaid was effective as of November 1, 2017.

You were eligible for retroactive Medicaid fee-for-service for the months of August 2017, September 2017 and October 2017.

You are not eligible for Medicaid for the months of April 2017, May 2017, June 2017 and July 2017.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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).

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

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).

Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

اردو (Urdu)

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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).