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

Notice of Decision

Decision Date: May 6, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000005441

[redacted]

Dear [redacted],

On March 30, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's December 14, 2014 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 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

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NY State of Health Account ID: [redacted]
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Issues

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

> Was your appeal of NY State of Health's December 14, 2014 eligibility determination notice timely?

Procedural History

On December 14, 2014, NY State of Health (NYSOH) issued an eligibility determination notice stating that you were eligible to receive advance payments of the premium tax credit (APTC) of up to $72.00 per month, and eligible for cost-sharing reductions, effective January 1, 2015. Your two children were eligible to enroll in Child Health Plus with a $15.00 premium per month each effective January 1, 2015. The notice further stated that you and your children were not eligible for Medicaid because the income you reported to NYSOH was greater than the allowable income limit for that program.

On October 22, 2015, a renewal notice was issued explaining that NYSOH did not have enough information from state and federal data sources to determine if you could continue to get help paying for your health insurance. You were asked to provide updated information on your account for your household by December 15, 2015.

On December 7, 2015, NYSOH received your updated application for financial assistance. That, day a preliminary eligibility determination was prepared stating that you and your two children were eligible for Medicaid.

Also on December 7, 2015, you contacted NYSOH Account Review Unit and requested an appeal of your household's eligibility for financial assistance as of January 1, 2015.

On December 8, 2015, an eligibility determination notice was issued, based on the December 7, 2015 application, stating that you and your two children eligible for Medicaid effective January 1, 2016. This determination was based on your reported household income of $6,100.00.

On December 10, 2015, an enrollment confirmation notice was issued confirming your household's enrollment in a Medicaid managed care plan effective January 1, 2016.

On March 30, 2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) You testified that you expected to file your 2015 taxes with a tax filing status of Head of Household with qualifying individuals. You will claim your two children as dependents on that tax return.

2) You are seeking insurance for yourself and two children.

3) The application that was submitted on December 12, 2014 listed annual household income of $43,960.00, consisting of $5,800.00 you earn from your employment and $19,080.00 each of your two children receive in Social Security Survivor benefits. You testified that this amount was correct.

4) Your application states that you will not be taking any deductions on your 2015 tax return.

5) The application submitted on December 7, 2015, listed an annual household income of $6,100.00, consisting of income your will earn from employment. The application also states that your two children will receive $19,428.00 each in Social Security benefits. You testified that this amount was correct.

6) You appealed the fact that your children's Social Security Survivor benefits were included in your December 14, 2014 eligibility determination.

This appeal was recorded as having been submitted on December 7, 2015, according NYSOH records.

7) You are further seeking reimbursement of premiums paid for all of 2015.

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

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, (3) an eligibility determination for an exemption, (4) a failure by the Exchange to provide timely notice of an eligibility determination, and (5) a denial of a request to vacate dismissal made by the NYSOH Appeals Unit (45 CFR § 155.505).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR § 155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

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)).

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the FPL for the applicable family size (42 CFR § 435.118(c); New York Department of Social Services Administrative Directive 13ADM-03).

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)).

End of Tax Year Reconciliation

At the end of a tax year, a person who elects to take the advance premium tax credit to help pay for the cost of an insurance premium must file a tax return to reconcile any differences between the amount of income the person reported to NYSOH and their actual gross income for that year. A person who received less tax credit than her maximum entitlement, based on gross income, may receive an income tax refund, or owe less in taxes. A person who received more tax credit than his maximum entitlement, based on gross income, will owe the excess as an additional income tax liability (26 CFR § 1.36B-4).

Legal Analysis

The issue under review is whether your appeal of NYSOH's December 14, 2014 eligibility determination notice was timely.

On December 14, 2014, NYSOH issued an eligibility determination notice stating that you and your children were not eligible for Medicaid because the income you provided NYSOH was greater than the allowable income limit for that program.

The record reflects that the first time you contacted NYSOH to file a formal complaint or appeal about the income NYSOH used when determining your and your children's eligibility for financial assistance was December 7, 2015. Individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by the Marketplace. According to the credible evidence in the record, you did not contact the Marketplace to file a formal complaint or appeal until December 7, 2015, which is well beyond 60 days from the date of any of the above listed eligibility determination notices.

Since you did not timely appeal the use of your children's income from Social Security Survivor benefits in the December 14, 2014 eligibility determination for financial assistance until December 7, 2015, your appeal of that determination notice is DISMISSED.

However, on December 8, 2015, an eligibility determination notice was issued stating that you and your two children were eligible for Medicaid effective January 1, 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.

Therefore, your case is RETURNED to NYSOH to determine the possibility of your and your children's eligibility for Retroactive Medicaid for the three months prior to January 1, 2016.

However, please be advised that if you are eligible to do so and elect to have your coverage converted to Medicaid for months in which you were enrolled in a qualified health plan, there could be adverse effects if any or all of the providers you utilized during that period do not accept Medicaid. This is because there is the potential that if your previous enrollment in a qualified health plan is cancelled, payments made by your health plan to providers for care you received could be demanded back by your plan. Your providers might then bill you directly for any services not covered by Medicaid.

Decision

Your appeal of the December 14, 2014, determination notice is DISMISSED.

You may request to have your household's Medicaid coverage which was effective January 1, 2016, made retroactive for the three months prior to January 1, 2016.

Your case is RETURNED to NYSOH to determine the possibility of your and your children's eligibility for Retroactive Medicaid for the three months prior to January 1, 2016.

Effective Date of this Decision: May 6, 2016

How this Decision Affects Your Eligibility

You and your two children remain eligible for Medicaid effective January 1, 2016.

Your case is being sent back to NYSOH to determine your and your children's eligibility for Retroactive Medicaid coverage for the months prior to January 1, 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
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  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

Your appeal of the December 14, 2014, determination notice is DISMISSED.

You may request to have your household's Medicaid coverage which was effective January 1, 2016, made retroactive for the three months prior to January 1, 2016.

You and your two children remain eligible for Medicaid effective January 1, 2016.

Legal Authority

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A Copy of this Decision Has Been Provided To:

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