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

Notice of Decision

Decision Date: May 1, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013686

[redacted]

Dear [redacted],

On April 19, 2017, you appeared, with the assistance of Spanish interpreters, by telephone at a hearing on your appeal of NY State of Health's July 17, 2016 disenrollment notice, and NYSOH's failure to determine you eligible for retroactive Medicaid for the month of September 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.

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

Decision

Decision Date: May 1, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013686

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly terminate your Essential Plan coverage effective July 31, 2016?
>
> Did NYSOH fail to determine you eligible for retroactive Medicaid coverage for the month of September 2016?

Procedural History

On June 3, 2016, NYSOH issued a notice stating, in relevant part, that it was time to renew your health insurance. That notice stated that based on information from federal and state sources, NYSOH could not make a decision about whether you qualify for financial help paying for your health coverage, and that you needed to update your account by July 15, 2016 or you may lose the financial assistance you were receiving.

No updates were made to your NYSOH account before by July 15, 2016.

On July 17, 2016, NYSOH issued an eligibility determination notice, in relevant part, that you were newly eligible to purchase a qualified health plan at full cost effective as of August 1, 2016.

Also on July 17, 2016, NYSOH issued a disenrollment notice stating, in relevant part, that your Essential Plan would terminate effective July 31, 2016.

On October 12, 2016, your NYSOH account was updated.

On October 13, 2016, NYSOH issued an eligibility determination notice, in relevant part, that you were eligible to enroll in the Essential Plan for a limited time effective as of October 1, 2016. The notice directed you to submit proof of income by October 27, 2016.

Also on October 13, 2016, NYSOH issued an enrollment notice confirming, in relevant part, that you were enrolled in an Essential Plan 4 health plan, with a plan enrollment start date of October 1, 2016.

On November 30, 2016, your NYSOH account was updated.

On December 1, 2016, NYSOH issued a notice confirming that on November 30, 2016, you requested a telephone hearing. The notice stated that you were seeking to be found "eligible for Medicaid backdating for previous months."

On April 19, 2017, you had a telephone hearing, with the assistance of Spanish interpreters, with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was left open until April 19, 2017 to allow you to submit additional documentation.

On April 19, 2017, you faxed fourteen-pages to NYSOH Appeals Unit. That documentation has been incorporated into the record and will be referred to as "Appellant Exhibit A." The record is now complete and closed.

Findings of Fact

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

1) Your account reflects that you receive your notices from NYSOH by regular mail.

2) You testified that you did not receive a notice from NYSOH directing you update your NYSOH account in order to renew your financial assistance.

3) Your account reflects that it was not updated until October 12, 2016.

4) According to your November 30, 2016, you indicated that you wanted help paying for medical bills from the last three months.

5) You testified that you filed a 2016 federal income tax return, with the tax status of single, and claimed one of your children as a dependent on that return.

6) You testified that you were unemployed from February 2016 through September 2016 and did not receive any income during that time.

7) You submitted earnings statements from your employer, [redacted] You were issued gross pay of:

(a) $378.70 on 10/07/2016, with year-to-date (YTD) of $518.70;
(b) $330.80 on 10/14/2016;
(c) $388.00 on 10/21/2016;
(d) $399.20 on 10/28/2016

(Appellant Exhibit A pgs. 10-13).

8) You submitted a statement of account, dated November 2, 2016, from [redacted]. The notice states you are being billed:

(a) $102.00 for a [redacted] on [redacted]
(b) $1,500.00 for a [redacted]
(c) $48.00 for [redacted]
(d) $48.00 for [redacted] on
(e) $150.00 for [redacted] on [redacted]

(Appellant Exhibit A pg. 14).

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

Applicable Law and Regulations

Essential Plan Renewal

In general, NYSOH will review Essential Plan eligibility no more frequently than once every 12 months from the effective date of eligibility as long as enrollees are under age 65, not enrolled in minimum essential coverage, remain state residents, and do not have any changes in circumstances. An individual enrolled in the Essential Plan shall have his or her coverage continued until the end of the 12 month period, provided he or she does not lose eligibility by reason of citizenship status, lack of state residence, failure to provide a valid social security number, providing inaccurate information that would affect eligibility when requesting or renewing health coverage, failure to make the applicable premium payment, or changes in circumstances (42 CFR § 600.340(a); 42 CFR § 600.320(d); NY Social Services Law § 369-gg(3) and (4)(d)); New York's Basic Health Plan Blueprint, pp. 8 and 16, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must

require the qualified individual to report any changes within 30 days (42 CFR § 600.340(e). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates that may have been provided by the individual (42 CFR §600.345; (NY Social Services Law § 369-gg(4)(c); 45 CFR § 155.335(g); New York's Basic Health Plan Blueprint, p. 17, as approved January 2016; *see* https://www.medicaid.gov/basic-health-program/basic-health-program.html).

For individuals seeking enrollment in an Essential Plan, New York State has elected to follow the same rules that NYSOH uses in determining effective dates for individuals seeking enrollment in qualified health plans (NY Social Services Law § 369-gg(4)(c); New York's Basic Health Plan Blueprint, p. 16, as approved January 2016; *see* https://www.medicaid.gov/basic-health-program/basic-health-program.html).

The effective date of coverage by an Essential Plan is determined by the date on which an applicant selects a plan for enrollment. For individuals who are eligible for enrollment, NYSOH must generally ensure that coverage is effective the first day of the following month for selections received by NYSOH from the first to the fifteenth of any month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(i); *see also* 42 CFR § 600.320). For selections received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(ii)).

<u>De Novo Review</u>

The NYSOH Appeals Unit must review each appeal de novo and "consider all relevant facts and evidence adduced during the appeals process" (45 CFR § 155.535(f)). "*De novo review* means a review of an appeal without deference to prior decisions in the case" (45 CFR § 155.500).

<u>Medicaid - Adults</u>

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); NY Social Services Law § 366(1)(b)).

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).

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 Federal Register 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 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 under review is whether NYSOH properly terminated your Essential Plan coverage effective July 31, 2016.

Generally, NYSOH will redetermine a qualified individual's eligibility for the Essential Plan once every 12 months without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency. NYSOH's June 3, 2016, renewal notice stated that there was not enough information to determine whether you were eligible to continue your financial assistance for health insurance, and that you needed to supply additional information by July 15, 2016, or your financial assistance may end.

Because there was no timely response to this notice, you were terminated from your Essential Plan effective July 31, 2016.

You testified that you did not receive any notice from NYSOH telling you that you needed to update the information in your NYSOH account. You testified, and your NYSOH account confirms, that you elected to receive notifications by regular mail. However, there is no evidence in the record that any of the notices that were sent to your mailing address were returned as undeliverable.

Therefore, the record reflects that NYSOH properly notified you of your annual renewal and that information in your NYSOH account needed to be updated in order to ensure your enrollment in your health plan and eligibility for financial assistance would continue.

Therefore, the July 17, 2016, disenrollment notice is AFFIRMED.

The second issue under review is whether NYSOH failed to determine you eligible for Medicaid in the month of September 2016.

The record does not contain a notice of eligibility determination or redetermination regarding the issue of whether or not you qualify for retroactive Medicaid for the month of September 2016. It does contain the notice acknowledging your appeal request, which demonstrates that on November 30, 2016, you were appealing to be found “eligible for Medicaid backdating for previous months.”

Here, the lack of a notice of eligibility determination on the issue of retroactive Medicaid for the month of September 2016 does not prevent the Appeals Unit from reaching the merits of the case or constitute material error. Under 45 CFR § 155.505(b), you are as entitled to appeal NYSOH’s failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to the notice of eligibility determination had it been issued. Therefore, the issue under review is whether you were properly denied retroactive Medicaid coverage for September 2016.

According to your October 13, 2016 eligibility determination and enrollment notices, you were determined eligible for and enrolled in an Essential Plan effective October 1, 2016. Furthermore, your NYSOH account reflects that you wanted help paying for medical bills from the last three months.

When an individual files an application for financial assistance, their eligibility for retroactive Medicaid depends on the date of application. It is not contingent whether that application resulted in the applicant being determined eligible for Medicaid. An individual, who has filed an application for financial assistance through NYSOH, has the right to be evaluated for Medicaid for the three months before the month of their application.

You testified that you filed a 2016 federal income tax return, with the tax status of single, and claimed one dependent on that tax return. Therefore, you are in a two-person household.

Medicaid can be provided through NYSOH to adults who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size, which is a monthly income of $1,843.00 for a two-person household.

The available record supports that you were unemployed from February 2016 through September 2016, and began working at [redacted] in September 2016. The earliest earnings statement submitted states that you were

issued $378.70 on 10/07/2016, with YTD gross pay of $518.70. Therefore, the credible record supports that you were issued $140.00 or less gross pay in September 2016. Based on the available record, your September 2016 household income did not exceed the Medicaid income threshold.

Therefore, NYSOH failed to determine you eligible for retroactive Medicaid benefits for the month of September 2016. Your case is RETURNED to NYSOH to enroll you in Medicaid coverage for the month of September 2016.

You testified and provide documentation to show that you are being billed for medical services that were received in October 2016. Your NYSOH account reflects that you have been found eligible for and enrolled in the Essential Plan for the month of October 2016. Your case is RETURNED to NYSOH's Plan Management Unit to ensure that the health plan is properly paying the medical services received in October 2016.

Decision

The July 17, 2016 disenrollment notice is AFFIRMED.

NYSOH failed to determine you eligible for retroactive Medicaid for the month of September 2016.

Your case is RETURNED to NYSOH to enroll you in Medicaid coverage for the month of September 2016.

Your case is RETURNED to NYSOH's Plan Management Unit to ensure that the health plan is properly paying the medical services received in October 2016.

Effective Date of this Decision: May 1, 2017

How this Decision Affects Your Eligibility

You were properly disenrolled from your Essential Plan effective July 31, 2016.

NYSOH failed to determine you eligible for Medicaid coverage for the month of September 2016.

If You Disagree with this Decision (Appeal Rights)

This 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

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).

The July 17, 2016 disenrollment notice is AFFIRMED.

NYSOH failed to determine you eligible for retroactive Medicaid for the month of September 2016.

Your case is RETURNED to NYSOH to enroll you in Medicaid coverage for the month of September 2016.

Your case is RETURNED to NYSOH's Plan Management Unit to ensure that the health plan is properly paying the medical services received in October 2016.

You were properly disenrolled from your Essential Plan effective July 31, 2016.

NYSOH failed to determine you eligible for Medicaid coverage for the month of September 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).

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।

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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.

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