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

# Notice of Decision

Decision Date: June 2, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015370

[redacted]

Dear [redacted]

On May 2, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 9, 2016 enrollment confirmation notice and February 14, 2017 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 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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# Decision

Decision Date: June 2, 2017

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:

> Did NY State of Health (NYSOH) properly determine that your enrollment in your Medicaid Managed Care plan was effective January 1, 2017?
>
> Did NYSOH properly determine that you were not eligible for Medicaid for September 1, 2016 through October 31, 2016?

## Procedural History

On October 18, 2016, NYSOH issued a renewal notice stating that you were re-enrolled in your current health plan for another year and that you qualified for up to $254.05 of advance premium tax credits, effective January 1, 2017. The notice further stated that if there was a mistake or changes that needed to be made that you should update your account between November 16, 2016 and December 15, 2016 so that your new plan would be effective January 1, 2017.

On November 28, 2016, NYSOH received your updated application for financial assistance for the 2017 coverage year.

On November 29, 2016, NYSOH issued a notice of eligibility determination, based on your November 28, 2016 application, stating that you were eligible for Medicaid, effective November 1, 2016.

On December 9, 2016, NYSOH issued an enrollment confirmation notice, stating that you were enrolled in a Medicaid Managed Care plan, and that your coverage would start on January 1, 2017.

On January 31, 2017, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for September and October 2016.

Also on January 31, 2017, you spoke to NYSOH's Account Review Unit and filed an appeal, insofar as you did not have any type of Medicaid coverage in September or October 2016.

On February 14, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid for September 1, 2016 through October 31, 2016 because the monthly household income of $1,750.00 is over the allowable monthly income limit of $1,367.00.

On May 2, 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 up to May 17, 2017, to allow you to submit supporting documents.

On May 12, 2017, NYSOH received documentation and it was incorporated into the record as Appellant's Exhibit #1. As of May 17, 2017, the Appeals Unit did not receive any further documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day.

## Findings of Fact

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

1) You testified that you are seeking a September 1, 2016 start date for your Medicaid Managed Care plan or retroactive Medicaid from September 1, 2016 through October 31, 2016.

2) You testified that you expect to file your 2017 federal income tax return as single, and claim no dependents.

3) You submitted an application for financial assistance on January 31, 2017, requesting for help paying for bills in September and October 2016. That application states that for September and October 2016 your monthly income was $1,750.00. You testified that amount was incorrect.

4) You testified that you are paid bi-weekly.

5) You testified that you did not work in October 2016, and that you received disability benefits. You testified that you believe you received these benefits from your employer and that it would be part of your paystubs.

6) On November 10, 2016, a paystub dated September 30, 2016 for a gross pay amount of $1,379.32 was posted to your online account.

7) On November 18, 2016, a letter dated October 31, 2016 from your employer was posted to your online account, stating that you had been out of work on a [redacted] leave of absence beginning September 26, 2016, and that your anticipated return to work was November 14, 2016.

8) On May 12, 2017, you faxed four paystubs:
    a. dated September 16, 2016 for a gross pay amount of $1,033.34
    b. dated November 10, 2016 for a gross pay amount of $552.80
    c. dated November 25, 2016 for a gross pay amount of $622.23
    d. dated December 9, 2016 for a gross pay amount of $2,842.11

9) The record does not contain any additional paystubs, or any documentation regarding disability benefits received in October 2016.

10) You testified, and the record reflects, that you selected your Medicaid Managed Care Plan on December 8, 2016, and that your enrollment was effective on January 1, 2017.

11) You testified that you want your Medicaid Managed Care plan to begin on September 1, 2016.

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

## Applicable Law and Regulations

Medicaid

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 $11,880.00 for a one-person household (81 Fed. Reg. 4036).

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)).

Medicaid Managed Care (MMC) plan enrollments received on or before the fifteenth day of the month are effective the first day of the following month. Enrollments received after the fifteenth day of the month are effective the first day of the second following month (Medicaid Managed Care Model Contract (Appendix H-6(b)(ii) & (iii), effective 3/1/2014 – 2/28/2019; *see* 42 USC § 1315; § 364-j(1)(c); 18 NYCRR § 360-10.3(h), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

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 properly determined that your enrollment in a Medicaid Managed Care plan was effective January 1, 2017.

You testified that you were first able to enroll in a MMC plan on December 8, 2016.

The date on which a MMC plan can take effect depends on the day a person selects the plan for enrollment. A plan that is selected from the first day to and including the fifteenth day of a month will go into effect on the first day of the following month. A plan that is selected on or after the sixteenth day of the month will go into effect on the first day of the second following month.

On December 8, 2016, you were enrolled in a MMC plan, so it properly took effect on the first day of the following month; that is, on January 1, 2017.

Therefore, the December 9, 2016 enrollment confirmation notice stating that your enrollment in your MMC plan would be effective January 1, 2017, was correct and must be AFFIRMED.

The second issue is whether NYSOH properly determined that you were not eligible for Medicaid for September 1, 2016 through October 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.

You submitted an application for financial assistance on January 31, 2016 and requested help in paying for medical bills for September 1, 2016 to October 31, 2016. Your application listed a monthly income of $1,750.00 for September and October 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.

You testified that you are seeking Medicaid from September 1, 2016 to October 31, 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 September and October 2016, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,367.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during September and October 2016.

You testified that you are paid bi-weekly. You submitted multiple paystubs: dated September 16, 2016 for a gross pay amount of $1,033.34, dated September 30, 2016 for a gross pay amount of $1,379.32, dated November 10, 2016 for a gross pay amount of $552.80, dated November 25, 2016 for a gross pay amount of $622.23, and dated December 9, 2016 for a gross pay amount of $2,842.11. The record does not contain any additional paystubs or any documentation confirming the amount of disability benefits you received in October 2016.

Regarding your earnings in September 2016, if you are paid biweekly and were paid on September 16, 2016 and September 30, 2016, you would have also been paid on September 2, 2016. The record does not contain a paystub dated September 2, 2016. Additionally, you testified that you received disability benefits in October 2016 through your employer, but did not provide documentation regarding the amount of benefits you received. Therefore, there is insufficient documentation to prove your income for September or October 2016.

Since there is insufficient documentation in the record to prove your income in September and October 2016, NYSOH properly relied on the information provided in the application and determined that you were not eligible for Medicaid coverage during those month. Therefore, the February 14, 2017 eligibility determination stating that you were not eligible for Medicaid from September 1, 2016 to October 31, 2016, is correct and is AFFIRMED.

## Decision

The December 9, 2016 enrollment confirmation notice is AFFIRMED.

The February 14, 2017 eligibility determination notice is AFFIRMED.

## Effective Date of this Decision: June 2, 2017

## How this Decision Affects Your Eligibility

This decision does not change your eligibility.

The effective date of your Medicaid Managed Care plan is January 1, 2017.

NYSOH properly determined that you were not eligible for Medicaid from September 1, 2016 to October 31, 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

The December 9, 2016 enrollment confirmation notice is AFFIRMED.

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 February 14, 2017 eligibility determination notice is AFFIRMED.

This decision does not change your eligibility.

The effective date of your Medicaid Managed Care plan is January 1, 2017.

NYSOH properly determined that you were not eligible for Medicaid from September 1, 2016 to October 31, 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)**

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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।

**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)**

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).

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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