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

Notice of Decision

Decision Date: June 15, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015470

[redacted]

Dear [redacted],

On May 19, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 3, 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 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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nystateofhealth
The Official Health Plan Marketplace

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

Decision

Decision Date: June 15, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015470

Issues

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

> Did NY State of Health (NYSOH) properly determine your and your child's eligibility for Medicaid for the months of July 2016 through September 2016?
>
> Did NYSOH properly determine that you and your child were not eligible for Medicaid for November 2016 through January, 2017?

Procedural History

On February 2, 2017, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for November 2016, and January 2017. That same day, a preliminary determination was made based on your application that stated you were eligible for the Essential Plan and your child was eligible for Child Health Plus effective March 1, 2017. The household income listed in this application was $27,000.00.

Also on February 2, 2017, you spoke to NYSOH's Account Review Unit and appealed the timeliness of NYSOH's determination and requested an appeal regarding a defect within the Marketplace.

On February 3, 2017, an eligibility determination notice was issued, based on your February 2, 2017 application, stating that you were eligible for the Essential Plan with a $20.00 per month premium and your child was eligible for Child Health Plus for a cost of $9.00 per month starting March 1, 2017.

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Also on February 3, 2017, an eligibility determination notice was issued stating you were not eligible for Medicaid for November 1, 2016 through November 30, 2016 and not eligible for Medicaid for January 1, 2017 through January 31, 2017 because the monthly household income you provided of $2,250.00 was over the allowable monthly income limit of $1,843.00 for those months.

On February 3, 2017, an enrollment notice was issued confirming your February 2, 2017 enrollment in the Essential Plan, and your child's Child Health Plus plan with an effective date of March 1, 2017.

On May 19, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During your hearing, you amended your appeal to include that you were seeking Medicaid eligibility for you and your child back to July, 2016. The record was developed during the hearing and held open up to 15 days, to allow you to submit supporting documents showing your gross income for the months of November 2016 through January, 2017.

As of June 5, 2017, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. 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 testified that you are seeking Medicaid for you and your child going back to July, 2016.

2) Your child is [redacted] years old.

3) You testified you attempted to complete your application for financial assistance with the aid of an application counselor in July 2016.

4) You testified the first time you applied to NYSOH was in July, 2016.

5) You testified you had [redacted] visits in September, November, and December, 2016.

6) You testified between you and your daughter you have approximately $3,974.00 in outstanding medical bills. You were not sure of the exact dates they were incurred or the amounts.

7) You testified you were not sure if you could provide proof of your income for the prior three months from your February 2, 2017 application as you were "not on the best terms" with your former employer.

8) You testified you make approximately $14.00 an hour with an average of 35 hours a week.

9) Your February 2, 2017 application shows you entered amounts of $2,250.00 in income for the months of January 2017, and November 2016.

10) You testified that you expect to file your 2017 federal income tax return as single, and claim one dependent.

11) You had three accounts with NYSOH, one inactive, and two that are active. In two of these accounts no applications for insurance were submitted.

12) The only record of an application being made was the February 2, 2017 application under account [redacted].

13) The record supports an account [redacted] was created June 26, 2015, with address details being verified October 27, 2016, and January 5, 2017, but no application being submitted.

14) There is a record of an incident being filed for [redacted] on January 11, 2017 for two open accounts, and the account [redacted] was closed, with no appeal filed.

15) You reside in Kings 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 2016 FPL, which is $16,020.00 for a two-person household (81 Fed. Reg. 4036).

<u>Medicaid for Children</u>

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 federal poverty level (FPL) for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

In the case of an individual who expects to file a tax return and does not expect to be claimed by another taxpayer, the household consists of the taxpayer and all persons whom such individual expects to claim as a tax dependent (42 CFR § 435.603(f)(1).

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).

<u>Retroactive Medicaid</u>

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)).

<u>Valid and Timely Appeals</u>

An applicant has the right to appeal to NYSOH’s Appeals Unit: (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 45

CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

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)).

Legal Analysis

The first issue under review is whether NYSOH properly determined your and your child's eligibility for Medicaid for the months of July 2016 through September 2016.

During your telephone hearing, you amended your appeal to include the fact that you were seeking retro Medicaid for you and your child going back to July, 2016. You testified you were unable to submit a completed application due to system limitations experienced when applying to NYSOH in June, 2016. However, there is no record of any of your accounts being accessed or any account created in June 2016.

The only completed application that is available is from February 2, 2017.

Medicaid can only be provided to an individual who has filed an initial application. Without any prior application being submitted, an evaluation of you and your child's eligibility for retro Medicaid can only proceed with the three months prior to your application on February 2, 2017, that is for November, December, 2016 and January, 2017.

Therefore, there has been no valid appeal filed of an eligibility determination, or an application submitted and completed prior to February 2, 2017. As such, an appeal on the issue for Medicaid for you and your child going back to July, 2016 is invalid and is DISMISSED.

The second issue under review is whether NYSOH properly determined that you and your child were not eligible for Medicaid for the months of November 2016 through January 2017.

You are in a two-person household; you file your taxes with a tax filing status of single and claim one dependent on your tax return.

You submitted an application for financial assistance on February 2, 2017 and requested help in paying for medical bills for November 2016 to January, 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 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.

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, December, and January, 2017, you both would have needed to meet the non-financial criteria and you would need an income no greater than 138% and your child no greater than 154% of the FPL per month. In an analysis of a monthly basis for financial eligibility you would have to have an income no greater than $1,843.00 for yourself, and no greater than $2,056.00 for your child, per month.

There is no indication in the record that you or your child would have been ineligible for Medicaid based on non-financial criteria during the months of November, 2016, through January 2017.

The determination issued on February 3, 2017 finding you ineligible for retro Medicaid for November 2016, and January 2017 indicated you had earned $2,250.00 for the months of November 2016, and January, 2017. There is no record of your attested earned income for the month of December 2016, other than your testimony at your hearing.

After your hearing, you were asked to provide additional income documentation within 15 days to show your gross income for the months of November, and December 2016, and January 2017. As of the close of the record no documentation was received and a determination can only be made based upon your testimony and prior application on February 2, 2017.

Since your monthly gross income of $2,250.00 as attested to in your February 2, 2017 application and confirmed by your testimony was more than the $1,843.00 monthly Medicaid limit for November 2016, December 2016, and January 2017, NYSOH properly determined that you were not eligible for Medicaid coverage during those months.

Since your monthly gross income of $2,250.00 was more than the $2,056.00 monthly Medicaid limit for November 2016, December 2016, and January 2017, NYSOH properly determined your child was not eligible for Medicaid coverage during those months.

Therefore, the February 3, 2017 eligibility determination stating that you were not eligible for Medicaid in the month of November 2016 and January 2017, is correct and AFFIRMED, the notice is MODIFIED to state that your child is also not eligible for Medicaid in the months of November 2016 and January 2017.

Decision

Your appeal for retro Medicaid for you and your child for the months of July, 2016 through September, 2016 is DISMISSED.

The February 3, 2017 eligibility determination is AFFIRMED the notice is MODIFIED to state that your child is also not eligible for Medicaid in the months of November 2016 and January 2017.

Effective Date of this Decision: June 15, 2017

How this Decision Affects Your Eligibility

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

You are not eligible for Medicaid in the month of January, 2017.

Your child is ineligible for Medicaid for the month of November, and December 2016.

Your child is not eligible for Medicaid in the month of January, 2017.

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

Your appeal for retro Medicaid for you and your child for the months of July, 2016 through September, 2016 is DISMISSED.

The February 3, 2017 eligibility determination is AFFIRMED the notice is MODIFIED to state that your child is also not eligible for Medicaid in the months of November 2016 and January 2017.

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

You are not eligible for Medicaid in the month of January, 2017.

Your child is ineligible for Medicaid for the month of November, and December 2016.

Your child is not eligible for Medicaid in the month of January, 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)

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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 निःशुल्क 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.

(Urdu)اردو

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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