



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

Notice of Decision

Decision Date: June 26, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000015532

[REDACTED]

Dear [REDACTED],

On May 9, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 18, 2017 eligibility determination notice, insofar as you were not found eligible for retroactive Medicaid during the month of August 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 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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Decision

Decision Date: June 26, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000015532

[REDACTED]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

Did NY State of Health (NYSOH) properly determine that you were not eligible for Medicaid for December 2016, and that you were not eligible for retroactive Medicaid for the period from August 1, 2016 to August 31, 2016?

Procedural History

On November 1, 2016, NYSOH received your initial application for financial assistance with health insurance.

On November 2, 2016, NYSOH issue a notice stating that the information contained in the November 1, 2016 application did not match what NYSOH received from state and federal data sources. You were requested to provide income documentation by November 16, 2016 so that your eligibility determination could be confirmed. In addition, you were requested to provide proof of your citizenship status by January 30, 2017. The notice cautioned that if you missed the above referenced due dates, NYSOH would not be able to determine your eligibility for health insurance coverage.

On November 11, 2016, NYSOH received (1) a copy of your U.S. Passport issued to you on August 27, 2014, valid through August 26, 2024, and (2) a letter issued by your employer, [REDACTED], dated November 8, 2016, confirming that you were employed from June 20, 2016 until September 15, 2016.

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On November 29, 2016, NYSOH issued an eligibility redetermination notice stating that you were found eligible to purchase a qualified health plan (QHP) at full cost, effective January 1, 2017, because NYSOH had not received the requested documentation by the due date to verify your income.

On December 27, 2016, NYSOH received an update to your application for financial assistance with health insurance.

Also on December 27, 2016, NYSOH received a duplicate copy of the letter issued to you by your employer, dated November 8, 2016, stating that you were employed from June 20, 2016 until September 15, 2016.

On December 28, 2016, NYSOH issue a notice stating that the information contained in the December 27, 2016 application did not match what NYSOH received from state and federal data sources. You were requested to provide income documentation by January 11, 2017 so that your eligibility determination could be confirmed. The notice cautioned that you missed the above referenced due dates, NYSOH would not be able to determine your eligibility for health coverage.

On January 17, 2017, NYSOH redetermined your eligibility.

On January 18, 2017, NYSOH issued a notice of eligibility redetermination notice stating that you were eligible for Medicaid. This eligibility was effective as of December 1, 2016.

On February 3, 2017, NYSOH received an update to your application in which you requested help in paying for medical bills from the last three months. In response to your application, NYSOH prepared a preliminary eligibility determination notice stating that you were no longer eligible for Medicaid; however, your Medicaid coverage would continue until November 30, 2017 because certain individuals who qualify for Medicaid get coverage for 12 continuous months from the date they were last determined eligible. No notice of eligibility determination was issued with respect to your request for retroactive Medicaid.

Also on February 3, 2017, NYSOH you spoke to NYSOH's Account Review Unit and appealed the initial start date of your Medicaid coverage insofar as it did not begin on November 1, 2016, and appealed that you had not been granted retroactive Medicaid coverage during the month of August 2016.

On February 4, 2017, NYSOH issued an eligibility determination notice stating that you were no longer eligible for Medicaid; however, your Medicaid coverage would continue until November 30, 2017 because certain individuals who qualify for Medicaid get coverage for 12 continuous months from the date they were last

determined eligible. However, no determination was issued with respect to your request for retroactive Medicaid.

On May 9, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was held open until May 24, 2017, to allow you to submit as supporting documentation all earnings statements you received from your employer during the month of August 2017.

On May 24, 2017, NYSOH received (1) a copy of an earnings statement issued to you by your employer, [REDACTED], on August 12, 2016, and (2) a letter stating that you were still awaiting the other earnings statement issued to you by your employer during August 2016.

As of May 24, 2017, the Appeals Unit did not receive any additional documents from you. 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 the period from August 1, 2016 to August 31, 2016.
- 2) You testified that, while your application correctly reflects that you will not be filing a tax return, you are in fact claimed as a dependent by your mother, who is not listed on your application.
- 3) You submitted your initial application for financial assistance on November 1, 2016.
- 4) In response to NYSOH's request, on November 11, 2016, you provided a copy of your U.S. Passport, and a letter issued by your employer confirming that you were no longer working as of September 15, 2016.
- 5) You testified that based on the documentation you provided on November 11, 2016, NYSOH should have found you eligible for Medicaid coverage effective November 1, 2016, not December 1, 2016. You further testified that based on a November 1, 2016 start date of your Medicaid coverage, you should have been eligible for retroactive Medicaid coverage during the month of August 2016.
- 6) On May 24, 2017, you uploaded an earnings statement issued by your employer dated August 12, 2016, which reflects a gross pay amount of

\$1,110.52. You also provided a written statement indicating that you were still awaiting your employer to provide the additional earnings statements you received during August 2016.

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

Applicable Law and Regulations

Medicaid

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 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)).

Verification Process

For individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income (45 CFR §155.320(c)(1)(i), 42 CFR § 435.945).

If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR §155.315(f) 42 CFR § 435.952).

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)).

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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 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 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 issue under review is whether NYSOH properly determined that you were eligible for Medicaid no earlier than December 1, 2016, and that you were not eligible for retroactive Medicaid for the period from August 1, 2016 to August 31, 2016.

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income.

If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence.

You provided NYSOH with your initial application on November 1, 2016. The income amount that was entered into this application did not match federal and state data sources. As a result, NYSOH asked that you submit additional documentation to confirm your income.

You did submit some income documentation on November 11, 2016.

However, contrary to the information contained in your NYSOH application, you testified that it was true that while you did not file taxes for 2016, your mother claimed you as a dependent. Accordingly, since your mother's income information is not contained within your application, there is insufficient evidence to determine whether you would have been eligible for Medicaid in November 2016 or August 2016.

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).

Decision

There is no basis to revise the January 18, 2017 eligibility determination notice, which is therefore AFFIRMED. There is also insufficient evidence for NYSOH to assess whether you would have been eligible for retroactive Medicaid during the month of August 2016.

Effective Date of this Decision: June 26, 2017

How this Decision Affects Your Eligibility

Your eligibility for Medicaid has not changed.

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 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).

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

There is no basis to revise the January 18, 2017 eligibility determination notice, which is therefore AFFIRMED. There is also insufficient evidence for NYSOH to assess whether you would have been eligible for retroactive Medicaid during the month of August 2016.

Your eligibility for Medicaid has not changed.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&btumi ama wo obi a okyerE 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 کرم 1-855-355-5777 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 דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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