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

Notice of Decision

Decision Date: May 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015587

[redacted]

Dear [redacted]

On May 4, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 19, 2016 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).

This page intentionally left blank.

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).

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

Decision

Decision Date: May 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015587

[redacted]

Issues

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

> Did NY State of Health properly determine that you were eligible for the Essential Plan, effective December 1, 2016?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid?

Procedural History

On September 23, 2016, NY State of Health (NYSOH) received your application for financial assistance with health insurance.

On September 25, 2016, NYOSH issued a notice stating that the information in your application did not match federal and state data sources and more information was needed to confirm the information in your application. You were directed you to submit income documentation by October 8, 2016.

On October 18, 2016, NYSOH received your updated application for financial assistance with health insurance.

On October 19, 2016, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan, for a limited time, effective December 1, 2016. This notice further directed you to submit income documentation by January 16, 2016 to confirm your eligibility.

Also on October 19, 2016, NYSOH issued a plan enrollment notice confirming your enrollment in an Essential Plan, effective December 1, 2016.

On December 13, 2016, you uploaded a document to your NYSOH account.

On December 30, 2016, NYSOH validated and verified the income documentation you submitted and updated your NYSOH account.

On December 31, 2016, NYOSH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan, effective February 1, 2017.

Also on December 31, 2016, NYSOH issued a plan enrollment notice confirming your enrollment in an Essential Plan, effective December 1, 2016.

On February 6, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as you were not found eligible for Medicaid and you were not found eligible for Medicaid for the month of September 2016.

On May 4, 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 to May 19, 2017, to allow you to submit supporting documents.

On May 18, 2017, NYSOH's Appeals Unit received a fax containing income documentation, and the record was closed upon receipt. Your fax was made part of the record as "Appellant's Exhibit #1."

Findings of Fact

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

1) You are seeking insurance for yourself.

2) You testified that you expect to file your taxes with a tax filing status of single. You will claim no dependents on that tax return.

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

4) The application that was submitted on September 23, 2016 listed an expected annual household income of $13,000.00, consisting of income you earn from your employment.

5) The application that was submitted on October 18, 2016 listed an annual household income of $16,849.00, consisting of income you earn from your employment. You testified that this amount is incorrect.

6) You testified that you work as an [redacted] for a [redacted].

7) You testified that you are paid daily and the amount of income varies depending on the number of [redacted] assignments you take.

8) You testified that you would like to be found eligible for Medicaid, and not the Essential Plan.

9) You testified that you are looking for retroactive Medicaid for September 2016 because you have unpaid medical bills from that month.

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

Applicable Law and Regulations

Verification Process

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 (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).

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45

CFR § 155.300(a)). On the date of your application, that was the 2015 FPL, which is $11,770.00 for a one -person household (80 Federal Register 3236, 3237).

A person who has a household income that is at or below 150% of the FPL has a $0.00 premium contribution (New York's Basic Health Plan Blueprint, p. 21, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a $20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016).

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).

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).

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 under review is whether NYSOH properly determined that you were eligible for the Essential Plan, effective December 1, 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 updated your NYSOH account on September 23, 2016. The application that was submitted on September 23, 2016 listed an expected annual household income of $13,000.00.

The income amount that was entered into this application did not match federal and state data sources. As a result, NYOSH asked that you submit additional documentation to confirm your household income.

However, instead of submitting income documentation to confirm the income amount listed in the September 23, 2016 application, you submitted an updated application on October 18, 2016. The application that was submitted on October 18, 2016 listed an annual household income of $16,849.00. You testified that this amount was incorrect, but NYSOH relied upon this information when determining your eligibility.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $11,770.00 for a one-person household. Since an annual household income of $16,849.00 is 143/15% of the 2015 FPL, NYSOH properly found you to be eligible for the Essential Plan based on the information in your October 18, 2016 application.

The second issue under review is whether NYSOH properly determined that you were ineligible for Medicaid.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 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. On the date of your application, the relevant FPL was $11,880.00 for a one-person household. Since $16,849.00 is 141.83% of the 2016 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your October 18, 2016 application.

However, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

Your application from October 18, 2016 states that your expected annual income is $16,849.00 and NYSOH relied upon this information when making your eligibility determination. Using the information provided in your October 18, 2016 application, the system calculated a monthly income of $1,404.08. Given that there is no other reliable income documentation indicating the amount you made in October 2016 in the record, NYSOH Appeal's Unit must rely upon the system calculated income amount for this Decision.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,367.00 per month. Since the system calculated your monthly income to be $1,404.08 in October 2016, you do not qualify for Medicaid based on monthly income as of the date of your October 18, 2016 application.

Since the October 19, 2016 eligibility determination properly stated that, based on the information you provided in your October 18, 2016 application, you were eligible for the Essential Plan and ineligible for Medicaid, it is correct and is AFFIRMED.

During the hearing, you testified that you are also seeking Medicaid for the month of September 2016.

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.

To be eligible for Medicaid in September 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 2016.

You testified that you are paid daily and your income varies depending on what [redacted] assignments you take. You further testified that you are an [redacted] with a [redacted] service company and are paid through a [redacted]".

You faxed three screen shots dated September 1, 2016 to September 30, 2016. However, this document is incomplete as it does not contain enough information; including your name, or anything specifically showing that the documentation

provided is in fact a screen shot of your [redacted] payment system. Therefore, the documentation you submitted is not sufficient to calculate the amount of income you made in the month of September 2016.

Therefore, your case will not be returned to NYOSH to recalculate whether you were eligible for Medicaid for the month of September 2016.

Decision

The October 19, 2016 eligibility determination notice is AFFIRMED.

The record contains insufficient documentation to return your case to NYSOH to recalculate your eligibility for Medicaid for the month of September 2016.

This Decision has no effect on any subsequent eligibility determinations made by NYSOH.

Effective Date of this Decision: May 26, 2017

How this Decision Affects Your Eligibility

NYSOH properly determined you were eligible for the Essential Plan.

NYSOH properly determined you were ineligible for Medicaid.

The record contains insufficient documentation to determine whether you were eligible for Medicaid 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

The October 19, 2016 eligibility determination notice is AFFIRMED.

The record contains insufficient documentation to return your case to NYSOH to recalculate your eligible for Medicaid for the month of September 2016.

NYSOH properly determined you were eligible for the Essential Plan.

NYSOH properly determined you were ineligible for Medicaid.

The record contains insufficient documentation to determine whether you were eligible for Medicaid for the month of September 2016.

This Decision has no effect on any subsequent eligibility determinations made by NYSOH.

Legal Authority

We are sending you this notice 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।

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).

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.

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.

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).