



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

## Notice of Decision

Decision Date: August 3, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000016627

[REDACTED]

Dear [REDACTED]

On June 29, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 7, 2017 enrollment confirmation notice and 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: August 3, 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 an Essential Plan was effective April 1, 2017?

Did NYSOH properly determine that you were not eligible for Medicaid for the months of January, February, and March 2017?

## Procedural History

On March 6, 2017, NYSOH received your updated application for financial assistance with health insurance. That day, a preliminary eligibility determination was prepared stating that you were eligible for the Essential Plan, effective April 1, 2017, and that you were not eligible for Medicaid in January 2017.

Also on March 6, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as you did not have coverage starting in January 2017.

On March 7, 2017, NYSOH issued a notice of eligibility determination, based on your March 6, 2017 application, stating that you were eligible to enroll in the Essential Plan, effective April 1, 2017.

Also on March 7, 2017, NYSOH issued a notice of enrollment, based on your plan selection on March 6, 2017, stating that you were enrolled in an Essential Plan, and that your plan would start April 1, 2017.

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Also on March 7, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid in January 2017 because the program you were eligible for cannot pay for care received in the past.

On June 29, 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 July 14, 2017 to allow you time to submit documentation.

On July 6, 2017, NYSOH received the requested documentation, it was incorporated into the record as "Appellant's Exhibit #1" and the record was closed.

## **Findings of Fact**

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

- 1) You submitted an updated application to NYSOH for financial assistance on March 6, 2017.
- 2) You testified, and the record reflects, that you enrolled in an Essential Plan on March 6, 2017.
- 3) You testified that you are seeking any coverage to begin on January 1, 2017 because you have outstanding bills for services rendered.
- 4) You testified that you expect to file your 2017 federal income tax return as single, and claim one dependent.
- 5) You testified that you are paid bi-weekly and that you work about 30 hours a week at \$14.00 an hour.
- 6) You faxed seven paystubs to NYSOH on July 6, 2017:
  - a. dated January 6, 2017 for a gross pay amount of \$1,035.00
  - b. dated January 20, 2017 for a gross pay amount of \$1,102.50
  - c. dated February 3, 2017 for a gross pay amount of \$1,057.50
  - d. dated February 17, 2017 for a gross pay amount of \$1,035.00
  - e. dated March 3, 2017 for a gross pay amount of \$1,110.00
  - f. dated March 17, 2017 for a gross pay amount of \$990.00
  - g. dated March 31, 2017 for a gross pay amount of \$1,117.50
- 7) Your application reflects that you do not plan on taking any deductions on your tax return

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

## **Applicable Law and Regulations**

### Essential Plan Effective Date

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)).

### 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 2017 FPL, which is \$16,240.00 for a two-person household (82 Fed. Reg. 8831).

### 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

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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 the Essential Plan was effective April 1, 2017.

You testified, and the record indicates, that you updated your NYSOH application on March 6, 2017. As a result, you were found eligible for the Essential Plan as of April 1, 2017 and enrolled into a plan that day.

The date on which enrollment in an Essential 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 goes into effect on the first day of the following month. A plan that is selected from the sixteenth day of the month to the end of the month goes into effect on the first day of the second following month.

On March 6, 2017, you selected an Essential Plan, so your enrollment properly took effect on the first day of the first month following March 2017; that is, on April 1, 2017.

Therefore, the March 7, 2017 enrollment confirmation notice stating that your enrollment in the Essential Plan was effective April 1, 2017, is correct and must be AFFIRMED.

The second issue under review is whether NYSOH properly determined that you were not eligible for Medicaid for the months of January, February, and March 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 March 6, 2017 and requested help in paying for medical bills for 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.

You testified that you are seeking Medicaid from January 2017 through March 2017.

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 January 2017 or February 2017, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is \$1,869.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during January, February, or March 2017.

You testified that you are paid bi-weekly. The record indicates that in the month of January 2017, you had a monthly household income of \$2,137.50. Since \$2,137.50 is over the Medicaid limit of \$1,869.00, you were not eligible for Medicaid in the month of January 2017.

The record indicates that in the month of February 2017 you had a monthly household income of \$2,092.50. Since \$2,092.50 is over the Medicaid limit of \$1,869.00, you were not eligible for Medicaid in the month of February 2017.

The record indicates that in the month of March 2017 you had a monthly household income of \$3,217.50. Since \$3,217.50 is over the Medicaid limit of \$1,869.00, you were not eligible for Medicaid in the month of March 2017.

Since the March 7, 2017 notice of eligibility determination found you were not eligible for Medicaid for January 1, 2017 to January 31, 2017, because the program you were eligible for cannot pay for any care you received in the past, it is MODIFIED to state that you were not eligible for Medicaid for January 1, 2017 to March 31, 2017 because your income is over the monthly Medicaid limit.

## **Decision**

The March 7, 2017 enrollment confirmation notice is AFFIRMED.

The March 7, 2017 eligibility determination is MODIFIED to state that you were not eligible for Medicaid for January 1, 2017 to March 31, 2017 because your income is over the monthly Medicaid limit.

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).

**Effective Date of this Decision:** August 3, 2017

## **How this Decision Affects Your Eligibility**

This decision does not change your eligibility.

The effective date of your Essential Health Plan is April 1, 2017.

You are not eligible for Medicaid in the months of January, February, or March 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 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  
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Albany, NY 12211
- By fax: 1-855-900-5557

### **Summary**

The March 7, 2017 enrollment confirmation notice is AFFIRMED.

The effective date of your Essential Health Plan is April 1, 2017.

The March 7, 2017 eligibility determination is MODIFIED to state that you were not eligible for Medicaid for January 1, 2017 to March 31, 2017 because your income is over the monthly Medicaid limit.

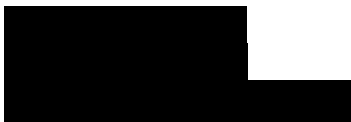
This decision does not change your eligibility.

You are not eligible for Medicaid in the months of January, February, or March 2017.

### **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 مجاناً.

### **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 bɛtumi ama wo obi a okyerɛ 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 איר געבן א דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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