



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

Notice of Decision

Decision Date: August 24, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000017462

[REDACTED]

Dear [REDACTED],

On July 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 18, 2017 eligibility determination notice and March 30, 2017 eligibility determination and plan enrollment notices.

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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DEPARTMENT OF HEALTH
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Decision

Decision Date: August 24, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000017462



Issues

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

Did NY State of Health (NYSOH) provide a timely determination of your eligibility for financial assistance?

Did NYSOH properly determine that you were enrolled in an Essential Plan with an enrollment start date of June 1, 2017?

Did NYSOH properly determine that you were not eligible for Medicaid from February 1, 2017 through February 28, 2017?

Procedural History

On December 15, 2016, you submitted an application for financial assistance.

Also on December 15, 2016, you uploaded additional income documentation to your NYSOH account.

On December 16, 2016, NYSOH issued a notice stating that the December 15, 2016, application had been reviewed and the income information in your application did not match what NYSOH received from state and federal data sources. The notice directed you to submit additional information by December 30, 2016, to confirm the information in your application.

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On January 5, 2017, NYSOH issued a notice stating that the documentation reviewed did not confirm the information in your application. The notice directed you to provide more proof of income to verify the information in your account.

On January 16, 2017, you uploaded additional income documentation to your NYSOH account.

On February 4, 2017, February 16, 2017, and February 24, 2017, NYSOH issued notices stating that the documentation reviewed does not confirm the information in your application. Each notice directed you to provide more proof of income to verify the information in your account.

On February 27, 2017 and March 10, 2017, you faxed additional income documentation to NYSOH.

On March 17, 2017, your NYSOH account was updated.

On March 18, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan with a \$20.00 premium per month, effective May 1, 2017.

On March 29, 2017, your NYSOH account was updated, and you spoke to NYSOH's Account Review Unit and requested an appeal relative to your eligibility for retroactive Medicaid coverage.

On March 30, 2017, NYSOH issued an eligibility determination notice stating that your request for retroactive Medicaid coverage for January 1, 2017 through February 28, 2017 was denied.

On March 30, 2017, NYSOH issued a plan enrollment notice confirming that as of March 29, 2017, you were enrolled in an Essential Plan with an enrollment start date of May 1, 2017.

On July 14, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

- 1) You testified you want your Essential Plan backdated or be determined eligible for retroactive Medicaid for the month of February 2017.

- 2) According to your December 15, 2016 application, you attested to an expected yearly income of \$20,800.00 and a current income of \$1,200.00.
- 3) On December 16, 2016, January 6, 2017, February 4, 2017, February 16, 2017, and February 24, 2017, NYSOH issued notices that provided a list of acceptable documentation to confirm your income including: "Paycheck stubs (for the last 4 weeks)" (see Documents [REDACTED]).
- 4) On December 15, 2016 and January 16, 2017, you uploaded biweekly earnings statements for the pay dates of November 4, 2016 and November 18, 2016 (see Documents [REDACTED]).
- 5) According to your account, the documentation submitted on December 15, 2016 and January 16, 2017 was invalidated because you did not submit your two most recent earnings statements.
- 6) On February 27, 2017, you faxed your earnings statements for the pay dates of February 3, 2017 and February 17, 2017 to NYSOH. Each earnings statement indicated that you were issued \$1,281.25 in gross pay (see Document [REDACTED]).
- 7) According to your account, you enrolled in an Essential Plan on March 29, 2017.
- 8) According to your account, on March 29, 2017 you indicated that you wanted help paying medical bills for the month of February 2017.
- 9) According to your NYSOH account, you expect to file a 2017 federal income tax return with the tax status of single and do not expect to claim any dependents on that tax return.
- 10) According to your account, you do not expect to claim any deductions on your 2017 federal income tax return.
- 11) You testified that you are seeking health insurance for the month of February 2017 to cover medical expenses that you incurred in 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 – Essential Plan

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow the NYSOH to verify the household's income (45 CFR §155.320(c)(1)(i)). 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 §600.345 (a)) See also New York's Basic Health Plan Blueprint, p. 17, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/basic-health-program.html>).

Timely Notice of Eligibility Determination - Essential Plan

When an individual applies for insurance, NYSOH must determine that person's eligibility promptly and without undue delay (45 CFR § 155.310(e)(1); 42 CFR § 435.1200(b)(3)(iii)).

To assess whether an eligibility determination was untimely, NYSOH must base the time period from the date of application to the date NYSOH notifies the applicant of its decision (45 CFR § 155.310(e)(2)). However, if the applicant submits an incomplete application or there is not sufficient information for NYSOH to make an eligibility determination, then NYSOH must notify that applicant that more information is needed to complete the application (45 CFR § 155.310(k)(1)).

The terms of 42 CFR § 435.912 (timely determination of eligibility under the Medicaid program) applies to eligibility determinations for enrollment in the Essential Plan (42 CFR § 600.320(b)). NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the application (42 CFR § 435.912).

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

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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 \$12,060.00 for a one-person household (82 Federal Register 8831).

Medicaid Retroactive Coverage:

NYSOH must make Medicaid eligibility effective no later than the third month before the month of application if the individual received medical services that would have been covered under Medicaid and would have been eligible for Medicaid at the time he received the services if they had applied (42 CFR 435.915(a)). NYSOH 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 provided you with a timely determination of your eligibility for financial assistance.

On December 15, 2016 you submitted an application through NYSOH. In that application you attested to an expected yearly income of \$20,800.00 and a current income of \$1,200.00.

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.

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In your case, the income information that was entered into the December 15, 2016 application did not match federal and state data sources. As a result, on December 16, 2016 NYSOH issued a notice directing you to submit additional income documentation to confirm your eligibility. The notice issued by NYSOH directed you to submit additional documentation that included a list of acceptable documentation, including paycheck stubs for the last 4 weeks (see Document [REDACTED]).

On December 15, 2016 and January 16, 2017, you submitted biweekly earnings statements for the pay dates of November 4, 2016 and November 18, 2016 (see Documents [REDACTED]). However, that documentation was invalidated because they were not your two most recent earnings statements for the last four weeks.

On January 6, 2017, February 4, 2017, February 16, 2017, and February 24, 2017, NYSOH issued notices that provided a list of acceptable documentation to confirm your income including: "Paycheck stubs (for the last 4 weeks)" (see Documents [REDACTED]).

On February 27, 2017, you submitted your earnings statements for the pay dates of February 3, 2017 and February 17, 2017 to NYSOH. Since they were your two most recent earnings statements, your application was considered complete as of February 27, 2017.

NYSOH must provide Essential Plan applicants notice of their eligibility determination within 45 days from the date of the completed application. To assess whether an eligibility determination was untimely, NYSOH must base the time period from the date of the completed application to the date NYSOH notifies the applicant of its decision.

NYSOH issued an eligibility determination notice on March 18, 2017 that stated you were eligible for the Essential Plan effective May 1, 2017. Since NYSOH issued an eligibility determination 29 days from the date your application was considered complete, the March 18, 2017 eligibility determination notice was timely made.

The second issue under review is whether NYSOH properly determined that your enrollment in your Essential Plan would begin as of May 1, 2017.

The record reflects that you enrolled in an Essential Plan on March 29, 2017

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 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.

Since your plan was selected on March 29, 2017, the plan would therefore properly take effect on the first day of the second month following after March 29, 2017; that is, on May 1, 2017.

Therefore, the March 30, 2017 plan enrollment notice is AFFIRMED.

The third issue under review is whether NYSOH properly determined that you were not eligible for Medicaid from February 1, 2017 through February 28, 2017.

The record supports that you were found eligible for the Essential Plan effective June 1, 2017, and it was indicated in your March 29, 2017 application that you were seeking help paying for medical bills for the month of February 2017.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's application if they would have been eligible for Medicaid in those three months had they applied.

Medicaid can be provided through the 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 dates of your applications, the FPL was \$12,060.00 for a one-person household. Financial eligibility for Medicaid applicants who are not currently receiving Medicaid benefits may be based on current monthly household income and family size. In order for an adult to be eligible for Medicaid in a one-person household, their monthly income must not exceed \$1,387.00.

The record reflects that you were issued \$1,281.25 in gross pay on February 3, 2017 and February 17, 2017 (see Document [REDACTED]). Therefore, your February 2017 income was \$2,562.50.

As such, your household income of \$2,562.50 exceeded the income threshold of \$1,387.00 for you to be eligible for Medicaid in February 2017.

Therefore, the March 30, 2017 eligibility determination notice stating that you were ineligible for Medicaid from February 1, 2017 through February 28, 2017 is AFFIRMED.

Decision

The March 18, 2017 eligibility determination was timely.

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 March 30, 2017 plan enrollment notice is AFFIRMED.

The March 30, 2017 eligibility determination notice stating that you were ineligible for Medicaid from February 1, 2017 through February 28, 2017 is AFFIRMED.

Effective Date of this Decision: August 24, 2017

How this Decision Affects Your Eligibility

Your enrollment in your Essential Plan was effective as of June 1, 2017.

You are not eligible for Medicaid from February 1, 2017 through February 28, 2017, because your monthly household income was over the allowable income limits for this program during that month.

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

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- 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):

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- 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 March 18, 2017 eligibility determination was timely.

The March 30, 2017 plan enrollment notice is AFFIRMED.

The March 30, 2017 eligibility determination notice stating that you were ineligible for Medicaid from February 1, 2017 through February 28, 2017 is AFFIRMED.

Your enrollment in your Essential Plan was effective as of June 1, 2017.

You are not eligible for Medicaid from February 1, 2017 through February 28, 2017, because your monthly household income was over the allowable income limits for this program during that month.

Legal Authority

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

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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 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 אייך געבן א דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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