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

Notice of Decision

Decision Date: August 18, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018413

[redacted]

Dear [redacted],

On July 24, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 24, 2017 enrollment confirmation notice and March 24, 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 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 18, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018413

[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 your enrollment in an Essential Plan was effective February 1, 2017?
>
> Did NY State of Health properly determine that you were not eligible for retroactive Medicaid for December 1, 2016 through December 31, 2016?

Procedural History

On January 17, 2017, you submitted an application for financial assistance with insurance and indicated that you were seeking help paying for medical bills for December 2016.

On January 18, 2017, NYSOH issued a notice of eligibility determination, based on your January 17, 2017 application, stating that you were eligible to enroll in the Essential Plan for a limited time, effective February 1, 2017. This notice directed you to submit income documentation by April 17, 2017 in order to confirm your eligibility.

Also on January 18, 2017, NYSOH issued a notice of enrollment, based on your plan selection on January 17, 2017, stating that you were enrolled in an Essential Plan, and that your plan would start February 1, 2017.

On March 23, 2017, NYSOH redetermined your eligibility for financial assistance.

On March 24, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan, effective May 1, 2017.

Also on March 24, 2017, NYSOH issued a notice of eligibility determination stating that you were not eligible for Medicaid for December 1, 2016 through December 31, 2016 because the program you are eligible for cannot pay for any care you received in the past.

On April 26, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your enrollment in the Essential insofar as it did not begin December 1, 2016 or in the alternative that you were denied retroactive Medicaid for the month of December 2016.

On July 24, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open for fourteen days to allow you the opportunity to submit additional income documentation. On August 2, 2017, you faxed paystubs to NYSOH. These paystubs are marked as document [redacted].

An additional eight days was granted to allow you to submit further income documentation. On August 8, 2017, the Appeals Unit received via fax copies of three paystubs. These documents were collectively marked as Appellant's Exhibit #1 and incorporated into the record. The record is now closed.

Findings of Fact

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

1) You submitted an application to NYSOH for financial assistance on January 17, 2017.

2) Your NYSOH account reflects that you enrolled in an Essential Plan on January 17, 2017.

3) You testified that you had a public assistance case and had coverage outside of NYSOH which ended at the end of November 2016.

4) You testified that you did not receive any letter that you were being disenrolled from your previous coverage and that you did not know you did not have coverage until late December 2016.

5) You testified that you were pregnant in December 2016 and have medical bills from December 2016 for medical procedures you had related to your pregnancy.

6) You testified that you file your tax return as head of household. You testified that you anticipate claiming your significant other, disabled father, and two children as dependents on your tax return.

7) You testified that you are the sole source of income for your household.

8) The application that you submitted on January 17, 2017 states that you will claim only your two children as dependents.

9) You testified that you are paid biweekly and that you are paid about $1,308.00 every check.

10) You testified that you reside in Kings County.

11) You testified that your annual expected income is currently $34,000.00 and that you will claim a deduction for student loan interest.

12) You submitted three paystubs that show your gross income in December 2016 was $3,924.00; these are for pay date December 2, 2016 for a gross pay amount of $1,308.00, December 16, 2016 for a gross pay amount of $1,308.00, and December 30, 2016 for a gross pay amount of $1,308.00.

13) The Hearing Officer requested that you submit your 2016 tax return showing how many dependents you claimed for 2016. You did not submit your 2016 tax return by August 15, 2017.

14) You testified and the record reflects, that you are seeking to have your enrollment in your Essential Plan begin on December 1, 2016 or in the alternative to be found eligible for Medicaid from December 1, 2016 through December 30, 2016 because you have medical bills for that month.

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)).

Household Composition

For purposes of Medicaid eligibility, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

Medicaid for Pregnant Women

Medicaid is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the FPL for the applicable family size (see 42 CFR § 435.116(c); NY Department of Health Administrative Directive 13ADM-03).

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). In the month in which you were seeking retroactive coverage, that was the 2016 FPL, which is $24,300.00 for a four-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 is whether NYSOH properly determined that your enrollment in the Essential Plan was effective February 1, 2017.

You testified, and the record indicates, that you submitted your NYSOH application on January 17, 2017. As a result, you were found eligible for and enrolled in the Essential Plan as of February 1, 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 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 January 17, 2017, you selected an Essential Plan, so your enrollment should have taken effect on the first day of the second month following January 2017; that is, on March 1, 2017.

However, NYSOH has elected to grant you an earlier enrollment in your Essential Plan as of February 1, 2017.

Therefore, the March 24, 2017 enrollment confirmation notice stating that your enrollment in the Essential Plan was effective February 1, 2017, is correct and must be AFFIRMED.

The second issue under review is whether NYSOH properly determined that you were not eligible for retroactive Medicaid for December 1, 2016 through December 31, 2016.

According to your January 17, 2017 application, you expected to file your 2017 tax return as head of household and claim two dependents on that return, therefore, according to your application, you were in a three-person household.

However, you testified that in December 2016, the month for which you are seeking coverage, you were pregnant.

When calculating family size for Medicaid purposes, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman but also the number of children she expects to deliver.

You testified that you also claim your significant other and your father as dependents. However, the application you submitted on January 17, 2017 did not include your significant other or your father. You also have not submitted your 2016 tax return to support your assertion that you claim these individuals in addition to your two children as dependents.

Therefore, in December 2016, you were part of a four-person household.

You submitted an application for financial assistance on January 17, 2017 and requested help in paying for medical bills for December 2016.

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.

The record reflects that you are seeking Medicaid from December 1, 2016 through December 31, 2016.

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 December 2016, you would have needed to meet the non-financial criteria and have an income no greater than 223% of the FPL, which is $4,516.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during December 2016.

You testified that you are paid bi-weekly. You submitted paystubs for pay date December 2, 2016 for a gross pay amount of $1,308.00; for pay date December 16, 2016 for a gross pay amount of $1,308.00; and for pay date December 30, 2016 for a gross pay amount of $1,308.00. Therefore, the record indicates that in the month of December 2016, you had a monthly household income of $3,924.00.

As you were unable to indicate on your January 17, 2017 application to NYSOH that you were pregnant in December 2016, NYSOH utilized 138% of the FPL for a three-person household, which was $2,319.00 per month in 2016 instead of the proper 223% of the FPL for a pregnant woman.

Therefore, the March 24, 2017 eligibility determination notice stating that you were not eligible for Medicaid in the month of December 2016 is RESCINDED.

Your case is RETURNED to NYSOH for a redetermination of your eligibility for retroactive Medicaid coverage for December 2016 based on a four-person household, utilizing 223% of the FPL for a pregnant woman, and a household income of $3,924.00 for December 2016.

Decision

The March 24, 2017 enrollment confirmation notice is AFFIRMED.

The March 24, 2017 eligibility determination notice stating that you were not eligible for Medicaid in the month of December 2016 is RESCINDED.

Your case is RETURNED to NYSOH for a redetermination of your eligibility for retroactive Medicaid coverage for December 2016 based on a four-person household, utilizing 223% of the FPL for a pregnant woman, and a household income of $3,924.00 for December 2016.

Effective Date of this Decision: August 18, 2017

How this Decision Affects Your Eligibility

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

This is not a final determination of your eligibility for financial assistance for December 2016. Your case is being sent back to NYSOH for a redetermination of your eligibility for retroactive Medicaid coverage for December 2016 based on a four-person household, utilizing 223% of the FPL for a pregnant woman, and a household income of $3,924.00 for December 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.

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).

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 March 24, 2017 enrollment confirmation notice is AFFIRMED.

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

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 24, 2017 eligibility determination notice stating that you were not eligible for Medicaid in the month of December 2016 is RESCINDED.

Your case is RETURNED to NYSOH for a redetermination of your eligibility for retroactive Medicaid coverage for December 2016 based on a four-person household, utilizing 223% of the FPL for a pregnant woman, and a household income of $3,924.00 for December 2016.

This is not a final determination of your eligibility for financial assistance for December 2016. Your case is being sent back to NYSOH for a redetermination of your retroactive Medicaid coverage for December 2016.

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.

□□□□□ (Bengali)

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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.

(Yiddish) אידיש

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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).