STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: March 12, 2018

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000024918

[redacted]

Dear [redacted],

On February 1, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 28, 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
  PO 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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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
PO Box 11729
Albany, NY 12211

Decision

Decision Date: March 12, 2018

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000024918

[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 you were not eligible for Medicaid assistance for the month of January 2017?

Procedural History

On January 18, 2017, January 21, 2017, and February 7, 2017, NYSOH issued notices stating the income information in your applications did not match information received from state and federal data sources. You were directed to submit proof of your income or NYSOH would not be able to determine your eligibility for health coverage. The notices included a "Documentation List" providing the types of documents accepted to prove various kinds of income. The list indicated that to prove wages, an applicant must submit paycheck stubs for the last four weeks or a letter from the employer.

On February 27, 2017, an updated application was submitted on your behalf requesting retroactive coverage for the month of January 2017.

On February 28, 2017, NYSOH issued an eligibility determination notice stating you were eligible to receive up to $520.00 monthly in advance payments of the premium tax credit (APTC), effective April 1, 2017.

Also on February 28, 2017, NYSOH issued an enrollment notice stating you were enrolled in a qualified health plan (QHP) with APTC applied, effective February 1, 2017.

Additionally, on February 28, 2017, NYSOH issued a notice stating you were not eligible for retroactive Medicaid coverage for the month of January 2017, because your monthly income was over the allowable income limit.

On March 1, 2017, another updated application was submitted on your behalf. That application requested retroactive coverage for the months of December 2016 and February 2017.

On March 2, 2017, NYSOH issued a notice stating the income information in your applications did not match information received from state and federal data sources. You were directed to submit proof of your income or NYSOH would not be able to determine your eligibility for health coverage.

Also on March 2, 2017, NYSOH issued a notice stating your QHP enrollment would end on March 31, 2017, because you were no longer eligible to enroll in that plan.

On March 11, 2017, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective March 1, 2017.

Also on March 11, 2017, NYSOH issued a notice stating you were eligible for retroactive Medicaid coverage for the month of December 2016, because the monthly income you provided was under the allowable income limit. The notice directed you to submit proof of your income for the month of February 2017 by March 25, 2017, so NYSOH could determine your eligibility for retroactive Medicaid coverage for that month.

On March 17, 2017, NYSOH issued an enrollment notice, based on your March 16, 2017 plan selection, confirming your enrollment in a Medicaid Managed Care plan, effective May 1, 2017.

On May 17, 2017, NYSOH issued a notice stating you were eligible for retroactive Medicaid coverage for the month of February 2017.

On November 28, 2017, you contacted NYSOH’s Account Review Unit and requested an appeal insofar as you were not eligible for retroactive coverage for the month of January 2017.

On February 1, 2018, you had a telephone hearing with a Hearing Officer from NYSOH’s Appeals Unit. The record was developed at the hearing and closed thereafter.

Findings of Fact

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

1) On January 17, 2017 and January 20, 2017 updated applications were submitted on your behalf listing annual expected income for 2017 in amounts ranging from $0.00 to $800.00. The applications indicated you would file your 2017 tax return with a tax filing status of head of household and you would claim your child as a dependent. Those applications, listed annual employment income for your child in amounts ranging from $6,240.00 to $11,000.00.

2) According to your account, NYSOH was unable to verify the income information in your applications and you were directed to submit proof of your household income before NYSOH could determine your eligibility for health coverage.

3) On January 17, 2017, NYSOH received a letter from your former employer indicating the last date of your employment would be January 21, 2017. That letter stated that your “weekly rate” was $1,297.60.

4) On February 1, 2017, NYSOH received a copy of an Official Record of Benefit Payment History from the NYS Department of Labor indicating you were in receipt of $430.00 of weekly unemployment insurance benefits, effective February 13, 2017.

5) Also on February 1, 2017, NYSOH received a copy of three nonconsecutive weekly paystubs for your child.

6) According to your account, your income documentation was invalidated by NYSOH, because it did not comply with the document request. Additional documentation was requested.

7) On February 6, 2017, multiple updated applications were submitted on your behalf changing your tax filing status to single and indicating you would not claim any dependents. The final application submitted that day listed your annual expected income for 2017 as $3,000.00.

8) According to your account, NYSOH was unable to verify the income information in your applications and you were directed to submit proof of your household income before NYSOH could determine your eligibility for health coverage.

9) On February 27, 2017, an updated application was submitted on your behalf listing your tax status as single and indicating you would claim your one child as a dependent. That application listed your annual expected

household income for 2017 as $36,740.00 consisting of $4,500.00 you earned at your job with [redacted] in January 2017, $22,360.00 you would earn in annual unemployment insurance benefits and $9,880.00 your dependent child would earn in annual income.

10) The February 27, 2017 application requested retroactive coverage for the month of January 2017 and listed your household income for that month as $5,000.00; $4,500.00 you earned at your employment and $500.00 your child earned that month.

11) Based on the information in the February 27, 2017 application, NYSOH determined you eligible to receive up to $520.00 in APTC, effective April 1, 2017.

12) According to your account, a QHP was selected for you that day. You were granted a special enrollment period to enroll into a QHP outside the open enrollment period for 2017 based on the information in your application indicating that you lost your prior employer sponsored health coverage on January 24, 2017. Coverage through your QHP began February 1, 2017.

13) NYSOH denied your request for retroactive coverage for the month of January 2017 on the grounds you were over the income limit to qualify for Medicaid in that month based on the information in your application.

14) On March 1, 2017, another updated application was submitted on your behalf. That application indicated you would not claim any dependents on your tax return and listed your annual expected income for 2017 as $12,980.00 consisting of $1,800.00 you earned in January 2017 from your employment and $11,180.00 you would earn in annual unemployment insurance benefits. That application requested retroactive coverage for the months of December 2016 and February 2017 and listed your monthly income as $1,081.67 and $430.00 in those months, respectively.

15) According to notes in your account, on March 1, 2017, NYSOH received a request on your behalf to backdate your QHP coverage to January 1, 2017 based on a purported loss of employer sponsored health insurance on December 31, 2016.

16) According to your account, NYSOH was unable to verify the income information in your March 1, 2017 application and you were placed in a pending Medicaid status with proof of your income requested prior to NYSOH determining your eligibility.

17) You were disenrolled from your QHP, effective March 31, 2017, due to your pending Medicaid status.

18) On March 2, 2017, a copy of the Official Record of Benefit Payment History from the NYS Department of Labor indicating you were in receipt of unemployment insurance benefits was uploaded to your account again.

19) According to notes in your account from March 8, 2017, NYSOH agreed to backdate your QHP coverage to January 1, 2017 and attempted to reach you by telephone to advise you of the backdate. According to the notes, on March 9, 2017, NYSOH spoke to a certified application counselor (CAC) on your behalf to advise that the backdate request had been approved.

20) On March 8, 2017, your health plan initiated termination of your QHP coverage for non-payment of premium.

21) On March 10, 2017, NYSOH verified your income documentation and determined you eligible for Medicaid, effective March 1, 2017.

22) A Medicaid Managed Care plan enrollment request was submitted on your behalf on March 16, 2017 and coverage through that plan became effective on May 1, 2017.

23) NYSOH determined you eligible for retroactive Medicaid for the month of December 2016 based on the information in your March 1, 2017 application indicating your income for that month was $1,081.67. NYSOH requested documentation of your income for the month of February 2017 prior to determining your eligibility for retroactive Medicaid coverage for that month.

24) On May 16, 2017, NYSOH determined you eligible for retroactive Medicaid coverage for the month of February 2017.

25) You appealed insofar as you were not eligible for health coverage through NYSOH for the month of January 2017.

26) You testified that you were employed until January 21, 2017.

27) You testified that you were covered by an employer sponsored health plan until January 21, 2017.

28) You testified that you were hospitalized on [redacted] until [redacted] and that you were [redacted] during that time.

29) You testified that the applications submitted during the time [redacted] were submitted by a CAC at [redacted].

30) You testified that you will file your 2017 tax return with a tax filing status of single.

31) You testified that you do not know if you can claim your child as a dependent on your 2017 tax return.

32) You testified that you were paid biweekly at your job with [redacted]. You testified that in the month of January 2017 you received one full biweekly paycheck and one partial paycheck.

33) You testified that the $4,500.00 income amount listed in the February 27, 2017 application as your monthly income for the month of January 2017 was accurate.

34) You testified that you initially enrolled in a QHP, but you never made a premium payment. You testified that you were going to pay the premium in March but your CAC told you not to.

35) You testified that you have significant outstanding medical bills from the month of January 2017.

36) You testified that you do not understand why you were granted retroactive Medicaid coverage for the months of December 2016 and February 2017, but not for January 2017, because you worked full time at [redacted] in the month of December 2016 and made more than you did in January 2017.

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).

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 (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 USC § 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 you were not eligible for Medicaid coverage for the month of January 2017.

NYSOH received several applications for financial assistance with health insurance submitted on your behalf in January 2017. According to your account, NYSOH was unable to verify the income information listed in those applications.

Pursuant to the above cited regulations, 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.

In the eligibility determination notices issued by NYSOH on January 18, 2017 and January 21, 2017, you were advised of an inconsistency in your application

and you were directed to submit proof of your household income before NYSOH could determine your eligibility for health coverage. Although your account confirms that on January 17, 2017, NYSOH received a letter from your former employer indicating the last date of your employment would be January 21, 2017 and that your “weekly rate” was $1,297.60, no documentation of your dependent child’s income was submitted until February 1, 2017. Furthermore, the documentation of your child’s income received was insufficient as it only included three weekly paystubs, thus, it failed to comply with the document request. Accordingly, it is concluded that you failed to submit a completed application for financial assistance to NYSOH in January 2017.

On February 27, 2017, an updated application was submitted on your behalf listing your tax status as single and indicating you would claim your one child as a dependent. That application listed your annual expected household income for 2017 as $36,740.00. The February 27, 2017 application requested retroactive coverage for the month of January 2017 and listed your household income for that month as $5,000.00; $4,500.00 you earned at your employment and $500.00 your child earned that month. You testified that the income information in the February 27, 2017 application was accurate.

Based on the information in the February 27, 2017 application, NYSOH determined you eligible to receive up to $520.00 in APTC and you were enrolled in a QHP, effective February 1, 2017. Additionally, NYSOH denied your request for retroactive coverage for the month of January 2017 on the grounds the monthly income amount listed in your application was over the income limit to qualify for Medicaid for that month. You appealed insofar as you were not eligible for Medicaid for the month of January 2017.

Pursuant to the regulations, 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 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.

Pursuant to the regulations, 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, you would have needed to meet the non-financial criteria and have a household income no greater than 138% of the applicable FPL. Although you testified that you are unsure whether you will claim your child as a dependent on your 2017 tax return, the subject determination issued by NYSOH relied upon the information in your application indicating you would. However, even utilizing the higher monthly FPL for a two-person

household in 2017 of $1,868.00, the income you received in January 2017 exceeded that amount.

Since the evidence establishes that you were employed in January 2017 at a rate of $1,297.60 and that you received, at least, two full weeks of pay in that month, that income alone would exceed the $1,868.00 monthly income limit to qualify you for Medicaid in the month of January 2017. Therefore, the evidence establishes, you were not eligible for Medicaid in the month of January 2017.

Accordingly, the February 28, 2017 notice denying your request for retroactive Medicaid coverage for the month of January 2017 was correct and is AFFIRMED.

It is noted that your account confirms you were granted retroactive Medicaid coverage for the month of December 2016. You testified that you received more income in December 2016 than you did in January 2017, so you did not understand why you were not eligible for the same coverage in January. However, your account confirms that your eligibility for retroactive coverage for December 2016 was based on attestations in your March 1, 2017 application that your income for the month of December 2016 was $1,081.67. Although based on your own testimony the information in that application was not accurate, the resulting determination is not presently under review; therefore, the Appeals Unit will not disturb that finding.

It is further noted, that following the February 27, 2017 application, you were determined eligible to receive APTC and you were enrolled in a QHP effective, February 1, 2017. Notes in your account confirm that NYSOH agreed to backdate this enrollment to January 1, 2017, following a March 1, 2017 request based on a purported December 31, 2017 loss of prior coverage, notwithstanding the evidence establishing your prior coverage ended January 21, 2017. However, that enrollment was subsequently cancelled by the health plan on March 8, 2017 for failure to pay the premiums. You confirmed that you did not make a premium payment to the health plan. Therefore, there is no basis to enforce a January 1, 2017 start date to QHP coverage that was subsequently terminated for non-payment of the premium. Accordingly, you did not have QHP coverage in the month of January 2017.

Decision

The February 28, 2017 notice denying your request for retroactive coverage for January 2017 is AFFIRMED.

Effective Date of this Decision: March 12, 2018

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

You were not eligible for coverage through NYSOH in January 2017.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as a portion of your case was decided, the 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):

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- By calling the Customer Service Center at 1-855-355-5777
- By mail at:

  NY State of Health Appeals
  PO Box 11729
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The February 28, 2017 notice denying your request for retroactive coverage for January 2017 is AFFIRMED.

This decision does not change your eligibility.

You were not eligible for coverage through NYSOH in January 2017.

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 नि:शुल्क 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.

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