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

Notice of Decision

Decision Date: February 15, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024920

[redacted]

[redacted]

On January 17, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's June 20, 2017 and the November 11, 2017 eligibility determination 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
  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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Issues

The issue presented for review by the Appeals Unit of NY State of Health (NYSOH) are:

> Was your appeal of the June 20, 2017 notice of eligibility determination timely?
>
> Did NYSOH properly determine that you were not eligible to receive retroactive Medicaid assistance for October 2017?

Procedural History

On June 20, 2017, NYSOH issued an eligibility determination notice, stating that you were eligible to receive up to $173.00 per month in advance payments of the premium tax credit (APTC), but ineligible for cost-sharing reductions (CSR), the Essential Plan, or Medicaid, all effective August 1, 2017.

Also on June 20, 2017, NYSOH issued a notice confirming that you would be disenrolled from your Medicaid Plan because you were no longer eligible for that coverage. Another notice was issued on June 20, 2017 confirming your enrollment in a bronze-level qualified health plan.

In August 2017 you changed your health insurance coverage to a gold-level plan, effective September 1, 2017.

On October 28, 2017, NYSOH issued a renewal notice, stating that based on information obtained from federal and state sources, you would be eligible to

receive up to $168.22 per month in APTC, effective January 1, 2018. You would not be eligible for CSR.

On November 10, 2017, you updated your application.

On November 11, 2017, NYSOH issued a notice of eligibility determination, stating that you were eligible to receive up to $173.00 per month in APTC, but ineligible for CSR, the Essential Plan, or Medicaid, effective December 1, 2017.

Also on November 11, 2017, NYSOH issued a denial of your request for retroactive Medicaid assistance for October 2017.

On November 28, 2017, you contacted NYSOH's Account Review Unit and requested an appeal, purportedly regarding the deductible and copays required for your coverage.

On January 17, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit, and the record was closed.

Findings of Fact

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

1) On June 19, 2017, an updated application for financial assistance was submitted on your behalf.

2) On June 20, 2017, NYSOH issued an eligibility determination notice finding you eligible to receive up to $173.00 in APTC, effective August 1, 2017. According to that notice, you were not eligible for CSR because your income was over the allowable limit for that program.

3) The June 20, 2017 notice contained language advising you that "you were obligated to report to NY State of Health any changes that would affect your eligibility for enrollment in health insurance within 30 days of such change" and that such changes included becoming pregnant.

4) You enrolled in a bronze level qualified health plan, effective August 1, 2017.

5) On August 18, 2017 you switched to a gold level qualified health plan. That enrollment was effective September 1, 2017.

6) The enrollment confirmation notice issued by NYSOH on August 19, 2017 confirmed that your gold level qualified health plan had a $900.00 annual deductible.

7) You testified that you contacted your health plan in October 2017 to report a pregnancy, but you did not report your pregnancy to NYSOH.

8) You testified that you have an outstanding deductible owed for treatment received in the month of October 2017 and you were seeking review of your eligibility for financial assistance for that month only.

9) An updated application for financial assistance was submitted on your behalf on November 10, 2017. That application requested retroactive coverage for the month of October 2017 and listed your income for that month as $2,500.00.

10) The November 10, 2017 application indicated you would file your tax return with a tax filing status of single and you would claim no dependents.

11) You testified, and your application indicated, that you were no longer pregnant in November 2017.

12) You were determined eligible to receive up to $173.00 in APTC, effective December 1, 2017. NYSOH determined you were not eligible to receive CSR, because your annual income exceeded the income limit for that program.

13) NYSOH denied your request for retroactive assistance for the month of October 2017 on the grounds the program you were eligible for could not pay for any care you received in the past.

14) The first record of you contacting NYSOH to dispute your eligibility for financial assistance for the month of October 2017 was on November 28, 2017, the same day you requested the appeal.

15) You testified that you were not appealing your eligibility for 2018, because you would be covered through your employer as of January 1, 2018.

16) You are only seeking review of your eligibility for financial assistance for the month of October 2017.

17) You testified that you did not report your pregnancy to NYSOH in October 2017, because you reported it to your health plan and you did not know you also had to report it to NYSOH.

18) You testified that when you reported your pregnancy to your health plan your “policy should have changed” and you should have been eligible for more financial assistance for that month.

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

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) a failure by NYSOH to provide timely notice of an eligibility determination 45 CFR § 155.505; and (4) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR § 155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

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 (81 Fed. Reg. 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 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 your appeal of NYSOH's June 20, 2017 notice of eligibility determination was timely.

On June 20, 2017, NYSOH issued an eligibility determination notice finding you eligible to receive up to $173.00 in APTC, effective August 1, 2017. According to that notice, you we not eligible for CSR, because your income was over the allowable limit for that program. You initially enrolled into a bronze level qualified health plan, but later switched to a gold level plan, effective September 1, 2017. The enrollment confirmation notice issued by NYSOH on August 19, 2017 confirmed that your gold level qualified health plan had a $900.00 annual deductible.

You testified that you have an outstanding deductible owed for treatment received in the month of October 2017 and you were seeking review of your eligibility for financial assistance for that month only.

The evidence establishes that following your June 19, 2017 application update, there were no additional updates received by NYSOH until November 10, 2017. Thus, there were no determinations concerning your eligibility for financial assistance issued by NYSOH between June 20, 2017 and November 9, 2017. Accordingly, the June 20, 2017 eligibility determination issued by NYSOH determined your eligibility for financial assistance for the month of October 2017.

Pursuant to the above cited regulations, individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of your eligibility for financial assistance for the month of October 2017, as stated in the June 20, 2017 eligibility determination notice, an appeal should have been filed by August 19, 2017. The record reflects that the appeal in this matter was not filed until November 28, 2017, after the 60-day timeframe in which to appeal the June 20, 2017 eligibility determination notice had passed. Moreover, there is no evidence in your account that would justify tolling the regulatory timeframe. As such, there has been no timely appeal of the June 20, 2017 eligibility determination notice, and your appeal on your eligibility for financial assistance, as confirmed in that notice, must be DISMISSED.

The second issue under review is whether NYSOH properly determined you were not eligible for retroactive Medicaid coverage for the month of October 2017.

On November 10, 2017, NYSOH received an updated application for financial assistance submitted on your behalf. That application requested help paying for medical bills for the month of October 2017.

NYSOH issued a notice on November 11, 2017 denying your request for retroactive coverage for the month of October 2017, on the grounds the program you were eligible for could not pay for any care you received in the past. You testified you are seeking review of your eligibility for financial assistance for the month of October 2017, thus, the Appeals Unit will review the November 11, 2017 denial of retroactive Medicaid coverage for that month.

Pursuant to the regulations, when an individual file, 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.

Therefore, the basis for the denial of retroactive coverage for the month of October 2017, as stated in the November 11, 2017 notice, is not supported by the regulations. However, notwithstanding, the record establishes that you were not eligible for retroactive Medicaid coverage for the month of October 2017 based on the information in your applications.

According to the November 10, 2017 application, your income for the month of October 2017 was $2,500.00. That application also indicated that you would file your tax return with a tax filing status of single and you would claim no dependents.

Although you testified that you were pregnant in the month of October 2017 and that you reported your pregnancy to your health plan, your account confirms that a pregnancy was never reported to NYSOH. Furthermore, the evidence establishes that you were advised in the June 20, 2017 eligibility determination notice of your duty to report to NYSOH any changes affecting your eligibility, such as a pregnancy, within 30 days. Since your account confirms that you failed to report your pregnancy to NYSOH, despite being on notice of your duty to do so, there was no basis for NYSOH to consider any pregnancy in determining your eligibility for retroactive Medicaid coverage for the month of October 2017.

Thus, according to the competent evidence of record, you were in a two-person household for the month of October 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 October 2017, you would have needed to meet the non-financial criteria and have a household income no greater than 138% of the applicable FPL, which is $1,387.00 per month. It is noted that there is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during October 2017.

Since, based on your application, you earned $2,500.00 in October 2017, over the $1,387.00 income limit to qualify for Medicaid in that month, you are not eligible for retroactive coverage for October 2017.

It is noted that even if you were found to have been in a three-person household in October, your monthly household income for October 2017 would still be over het allowable limit.

Thus, the November 11, 2017 notice, to the extent it found you ineligible for retroactive coverage for the month of October 2017, was correct and is Affirmed.

Based on your testimony that you are only seeking review of your eligibility for financial assistance for the month of October 2017 and you are not appealing your eligibility for December 2017 or January 2018, the Appeals Unit will not review any additional eligibility determinations.

Decision

Your appeal of the June 20, 2017 eligibility determination notice is untimely and is DISMISSED.

The November 11, 2017 notice, to the extent it found you ineligible for retroactive coverage for the month of October 2017, was correct and is AFFIRMED.

Effective Date of this Decision: February 15, 2018

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

You were not eligible for retroactive Medicaid coverage for the month of October 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 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
  PO Box 11729
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

Your appeal of the June 20, 2017 eligibility determination notice is untimely and is DISMISSED.

The November 11, 2017 notice, to the extent it found you ineligible for retroactive coverage for the month of October 2017, was correct and is AFFIRMED.

This decision does not change your eligibility.

You were not eligible for retroactive Medicaid coverage for the month of October 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.

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).