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

Notice of Decision

Decision Date: March 23, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026243

[redacted]

Dear [redacted]

On March 2, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 14, 2017 and December 23, 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
  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: March 23, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026243

[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 that your enrollment in an Essential Plan was effective December 1, 2017?
>
> Did NYSOH properly determine that you were not eligible for Medicaid for November 1, 2017 through November 30, 2017?

Procedural History

On November 13, 2017, you updated your application for financial assistance with health insurance through NYSOH.

On November 14, 2017, NY State of Health (NYSOH) issued a notice of eligibility determination, based on your November 13, 2017 application, stating that you were eligible to enroll in the Essential Plan with no monthly premium, effective December 1, 2017.

Also on November 14, 2017, NYSOH issued a notice of enrollment, based on your plan selection on November 13, 2017, stating that you were enrolled in an Essential Plan, and that your plan would start December 1, 2017.

On December 22, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your enrollment in the Essential Plan, insofar as it did not begin November 1, 2017.

Also on December 22, 2017, you updated your NYSOH account, and indicated that you were seeking help for paying for medical bills for September, October, and November 2017.

On December 23, 2017, NYSOH issued a notice of eligibility determination stating that you were not eligible for Medicaid for September 1, 2017 through November 30, 2017 because the program you are eligible for cannot pay for any care you received in the past.

On March 2, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, the issue under review was amended to include the December 23, 2017 denial of retroactive Medicaid, insofar as it denied you coverage for the month of November 2017. Also during the hearing, a Farsi interpreter, ID #[redacted], provided interpretation as needed.

The record was developed during the hearing and held open through March 19, 2018 to provide you with time to submit supporting documentation.

On March 5, 2018, you faxed documentation to the Appeals Unit. The record is now closed.

Findings of Fact

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

1) You submitted an application to NYSOH for financial assistance on November 13, 2017.

2) You testified that you were enrolled in Medicaid through your local Department of Social Services during 2017, but your coverage lapsed because you missed the renewal.

3) You testified that you had a medical procedure done [redacted] on [redacted], and discovered after the procedure that you had no health insurance coverage.

4) You testified that, as soon as you got home from [redacted], you called NYSOH to enroll in coverage.

5) Your NYSOH account reflects, that you updated your application and selected an Essential Plan for enrollment on November 13, 2017.

6) Your NYSOH account reflects that you updated your application again on December 22, 2017, and applied for retroactive Medicaid for the period of September 1, 2017 through November 30, 2017.

7) Your NYSOH account reflects that you expect to file your 2018 federal income tax return as married, filing jointly, and to claim one dependent.

8) Your application submitted on December 22, 2017, states that for the month of November 2017, your income was $2,500.00.

9) You testified that you are a [redacted], and that your income varies by month.

10) You testified that your income decreased in 2017 because of [redacted] you had to undergo.

11) You testified that you made $200.00 in the month of November 2017.

12) You testified that your spouse had no income in the month of November 2017.

13) After the hearing, you sent a five-page fax to the Appeals Unit, consisting of a bank statement for the period of October 20, 2017 through November 17, 2017, with a handwritten notation next to one deposit from October 25, 2017 for $291.00 that reads, “Income.” This faxed documentation is marked and entered into the record as “Appellant’s Exhibit One.”

14) You testified that you are looking to have coverage in the month of November 2017 so that your [redacted] and [redacted] bills can be paid.

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/downloads/ny-blueprint.pdf).

The effective date of coverage by an Essential Plan is determined by the date on which an applicant selects a plan for enrollment. For individuals who are eligible for enrollment, NYSOH must generally ensure that coverage is effective the first day of the following month for selections received by NYSOH from the first to the fifteenth of any month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(i); *see also* 42

CFR § 600.320). For selections received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(ii)).

Medicaid for Adults between the Ages of 19 and 65

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

In an analysis of Medicaid eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR § 435.4). On the date of your application, that was the 2017 FPL, which is $20,420.00 for a three-person household (82 Federal Register 8831).

Retroactive Medicaid

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of an initial application if the individual received medical services that would have been covered under Medicaid and the individual would have been eligible for Medicaid at the time he received the 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 NYSOH properly determined that your enrollment in the Essential Plan was effective December 1, 2017.

You testified, and the record confirms, that you updated your NYSOH application on November 13, 2017. As a result, you were found eligible for the Essential Plan as of December 1, 2017. You also selected an Essential Plan for enrollment on November 13, 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 November 13, 2017, you selected an Essential Plan, so your enrollment properly took effect on the first day of the first month following November: that is, on December 1, 2017.

Therefore, the November 14, 2017 eligibility determination and enrollment confirmation notices, stating that your eligibility for, and enrollment in, the Essential Plan were effective December 1, 2017, are correct and must be AFFIRMED.

The second issue under review is whether NYSOH properly determined that you were not eligible for Medicaid for November 1, 2017 through November 30, 2017.

You are in a three-person household; you file your taxes with a tax filing status of married, filing jointly, and claim one dependent on your tax return.

You applied to NYSOH for financial assistance on December 22, 2017, and requested help in paying for medical bills for September 1, 2017 through November 30, 2017. You testified that you are appealing for coverage for the month of November 2017 to cover medical bills from that month, so that this the eligibility that is reviewed here.

When an individual files an application for Medicaid, his or her eligibility for retroactive Medicaid assistance 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 eligibility 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.

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 2017, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $2,348.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on any non-financial criteria during November 2017.

You testified that you are a [redacted], and that you received only $200.00 in income during the month of November 2017. After the hearing, you faxed a copy of a bank statement for your personal bank account for the period of October 20, 2017 through November 17, 2017. On that bank statement, you wrote the word, “Income,” next to a deposit of $291.00 on October 25, 2017 (Appellant’s Exhibit One).

However, the bank statement is for a period that does not cover the entire month of November 2017. Additionally, there are other deposits whose sources are unclear. Therefore, the documentation is inadequate for purposes of confirming your monthly income in November 2017.

Though NYSOH’s December 23, 2017 eligibility determination was incorrect in its statement that you were not eligible for retroactive Medicaid because the program you are enrolled in cannot pay for coverage received in the past, there is insufficient cause to modify that determination, as the record does not contain enough information to determine whether you were financially eligible for Medicaid in the month of November 2017. Therefore, insofar as it states that you were not eligible for Medicaid in November 2017, the December 23, 2017 eligibility determination denying your request for retroactive coverage is AFFIRMED.

Decision

The November 14, 2017 eligibility determination is AFFIRMED.

The November 14, 2017 enrollment confirmation notice is AFFIRMED.

The December 23, 2017 eligibility determination denying your request for retroactive coverage is AFFIRMED, insofar as it denied of your request for retroactive Medicaid for the month of November 2017.

Effective Date of this Decision: March 23, 2018

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

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

There is not enough information regarding your income in the month of November 2017 to determine whether you were financially eligible for retroactive Medicaid coverage for 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

- 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

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).

Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The November 14, 2017 eligibility determination is AFFIRMED.

The November 14, 2017 enrollment confirmation notice is AFFIRMED.

The December 23, 2017 eligibility determination denying your request for retroactive coverage is AFFIRMED, insofar as it denied of your request for retroactive Medicaid for the month of November 2017.

This decision does not change your eligibility.

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

There is not enough information regarding your income in the month of November 2017 to determine whether you were financially eligible for retroactive Medicaid coverage for that month.

Legal Authority

We are issuing this determination 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।

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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 तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई 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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