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

Notice of Decision

Decision Date: May 17, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027058

[redacted]

Dear [redacted]

On April 17, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 15, 2017 discontinuous notice, December 15, 2017 plan enrollment notice, and January 11, 2018 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: May 17, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027058

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly determine that you were no longer eligible for Medicaid effective December 1, 2017?
>
> Did NYSOH properly determine your enrollment in your Silver-level qualified health plan was effective January 1, 2018?
>
> Did NYSOH properly determine you were not eligible for Medicaid retroactively from December 1, 2017 through December 31, 2017?

Procedural History

On December 13, 2016, NYSOH issued an eligibility determination notice and plan enrollment notice stating you were eligible for Medicaid, effective December 1, 2016, and you were enrolled in a Medicaid Managed Care plan, effective January 1, 2017.

On September 21, 2017, NYSOH redetermined your eligibility.

On September 22, 2017, NYSOH issued a change in mailing address notice stating NYSOH received information from the U.S. Postal Service that your address had changed.

On September 22, 2017, NYSOH issued a renewal notice stating it is time to renew your NYSOH coverage for 2018. The notice stated you now qualified for

up to $306.65 per month in APTC, as well as cost-sharing reductions if your enrolled in a Silver-level qualified health plan, effective December 1, 2017. The notice stated you needed to pick a health plan between October 16, 2017 and November 15, 2017. The notice was issued to [redacted].

On October 16, 2017, NYSOH received your updated application for financial assistance with your health insurance.

On October 17, 2017, NYSOH issued a notice stating the income information in your application did not match what NYSOH received from state and federal data sources. The notice directed you to provide more information to confirm your household income by October 31, 2017.

On October 18, 2017, NYSOH issued a disenrollment notice stating your Medicaid Managed Care plan would end on November 30, 2017.

On October 26, 2017, NYSOH issued a notice stating you updated your mailing address in your account.

On November 1, 2017, you submitted an updated application for financial assistance with your health insurance.

On November 2, 2017, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective December 1, 2017. The notice was issued to [redacted]

On November 15, 2017, NYSOH issued a discontinuance notice stating you were no longer eligible for health insurance through NYSOH, effective November 15, 2017. The notice stated this was because NYSOH sent you information including notices about your eligibility and coverage, by U.S. mail to the mailing address provided in your account that were returned to NYSOH as undeliverable.

On December 6, 2017, NYSOH received your updated application for financial assistance with your health insurance. You also updated your address on this date.

On December 7, 2017, NYSOH issued a notice stating you updated your mailing address in your account.

On December 7, 2017, NYSOH issued an eligibility determination notice stating you were eligible for APTC up to $364.00 per month as well as cost-sharing reductions if you enrolled in a Silver-level qualified health plan, effective January 1, 2018. The notice was issued to [redacted]

On December 15, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a Silver-level qualified health plan, effective January 1, 2018.

On January 10, 2018, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as your enrollment in your qualified health plan began as of January 1, 2018, and not December 1, 2017.

On January 11, 2018, NYSOH issued an eligibility determination notice stating your request for help paying medical bills from December 1, 2017 through December 31, 2017, was denied because the program you are eligible for cannot pay for any care you received in the past.

On April 17, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) You expect to file your 2017 federal income tax return as single, and claim no dependents.

2) According to the October 16, 2017 application, you attested to an expected annual household income of $13,802.00. This amount included an adjusted gross income of $25,682.00 less $11,880.00 in self-employment tax.

3) You were determined eligible for Medicaid, effective December 1, 2017, as a result of your October 16, 2017 application, which listed your income as $13,802.00.

4) Your 2016 federal tax return states your self-employment tax deduction for that year was $1,534.00 and one-half of which is $767.00, which was deducted to reach an adjusted gross income of $25,682.00 (*see* Document [redacted]

5) NYSOH received return mail notices from your mailing address on October 23, 25, 2017 and November 13, 2017.

6) The notice issued on November 15, 2017, states you were no longer eligible because NYSOH sent you information including notices about your eligibility and coverage by U.S. mail to the mailing address

provided in your account and the mailings were returned to NYSOH as undeliverable.

7) Your NYSOH account indicates that, when your Application Counselor updated your application with NYSOH on October 16, 2017, your street number was changed from [redacted] You testified your correct address is [redacted] and you were not aware of the error.

8) According to the December 6, 2017 application, you attested to an increased expected household income of $25,682.00, which is your adjusted gross income as listed on your 2016 federal tax return.

9) You enrolled in a Silver-level qualified health plan on December 14, 2017 for an effective start date of January 1, 2018.

10) You submitted an application for financial assistance on January 10, 2018, and requested help paying for medical bills in the month of December 2017.

11) You testified you received $2,000.00 in income from your personal business in the month of December 2017. You further testified you did not have any business expenses or travel expenses for this month.

12) You testified you want your Silver-level qualified health plan backdated one month to December 1, 2017, as you had medical bills which were not covered during that month.

13) Your application states you reside in [redacted] NY.

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

Applicable Law and Regulations

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 federal poverty level (FPL) for the applicable family size (42 CFR §§ 435.119(b), 435.911(b)(1), 435.603(d)(4); NY Social Services Law § 366(1)(b)).

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).

In an analysis of Medicaid eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR § 435.4). On the date of your application, that was the 2017 FPL, which is $12,060.00 for a one-person household (82 Federal Register 8831).

Generally, most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, even if they lose Medicaid eligibility because of any changes or updates they make to their NYSOH account. For example, even if income increases above the Medicaid limit allowed for the household size, the insured will remain covered under Medicaid for a 12-month period. This 12-month period is referred to as "continuous coverage" and is set based on the start date of the original Medicaid eligibility determination or the date of a subsequent Medicaid eligibility determination based on modified adjusted gross income (NY Social Services Law § 366(4)(c)).

In the following situations, individuals are not entitled to receive continuous coverage:

- Unable to locate;
- Death;
- Consumer requests to have his/her Medicaid closed;
- Failure to provide or cooperate in obtaining a Social Security Number, if otherwise required;
- Failure to provide documentation of citizenship after the reasonable opportunity period;
- Moved out of State;
- Coverage established under MAGI in error;
- Undocumented pregnant women (only get 60 days post-partum);
- Failure to comply with absent parent (IV-D) requirements; and
- Individuals receiving treatment in a setting where Medicaid eligibility is not available

(*see* 42 CFR § 435.916(a); N.Y. Soc. Serv. Law § 366(4)(c); GIS 15 MA/22).

<u>Retroactive Medicaid</u>

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)).

Redetermination During a Benefit Year

Any change resulting from redeterminations during a benefit year should be made effective the first day of the month following the date of the notice of redetermination, except that redeterminations resulting from changes made after a date specified by the state, which can be no earlier than the 15th of the month, may not be made effective until the first day of the month after the month following the date of the notice of redetermination. (45 CFR § 155.330(f)(1) and (2)). New York has specified that changes made after the 15th of a given month will take effect the month after the following month.

Legal Analysis

Initially and according to your NYSOH account, you were eligible for Medicaid as of December 1, 2016 and enrolled in a Medicaid Managed Care plan as of January 1, 2017. Therefore, your twelve months of continuous coverage was due to end as of November 30, 2017. As a result, on September 22, 2017, NYSOH issued a renewal notice indicating in part that any changes to your account needed to be made between October 16, 2017 and November 15, 2017, for coverage to continue without interruption as of December 1, 2017.

The first issue under review is whether NYSOH properly determined you were no longer eligible for Medicaid effective December 1, 2017.

According to the record, you expect to file your 2017 tax return as single and claim no dependents. Therefore, you are in a one-person household for purposes of this analysis.

On your October 16, 2017 and November 1, 2017 applications, you attested to an expected annual household income of $13,802.00. This amount included an adjusted gross income of $25,682.00 less $11,880.00 in self-employment tax.
.
Medicaid can be provided through NYSOH to adults between the ages of 19 and 64 who meet the non-financial requirements and have a household MAGI that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $12,060.00 for a one-person household. Since $13,802.00 is 116.18% of the 2017 FPL, NYSOH found you to be eligible for Medicaid on an expected annual income basis, using the information provided in your application and, on November 2, 2017, NYSOH issued an eligibility

determination that stated you were eligible for Medicaid, effective December 1, 2017.

However, your application states an incorrect amount of self-employment tax deduction of $11,880.00. The amount of self-employment tax you are permitted to take to reach adjusted gross income is one-half, the actual amount of $1,534.00, which is $767.00 as listed in your 2016 federal tax return (*see* Document [redacted] You submitted an updated application on December 6, 2017, that listed your expected annual household income to the amount stated in your 2016 tax return of $25,682.00

Under New York State law, once a person is eligible for Medicaid, that eligibility continues for 12 months, even if the household income rises above 138% of the FPL. This provision is called "continuous coverage." However, individuals are not entitled to receive Medicaid continuous coverage if their eligibility was established initially in error according to an incorrect MAGI.

You were determined no longer eligible for Medicaid as of November 15, 2017, because of return mail notices received on October 23, 2017, October 25, 2017, and November 13, 2017. The record shows your address was updated by your Application Counselor on October 16, 2017. This application changed your address from [redacted] to [redacted] You testified your correct street number is "[redacted] and you were not aware of the error in the street number, which resulted in your eligibility for Medicaid being discontinued.

Notwithstanding, the street number error of your submitted application on October 16, 2017 does not entitle you to Medicaid coverage for the month of December 2017. Instead, since your Medicaid eligibility was premised on an incorrect MAGI, the November 2, 2017 eligibility determination notice was issued in error. To rectify this error, the November 15, 2017 discontinuance notice is MODIFIED to state that you were no longer eligible for Medicaid as of December 1, 2017, because coverage was established under MAGI in error.

The second issue under review is whether NYSOH properly determined your enrollment in your Silver-level qualified health plan was effective January 1, 2018

The record shows that, on December 6, 2017, you updated the information in your NYSOH account and submitted a request to enroll in a qualified health plan on December 14, 2017.

When an individual changes information in their application on or before the 15th of any month, NYSOH must make the redetermination that results from the change effective the first day of the following month. Additionally, the date on which a qualified health 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 an including

the fifteenth day of a month goes into effect on the first day of the following month. When you submitted your enrollment in your Silver-level qualified health plan on December 14, 2017, the proper effective date was the first day of the month following December 2017; that is, on January 1, 2018.

Therefore, NYSOH's December 15, 2017 plan enrollment notice is AFFIRMED because it properly began your enrollment in your qualified health plan on January 1, 2018.

The third issue under review is whether NYSOH properly determined you were not eligible for Medicaid from December 1, 2017 through December 31, 2017.

You submitted an application for financial assistance on January 10, 2018, and requested help paying medical bills for the month of December 2017.

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.

To be eligible for Medicaid retroactively 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 $1,387.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during December 2017.

You testified that you received a gross amount of income in the month of December 2017 of $2,000.00 and did not have any deductions for business expenses or travel. Therefore, the record indicates that in the month of December 2017, you had a monthly household income of $2,000.00.

Since your income of $2,000.00 was more than the $1,387.00 monthly Medicaid limit for December 2017, NYSOH properly determined that you were not eligible for Medicaid coverage during that month. However, the January 11, 2018 eligibility determination states that you were not eligible for Medicaid for the month of December 2017, because the program you are eligible for cannot pay for any care you received in the past is not a valid reason under the law. Therefore, the January 11, 2018 eligibility determination notice is MODIFIED to state your request for help with paying medical bills from December 1, 2017

through December 31, 2017, is denied because your monthly income of $2,000.00 was over the allowable income limit of $1,387.00 for Medicaid.

Decision

The November 15, 2017 discontinuance notice is MODIFIED to state that you were no longer eligible for Medicaid as of December 1, 2017.

The December 15, 2017 plan enrollment notice is AFFIRMED.

The January 11, 2018 eligibility determination notice is MODIFIED to state your request for help with paying medical bills for December 1, 2017 through December 31, 2017, is denied because your monthly income of $2,000.00 was over the allowable income limit of $1,387.00 for Medicaid.

Effective Date of this Decision: May 17, 2018

How this Decision Affects Your Eligibility

You were ineligible for Medicaid effective December 1, 2017, because coverage was established under MAGI in error.

You were eligible for and enrolled in a Silver-level qualified health plan effective January 1, 2018.

You were ineligible for Medicaid retroactively for the month of December 2017.

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
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The November 15, 2017 discontinuance notice is MODIFIED to state that you were no longer eligible for Medicaid as of December 1, 2017.

The December 15, 2017 plan enrollment notice is AFFIRMED.

The January 11, 2018 eligibility determination notice is MODIFIED to state your request for help with paying medical bills for December 1, 2017 through

December 31, 2017, is denied because your monthly income of $2,000.00 was over the allowable income limit of $1,387.00 for Medicaid.

You were ineligible for Medicaid effective December 1, 2017, because coverage was established under MAGI in error.

You were eligible for and enrolled in a Silver-level qualified health plan effective January 1, 2018.

You were ineligible for Medicaid retroactively for the month of December 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).