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

Notice of Decision

Decision Date: May 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027763

[redacted]

Dear [redacted]

On March 15, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's January 17, 2018 eligibility determination.

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 NY State of Health 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 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027763

[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 eligible to enroll in the Essential Plan effective March 1, 2018?

Did NYSOH properly determine that you were not eligible for Medicaid, as of January 17, 2018?

Did NYSOH properly determine that you were not eligible for Medicaid for December 1, 2017 through December 31, 2017?

Procedural History

On January 2, 2018, NYSOH received your initial application for financial assistance.

On January 3, 2018, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan for a limited time, effective February 1, 2018. The notice further directed you to provide documentation confirming your income by April 2, 2018.

Also on January 3, 2018, NYSOH issued a notice confirming your enrollment in an Essential Plan, effective February 1, 2018.

On January 4, 2018, the system updated your application.

On January 5, 2018, NYSOH issued an eligibility determination notice, based on the system updated application of January 4, 2018, stating that you were eligible to enroll in the Essential Plan for a limited time, effective February 1, 2018. The notice further directed you to provide documentation confirming your income by April 2, 2018 and proof of your immigration status by April 4, 2018.

On January 10, 2018, you uploaded to your NYSOH account a copy of your I-766 employment authorization card.

On January 11, 2018, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan for a limited time, effective February 1, 2018. The notice further directed you to provide documentation confirming your income by April 2, 2018.

On January 12, 2018, you uploaded proof of income documentation.

On January 13, 2018, NYSOH issued a notice stating that the documentation you submitted had been reviewed and did not confirm the information in your application. You were directed to submit acceptable proof of income by April 2, 2018.

On January 15, 2018, you uploaded proof of income documentation which together with the documentation you submitted on January 12, 2018 was reviewed and verified on January 16, 2018 as valid proof of income. Based on this verified income documentation, your household income was increased from $15,984.00 to $22,303.71 and an updated application for financial assistance was submitted by NYSOH on your behalf.

On January 17, 2018, NYSOH issued an eligibility determination notice based on the system updated January 16, 2018 application, stating that you are eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective March 1, 2018. It further stated that you did not qualify for Medicaid because the household income of $22,303.71 is over the allowable income limit.

Also on January 17, 2018, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid for December 1, 2017 through December 31, 2017 because the monthly household income of $1,858.65 is over the allowable monthly income limit of $1,387.00.

Also on January 17, 2018, NYSOH issued a notice confirming your enrollment in an Essential Plan 1 with a $20.00 monthly premium, effective February 1, 2018.

On January 25, 2018, you contacted NYSOH’s Account Review Unit and requested an appeal of the January 17, 2018 eligibility determination notice insofar as you were not eligible for Medicaid.

On March 15, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Arabic interpreter [redacted] provided interpreter services. The record was developed during the hearing and held open until March 23, 2018 to allow you to submit supporting documents.

On March 16, 2018 and March 30, 2018, NYSOH Appeals Unit received via secure facsimile your supporting documents. Those documents were marked as Appellant's [redacted] and [redacted] respectively and are incorporated into the record.

Findings of Fact

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

1) You testified that you are seeking insurance for yourself.

2) According to your NYSOH account and your testimony, you are an Immigrant Non-Citizen.

3) Your I-766 Employment Authorization Card indicates you are in category code C08 and the card is valid from [redacted] to [redacted]

4) According to your NYSOH account and your testimony, you intend to file your taxes as single and claim no dependents.

5) According to your NYSOH account and your testimony, you reside in Nassau County.

6) According to the documentation you submitted and your testimony, you began work as [redacted] on [redacted]

7) You submitted two earning statements; the first was for pay date December 22, 2017 for the period of December 3, 2017 to December 16, 2017 for gross wages of $613.54 and the second for pay date January 5, 2018 for period of December 17, 2017 to December 30, 2017 for gross wages of $1,102.13.

8) According to your NYSOH account, your expected household income was increased from $15,984.00 to $22,303.71, based on the documentation you provided, and an updated application for financial assistance was submitted by NYSOH on your behalf on January 16, 2018.

9) According to your NYSOH account, on January 16, 2018 NYSOH determined that you were eligible for the Essential Plan with a $20.00 monthly premium effective March 1, 2018.

10) According to your NYSOH account, in the January 16, 2018 application, you requested help paying for medical bills for the previous three months.

11) You testified that you received [redacted] treatment in December 2017 and you need Medicaid coverage for that month because of this treatment.

12) Your application states that you will not be taking any deductions on your tax return.

13) Your application states that you live in Nassau County.

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

Applicable Law and Regulations

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). 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).

A person who has a household income that is at or below 150% of the FPL has a $0.00 premium contribution (New York's Basic Health Plan Blueprint, p. 21, as approved January 2016; *see* www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a $20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016).

The Essential Plan is considered minimum essential coverage therefore, a person who is eligible for the Essential Plan is not eligible for any premium tax credit because they are eligible for minimum essential coverage through the individual market (*see* 26 CFR § 1.36B-2(c)(1), 26 USC § 5000A(f)(1)(C)).

Medicaid

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 (82 Fed. Reg. 8831).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

Retroactive Medicaid

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of an initial application if the individual received medical services that would have been covered under Medicaid and the individual would have been eligible for Medicaid at the time he received the services if he had applied (42 USCA § 1396A(34); 42 CFR § 435.915(a)). The Department of Health may make eligibility effective for fee-for-service Medicaid on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

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).

Legal Analysis

The first issue under review is whether NYSOH properly determined you were eligible for the Essential Plan.

You testified, and the record indicates, that you submitted an initial application for financial assistance to NYSOH on January 2, 2018.

As a result, of that January 2, 2018 application, you were required to submit proof of your household income. On January 12, 2018 and on January 15, 2018, you uploaded to your NYSOH account, two earning statements; the first was for pay date December 22, 2017 for the period of December 3, 2017 to December 16, 2017 for gross wages of $613.54 and the second for pay date January 5, 2018 for period of December 17, 2017 to December 30, 2017 for gross wages of $1,102.13. On January 16, 2018, NYSOH verified those income documents and your household income was increased from $15,984.00 to $22,303.71, and your eligibility for financial assistance with health insurance was redetermined.

The application that was submitted on your behalf on January 16, 2018 listed an annual household income of $22,303.71 and the eligibility determination relied upon that information.

You are in a one-person household. You expect to file your 2018 income taxes as single and will claim no dependents on that tax return.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is between 138% and 200% 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 an annual household income of $22,303.71 is 184.94% of the 2017 FPL, NYSOH properly found you to be eligible for the Essential Plan.

The second issue is whether NYSOH properly determined that you were not eligible for Medicaid.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income 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 $22,303.71 is 184.04% of the 2017 FPL, NYSOH

properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.
Since the January 17, 2018 eligibility determination notice properly stated that, based on the information you provided, you were eligible for the Essential Plan, it was correct and is AFFIRMED.

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

You applied for financial assistance through NYSOH on January 16, 2018 and requested help in paying for medical bills for the month of December 2017.

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.

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.

You testified that you are seeking Medicaid for the month of December 2017 because you had medical treatment that month in an [redacted] and have bills for that treatment.

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 $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 and provided documentation that you started employment as a [redacted] on [redacted]. You submitted earning statements that show you were paid only once in December 2017. The earning statement dated December 22, 2017 shows that you received $613.54 in gross wages. Therefore, the record indicates that in the month of December 2017, you had a monthly household income of $613.54.

Since the record now contains a more accurate representation of what your income was for the month of December 2017, your case is RETURNED to NYSOH to consider your request for retroactive coverage for December 2017

based on a household size of one person and household income of $613.54 for the month of December 2017.

Decision

The January 17, 2018 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage based on a household size of one and household income of $613.54 for the month of December 2017 and to notify you accordingly.

Effective Date of this Decision: May 10, 2018

How this Decision Affects Your Eligibility

You remain eligible for the Essential Plan.

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your eligibility for retroactive Medicaid for the month of December 2017 based on the evidence in the record.

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 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
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The January 17, 2018 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage based on a household size of one and household income of $613.54 for the month of December 2017 and to notify you accordingly.

You remain eligible for the Essential Plan.

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your eligibility for retroactive Medicaid for the month of December 2017 based on the evidence in the record.

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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