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

Notice of Decision

Decision Date: April 27, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028587

On April 6, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's January 13, 2018 eligibility determination notice, and February 8, 2018 plan enrollment 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 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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nystateofhealth
The Official Health Plan Marketplace

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

Decision

Decision Date: April 27, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000028587

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 not eligible for Medicaid for the months of September 2017 and October 2017?
>
> Did NYSOH properly determine that your enrollment in your Medicaid Managed Care plan was effective March 1, 2018?

Procedural History

On December 18, 2017, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for September 2017, October 2017 and November 2017.

On December 19, 2017, NYSOH issued a notice stating that more information was needed to make a determination as to your eligibility for financial assistance. The notice explained the income information you entered into your application did not match what was obtained from state and federal data sources. You were instructed to submit income documentation for your household by January 2, 2018.

On January 13, 2018, NYSOH issued a denial notice stating that you did not qualify for health coverage through NYSOH or financial assistance because proof of your income was not received by the due date.

Also on January 13, 2018, NYSOH issued an eligibility determination notice stating that you were not eligible for retroactive Medicaid coverage for the months of September 2017, October 2017, and November 2017, because you did not provide proof of your income.

On February 7, 2018, you updated your application for financial assistance. That day, a preliminary eligibility determination was prepared stating that you were eligible for Medicaid beginning February 1, 2018, and retroactive Medicaid for the months of November 2017, December 2017 and January 2018. You selected a Medicaid Managed Care plan for enrollment as of March 1, 2018.

Also on February 7, 2018, you spoke to NYSOH's Account Review Unit and appealed the denial of your request for Medicaid for the months of September 2017 and October 2017, and the start date of your enrollment in your Medicaid Managed Care plan insofar as it did not begin on January 1, 2018.

On February 8, 2018, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in Medicaid, effective February 1, 2018.

Also on February 8, 2018, NYSOH issue a plan enrollment notice stating that your enrollment in your Medicaid Managed Care plan was effective March 1, 2018.

Finally, on February 8, 2018, NYSOH issued a retroactive Medicaid eligibility notice stating that you were eligible for Medicaid for the months of November 2017, December 2017, and January 2018.

On April 6, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held until April 20, 2018, to allow you to submit supporting documents.

As of April 20, 2018, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day and this Decision is based on the record as developed at the time of the hearing.

Findings of Fact

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

1) You testified that you are seeking retroactive Medicaid for the months of September 2017 and October 2017, because you have medical bills from those months.

2) According to your NYSOH account and your testimony, you submitted an application for financial assistance on December 18, 2017 online with the assistance of a Certified Application Counselor (CAC). Your application states that you have no income in December 2017, will not have income for 2018, that your income for the months of September 2017 and October 2017, and November 2017 was $0.00, and that you rely on your girlfriend for financial support.

3) You testified that this information was correct. You further testified that you have not worked since 2015, that you do not have any income, that you rely on your family for support, and that you do not have an address because you do not have a permanent place to live, but you have a family member who allows you to use her home address to receive mail.

4) According to the wage details as obtained from federal and state data sources pulled on December 18, 2017, as contained in your NYSOH account, you had no yearly income for 2016, and only had income of $540.00 in the first quarter of 2017. There are no other wage details.

5) On December 19, 2017, NYSOH issued a notice requesting you submit proof of your income by January 2, 2018.

6) According to your NYSOH account and your testimony, you did not submit income documents because you have no sources of income

7) According to your NYSOH account and your testimony, you updated your application for financial assistance on February 7, 2018, over the telephone with the assistance of a CAC. That application states that you will not have income for 2018, that your income for the months of November 2017, December 2017, and January 2018 was $0.00.

8) On February 8, 2018, you were found eligible for Medicaid beginning February 1, 2018, and retroactive Medicaid for the months of November 2017, December 2017, and January 2018, because you had no income in any of these months.

9) According to your NYSOH account, you selected a Medicaid Managed Care plan for enrollment on February 7, 2018, which began March 1, 2018.

10) The applications submitted on December 18, 2017 and February 7, 2018, state that you plan on filing your taxes as single, and you will not claim any dependents.

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

Applicable Law and Regulations

Medicaid

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

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)).

Medicaid Managed Care plan enrollments received on or before the fifteenth day of the month are effective the first day of the following month. Enrollments received after the fifteenth day of the month are effective the first day of the second following month (Medicaid Managed Care Model Contract (Appendix H-6(b)(ii) & (iii), effective 3/1/2014 – 2/28/2019; *see* 42 USC § 1315; § 364-j(1)(c); 18 NYCRR § 360-10.3(h), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were not eligible for Medicaid for the months of September 2017 and October 2017.

You submitted an application for financial assistance on December 18, 2017, and indicated that you were seeking help for paying for medical bills for September 2017, October 2017 and November 2017. Your application states that you have no income in December 2017, will not have income for 2018, that your income for the months of September 2017, October 2017, and November 2017 was $0.00, and that you rely on your girlfriend for financial support. Your testimony is corroborated by the wage details in your NYSOH account.

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.

You testified that you are seeking retroactive Medicaid for September 2017 and October 2017 because you had health problems during those months and received medical 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 September 2017 and October 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.

The January 13, 2018 notice denying you retroactive Medicaid for the months of September 2017 and October 2017, states that you are not eligible for Medicaid during these months because you did not provide the income documentation needed to verify the income listed in your December 18, 2017 application.

However, the credible evidence of record, including the wage details from federal and state data sources, reflects that you did not have income during the months of September 2017, October 2017, November 2017, and December 2017.

You credibly testified that you have not worked since 2015, and that you rely on your girlfriend and family for financial support. You further testified that you do not have an address because you do not have a permanent place to live, and that you have a family member who allows you to use her home address to receive mail.

Additionally, you attested that you do not have income in both your December 18, 2017 and February 7, 2018 applications, but you were only asked to submit proof that you had no income after your December 18, 2017 application. Your attestation along with the wage details obtained from federal and state data sources on December 18, 2017, were sufficient to establish you had no income for your February 7, 2018 application. As a result, NYSOH determined that you were eligible for Medicaid beginning February 1, 2018, and eligible for retroactive Medicaid for the months of November 2017, December 2017 and January 2018.

Since you credibly testified that you do not have income, as corroborated by the wage details NYSOH obtained from federal and state data sources on December 18, 2017, that you do not have a residence, that you receive financial support from your girlfriend and family, and because NYSOH determined your attestation

to this effect was sufficient to establish you did not have income for the months of November 2017, December 2017 and January 2018, it is reasonable to conclude that, based on all the facts and circumstances in your particular case, there is sufficient evidence that you did not have income in the months of September 2017 and October 2017.

Therefore, the January 13, 2018 denial notice and eligibility determination notice of retroactive Medicaid stating respectively that you were not eligible for Medicaid as of January 1, 2018, and not eligible for retroactive Medicaid in the months of September 2017 through November 2017, are incorrect and are RESCINDED.

The February 8, 2018 eligibility determination notice finding you eligible for Medicaid effective February 1, 2018, is MODIFIED to state you were eligible for Medicaid as of December 1, 2017.

The February 8, 2018 eligibility determination stating in part that you were eligible for retroactive Medicaid for the month of November 2017, will not be disturbed. The remainder of that notice stating that you were eligible for retroactive Medicaid in December 2017 and January 2018 is SUPERCEDED (replaced) by the modification of the eligibility determination notice directly above.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for September 2017 and October 2017, using a household income of $0.00 and a one-person household, for an individual residing in [redacted].

The second issue is whether NYSOH properly determined that your enrollment in your Medicaid Managed Care plan was effective March 1, 2018.

The record reflects that you contacted NYSOH on February 7, 2018 and selected a Medicaid Managed Care plan for enrollment that day.

The date on which a Medicaid Managed Care 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 will go into effect on the first day of the following month. A plan that is selected on or after the sixteenth day of the month will go into effect on the first day of the second following month.

On February 7, 2018, you selected a Medicaid Managed Care plan, so it properly took effect on the first day of the month following after February; that is, on March 1, 2018.

Therefore, the February 8, 2018 plan enrollment notice stating that your enrollment in your Medicaid Managed Care plan would be effective March 1, 2018, was correct and must be AFFIRMED.

Decision

The January 13, 2018 denial notice and eligibility determination notice of retroactive Medicaid stating respectively that you were not eligible for Medicaid as of January 1, 2018, and not eligible for retroactive Medicaid in the months of September 2017 through November 2017, are incorrect and are RESCINDED.

The February 8, 2018 eligibility determination notice stating that you were eligible for Medicaid effective February 1, 2018, is MODIFIED to state you were eligible for Medicaid as of December 1, 2017.

The February 8, 2018 eligibility determination stating in part that you were eligible for retroactive Medicaid for the month of November 2017, will not be disturbed. The remainder of that notice stating you were eligible for retroactive Medicaid in December 2017 and January 2018 is SUPERCEDED (replaced) by the modification of the eligibility determination notice directly above.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for September 2017 and October 2017, using a household income of $0.00 and a one-person household, for an individual residing in [redacted], and to notify you accordingly.

The February 8, 2018 plan enrollment notice is AFFIRMED.

Effective Date of this Decision: April 27, 2018

How this Decision Affects Your Eligibility

By this Decision, you are determined eligible for Medicaid effective December 1, 2017. You will have coverage under Medicaid Fee-For-Services as of December 1, 2017 through February 28, 2018.

Your eligibility for retroactive Medicaid coverage for the month of November 2017 remains in effect.

This is not a final determination of your eligibility for retroactive Medicaid for the months of September 2017 and October 2017. Your case is sent back to NYSOH to redetermine your eligibility for each of these months based on the parameters noted above. NYSOH will notify you of its redetermination.

The effective date of your Medicaid Managed Care plan is March 1, 2018.

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 January 13, 2018 denial notice and eligibility determination notice of retroactive Medicaid stating that you were not eligible for Medicaid as of January 1, 2018, and not eligible for retroactive Medicaid in the months of September 2017 through November 2017, are incorrect and are RESCINDED.

The February 8, 2018 eligibility determination notice stating that you were eligible for Medicaid effective February 1, 2018, is MODIFIED to state you were eligible for Medicaid as of December 1, 2017.

The February 8, 2018 eligibility determination stating in part that you were eligible for retroactive Medicaid for the month of November 2017, will not be disturbed. The remainder of that notice stating you were eligible for retroactive Medicaid in December 2017 and January 2018 is SUPERCEDED (replaced) by the modification of the eligibility determination notice directly above.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for September 2017 and October 2017, using a household income of $0.00 and a one-person household, for an individual residing in [redacted], and to notify you accordingly.

The February 8, 2018 plan enrollment notice is AFFIRMED.

By this Decision, you are determined eligible for Medicaid effective December 1, 2017. You will have coverage under Medicaid Fee-For-Services as of December 1, 2017 through February 28, 2018.

Your eligibility for retroactive Medicaid coverage for the month of November 2017 remains in effect.

This is not a final determination of your eligibility for retroactive Medicaid for the months of September 2017 and October 2017. Your case is sent back to NYSOH to redetermine your eligibility for each of these months based on the parameters noted above. NYSOH will notify you of its redetermination.

The effective date of your Medicaid Managed Care plan is March 1, 2018.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

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)

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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।

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 निःशुल्क 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.

(Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 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).

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