



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

Notice of Decision

Decision Date: April 06, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000014295

[REDACTED]

Dear [REDACTED],

On March 21, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 10, 2016 eligibility determination notice and December 15, 2016 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 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).

This page intentionally left blank.



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

Decision

Decision Date: April 06, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000014295

[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 a qualified health plan at full cost, effective December 1, 2016?

Did NYSOH properly determine that your Medicaid Managed Care plan coverage began effective January 1, 2017?

Procedural History

On December 8, 2015, NYSOH issued an eligibility determination notice based on the December 7, 2015 application requesting financial assistance. The notice stated that you remained eligible for Medicaid, effective December 1, 2015.

Also on December 8, 2015, NYSOH issued an enrollment notice confirming your enrollment in a Medicaid Managed Care (MMC) plan as of December 7, 2015. The notice confirmed that your MMC plan coverage had been in effect since February 1, 2015.

On October 8, 2016, NYSOH issued a renewal notice, stating that it was time to renew your health insurance for the upcoming coverage year. That notice stated that, based on information from federal and state sources, NYSOH could not determine whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by November 15, 2016 or you might lose the financial assistance you were currently receiving.

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).

On November 9, 2016, NYSOH received an update to your application, in which you declined financial assistance.

On November 10, 2016, NYSOH issued an eligibility determination notice stating that you were newly eligible to purchase a qualified health plan at full cost, effective December 1, 2016.

Also on November 10, 2016, NYSOH issued a disenrollment notice confirming that your MMC plan coverage would end effective November 30, 2016.

Finally, on November 10, 2016, NYSOH issued an enrollment notice confirming your selection of a qualified health plan (QHP) as of November 9, 2016. The notice stated that your QHP coverage would begin effective December 1, 2016, and that a premium of \$750.76 was due before coverage would begin.

On December 14, 2016, NYSOH received three additional updates to your application for health insurance. The first two updates reflected that you were not seeking financial assistance to help pay for health insurance through NYSOH, while the final update reflected that you were in fact seeking financial assistance.

On December 15, 2016, NYSOH issued an eligibility determination notice based on the final application update submitted to your account on December 14, 2016. The notice stated that you were eligible for Medicaid, effective December 1, 2016.

Also on December 15, 2016, NYSOH issued a disenrollment notice confirming that your QHP coverage would end effective January 1, 2017. This was because you were no longer eligible for QHP through NYSOH based on your eligibility determination.

Finally, on December 15, 2016, NYSOH issued an enrollment notice confirming your selection of an MMC plan as of December 14, 2016. The notice stated that your MMC plan coverage would resume effective January 1, 2017.

On December 23, 2016, you spoke to NYSOH's Account Review Unit and appealed insofar as you were seeking for your QHP coverage to be cancelled effective December 1, 2016, and for your MMC plan coverage to continue uninterrupted.

On March 21, 2017, 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 were enrolled in an MMC plan with coverage beginning February 1, 2015.
- 2) You testified that you received the renewal notice issued on October 8, 2016, and called up NYSOH to renew your coverage for the following plan year.
- 3) NYSOH received a revised application on November 9, 2016, which indicated that you were not seeking financial assistance.
- 4) You testified that when you spoke with the NYSOH representative on November 9, 2016 to update your application, you were seeking to remain eligible for Medicaid since you had been enrolled in Medicaid for the prior two years.
- 5) You were found eligible to enroll in a QHP at full cost, effective December 1, 2016.
- 6) You enrolled in a QHP on November 9, 2016 at the full cost of \$750.76 per month, with coverage beginning December 1, 2016.
- 7) You testified that you enrolled in the QHP and paid the premium of \$750.76 because you believed it was for a full year of coverage, not for just the month of December 2016.
- 8) You testified that you had been reenrolled for the QHP coverage for the 2017 plan year, and the premium increased by \$100.00 per month, and that this coverage was unaffordable to you.
- 9) You testified, and your account reflects, that you further revised your application on December 14, 2016, and were found eligible for Medicaid effective December 1, 2016.
- 10) You testified, and your account reflects, that you enrolled in an MMC on December 14, 2016, and your coverage under that plan resumed effective January 1, 2017.
- 11) You testified that you wanted your QHP coverage cancelled effective December 1, 2016 so that you could be reimbursed for expenses you incurred, in addition to having your MMC plan coverage resume as of December 1, 2016, rather than January 1, 2017.

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

Applicable Law and Regulations

Medicaid Renewal

In general, NYSOH must review Medicaid eligibility once every 12 months or “whenever it receives information about a change in a beneficiary’s circumstances that may affect eligibility” (42 CFR § 435.916(a)(1), (d)). NYSOH must make its “redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual’s account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency” (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates that may have been provided by the individual (45 CFR §155.335(h)).

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 2010,13 ADM-03(III)(F)).

Medicaid Managed Care (MMC) 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; NY Social Services Law § 364-j(1)(c); 18 NYCRR § 360-10.3(h); Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13 ADM-03(III)(F)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible to enroll in a QHP at full cost, effective December 1, 2016.

You were originally found eligible for Medicaid, effective November 1, 2015. Your MMC plan coverage had been in effect since February 1, 2016.

Generally, NYSOH must redetermine a qualified individual's eligibility for Medicaid once every 12 months without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency. NYSOH's October 8, 2016 renewal notice stated that there was not enough information to determine whether you were eligible to continue your financial assistance for health insurance, and that you needed to supply additional information by November 15, 2016, or your financial assistance might end.

The record reflects that you updated your account on November 9, 2016, and application update in which you did not request financial assistance, and were found eligible to enroll in a QHP at full cost, effective December 1, 2016.

The record reflects that you enrolled in a QHP with a premium of \$750.76 per month, with such coverage beginning December 1, 2016.

You credibly testified that you never intended to switch your application from one seeking financial assistance to one in which you were not seeking financial assistance during your November 9, 2016 call with a NYSOH representative. You further testified that you enrolled in a QHP at that point since you believed that was the coverage you were entitled to, and that your \$750.76 premium paid during the month of December 2016 was for the entire coverage year, not just for the month of December 2016.

Additionally, despite multiple contacts between you and NYSOH, NYSOH has not produced any evidence to contradict your statement that you had no intention of changing your application to one no longer requesting financial assistance.

Based both on your prior and current eligibility for Medicaid, and the information provided in your applications that those time, we find your testimony credible insofar as you were not seeking to switch your application to one not seeking financial assistance on November 9, 2016.

Accordingly, the November 10, 2016 eligibility determination notice is **RESCINDED**.

The second issue is whether NYSOH properly determined that your MMC plan coverage began not earlier than effective January 1, 2017.

You first renewed your eligibility for financial assistance through NYSOH for the upcoming coverage year on November 9, 2016, and therefore we must assume that the information you provided at that time is the information that would have been used had you been timely informed of the need to update your account, as stated in the renewal notice.

Had the information been submitted at that time, your enrollment in your MMC plan would have begun on December 1, 2016.

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).

Therefore, the December 15, 2016 enrollment notice is MODIFIED to state that your enrollment in your MMC plan was effective December 1, 2016.

Furthermore, your case is RETURNED to NYSOH to facilitate with your QHP insurance carrier for reimbursement of the premium paid, if any, for coverage during December 2016.

Decision

The November 10, 2016 eligibility determination notice is RESCINDED.

The December 15, 2016 enrollment notice is MODIFIED to state that your enrollment in your MMC plan was effective December 1, 2016.

Your case is RETURNED to NYSOH to facilitate with your QHP insurance carrier for reimbursement of the premium paid, if any, for coverage during December 2016.

Effective Date of this Decision: April 06, 2017

How this Decision Affects Your Eligibility

Your QHP coverage is cancelled effective December 1, 2016.

Your MMC plan coverage is reinstated for the month of December 2016.

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

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).

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 10, 2016 eligibility determination notice is RESCINDED.

The December 15, 2016 enrollment notice is MODIFIED to state that your enrollment in your MMC plan was effective December 1, 2016.

Your QHP coverage is cancelled effective December 1, 2016.

Your MMC plan coverage is reinstated for the month of December 2016.

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).

Your case is RETURNED to NYSOH to facilitate with your QHP insurance carrier for reimbursement of the premium paid, if any, for coverage during December 2016.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



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 مجاناً.

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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&btumi ama wo obi a okyerE 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).