



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

Notice of Decision

Decision Date: May 31, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000014508

[REDACTED]

Dear [REDACTED]

On March 31, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 23, 2016 eligibility determination notice and the December 29, 2016 enrollment confirmation notice, as well as NYSOH's determination that your fee-for-service Medicaid coverage became effective November 1, 2016.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:
NY State of Health Appeals
P.O. Box 11729
Albany, NY 12211
- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the Account ID at the top of this notice.

Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY - Spanish: 1-877-662-4886).

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DEPARTMENT OF HEALTH
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Decision

Decision Date: May 31, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000014508

[REDACTED]

Issues

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

Did NY State of Health (NYSOH) properly determine, in the first preliminary determination of December 22, 2016, that your fee-for-service Medicaid coverage became effective November 1, 2016?

Did NYSOH properly determine your enrollment in your Medicaid Managed Care plan was effective no earlier than February 1, 2017?

Procedural History

On October 19, 2016, NYSOH issued a renewal notice stating that NYSOH did not have enough information to determine your eligibility for the upcoming coverage year, and that you needed to update your application between November 16, 2016 and December 15, 2016 to see what you would qualify for on January 1, 2017.

On November 27, 2016, NYSOH issued a disenrollment notice advising you that your enrollment in your plan would end on December 31, 2016 because you were no longer eligible to remain enrolled in that plan, referring to the eligibility determination notice previously sent.

On November 30, 2016, NYSOH received your updated application for financial assistance with health insurance.

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On December 1, 2016, NYSOH issued a notice stating that the information in your application did not match information obtained from state and federal data sources. The notice directed you to submit proof of your income by December 15, 2016 or NYSOH would not be able to determine your eligibility for health insurance for the upcoming year.

On December 22, 2016, NYSOH systematically redetermined your eligibility. A preliminary eligibility determination was prepared that day finding you eligible for Medicaid, effective November 1, 2016.

Also on December 22, 2016, you contacted NYSOH and updated the income information in your application.

On December 23, 2016, NYSOH issued an eligibility determination notice, based on your December 22, 2016 updated application, not the systematic determination, stating that based on your new application, you were no longer eligible for Medicaid, effective January 1, 2017. Based on the systematic determination that had been done earlier that day, finding you preliminarily eligible for Medicaid, NYSOH found that your Medicaid coverage would continue until October 31, 2017, because certain individuals who qualified for Medicaid get coverage for 12 continuous months from the date they were last determined eligible. However, no formal eligibility determination was issued regarding the earlier, preliminary determination.

On December 29, 2016, NYSOH issued a notice of enrollment, based on your December 28, 2016 plan selection, confirming your enrollment in a Medicaid Managed Care plan, effective February 1, 2017.

On January 2, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were not eligible for 12 months of continuous Medicaid coverage beginning January 1, 2017.

On March 31, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open until April 14, 2017 to allow you to submit supporting documents.

On April 3, 2017, April 12, 2017, and April 13, 2017, NYSOH received the requested documentation and it was collectively incorporated into the record as Appellant's Exhibit #1, the record closed thereafter.

Findings of Fact

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

- 1) You enrolled in a qualified health plan (QHP) through NYSOH, effective January 1, 2016.
- 2) On October 19, 2016, NYSOH issued a notice directing you to update your account by December 15, 2016 for the upcoming coverage year.
- 3) On November 27, 2016, NYSOH issued a disenrollment notice indicating your coverage through your QHP would end on December 31, 2016.
- 4) On November 30, 2016, you updated your application online. That application listed your annual income as \$6,206.00 consisting of \$2,300.00 in earned income from your employer [REDACTED] and \$3,906.00 in unemployment insurance benefits (UIB).
- 5) Also on November 30, 2016, you uploaded income documentation from the NYS Department of Labor relating to an October 17, 2016 claim of Unemployment Insurance Benefits [REDACTED]. The documentation indicated your weekly gross benefit rate was \$217.00.
- 6) You testified the income amount listed in the November 30, 2016 application was inaccurate for 2016 because it did not include the income you earned from your employer [REDACTED].
- 7) You uploaded a letter to your NYSOH account on April 12, 2017 indicating you had checked your notes after the hearing and determined that the income amount listed in the November 30, 2016 application was your anticipated income for 2017 [REDACTED], because you had lost your job with [REDACTED] in October 2016, so you did not include that income in the application for the upcoming year.
- 8) You testified you lost your job with [REDACTED] in October 2016 and your only income in November 2016 was UIB of \$217 gross weekly.
- 9) On April 3, 2017, you uploaded a print-out from NYS Department of Labor website of your Official Record of Benefit Payment History indicating you received the following payments in November 2016:
 - a. \$108.50 gross payment on November 13, 2016
 - b. \$217.00 gross payment on November 20, 2016

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c. \$217.00 gross payment on November 27, 2016

- 10) On December 15, 2016, NYSOH verified the documents you had previously submitted on November 30, 2016. Based on this documentation, NYSOH confirmed the annual income amount of \$6,206.00 listed in the November 30, 2016 application.
- 11) Your eligibility was systematically redetermined on December 22, 2016 and NYSOH prepared a preliminary determination that day finding you eligible for Medicaid, effective November 1, 2016.
- 12) Subsequently, on December 22, 2016, you contacted NYSOH and updated the income information in your application increasing it to \$15,447.87.
- 13) You testified the income amount listed in the December 22, 2016 application was your estimated annual income for 2016.
- 14) Based on the application updated on December 22, 2016, NYSOH issued an eligibility determination notice dated December 23, 2016 stating you were no longer eligible for Medicaid, but your Medicaid coverage would be continued until October 31, 2017, because certain individuals who qualified for Medicaid get coverage for 12 continuous months from the date they were last determined eligible.
- 15) The December 23, 2016 eligibility determination notice stated that you were no longer eligible for Medicaid because the income you provided of "\$15,447.87 [wa]s over the allowable income limit of \$16,395.00" (*sic*).
- 16) According to your account, you selected a Medicaid Managed Care plan on December 28, 2016. Your coverage through this plan became effective February 1, 2017.
- 17) You testified your Medicaid coverage should not begin before January 1, 2017 because you were covered by your QHP prior to then, so you did not need Medicaid coverage.
- 18) You testified that it does not make sense that your Medicaid coverage would begin prior to the date of your eligibility determination.
- 19) You testified you should be guaranteed 12 months of continuous Medicaid coverage running from January 1, 2017 to December 31, 2017.
- 20) You testified you were not permitted to enroll in a Medicaid Managed Care plan until the end of December because the application process dragged on for a month. Therefore, you testified your coverage did not begin until

February 1, 2017 resulting in a gap in coverage through a health plan for the month of January 2017.

- 21) You testified you are seeking to have your coverage through your Medicaid Managed Care plan backdated to January 1, 2017.
- 22) You testified you will file your 2017 tax return with a tax filing status of married filing single and you will claim no dependents on that return.

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

Applicable Law and Regulations

Medicaid - Eligibility

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)).

Medicaid – Effective Dates of Coverage

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)).

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)).

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).

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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 your fee-for-service Medicaid coverage became effective November 1, 2016.

On October 19, 2016, NYSOH issued a notice directing you to update your account by December 15, 2016 for the upcoming coverage year. In response, on November 30, 2016, you updated your application listing your anticipated annual income for 2017 as \$6,206.00. Also on November 30, 2016, you submitted income documentation from the NYS Department of Labor relating to an October 17, 2016 claim for Unemployment Insurance Benefits (UIB). This documentation indicated your weekly gross benefit rate was \$217.00. Following the November 30, 2016 application your eligibility was pending NYSOH's verification of the income amount listed in your application.

On December 15, 2016, NYSOH verified your income documentation and confirmed the information in your November 30, 2016 application. On December 22, 2016, your eligibility was systematically redetermined and NYSOH prepared a preliminary determination that day finding you eligible for Medicaid, effective November 1, 2016.

However, before NYSOH could issue a written eligibility determination, on December 22, 2016 you contacted NYSOH and updated the income information in your application, increasing it to \$15,447.87. You testified this amount was your estimated annual income for 2016. As a result, NYSOH issued an eligibility determination notice on December 23, 2016 stating you were no longer eligible for Medicaid, but that your Medicaid coverage would be continued until October 31, 2017, because certain individuals who qualified for Medicaid get coverage for 12 continuous months from the date they were last determined eligible.

You appealed the effective dates of your fee-for-service Medicaid coverage as stated in the December 23, 2016 eligibility determination insofar as you were not found eligible for 12 months of continuous Medicaid coverage beginning January 1, 2017.

Pursuant to the above regulations, 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. You updated your application on November 30, 2016 with your anticipated annual income for 2017 and you submitted proof of your income the same day. This documentation was later verified by NYSOH and you were

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determined eligible for Medicaid on December 22, 2016, based on your verified November 30, 2016 application. Accordingly, as your eligibility was based on an application filed in November 2016, your eligibility properly became effective the first day of that month; that is, November 1, 2016.

Although you testified, and your account confirms, you had coverage through your qualified health plan in November and December 2016, and therefore you did not need Medicaid coverage, this is not relevant to a determination of the effective date of your Medicaid coverage. As discussed above, the effective date of your Medicaid coverage is based on the date in which you submitted the application resulting in your Medicaid eligibility. Your account confirms you were simultaneously covered by your qualified health plan and fee-for-service Medicaid in the months of November and December 2016.

The second issue under review is whether NYSOH properly determined your enrollment in your Medicaid Managed Care plan was effective no earlier than February 1, 2017.

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.

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.

As discussed above, you submitted an updated application on November 30, 2016 listing your anticipated 2017 annual income as \$6,206.00. The income amount in this application did not match information received by NYSOH from federal and state data sources, and did not accurately reflect your income for 2016. Accordingly, you were directed to submit documentation to confirm your income.

On November 30, 2016, you uploaded income documentation from the NYS Department of Labor relating to an October 17, 2016 claim of Unemployment Insurance Benefits. The documentation indicated your weekly gross benefit rate was \$217.00. According to your account, this documentation was verified by NYSOH on December 15, 2016 and you were determined eligible for Medicaid based on the verified income amount listed in your November 30, 2016 application. However, a Medicaid Managed Care plan enrollment was not submitted until December 28, 2016. This resulted in a February 1, 2017 coverage start date.

You testified you tried to select a Medicaid Managed Care plan several times online in the month of December 2016, but you were not permitted to do so until

the end of the month. You testified that as a result, you did not have coverage through a health plan in the month of January 2017.

As the evidence confirms the income documentation you submitted on November 30, 2016 was verified by NYSOH on December 15, 2016 resulting in your eligibility for Medicaid, it is concluded you should have been permitted to select a Medicaid Managed Care plan that day.

Based on the regulations, 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.

Had you been permitted to select a Medicaid Managed care plan on December 15, 2016, the date the information in your November 30, 2016 application was confirmed, your coverage through this plan would have become effective on the first day of the first month following December; that is, on January 1, 2017.

Therefore, the December 29, 2016 enrollment confirmation notice stating your Medicaid Managed Care plan coverage was effective February 1, 2017 is MODIFIED to reflect your coverage was effective January 1, 2017.

Decision

The December 23, 2016 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to issue an eligibility determination notice based on the verified November 30, 2016 application in accordance with this decision.

The December 29, 2016 enrollment confirmation notice is MODIFIED to reflect your Medicaid Managed Care plan coverage was effective January 1, 2017.

Your case is RETURNED to NYSOH to facilitate a correction of your Medicaid Managed Care plan enrollment start date in accordance with this decision.

Effective Date of this Decision: May 31, 2017

How this Decision Affects Your Eligibility

Your eligibility for fee-for-service Medicaid was effective November 1, 2016.

Your case is being sent back to NYSOH to issue an eligibility determination notice based on your November 30, 2016 application in accordance with this decision.

The effective date of your Medicaid Managed Care plan is January 1, 2017.

Your case is being sent back to NYSOH to ensure your enrollment in your Medicaid Managed Care plan is effective January 1, 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 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).

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 December 23, 2016 eligibility determination is **RESCINDED**.

Your case is **RETURNED** to NYSOH to issue an eligibility determination notice based on the verified November 30, 2016 application in accordance with this decision.

The December 29, 2016 enrollment confirmation notice is **MODIFIED** to reflect your Medicaid Managed Care plan coverage was effective January 1, 2017.

Your case is **RETURNED** to NYSOH to facilitate a correction of your Medicaid Managed Care plan enrollment start date in accordance with this decision.

Your eligibility for fee-for-service Medicaid was effective November 1, 2016.

The effective date of your Medicaid Managed Care plan is January 1, 2017.

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 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&tumi 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.

שׂוּדִישׁ (Yiddish)

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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).