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

Notice of Decision

Decision Date: May 18, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014812

[redacted]

Dear [redacted],

On April 11, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 17, 2016 eligibility determination, January 4, 2017 eligibility determination and January 8, 2017 plan enrollment notices.

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

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

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- Sending a Fax to 1-855-900-5557

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

Legal Authority

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

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

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

Decision

Decision Date: May 18, 2017

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000014812

[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 you were eligible for an advance payment of the premium tax credit (APTC) in an amount of up to $789.00 per month, effective January 1, 2017?
>
> Did NYSOH properly determine you were ineligible for Medicaid effective December 1, 2016?
>
> Did NYSOH properly determine that your Medicaid Managed Care plan began February 1, 2017?

Procedural History

On October 31, 2016 and November 1, 2016, in response to NYSOH's request, you submitted your spouse's four consecutive paystubs dated October 2016 (*see* Document [redacted]).

On November 1, 2016 and November 2, 2016, NYSOH issued notices stating more information was needed to make a determination. The notice explained the income documentation you provided NYSOH did not match what was obtained from state and federal data sources. You were asked to submit income documentation for your household by November 15, 2016 and November 16, 2016, respectively.

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On November 17, 2016, November 26, 2016, and December 1, 2016, NYSOH issued notices, based on your November 16, 2016, November 25, 2016 and November 30, 2016 updated applications respectively, stating more information was needed to make a determination. The notices explained the income documentation you provided NYSOH did not match what was obtained from state and federal data sources. You were asked to submit additional income documentation for your household by December 1, 2016, December 10, 2016, and December 15, 2016, respectively.

On November 21, 2016, NYSOH invalidated your spouse's October 2016 pay stubs.

On December 1, 2016, December 9, 2016, and December 13, 2016, in response to NYSOH's requests, you submitted your spouse's four consecutive weekly paystubs dated November 10, 2016 through December 1, 2016 (including his final paystub from his former employer), an attestation letter stating that you were no longer employed and that your spouse was your sole source of income, proof of your spouse's termination of former employment, and proof of his new employment including his hourly rate of pay and number of hours expected to work each week (*see* Documents [redacted])

These documents were subsequently validated by NYSOH on December 16, 2016 and a new application was submitted on your behalf

On December 17, 2016, NYSOH issued an eligibility determination notice finding you eligible to share with your spouse in advance payments of the premium tax credit in an amount up to $789.00 per month effective January 1, 2017.

On December 22, 2016, NYSOH issued a notice, based on your December 21, 2016 updated application, stating more information was needed to make a determination. The notice explained the income documentation you provided NYSOH did not match what was obtained from state and federal data sources. You were asked to submit income documentation for your household by January 5, 2017.

On December 23, 2016, you submitted your spouse's three consecutive paystubs from his new employer, a letter of attestation that your spouse does not have four paystubs from his new employer, and a letter of attestation that you have not worked since May 2016 (*see* Documents: [redacted])

These income documents were validated by NYSOH on January 3, 2017.

On January 4, 2017, NYSOH issued an eligibility determination notice finding you eligible for Medicaid effective January 1, 2017.

On January 8, 2017, NYSOH issued a plan enrollment notice, based on your January 7, 2017 plan selection, confirming your selection of a Medicaid Managed Care plan and an enrollment start date of February 1, 2017.

On January 12, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of the start date of your Medicaid Managed Care plan, requesting that it begin December 1, 2016.

On April 11, 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) According to your NYSOH account and your testimony you are seeking to have your health coverage backdated to December 1, 2016. Additionally, you would like your Medicaid Managed Care plan to start as of that date.

2) According to your NYSOH account, you initially applied for health insurance through NYSOH on October 17, 2016. You were placed in pending Medicaid status and were required to submit proof of household income to confirm your eligibility.

3) According to your NYSOH account and your testimony, you filed your 2016 taxes with a tax filing status of married filing jointly. You claimed two dependents on that tax return.

4) The application that was submitted on October 17, 2016 listed annual household income of $27,560.00, consisting of earnings your spouse receives from employment. You testified that your spouse's earnings are your sole source of household income.

5) You testified that, on October 17, 2016, you submitted your proof of household income including your spouse's paystubs and a letter of attestation stating that you were no longer employed as of May 2016. You testified that you submitted a letter of no employment for yourself because, when you called NYSOH and a representative, you were advised that this was the only thing you still needed to submit.

6) According to your NYSOH account, as of December 13, 2016, you submitted the following: (1) your spouse's consecutive weekly paystubs including his final paystub for [redacted]; (2) an attestation letter stating that you were no longer employed; (3) proof of your spouse's termination of former employment; and (4) proof of his new employment including his hourly rate of pay and number of hours expected to work each week.

7) These documents show that your gross household income for December 2016 was expected to be $2,653.74, based on your spouse's final $253.74 paystub from [redacted], dated December 1, 2016 and an estimated $2,400.00 ($600.00 per week for four weeks) from his new employer, [redacted], in December 2016.

8) According to your NYSOH account, when NYSOH validated your spouse's income, they added his 2016 expected annual income to his expected annual income for 2017. This resulted in a determination using an annual household income of $53,415.57; upon which you were found eligible for APTC, effective January 1, 2017.

9) On December 23, 2016, you submitted your spouse's three consecutive paystubs from his new employer, all with December 2016 dates, a letter of attestation that your spouse does not have four paystubs from his new employer, and a letter of attestation that you have not worked since May 2016; which were subsequently validated by NYSOH on January 3, 2017 (*see* Documents [redacted].

10) These documents, along with the earlier submissions, show that your gross December 2016 household income was to be $2,300.41, based on a final $253.74 paystub from [redacted] dated December 1, 2016 and approximately $2,046.67 from paystubs from [redacted] in December 2016, assuming your last spouse's last weekly earnings received in December 2016 were $600.00. Based on this income documentation, you were found eligible for Medicaid, effective January 1, 2017.

11) According to you NYSOH account, you selected a Medicaid Managed Care plan on January 7, 2017.

12) You testified that you want your Medicaid Managed Care plan to begin on December 1, 2016 because you have medical bills for the month of December 2016.

13) Your application states that you will not be taking any deductions on your 2016 tax return.

14) Your application states that you live in Sullivan County, New York.

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

Applicable Law and Regulations

Advance Payments of Premium Tax Credit

Advance payments of the premium tax credit (APTC) are generally available to a person who is eligible to enroll in a qualified health plan (QHP) and (1) expects to have a household income between 138% and 400% of the applicable federal poverty level (FPL), (2) expects to file a tax return and claim a personal exemption deduction for a person who meets the eligibility requirements to enroll in a QHP, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)).

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 2016 FPL, which is $24,300.00 for a four-person household (81 Fed. Reg. 4036).

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 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, N.Y. Soc. Serv. Law §364-j(1)(c); 18 NYCRR § 360-10.3(h)).

Legal Analysis

The first issue under review is whether NYSOH properly determined you were eligible for an advance payment of the premium tax credit (APTC) in an amount of up to $789.00 and not Medicaid as of your December 16, 2016 application.

In the application submitted on December 16, 2016, NYSOH updated your account, based on the income documentation you submitted, and calculated that your household income was $53,415.57. NYSOH then relied upon this income information in determined your eligibility for financial assistance.

However, it appears that NYSOH calculated your household income to be $53,415.57 by adding your spouse's 2016 expected annual income to his expected annual income for 2017. Therefore, it is reasonable to conclude that NYSOH improperly calculated your annual household income to be $53,415.57 and improperly determined you eligible for APTC based on an incorrect household income amount, effective January 1, 2017.

Since the December 16, 2016 preliminary eligibility determination relied upon a household income that NYSOH miscalculated and the December 17, 2016 notice improperly stated that, based on this misinformation, you were conditionally eligible for APTC in an amount of up to $789.00 per month and ineligible for Medicaid, the December 17, 2016 eligibility determination notice is incorrect and must be RESCINDED.

The second disuse under review is whether NYSOH properly determine you were ineligible for Medicaid effective December 1, 2016.

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. The record reflects that your application was complete on December 16, 2016, the date that NYSOH had validated your proof of income.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits can be based on annual household or current monthly household income and family size.

The record further reflects that your monthly income was ascertainable as of December 16, 2016 to be $2,653.74, based on a final $253.74 paystub from [redacted] dated December 1, 2016 and an estimated $600.00 per week for four weeks of paystubs from [redacted] in December 2016. However, as of December 23, 2016, you submitted additional documentation that shows your December 2016 monthly household income is $2,300.41. Therefore, the correct monthly household income for December 2016 application was $2,300.41.

Since the record now contains a more accurate representation of what your monthly household income is for December 2016, your case is RETURNED to NYSOH to redetermine your eligibility for and coverage with Medicaid as of December 1, 2016, based on a household size of four people and a December 2016 monthly household income of $2,300.41.

Therefore, the remaining issue under review is whether NYSOH properly determined that your enrollment in your Medicaid Managed Care plan began February 1, 2017.

The record reflects that you contacted NYSOH on January 7, 2017 and enrolled into a Medicaid Managed Care plan.

Ordinarily, the date on which a Medicaid Managed Care plan can take effect depends on the day a person selects the plan for enrollment.

However, in your case, on December 16, 2016, NYSOH miscalculated your income and found you eligible for APTC instead of Medicaid. Since your application for Medicaid was completed as of December 16, 2016 and could be determined, you should have been able picked a plan on that day.

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.

Since your income was ascertainable and you could have chosen a plan on December 16, 2016, your Medicaid Managed Care plan would have properly taken effect on the first day of the second month following December 2016; that is, on February 1, 2017.

Therefore, the January 8, 2017 enrollment confirmation notice stating that your enrollment in your Medicaid Managed Care plan would be effective February 1, 2017, was correct and must be AFFIRMED.

Decision

The December 17, 2016 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for and coverage with Medicaid as of December 1, 2016, based on a household size of four people and a December 2016 monthly household income of $2,300.41.

The January 8, 2017 enrollment confirmation notice is AFFIRMED.

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).

Effective Date of this Decision: May 18, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility for December 2016. Your case is being sent back to NYSOH to redetermine your eligibility for Medicaid as of December 1, 2016, based on the evidence adduced at the hearing.

NYSOH will notify you once this has been done and what further action may be required on your part, if applicable.

Your enrollment in your Medicaid Managed Care plan is effective February 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 17, 2016 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for and coverage with Medicaid as of December 1, 2016, based on a household size of four people and a December 2016 monthly household income of $2,300.41.

The January 8, 2017 enrollment confirmation notice is AFFIRMED.

This is not a final determination of your eligibility for December 2016. Your case is being sent back to NYSOH to redetermine your eligibility for Medicaid as of December 1, 2016, based on the evidence adduced at the hearing.

NYSOH will notify you once this has been done and what further action may be required on your part, if applicable.

Your enrollment in your Medicaid Managed Care plan is effective February 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:

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 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.

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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