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: AP000000015662

[redacted]

Dear [redacted],

On May 10, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 1, 2016 eligibility determination and disenrollment 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: AP000000015662

[redacted]

Issue

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

> Did NY State of Health (NYSOH) properly determine that you were enrolled in Medicaid Fee-for-Service coverage that terminated on February 29, 2016?

Procedural History

On January 31, 2016, NYSOH received your application for financial assistance with your health insurance.

On February 1, 2016, NYSOH issued notice of eligibility determination stating that you were newly eligible to receive up to $237.00 per month in advance payments of the premium tax credit, and eligible for cost-sharing reductions, effective March 1, 2016. The notice also stated that your current coverage would end on February 29, 2016.

That same day, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in a qualified health plan, with the application of your tax credit to your monthly premium, beginning March 1, 2016.

Also on February 1, 2016, NYSOH issued a disenrollment notice stating that your enrollment in your Medicaid Fee-For-Service coverage was discontinued as of February 29, 2016 because you were no longer eligible to remain enrolled in your current health insurance.

On February 8, 2017, you contacted the NYSOH Account Review Unit and requested an appeal of NYSOH's refusal to retroactively terminate the Medicaid Fee-For-Service coverage you were enrolled into for January and February 2016.

On May 10, 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) Your NYSOH account reflects that you filed three applications for health insurance on January 31, 2016, and the second two were for financial assistance.

2) Your NYSOH account reflects that the second application you filed on January 31, 2016 requested financial assistance, and listed $0.00 in expected annual income.

3) Your NYSOH account reflects that your third and final application on January 31, 2016 resulted in a determination that you were eligible to receive tax credits and cost-sharing reductions as of March 1, 2016.

4) You testified that you were not aware that you were filing multiple applications for health insurance on January 31, 2016, and that you believed you were using a calculator tool that would allow you to see what your eligibility would be based on different income amounts.

5) You testified that you never wanted to apply for Medicaid, or receive Medicaid.

6) Your NYSOH account is void of any eligibility determinations stating that you were eligible for Medicaid as of January 1, 2016.

7) Complaint number [redacted] reflects that you contacted NYSOH on February 11, 2016 to request retroactive disenrollment from Fee-For-Service Medicaid for the months of January and February 2016.

8) NYSOH's records reflect that this complaint was closed on February 16, 2016 with the comment, "It is not possible to retroactively terminate FFS. Closing complaint."

9) There is no indication in NYSOH's records that you were notified of the resolution of this complaint.

10) On February 8, 2017, you contacted NYSOH again to request retroactive disenrollment, and you filed an appeal on that day.

11) You testified that you do not want any Medicaid enrollment on your record because it was never your intention to apply for Medicaid, and because you are a legal permanent resident and do not want to have any problems in the future.

12) You testified that you did not need, nor use, the Medicaid coverage in the months of January and February 2016.

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

Applicable Law and Regulations

Timely Notice of Medicaid Eligibility

When an individual applies for insurance through NYSOH, NYSOH must determine that person's eligibility promptly and without undue delay (45 CFR § 155.310(e)(1); 42 CFR § 435.1200(b)(3)(iii)).

To assess whether an eligibility determination was untimely, NYSOH must base the time period from the date of application to the date NYSOH notifies the applicant of its decision (45 CFR § 155.310(e)(2)). However, if the applicant submits an incomplete application or there is not sufficient information for NYSOH to make an eligibility determination, then NYSOH must notify that applicant that more information is needed to complete the application (45 CFR § 155.310(k)(1)).

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the application (42 CFR § 435.912).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were enrolled in Medicaid Fee-For-Service coverage, and that this enrollment was in place during the months of January and February 2016.

You updated your NYSOH account on January 31, 2016, and three separate applications were filed on that same day. The second application that was filed requested financial assistance and listed an income of $0.00. The third application resulted in a finding that you were eligible to receive tax credits and

cost-sharing reductions as of March 1, 2016. That same day, you selected a qualified health plan, and your enrollment began on March 1, 2016.

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the completed application.

The record is void of any eligibility determination notice stating that you were eligible for Medicaid effective January 1, 2016. The only eligibility determination notice that resulted from your January 31, 2016 account updates is the one that stated that you were eligible to receive tax credits and cost-sharing reductions.

Therefore, as you were never found eligible for Medicaid, the February 1, 2016 eligibility determination notice is MODIFIED to remove any reference to your "current coverage" ending as of February 29, 2016. Additionally, the February 1, 2016 disenrollment notice is MODIFIED to state that you are disenrolled from Fee-For-Service Medicaid as of January 1, 2016, as you were never found eligible for that coverage.

Your case is RETURNED to NYSOH to effectuate these changes.

Decision

The February 1, 2016 eligibility determination is MODIFIED to remove the reference to your "current eligibility" ending on February 29, 2016.

The February 1, 2016 disenrollment notice is MODIFIED to state that your enrolment in Fee-For-Service Medicaid is terminated, effective January 1, 2016.

Your case is RETURNED to NYSOH to effectuate these changes.

Effective Date of this Decision: May 18, 2017

How this Decision Affects Your Eligibility

Your NYSOH account does not contain any eligibility determinations that indicate that you were found eligible for Medicaid as of January 1, 2016.

Your case is being sent back to NYSOH to remove you from Fee-For-Service Medicaid for the months of January and February 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 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

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).

Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The February 1, 2016 eligibility determination is MODIFIED to remove the reference to your “current eligibility” ending on February 29, 2016.

The February 1, 2016 disenrollment notice is MODIFIED to state that your enrolment in Fee-For-Service Medicaid is terminated, effective January 1, 2016.

Your case is RETURNED to NYSOH to effectuate these changes.

Your NYSOH account does not contain any eligibility determinations that indicate that you were found eligible for Medicaid as of January 1, 2016.

Your case is being sent back to NYSOH to remove you from Fee-For-Service Medicaid for the months of January and February 2016.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

[redacted]

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

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

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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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