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

Notice of Decision

Decision Date: June 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016076

Dear [redacted],

On May 31, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 21, 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: June 28, 2017

NY State of Health Account ID
Appeal Identification Number: AP000000016076

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 eligible for Medicaid Fee-For-Service coverage, effective June 1, 2016?

Procedural History

On December 21, 2015, NYSOH issued an eligibility determination notice stating that you were newly eligible to purchase a qualified health plan (QHP) at full cost, effective January 1, 2016.

On January 15, 2016, NYSOH issued a form 1095-A, Health Insurance Marketplace Statement, for 2015 reflecting that you had coverage through NYSOH from March 2015 to November 2015.

On June 20, 2016, NYSOH received an update to your application for health insurance in which you requested financial assistance.

On June 21, 2016, NYSOH issued an eligibility determination notice based on the information contained in the June 20, 2016 application. The notice stated that you were eligible for Medicaid, effective June 1, 2016.

On July 1, 2016, NYSOH issued an enrollment notice confirming your enrollment in a Medicaid Managed Care (MMC) plan as of June 30, 2016,. The notice stated that you had been enrolled in to this plan because you had not selected a health plan.

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On July 12, 2016, NYSOH received an update to your application for health insurance. This update reflected that you were no longer seeking financial assistance in purchasing health insurance.

On July 12, 2016, NYSOH issued a “void” Health Insurance Marketplace Statement, apparently reflecting that in fact you were not enrolled in coverage through NYSOH between March 2015 and November 2015.

On July 13, 2016, NYSOH issued a disenrollment notice stating that your MMC plan coverage ended effective August 1, 2016. This was because you were no longer eligible to enroll in health insurance through NYSOH.

On February 22, 2017, you spoke to NYSOH’s Account Review Unit and appealed your eligibility for Medicaid insofar as you were seeking a retroactive disenrollment date of June 1, 2016.

On May 31, 2016, 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 support the following findings of fact:

1) Your NYSOH account reflects that an update to your application was submitted on June 20, 2016 reflecting that you were seeking financial assistance in purchasing health insurance through NYSOH.

2) You were found eligible for Medicaid, effective June 1, 2016.

3) You were auto-enrolled in an MMC plan, effective August 1, 2016.

4) You testified that you never personally submitted an application to NYSOH on June 20, 2016, and that you never sought health insurance through NYSOH during 2016 since you were already covered under health insurance through your employer.

5) You testified that you believed that an application was processed on your behalf by a NYSOH representative on June 20, 2016 to correct an erroneous 1095-A that had been issued to you reflecting that you had coverage through NYSOH between March and November 2015. You further testified, and your NYSOH account reflects, that you were retroactively disenrolled from your QHP coverage effective March 1, 2015.

6) You testified that you only became aware of your Medicaid eligibility when you received the June 21, 2016 eligibility determination notice and CBIC card in the mail.

7) Your account was revised on July 12, 2016 by NYSOH reflecting that you were no longer seeking financial assistance in purchasing health insurance.

8) On July 13, 2016, NYSOH issued a disenrollment notice confirming that your MMC plan coverage had been retroactively cancelled effective August 1, 2016. However, you Medicaid Fee-For-Service coverage remained in effect beginning June 1, 2016.

9) You testified that you were seeking your Medicaid Fee-For-Service coverage cancelled as of June 1, 2016, since you were concerned about potential tax liabilities when you filed your 2016 tax return. You further testified that you were seeking, to the extent permissible, for a 1095 form issued by NYSOH reflecting that you did not have any coverage, including Medicaid, through NYSOH during the 2016 plan year.

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

Applicable Law and Regulations

<u>Medicaid</u>

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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were eligible for Medicaid Fee-For-Service coverage, effective June 1, 2016.

The record reflects that prior to the application update received on June 20, 2016, you were not enrolled in a QHP through NYSOH, but were actively attempting to resolve an outstanding issue in correcting the 1095-A issued to you reflecting that you were enrolled in coverage through NYSOH between March and November 2015.

It appears that because of these efforts to correct the 1095-A to properly reflect your non-enrollment in a QHP during 2015, your eligibility for financial assistance was redetermined by a NYSOH representative on June 20, 2016. This application update reflected that you were seeking financial assistance to purchase health insurance through NYSOH.

Accordingly, you were found eligible for Medicaid, effective June 1, 2016. You were subsequently auto-enrolled in an MMC with such coverage to begin effective August 1, 2016.

You credibly testified, and the additional update to your application on July 12, 2016 reflects, that you were no longer seeking coverage through NYSOH. While this application update effectively cancelled your MMC plan enrollment as of August 1, 2016, you Medicaid Fee-For-Service coverage was not affected.

You credibly testified that at no point during 2016 did you personally or intentionally update your NYSOH account to seek health insurance through NYSOH, since you were already covered by a plan issued by your employer.

Accordingly, we find there is sufficient evidence that your application on June 20, 2016 should not have been processed and that you should not have been found eligible for Medicaid, effective June 1, 2016.

Therefore, the June 21, 2016 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to issue, to the extent practical and necessary, a revised 1095-A form reflecting that you did not have coverage through NYSOH during 2016.

Decision

The June 21, 2016 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to issue, to the extent practical and necessary, a revised 1095 form reflecting that you did not have coverage through NYSOH during 2016.

Effective Date of this Decision: June 28, 2017

How this Decision Affects Your Eligibility

Your Medicaid Fee-For-Service coverage is cancelled effective June 1, 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
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The June 21, 2016 eligibility determination notice is RESCINDED.

Your Medicaid Fee-For-Service coverage is cancelled effective June 1, 2016.

Your case is RETURNED to NYSOH to issue, to the extent practical and necessary, a revised 1095 form reflecting that you did not have coverage through NYSOH during 2016.

Legal Authority

We are issuing this determination in accordance with 45 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).

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.

□□□□□ (Bengali)

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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.

(Urdu)اردو

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)

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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.

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