



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

## Notice of Decision

Decision Date: July 26, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000016392

[REDACTED]

Dear [REDACTED],

On June 12, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 12, 2016 eligibility determination notice, and the January 19, 2017 enrollment confirmation 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).

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## Decision

Decision Date: July 26, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000016392

[REDACTED]

## Issues

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

Was your appeal of the December 12, 2016 eligibility determination notice timely?

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

## Procedural History

On September 21, 2016, NYSOH received your updated application for financial assistance with health insurance.

On September 22, 2016, NYSOH issued a notice stating the income information listed in your application did not match information received from state and federal data sources. The notice directed you to submit proof of your income by October 6, 2016 or NYSOH would not be able to determine your eligibility for health coverage.

On October 1, 2016, October 13, 2016, October 27, 2016, November 15, 2016, and November 22, 2016, NYSOH issued notices indicating the documentation you submitted was insufficient to confirm the income information listed in your application. The notices directed you to submit additional documentation to verify your income.

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On December 11, 2016, NYSOH validated your income documentation and adjusted the income information in your application.

On December 12, 2016, NYSOH issued an eligibility determination notice stating you were eligible to enroll in the Essential Plan, effective January 1, 2017.

On December 28, 2016, NYSOH received your updated application for financial assistance with health insurance.

On December 29, 2016, NYSOH issued a notice stating the income information listed in your application did not match information received from state and federal data sources. The notice directed you to submit proof of your income by January 12, 2017 or NYSOH would not be able to determine your eligibility for health coverage.

On January 18, 2017, NYSOH verified your income documentation.

On January 19, 2017, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective January 1, 2017.

On January 27, 2017, NYSOH issued an enrollment notice, based on your January 26, 2017 plan selection, confirming your enrollment in a Medicaid Managed Care plan, effective March 1, 2017.

On March 1, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your enrollment in your Medicaid Managed Care plan, insofar as it did not begin December 1, 2016.

On June 12, 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 support the following findings of fact:

- 1) You were determined eligible for Medicaid, effective November, 1 2015 and you subsequently enrolled in a Medicaid Managed Care plan.
- 2) On September 21, 2016, you updated your application to renew your coverage for the upcoming coverage year. That application listed your annual income as \$4,350.00 consisting of \$200.00 per month you earned from [REDACTED] and \$75.00 you earned every two weeks from [REDACTED].

- 3) According to your account, NYSOH was unable to verify the income information listed in your application and you were directed to submit proof of your income.
- 4) You were disenrolled from your Medicaid Managed Care plan, effective October 31, 2016.
- 5) On September 21, 2016, you uploaded one weekly paystub from [REDACTED] [REDACTED]. According to your account, this documentation was invalidated by NYSOH, because four weeks of current paystubs from all income sources attested to in the application was required to prove your income. Additional income was requested.
- 6) On October 3, 2016, you uploaded three weekly paystubs from [REDACTED] [REDACTED] and two weekly paystubs from [REDACTED] [REDACTED].
- 7) You testified the [REDACTED] [REDACTED] paystubs were from your job at [REDACTED].
- 8) NYSOH invalidated the paystubs submitted on October 3, 2016, because you did not submit four full weeks of paystubs for each employer.
- 9) On October 17, 2016, you uploaded one additional weekly paystub from [REDACTED] [REDACTED] with a check date of October 14, 2016. This document was invalidated by NYSOH, because you failed to submit four consecutive weeks of paystubs from both employers.
- 10) On November 1, 2016, you uploaded four weekly paystubs from [REDACTED] [REDACTED] and four weekly paystubs from [REDACTED] [REDACTED].
- 11) According to your account, NYSOH validated your paystubs on December 11, 2016 and adjusted the income in your application by increasing the annual income amount for [REDACTED] from \$2,400.00 to \$11,732.50 and increasing the annual income amount listed for [REDACTED] from \$1,950.00 to \$10,676.25 for a total annual income amount of \$22,408.75.
- 12) NYSOH issued an eligibility determination notice on December 12, 2016 stating you were eligible for the Essential Plan based on your recalculated annual income. You did not enroll in an Essential Plan.
- 13) On December 28, 2016, you updated your application, indicating your expected yearly income was \$0.00. The same day you uploaded a termination notice from [REDACTED] [REDACTED] dated December 23, 2016 indicating your employment had been terminated.

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- 14) According to your account, NYSOH verified the termination letter on January 18, 2017 and you were determined eligible for Medicaid, effective January 1, 2017.
- 15) According to your account, you selected a Medicaid Managed Care plan on January 26, 2017 and coverage through that plan became effective March 1, 2017.
- 16) You testified you are seeking to have the coverage through your Medicaid Managed Care plan backdated to December 1, 2016, because you have outstanding medical bills from the month of December 2016.
- 17) You testified you lost both of your jobs in December 2016. You testified you received your last paycheck from [REDACTED] in the last week of December and that you received your last paycheck from [REDACTED] in the middle of December 2016.
- 18) You testified that aside from the [REDACTED] and [REDACTED] job, you did not have any other employment in 2016, but that you did collect unemployment insurance benefits at the beginning of 2016, but you are not sure how much you collected in benefits.
- 19) Your applications indicate you will file your 2017 tax return with a tax filing status of single and you will claim no dependents.
- 20) Your applications indicate you live in [REDACTED].

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

## **Applicable Law and Regulations**

### Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) a failure by NYSOH to provide timely notice of an eligibility determination; and (4) a denial of a request for a special enrollment period (45 CFR § 155.505, 45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH (45 CFR § 155.520(b)(2); 18 NYCRR § 358-3.5(b)(1)).

### Verification Process

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow the Marketplace to verify the household's income (45 CFR § 155.320(c)(1)(i)). 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)).

### Medicaid – Effective Dates

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 first issue under review is whether your appeal of the December 12, 2016 eligibility determination notice was timely.

On September 21, 2016, you updated your application to renew your coverage for the upcoming coverage year. According to your account, NYSOH was unable to verify the income information listed in your application and documentation was requested in order to determine your eligibility. As a result, you were disenrolled from your Medicaid Managed Care plan, effective October 31, 2016.

Your account confirms you submitted numerous paystubs on several dates in September and October 2016. However, these documents were deemed invalid, because NYSOH determined the documentation did not comply with the directive in the notices requesting documentation that you submit 4 consecutive weeks of paystubs for each employer attested to in the application or a letter from each employer. According to your account, you uploaded several paystubs on

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November 1, 2016, but NYSOH did not verify this documentation until December 11, 2016. Subsequently, NYSOH issued a notice on December 12, 2016 stating that you were eligible for the Essential Plan, effective January 1, 2017, based on the income information you provided. On March 1, 2017, a formal appeal was filed on your behalf concerning your contention that you should have been permitted to enroll in a Medicaid Managed Care plan, effective December 1, 2016, because you timely submitted the requested income documentation.

Pursuant to the above cited regulations, individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of whether the December 12, 2016 eligibility determination notice constituted timely notice of your eligibility following your September 21, 2016 application or whether that determination was correct, an appeal should have been filed by February 10, 2017. The formal appeal in this case was not filed until March 1, 2017, after the 60-day period in which to appeal had passed. Moreover, the earliest record of you contacting NYSOH to contest your eligibility for the month of December 2016 is on February 27, 2017 when you first requested the effective date of your Medicaid Managed Care plan be backdated to December 1, 2016. As this contact occurred after the end of the 60-day period in which to appeal the December 12, 2016 eligibility determination, it does not constitute a proper appeal of that determination.

Therefore, given the facts of the case, there has been no timely appeal of the December 12, 2016 eligibility determination notice, and your appeal on the issue of whether that notice constituted timely notice of your eligibility following your September 21, 2016 application or whether that determination was correct, is **DISMISSED**.

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

You updated your account on December 28, 2016 indicating your expected yearly income was \$0.00. According to your account, NYSOH was unable to verify the income information listed in your application.

Pursuant to the above cited regulations, 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 it must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence.

The notice issued by NYSOH on December 29, 2016 indicated the income information listed in your application did not match information received from data

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sources and directed you to submit proof of your income by January 12, 2017 or NYSOH would not be able to determine your eligibility for health coverage. Your account confirms that on December 28, 2016, the same day you submitted your updated application, you uploaded a notice of termination from [REDACTED] dated December 23, 2016 indicating your employment had been terminated.

According to your account, NYSOH verified this documentation on January 18, 2017, indicating the documentation confirmed the information in your application and you were determined eligible for Medicaid January 1, 2017. Thus, your application was deemed completed on December 28, 2016, the date on which you submitted sufficient information verifying your income which qualified you for Medicaid.

Pursuant to 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.

Although your account indicates you did not select a Medicaid Managed Care plan until January 26, 2017, your account also confirms that NYSOH did not notify you of your eligibility for Medicaid and ability to enroll in a health plan until January 19, 2017. Had you been notified of your Medicaid eligibility and permitted to select a plan on December 28, 2016, the date on which you submitted a completed application for Medicaid, your coverage would have become effective on the first day of the second following month, because that date was after the fifteenth day of the month. Therefore, your Medicaid Managed Care plan should have become effective on February 1, 2017.

Thus, the January 27, 2017 enrollment notice stating your Medicaid Managed Care plan was to become effective March 1, 2017 is MODIFIED to reflect your coverage through that plan was effective February 1, 2017.

Your case is RETURNED to NYSOH to correct your enrollment in accordance with this decision and ensure your coverage through your Medicaid Managed Care plan is effective February 1, 2017.

## **Decision**

There has been no timely appeal of the December 12, 2016 eligibility determination notice, and your appeal on the issue of whether that notice constituted timely notice of your eligibility following your September 21, 2016 application or whether that determination was correct, is DISMISSED.

The January 27, 2017 enrollment notice is MODIFIED to reflect your coverage through that plan was effective February 1, 2017.

Your case is RETURNED to NYSOH to correct your enrollment in accordance with this decision and ensure your coverage through your Medicaid Managed Care plan is effective February 1, 2017.

**Effective Date of this Decision:** July 26, 2017

### **How this Decision Affects Your Eligibility**

The NYSOH Appeal Unit does not have jurisdiction to review your appeal of whether the December 12, 2016 eligibility determination notice constituted timely notice of your eligibility following your September 21, 2016 application or whether that determination was correct, because you did not file your appeal in time.

You should have been permitted to select a Medicaid Managed Care plan on December 28, 2016.

Your coverage through your Medicaid Managed Care plan should have been effective February 1, 2017.

Your case is being sent back to NYSOH to ensure you are enrolled in your Medicaid Managed Care plan, 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)).

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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**

There has been no timely appeal of the December 12, 2016 eligibility determination notice, and your appeal on the issue of whether that notice constituted timely notice of your eligibility following your September 21, 2016 application or whether that determination was correct, is **DISMISSED**.

The January 27, 2017 enrollment notice is **MODIFIED** to reflect your coverage thorough that plan was effective February 1, 2017.

Your case is RETURNED to NYSOH to correct your enrollment in accordance with this decision and ensure your coverage through your Medicaid Managed Care plan is effective February 1, 2017.

The NYSOH Appeal Unit does not have jurisdiction to review your appeal of whether the December 12, 2016 eligibility determination notice constituted timely notice of your eligibility following your September 21, 2016 application or whether that determination was correct, because you did not file your appeal in time.

You should have been permitted to select a Medicaid Managed Care plan on December 28, 2016.

Your coverage through your Medicaid Managed Care plan should have been 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:**



## 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 مجاناً.

### 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 bɛtumi ama wo obi a okyerɛ 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 איר געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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