



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

Notice of Decision

Decision Date: August 25, 2017

NY State of Health Account ID [REDACTED]
Appeal Identification Number: AP000000016985

[REDACTED]

Dear [REDACTED],

On August 3, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 22, 2016 disenrollment and January 31, 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).

This page intentionally left blank.



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

Decision

Decision Date: August 25, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000016985



Issues

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

Did NY State of Health (NYSOH) properly terminate your spouse's Essential Plan coverage effective November 30, 2016?

Did NYSOH properly determine that your spouse was enrolled in a Medicaid Managed Care (MMC) plan with an enrollment start date of March 1, 2017?

Procedural History

On April 30, 2016, NYSOH issued a plan enrollment notice confirming, in relevant part, that your spouse was enrolled in an Essential Plan with an enrollment start date of May 1, 2016. The notice stated that additional proof of income was needed by May 7, 2016, to confirm their eligibility.

On November 14, 2016, your NYSOH account was systemically updated.

On November 15, 2016, NYSOH issued an eligibility determination notice stating, in relevant part, that your spouse was newly eligible to purchase a qualified health plan (QHP) at full cost, effective December 1, 2016. The notice stated that your spouse did not qualify for financial assistance because NYSOH did not receive the income documentation needed to verify the income listed in your application.

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).

On November 22, 2016, NYSOH issued a disenrollment notice stating that your spouse's Essential Plan would end effective November 30, 2016.

On December 7, 2016, your NYSOH account was updated.

On December 8, 2016, NYSOH issued a notice stating that your December 7, 2016, application was received, but the income information in your application did not match what NYSOH received from state and federal data sources. The notice directed you to submit additional income documentation by December 22, 2016, to confirm your spouse's eligibility.

On December 10, 2016, you uploaded income and employment documentation to your NYSOH account (see Documents [REDACTED]).

On December 19, 2016, you faxed additional income and employment documentation to your NYSOH account (see Document [REDACTED]).

On December 29, 2016 and January 6, 2017, NYSOH issued notices stating that the documentation reviewed did not confirm the information in your application. The notice directed you to submit more proof to verify your income by February 5, 2017.

On January 10, 2017, you uploaded additional employment and income documentation to your NYSOH account (see Document [REDACTED]).

On January 20, 2017, your NYSOH account was updated.

On January 21, 2017, NYSOH issued an eligibility determination notice stating, in relevant part, that your spouse was eligible for Medicaid, effective December 1, 2016.

On January 31, 2017, NYSOH issued a plan enrollment notice confirming that as of January 30, 2017, your spouse was enrolled in an MMC plan with an enrollment start date of March 1, 2017.

On March 20, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal relative to your spouse's Essential Plan termination and the enrollment start date of their MMC plan in that it did not begin earlier.

On June 26, 2017, you had a scheduled telephone hearing with NYSOH's Appeals Unit; however, you did not appear.

Also on June 26, 2017, you uploaded a request to vacate the dismissal to your NYSOH account. Your request to reschedule your hearing was granted.

On June 28, 2017, NYSOH issued you a Notice of Dismissal for failing to appear for your scheduled telephone hearing.

On August 3, 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 proceeding.

Findings of Fact

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

- 1) You testified that you are seeking to have your spouse enrolled in an Essential Plan or MMC plan for the month of December 2016.
- 2) According to your NYSOH account, your spouse's Essential Plan was terminated effective November 30, 2016.
- 3) You testified that your spouse went to an [REDACTED] doctor on [REDACTED], and the office accepted the insurance card from their Essential Plan.
- 4) You testified that you were contacted by your spouse's [REDACTED] office on [REDACTED], and were informed that their insurance was no longer active.
- 5) According to your December 7, 2016 NYSOH application, you attested to two sources of income: [REDACTED] and [REDACTED].
- 6) On December 8, 2016, NYSOH issued a notice directing you and your spouse to submit additional income documentation. The notice provided an acceptable documentation list including: paycheck stubs for the last 4 weeks, and a letter from your employer on a company letterhead, signed by the employer and dated (see Document [REDACTED]).
- 7) On December 10, 2016 and January 10, 2017, you submitted a letter from your employer, [REDACTED]. The letter stated that you average \$500.00 per month, or \$6,000.00 per year (see Documents [REDACTED]).
- 8) On December 19, 2016, you faxed two paystubs from your employer, [REDACTED], to NYSOH. The paystubs indicated that you were issued \$800.00 in gross income on November 30, 2016 and December

15, 2016 each (see Document [REDACTED]; uploaded [REDACTED]).

- 9) According to your NYSOH account, your spouse was determined eligible for Medicaid, effective December 1, 2016, and had coverage through Medicaid Fee-For-Service as of that date.
- 10) According to your NYSOH account, you selected an MMC plan for your spouse on January 30, 2017, and they were enrolled in the MMC plan that same day with a March 1, 2017 enrollment start date.
- 11) You testified that your spouse incurred medical expenses in December 2016 and you want either the Essential Plan or MMC plan to cover those costs.

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

Applicable Law and Regulations

Appealable Issues

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) an eligibility determination for an exemption; (4) a failure by NYSOH to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

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

Medicaid Verification Process - Income

NYSOH may accept self-attestation of information needed to determine the income eligibility of an individual for Medicaid (42 CFR § 435.945(a)). NYSOH must request information relating to financial eligibility from other agencies in the State, other States, and Federal programs to the extent NYSOH determines such information is useful to verifying the financial eligibility for an individual (42 CFR § 435.948(a)).

An individual must not be required to provide additional information or documentation unless information needed by NYSOH cannot be obtained electronically or the information obtained electronically is not reasonably compatible with information provided by or on behalf of the individual (42 CFR § 435.952(c)).

Timely Notice of Eligibility Determination

When an individual applies for insurance, 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).

Medicaid Fee-For-Service

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)).

MMC Enrollment Start Date

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 NYSOH properly ended your spouse's Essential Plan effective November 30, 2016.

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).

The record indicates your spouse's Essential Plan was terminated effective November 30, 2016, as stated in the November 22, 2016 disenrollment notice, because you did not provide proof of income to confirm their eligibility for the Essential Plan. Further, you testified that you became aware that your spouse's coverage was no longer active as of December 7, 2016.

For an appeal to have been valid on the issue of the termination of your spouse's Essential Plan, as addressed in the November 22, 2016 disenrollment notice, an appeal should have been filed with 60 days or by January 21, 2017. According to the credible evidence in the record, you did not request an appeal until March 20, 2017. This date exceeds the 60 days from the November 22, 2016 disenrollment notice.

Therefore, your appeal request of the November 22, 2016 disenrollment notice was not timely, and the appeal of the termination of your spouse's Essential Plan, effective November 30, 2016, is DISMISSED.

The second issue under review is whether NYSOH properly determined that your spouse's MMC plan should have an enrollment start date of March 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 by giving the applicant the opportunity to submit satisfactory documentary evidence.

On December 7, 2016, you submitted an application for financial assistance through NYSOH. The household income that you attested to in your application did not match federal and state data sources. As a result, NYSOH issued you a notice on December 8, 2016, directing you to submit additional proof of income to NYSOH to confirm your spouse's eligibility for financial assistance. The notice provided an acceptable documentation list (see Document [REDACTED]).

On December 10, 2016 and January 10, 2017, you submitted letters from your employer, [REDACTED]. The letter stated that you average \$500.00 per month, or \$6,000.00 per year (see Documents [REDACTED]). Further, on December 19, 2016, you faxed two paystubs from your employer, [REDACTED], to NYSOH. The paystubs indicated that you were issued \$800.00 in gross income on November 30, 2016 and December 15, 2016 (see Document [REDACTED]; uploaded [REDACTED]).

The record reflects that as of December 19, 2016, you had sent the income documentation that you were directed to provide to NYSOH, as stated in the December 8, 2016 notice. Therefore, the application was complete as of December 19, 2016.

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

On January 21, 2017, NYSOH issued an eligibility determination notice stating, in relevant part, that your spouse was eligible for Medicaid, effective December 1, 2016. Since NYSOH issued an eligibility determination 33 days from the date your application was considered complete, the January 21, 2017 eligibility determination was timely issued.

The date on which a MMC plan can take effect depends on the day a person selects the plan for enrollment. A plan that is selected between the first day and fifteenth day of a month goes into effect on the first day of the following month. A plan that is selected from the sixteenth day of the month and the end of the month goes into effect on the first day of the second following month.

On January 30, 2017, you selected an MMC plan and they were enrolled that same day in that MMC plan with an enrollment start date of March 1, 2017. Therefore, the enrollment start date in your spouse's MMC plan would properly take effect on the first day of the second month following January 30, 2017; that is, on March 1, 2017.

Therefore, the January 31, 2017 plan enrollment notice is AFFIRMED.

Decision

Your appeal request of the November 22, 2016 disenrollment notice is DISMISSED as untimely.

The January 31, 2017 plan enrollment notice is AFFIRMED.

Effective Date of this Decision: August 25, 2017

How this Decision Affects Your Eligibility

Your spouse had coverage through Medicaid Fee-For-Service from December 1, 2017 through February 28, 2017.

Your spouse's MMC plan enrollment start date is March 1, 2017.

If You Disagree with this Decision (Appeal Rights)

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).

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

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).

- By fax: 1-855-900-5557

Summary

Your appeal request of the November 22, 2016 disenrollment notice is **DISMISSED** as untimely.

The January 31, 2017 plan enrollment notice is **AFFIRMED**.

Your spouse had coverage through Medicaid Fee-For-Service from December 1, 2016 through February 28, 2017.

Your spouse's MMC plan enrollment start date is March 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)

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).

000 00 00000000000000 0000 000 00000 00000 000 0000000000 000000000 00 00000,
00000000 000 1-855-355-5777 0000000 00 000000 0000 00 0000000 000 00000
00000000000 0000 0000000 0000 0000000 0000 000000

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. y&b&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.

שׂוֹדֵיִשׁ (Yiddish)

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).

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).