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

Notice of Decision

Decision Date: April 17, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000012691

[redacted]

Dear [redacted],

On February 10, 2017, you and your spouse appeared by telephone at a hearing on your appeal of NY State of Health's October 7, 2016 disenrollment notice, October 11, 2016 eligibility determination, and October 28, 2016 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: April 17, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000012691

[redacted]

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 Essential Plan coverage effective September 30, 2016, and begin your Medicaid coverage effective October 1, 2016?
>
> Did NYSOH properly determine your enrollment in your Medicaid Managed Care plan was effective December 1, 2016?

Procedural History

On January 20, 2016, NYSOH issued a notice of eligibility determination, stating you were eligible to enroll in the Essential Plan, effective March 1, 2016. You were subsequently enrolled in an Essential Plan, effective March 1, 2016.

On October 6, 2016, NYSOH received your updated application for health insurance.

On October 7, 2016, NYSOH issued a disenrollment notice stating your Essential Plan coverage was terminated, effective September 30, 2016, because you were no longer eligible to remain enrolled in the plan.

On October 11, 2016, NYSOH issued an eligibility determination notice, based on your October 6, 2016 updated application, stating you were conditionally eligible for Medicaid, effective October 1, 2016. The notice directed you to provide proof of your income by October 21, 2016.

On October 20, 2016, you spoke to NYSOH's Account Review Unit and appealed insofar as you were not eligible to enroll in a health plan as of October 1, 2016.

On October 26, 2016, NYSOH issued an eligibility determination notice, based on an October 25, 2016 systematic eligibility redetermination, stating you were eligible for Medicaid, effective November 1, 2016.

On October 28, 2016, NYSOH issued an enrollment confirmation notice, based on your October 27, 2016 plan selection, stating you were enrolled in a Medicaid Managed Care plan, effective December 1, 2016.

On February 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 support the following findings of fact:

1) You were enrolled in an Essential Plan as of April 1, 2016.

2) Your account confirms you contacted NYSOH on October 6, 2016, and your application was updated to report your pregnancy for the first time.

3) NYSOH Appeals Unit reviewed the recorded telephone call made on October 6, 2016 and confirmed you were advised by the representative your application was being updated for the first time to report your pregnancy. The representative informed you that your coverage would remain the same and you did not have to change health plans.

4) On the same day, your eligibility was redetermined with the updated information and you were determined presumptively eligible for Medicaid, effective October 1, 2016, pending confirmation of your household's income.

5) Your enrollment in your Essential Plan was systematically deleted on October 6, 2016. The coverage through this plan ended September 30, 2016.

6) On October 14, 2016, a copy of a Form 1040 from the 2015 tax return filed by you and your spouse was uploaded to your NYSOH account.

7) Your youngest child was born on [redacted].

8) On October 21, 2016, your youngest child was added to your NYSOH account.

9) On October 25, 2016, the system redetermined your eligibility based on a household size of five and the verified income documentation you provided and you were determined fully eligible for Medicaid, effective November 1, 2016.

10) Your account confirms you contacted NYSOH on October 27, 2016 and selected a Medicaid Managed Care plan. Your coverage through this plan was effective December 1, 2016.

11) Your account indicates that on October 28, 2016, NYSOH backdated your fee-for-service Medicaid coverage to October 1, 2016.

12) You had fee-for-service Medicaid coverage from October 1, 2016 to November 30, 2016.

13) You testified the hospital bills relating to the birth of your child in October 2016 were covered by Medicaid, but your doctor's bills are not covered because your doctor does not accept fee-for-service Medicaid.

14) You testified you are seeking reinstatement in your Essential Plan as of October 1, 2016. Alternatively, you are seeking to have your Medicaid Managed Care plan back dated to October 1, 2016.

15) During the hearing the issue was amended to include a review of the October 28, 2016 enrollment confirmation notice stating your coverage in a Medicaid Managed Care plan was effective December 1, 2016.

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

Applicable Law and Regulations

Changes in Eligibility for the Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully

present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

NYSOH must verify the eligibility of an applicant for the Essential Plan consistent with the standards set in 45 CFR § 155.315 and § 155.320 (New York's Basic Health Plan Blueprint, pgs. 16-17, as approved January 2016; *see* https://www.medicaid.gov/basic-health-program/basic-health-program.html; 42 CFR § 600.345(a)(2)).

An applicant is required to attest to their household's projected annual income. (45 CFR § 155.320(c)(3)(ii)(B)). For all individuals whose household income is needed, NYSOH must request tax return data from the Secretary of the Treasury and data regarding Social Security benefits from the Commissioner of Social Security in order to confirm that the information the applicant is attesting to is accurate (45 CFR § 155.320(c)(1)(i); 45 CFR § 155.320(c)(3)(ii)(A)).

If income data is unavailable, or if an applicant's attestation is not reasonably compatible with the income data NYSOH obtains, NYSOH must request additional information from the applicant to resolve the inconsistency (45 CFR §155.320 (c)(3)(iii), (iv)).

NYSOH must provide the applicant with notice of the inconsistency in their account and 90 days to provide satisfactory documentary evidence to resolve the inconsistency (45 CFR § 155.315 (f)(2)). If NYSOH remains unable to verify the attestation of the applicant, NYSOH must redetermine the applicant's eligibility based on the information available from the data sources unless the applicant demonstrates that they are unable to provide the required documentation (45 CFR § 155.315(f)(2), (g)).

Upon making an eligibility redetermination, NYSOH must notify the applicant and implement any updates in eligibility to the Essential Plan effective the first day of the following month for changes received by NYSOH from the first to the fifteenth of any month (45 CFR § 155.420(b)(1)(i); *see also* 42 CFR § 600.320(c)). For updates received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR § 155.420(b)(1)(ii); *see also* 42 CFR § 600.320(c)).

Medicaid Eligibility for Pregnant Women

Medicaid is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the FPL for the applicable family size (*see* 42 CFR § 435.116(c); NY Department of Health Administrative Directive 13ADM-03).

For purposes of Medicaid eligibility, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

Medicaid Coverage Start 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 is whether NYSOH properly terminated your Essential Plan coverage effective September 30, 2016.

Your account confirms you were enrolled in an Essential Plan effective April 1, 2016. You contacted NYSOH on October 6, 2016 and your application was updated to report your pregnancy for the first time. Following this update, your eligibility was redetermined for a household size of five, including your unborn child, and you were determined presumptively eligible for Medicaid, effective October 1, 2016, pending confirmation of your household's income.

Pursuant to the above cited regulations, to be eligible for the Essential Plan, applicants must not be otherwise eligible for minimum essential coverage. As discussed above, you were determined presumptively eligible for Medicaid as of October 1, 2016. As Medicaid is considered minimum essential coverage, you were no longer eligible to enroll in the Essential Plan as of September 30, 2016.

However, at the time of the October 6, 2016 updated eligibility redetermination, you were already enrolled in an Essential Plan. In accordance with the above regulations, NYSOH must implement any updates in eligibility to the Essential Plan effective the first day of the following month for changes received by NYSOH from the first to the fifteenth of any month. As the updated information, your pregnancy, was reported on October 6, 2016, which was prior to the

fifteenth day of the month, and change in your eligibility should have been implemented the first day of the following month; that is, November 1, 2016. Accordingly, your Essential Plan coverage should not have been terminated prior to October 31, 2016 without your consent.

Therefore, the October 7, 2016 disenrollment notice is MODIFIED to reflect that your Essential Plan coverage was terminated effective October 31, 2016. Additionally, the October 11, 2016 eligibility determination stating you were conditionally eligible for Medicaid, effective October 1, 2016, is MODIFIED to reflect this eligibility was effective November 1, 2016.

The second issue under review is whether NYSOH properly determined your enrollment in your Medicaid Managed Care plan was effective December 1, 2016.

Your account confirms you contacted NYSOH on October 27, 2016 to enroll into a Managed Care plan.

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.

On October 27, 2016, you selected a Medicaid Managed Care plan, so it properly took effect on the first day of the second month following October; that is, on December 1, 2016.

Therefore, the October 28, 2016 enrollment confirmation notice stating your enrollment in your Medicaid Managed Care plan would be effective December 1, 2016, was correct and must be AFFIRMED.

Decision

The October 7, 2016 disenrollment notice is MODIFIED to reflect that your Essential Plan coverage was terminated effective October 31, 2016.

The October 11, 2016 eligibility determination is MODIFIED to reflect your eligibility for Medicaid was effective November 1, 2016.

The October 28, 2016 enrollment confirmation notice is AFFIRMED.

Your case is RETURNED to NYSOH to reinstate your Essential Plan for the month of October 2016.

Effective Date of this Decision: April 17, 2017

How this Decision Affects Your Eligibility

The coverage through your Essential Plan ended October 31, 2016.

Your eligibility for Medicaid was effective November 1, 2016.

The effective date of your Medicaid Managed Care plan is December 1, 2016.

Your case is being sent back to NYSOH to ensure your Essential Plan is reinstated for the month of October 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 October 7, 2016 disenrollment notice is MODIFIED to reflect that your Essential Plan coverage was terminated, effective October 31, 2016.

The October 11, 2016 eligibility determination is MODIFIED to reflect your eligibility for Medicaid was effective November 1, 2016.

The October 28, 2016 enrollment confirmation notice is AFFIRMED.

Your case is RETURNED to NYSOH to reinstate your Essential Plan for the month of October 2016.

The coverage through your Essential Plan ended October 31, 2016.

Your eligibility for Medicaid was effective November 1, 2016.

The effective date of your Medicaid Managed Care plan is December 1, 2016.

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।

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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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