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

Notice of Decision

Decision Date: May 5, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013723

[redacted]

Dear [redacted],

On March 24, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 29, 2016 eligibility determination and disenrollment notices, December 1, 2016 eligibility determination notice, and December 7, 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: May 5, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013723

[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 the Medicaid Managed Care plan coverage you and your youngest child were enrolled in, effective November 30, 2016?
>
> Did NYSOH properly find that you, [redacted] were eligible for the Essential Plan, effective January 1, 2017?
>
> Did NYSOH properly find that your youngest child was reenrolled in her Medicaid Managed Care plan no earlier than January 1, 2017?

Procedural History

On July 8, 2016, NYSOH issued an eligibility determination notice, based on your July 7, 2016 updated application, stating you, [redacted] were eligible for Medicaid, effective August 1, 2016.

Also on July 8, 2016, NYSOH issued an enrollment confirmation notice stating you, [redacted] were enrolled in a Medicaid Managed Care plan, effective August 1, 2016.

On July 12, 2016, August 25, 2016, September 16, 2016, and October 7, 2016, in response to applications submitted on your behalf, NYSOH issued eligibility determination notices stating you, [redacted] were no longer eligible for Medicaid; however, your Medicaid coverage would be continued until June 30, 2017.

On August 24, 2016, you added your newborn daughter to your account, and on August 25, 2016, NYSOH issued an eligibility determination notice stating that more information was needed to determine your youngest child's eligibility.

On October 10, 2016, NYSOH issued an eligibility determination notice stating you were no longer eligible for Medicaid; however, your Medicaid coverage would be continued until June 30, 2017. The notice further stated your youngest child was conditionally eligible for Medicaid, effective September 1, 2016, pending proof of her citizenship status and Social Security number by November 22, 2016.

On October 15, 2016, NYSOH issued a notice stating your youngest child was enrolled in a Medicaid Managed Care plan, effective November 1, 2016.

On November 13, 2016, NYSOH issued a notice advising you that you needed to update your account to determine eligibility for your spouse.

On November 28, 2016, NYSOH received your updated application for health insurance, in which you declined financial assistance and stated that you and your youngest child no longer needed health insurance.

On November 29, 2016, NYSOH issued notices stating you and your youngest child were eligible for health insurance through NYSOH only at full cost, effective November 29, 2016, because you and your child no longer wanted to receive coverage.

Also on November 29, 2016, NYSOH issued a disenrollment notice stating the Medicaid Managed Care plan coverage for you and your youngest child would end on November 30, 2016, because you and your child were no longer eligible to remain enrolled.

On November 30, 2016, you updated your account, to once more request financial assistance and coverage for you and your youngest child. You also indicated your annual income was $48,000.00.

On December 1, 2016, NYSOH issued an eligibility determination notice, based on your November 30, 2016 updated application, stating you were eligible to enroll in the Essential Plan, effective January 1, 2017. The notice also stated your youngest child was conditionally eligible for Medicaid, effective December 1, 2016, pending proof of her citizenship status and Social Security number by February 28, 2017.

Also on December 1, 2016, NYSOH issued an enrollment confirmation notice, based on your November 30, 2016 plan selection, stating your youngest child was enrolled in a Medicaid Managed Care plan, effective January 1, 2017.

Additionally, on December 1, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of the November 30, 2016 disenrollment from the Medicaid Managed Care plans you and your child were enrolled in as well as the December 1, 2016 eligibility determination insofar as you, [redacted] were no longer eligible for Medicaid.

On December 7, 2016, NYSOH issued an enrollment confirmation notice stating you were enrolled in the Essential Plan, effective January 1, 2017.

On March 24, 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) You updated your application on July 7, 2016, indicating that you were pregnant.

2) You were determined eligible for Medicaid and you subsequently enrolled in a Medicaid Managed Care plan effective, August 1, 2016.

3) Your youngest child was born [redacted].

4) Your youngest child was added to the account and determined conditionally eligible for Medicaid, effective September 1, 2016, pending proof of her citizenship status and Social Security number.

5) Your youngest child was enrolled in a Medicaid Managed Care plan with coverage effective November 1, 2016.

6) Notes in your account on November 15, 2016 indicate NYSOH backdated your youngest child's Medicaid coverage to "mirror mom's coverage for month of birth."

7) You testified you accessed your NYSOH account on November 28, 2016 to update the information for the 2017 coverage year for your spouse who was up for renewal. You testified you were confused by the questions in the application as you believed you were asked if you wanted to re-apply for insurance for you and your youngest child. You testified that you answered no to this question. You testified you received an immediate response indicating the health coverage you and your youngest child were enrolled in was terminated.

8) Your account confirms the November 28, 2016 updated application indicates that you declined financial assistance and that you and your youngest child did not need health insurance.

9) You testified it was not your intention to terminate the health coverage you and your youngest child were enrolled in.

10) You testified once you figured out what happened you went back in to the application and corrected the fields indicating you and your child still needed health insurance; your account indicates that you updated your account two days later.

11) Your account confirms the updated application submitted November 30, 2016 indicates you and your youngest child needed health insurance.

12) As a result of the November 28, 2016 updated application, you and your child were disenrolled from your Medicaid Managed Care plans, effective November 30, 2016.

13) When you submitted the updated application on November 30, 2016, you, [redacted] were determined eligible for the Essential Plan, effective January 1, 2017. Your youngest child was determined eligible for Medicaid, effective December 1, 2016.

14) You enrolled in the Essential plan with coverage effective January 1, 2017.

15) You enrolled your youngest child in a Medicaid Managed Care plan, effective January 1, 2017.

16) You, [redacted] had no health coverage in the month of December 2016.

17) Your youngest child had fee-for-service Medicaid only in December 2016.

18) You testified you have outstanding medical bills for the month of December 2016.

19) You testified you are seeking reinstatement of your Medicaid Managed Care plan as of December 1, 2016. You testified you are seeking reinstatement of your youngest child's Medicaid Managed Care plan for the month of December 2016.

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

Applicable Law and Regulations

Medicaid

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the federal poverty level (FPL) for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

However, Medicaid is also available to pregnant women and infants under the age of one 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).

In an analysis of Medicaid eligibility, the determination is based on the FPL “for the applicable budget period used to determine an individual's eligibility” (42 CFR § 435.4). On the date of your application, that was the 2016 FPL, which is $24,300.00 for a four-person household (81 Federal Register 4036).

Medicaid – Continuous Coverage

Generally, most applications determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, even if they lose Medicaid eligibility because of any changes or updates they make to their NYSOH account. For example, even if income increases above the Medicaid limit allowed for the household size, the insured will remain covered under Medicaid for a 12-month period. This 12-month period is referred to as “continuous coverage” and is set based on the start date of the original Medicaid eligibility determination or the date of a subsequent Medicaid eligibility determination based on modified adjusted gross income (NY Social Services Law § 366(4)(c)).

However, a pregnant woman who only became eligible for Medicaid under NY Social Services Law § 366(1)(b)(2) and NY Department of Health Administrative Directive 13 ADM-03, which allow a pregnant woman to be eligible for Medicaid if her household income does not exceed 223% of the FPL for the applicable family size, is not eligible for 12 months of continuous coverage. Instead, her eligibility

will continue until the end of the month in which the sixtieth day after the end of the pregnancy occurs (NY Social Services Law § 366(4)(b)(1); 42 CFR § 435.116(c); NY Department of Health Administrative Directive 13 ADM-03).

Medicaid Start Date

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)).

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).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). On the date of your application, that was the 2015 FPL, which is $24,250.00 for a four-person household (80 Federal Register 3236, 3237).

A person who has a household income that is at or below 150% of the FPL has a $0.00 premium contribution (New York's Basic Health Plan Blueprint, p. 21, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a $20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016).

Essential Plan Effective Date

For individuals seeking enrollment in an Essential Plan, New York State has elected to follow the same rules that NYSOH uses in determining effective dates for individuals seeking enrollment in qualified health plans (NY Social Services Law § 369-gg(4)(c); New York's Basic Health Plan Blueprint, p. 16, as approved January 2016; *see* https://www.medicaid.gov/basic-health-program/basic-health-program.html).

The effective date of coverage by an Essential Plan is determined by the date on which an applicant selects a plan for enrollment. For individuals who are eligible for enrollment, NYSOH must generally ensure that coverage is effective the first day of the following month for selections received by NYSOH from the first to the fifteenth of any month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(i); *see also* 42 CFR § 600.320). For selections 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 §§ 155.410(f)(2), 155.420(b)(1)(ii)).

Legal Analysis

The first issue under review is whether NYSOH properly terminated the Medicaid Managed Care plan coverage you and your youngest child were enrolled in, effective November 30, 2016.

You updated your application on July 7, 2016, indicating that you were pregnant. As a result, you were determined eligible for Medicaid, and you were enrolled in Medicaid and in a Medicaid Managed Care plan effective August 1, 2016. Your youngest child was born [redacted] and was added to your account. She was determined eligible for Medicaid and enrolled in a Medicaid Managed Care plan, effective November 1, 2016.

Your account confirms you submitted an updated application on November 28, 2016 indicating you and your youngest child no longer needed health insurance, and declining financial assistance. As a result, NYSOH issued a notice stating you and your youngest child were no longer eligible for health insurance through NYSOH, effective November 29, 2016. The coverage you and your youngest child were receiving through your Medicaid Managed Care plans was terminated, effective November 30, 2016.

Although you testified that you had not intended to terminate the health coverage you and your child were receiving, the fact remains that you did change your

application to decline both financial assistance and health insurance, which is your right to do.

Given the unambiguous application, NYSOH acted properly in disenrolling you and your youngest child from Medicaid and your Medicaid Managed Care plan, and the November 29, 2016 notices stating you and your youngest child were no longer enrolled in Medicaid effective November 30, 2016, must be AFFIRMED.

The second issue under review is NYSOH properly find that you, [redacted] were eligible for the Essential Plan, effective January 1, 2017.

When you were found eligible for Medicaid, effective August 1, 2016, it was based on a finding that your annual household income was $40,000.00, or 164.61% of the FPL for a family of your size. In other words, you were only found eligible to enroll in Medicaid because of the more favorable eligibility requirements provided to pregnant women. When you reapplied for coverage on November 30, 2016, you were therefore not entitled to eligibility based on the standard policy of continuous coverage. Instead, your eligibility under the more favorable standards for pregnant women only extended to the last day of the month in which the sixtieth day after the end of the pregnancy occurs. Because your youngest child was born on [redacted], you could no longer be covered by the extended period after September 30, 2016, and your eligibility had to be determined based on standard rules.

With an income of $40,000.00, which is 164.95% of the applicable FPL, you were properly found eligible for the Essential Plan, with a $20.00 monthly premium.

Because this application was submitted on November 30, 2016, your eligibility for the Essential Plan was properly found to be January 1, 2017, the first day of the second month following your application.

Therefore, the subsequent December 1, 2016 eligibility determination stating you were eligible to enroll in the Essential Plan is AFFIRMED insofar as it related to your eligibility.

The third issue under review is whether NYSOH properly found that your youngest child was reenrolled in her Medicaid Managed Care plan no earlier than January 1, 2017.

As noted above, you reapplied for coverage and financial assistance for your youngest child on November 30, 2016. When she was found eligible for Medicaid, her coverage in fee-for-service Medicaid was resumed without a gap in coverage, effective December 1, 2016. Her reenrollment in her Medicaid Managed Care plan appropriately resumed on the first day of the second month following your November 30, 2016 application, of January 1, 2017.

Therefore, the December 7, 2016 enrollment confirmation notice must be AFFIRMED.

Decision

The November 29, 2016 eligibility determination and disenrollment notices are AFFIRMED.

The December 1, 2016 eligibility determination notice is AFFIRMED.

The December 7, 2016 enrollment confirmation notice is AFFIRMED.

Effective Date of this Decision: May 5, 2017

How this Decision Affects Your Eligibility

The eligibility and enrollment for you and your daughter will not be changed.

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 November 29, 2016 eligibility determination and disenrollment notices are AFFIRMED.

The December 1, 2016 eligibility determination notice is AFFIRMED.

The December 7, 2016 enrollment confirmation notice is AFFIRMED.

The eligibility and enrollment for you and your daughter will not be changed.

Legal Authority

We are sending you this notice 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।

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).

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 नि:शुल्क 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.

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).