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

Notice of Decision

Decision Date: April 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014817

[redacted]

Dear [redacted],

On April 5, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 5, 2017 enrollment 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
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Decision

Decision Date: April 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014817

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health (NYSOH) properly determine that your child's enrollment in his Medicaid Managed Care plan was effective no earlier than February 1, 2017?

Procedural History

On December 31, 2015, NYSOH issued an eligibility determination notice stating that your child was eligible for Medicaid, effective December 1, 2015.

On January 1, 2016, NYSOH issued an enrollment notice confirming your selection of a Medicaid Managed Care (MMC) plan for your child's enrollment as of December 31, 2015. The notice stated that your child was eligible for coverage under his MMC plan effective February 1, 2016.

On October 9, 2016, NYSOH issued a renewal and eligibility determination notice stating that your child was found eligible for coverage under Child Health Plus (CHP) with a $9.00 per month premium, effective December 1, 2016. The notice stated that your child was also enrolled into CHP plan since it was similar to the coverage he had before with this insurance company.

On October 17, 2016, NYSOH issued a disenrollment notice confirming that your child's MMC plan coverage would end effective November 30, 2016.

Also on October 17, 2016, NYSOH issued an enrollment notice confirming your child's re-enrollment in a CHP plan as of October 16, 2016. The notice stated that his CHP plan coverage would begin effective December 1, 2016 with a $9.00 monthly premium.

On December 6, 2016, NYSOH received an update to your application for health insurance.

On December 7, 2016, NYSOH issued a notice stating that more information was required for NYSOH to render a determination regarding your child's eligibility. It requested that you provide income documentation for your child by December 21, 2016.

Also on December 7, 2016, NYSOH issued a disenrollment notice confirming that your child's CHP plan coverage would end effective December 31, 2016.

On December 8, 2016, NYSOH received an additional update to your application for health insurance.

Also on December 8, 2016, NYSOH received two earning statements issued to you by your employer, [redacted], on October 25, 2016 and November 23, 2016.

On December 9, 2016, NYSOH issued a notice stating that more information was required for NYSOH to render a determination regarding your child's eligibility. It requested that you provide income documentation for your child by December 21, 2016.

On December 24, 2016, NYSOH issued an eligibility determination notice, based on a NYSOH eligibility redetermination as of December 23, 2016. The notice stated that your child was eligible for Medicaid effective January 1, 2017.

On January 5, 2017, NYSOH issued an enrollment notice confirming your selection of an MMC for your child's coverage as of January 4, 2017. The notice stated that your child's MMC plan coverage would begin effective February 1, 2017.

On January 12, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your child's enrollment in an MMC plan, insofar as it began on February 1, 2017, rather than January 1, 2017.

On April 5, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and remained open as the Hearing Officer directed you to provide as additional evidence to corroborate your testimony: a letter attesting that your child receives no income and that you the sole source of income in the household. The record

was to be closed at 5:00 p.m. on April 5, 2017, or upon the receipt of the above referenced documents, whichever occurred earlier.

That same day, you provided the above-referenced document to the Appeals Unit through your NYSOH online account.

Accordingly, the record was closed on April 5, 2017.

Findings of Fact

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

1) You testified that you are appealing only your child's eligibility.

2) As the result of an annual renewal, your child was found eligible for coverage through CHP with a $9.00 monthly premium, effective December 1, 2016.

3) You revised your application on December 6, 2016. In this application, you attested to an annual household income of $19,526.00, which was comprised of $751.00 in earnings from your employer, [redacted], once every two weeks. You testified that these income amounts were, and remain, accurate.

4) You testified that you live alone with your daughter.

5) Your application reflects that you expect to filed your 2016 tax return with a tax filing status of head of household, and would claim only your child as a dependent.

6) You were found eligible for Medicaid as reflected within the December 6, 2016 eligibility determination; however, you child's eligibility could not be determined since NYSOH requested that you provide additional income documentation for your child by December 21, 2016.

7) On December 8, 2016, you provided to NYSOH two earning statements reflecting that you received from your employer, [redacted], (1) $879.01 on October 25, 2016 and (2) $909.01 on November 23, 2016. These earning statements were verified by NYSOH on December 23, 2016.

8) You revised your application again on December 8, 2016, and were again requested to provide additional income documentation for your child for NYSOH to determine his eligibility.

9) NYSOH redetermined your household's eligibility on December 23, 2016, and your child was found eligible for Medicaid, effective December 1, 2016.

10) You selected a MMC plan for your child's coverage on January 4, 2017. Your child's MMC plan coverage began effective February 1, 2017.

11) You testified that you were seeking for your child's MMC plan coverage to begin effective January 1, 2017, rather than February 1, 2017, since you incurred substantial medical expenses for your child's care during the month of January 2017 that are not covered by Medicaid Fee-For-Service.

12) On April 5, 2017, you provided a letter attesting to your son not having received any income, and that you were sole source of his support.

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

Applicable Law and Regulations

Verification Process

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 (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 for Adults between the Ages of 19 and 65

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), 435.911(b)(1), 435.603(d)(4); NY Social Services Law § 366(1)(b)).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved 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 $16,020.00 for a two-person household (81 Federal Register 4036).

Generally, most adults 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)).

An individual will be enrolled or remain in their Medicaid plan with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, failing to provide a valid social security number, or having third party health insurance (NY Social Services Law § 366(4)(c)).

Medicaid for Children

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the FPL for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

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 was $16,020.00 for a two-person household (81 Federal Register 4036).

Medicaid 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)).

MMC plan enrollments received on or before the fifteenth day of the month are effective the first day of the following month. Enrollments received after the fifteenth day of the month are effective the first day of the second following month (Medicaid Managed Care Model Contract (Appendix H-6(b)(ii) & (iii), effective 3/1/2014 – 2/28/2019; *see* 42 USC § 1315; § 364-j(1)(c); 18 NYCRR § 360-

10.3(h), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

Legal Analysis

The issue is whether NYSOH properly determined that your child's enrollment in his MMC plan was effective no earlier than February 1, 2017.

The record reflects that because of an annual renewal, on October 9, 2016, you and your child were found eligible for the Essential plan and Child Health Plus coverage, respectively, effective December 1, 2016.

You testified, and your NYSOH account reflects, that you updated your application on December 6, 2016 and attested to a household income of $19,526.00. In response to this application, you were found eligible for Medicaid, effective December 1, 2016; however, your child's eligibility could not be determined at that time. On December 7, 2016, NYSOH issued a notice requesting additional income documentation for your child by December 21, 2016.

In response to that request, on December 8, 2016, you provided to NYSOH two earning statements reflecting that you received from your employer, [redacted], (1) $879.01 on October 25, 2016 and (2) $909.01 on November 23, 2016. These documents were verified as acceptable proof of income by NYSOH on December 23, 2016.

NYSOH reran your household eligibility on December 23, 2016 based on having received these documents, and your child was found eligible for Medicaid, effective December 1, 2016. However, you were prevented from selecting an MMC plan for your child until at least December 23, 2016.

The date on which an MMC 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.

The record reflects that you ultimately selected an MMC plan for your child's coverage on January 4, 2017, which resulted in a February 1, 2017 start date of his coverage under that plan.

However, we find there is sufficient evidence that you timely provided the requested income documents on December 8, 2016. We may therefore

reasonably infer that you would have selected this MMC plan for your child's coverage on that date, had you been permitted to do so.

Therefore, the January 5, 2017 enrollment notice is MODIFIED to state that your child's MMC plan coverage began effective January 1, 2017.

Your case is RETURNED to NYSOH to effectuate the changes to your child's MMC plan coverage, as referenced above.

Decision

The January 5, 2017 enrollment notice is MODIFIED to state that your child's MMC plan coverage began effective January 1, 2017.

Your case is RETURNED to NYSOH to effectuate the changes to your child's MMC plan coverage as referenced above.

Effective Date of this Decision: April 12, 2017

How this Decision Affects Your Eligibility

The effective date of your child's MMC plan coverage is January 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)).

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 January 5, 2017 enrollment notice is MODIFIED to state that your child's MMC plan coverage began effective January 1, 2017.

Your case is RETURNED to NYSOH to effectuate the changes to your child's MMC plan coverage as referenced above.

The effective date of your child's MMC plan coverage is January 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:

[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).