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

Notice of Decision

Decision Date: June 27, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015590

[redacted]

Dear [redacted],

On May 10, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 10, 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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Decision

Decision Date: June 27, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000015590

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 and your children's enrollment in your Medicaid Managed Care plan was effective no earlier than February 1, 2017?

Procedural History

On August 9, 2016, NYSOH issued a notice stating that your family's Medicaid coverage through Ulster County Department of Social Services would end after October 31, 2016. You were advised to log into your NYSOH account and renew your coverage by updating the information in your account between September 16, 2016 and October 15, 2016.

On November 11, 2016, NYSOH redetermined your household's eligibility for financial assistance with health insurance.

On November 12, 2016, NYSOH issued an eligibility determination notice stating that your spouse was eligible for Medicaid, effective November 1, 2017; however, NYSOH could not determine the eligibility of you or your children without additional income documentation. You were requested to provide additional income documentation by November 26, 2016; one acceptable proof would be the submission of paystubs for the last four weeks.

On November 22, 2016, NYSOH received four earning statements issued to you by your employer, between September 21, 2016 and November 2, 2016.

On December 9, 2016, NYSOH issued a notice stating that the documentation you provided was not sufficient to verify your information, without further clarification. You were requested to send additional income documentation for you and your youngest child by December 11, 2016 and for your two oldest children by December 26, 2016.

On December 12, 2016, NYSOH received two additional earning statements issued to you by [redacted] on November 16, 2016 and November 30, 2016.

On December 28, 2016, NYSOH received two additional earning statements issued to you by [redacted] on December 14, 2016 and December 28, 2016.

On January 4, 2017, NYSOH received duplicate copies of earnings statements already submitted reflecting payments made to you by your employer, [redacted], Inc. ([redacted]), between September 21, 2016 and December 28, 2016, as well as a letter from you stating that your children were all under age and did not receive income from any outside sources.

On January 6, 2017, NYSOH redetermined your household's eligibility for health insurance. In response to this application, NYSOH prepared a preliminary eligibility determination stating that you and your children were eligible for Medicaid, effective January 1, 2017.

Also on January 6, 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 you were seeking a start date of November 1, 2016, rather than February 1, 2017.

On January 7, 2017, NYSOH issued an eligibility determination notice stating that you and your children were eligible for Medicaid, effective January 1, 2017. This notice advised you to select a Medicaid Managed Care (MMC) plan for coverage for you and your children.

On January 10, 2017, NYSOH issued an enrollment notice confirming your selection of an MMC plan for you and your children as of January 9, 2017. The notice stated that your household's MMC plan coverage would begin effective February 1, 2017.

On February 14, 2017, NYSOH issued four separate eligibility determination notice stating that you and your children were eligible for retroactive Medicaid between November 1, 2016 and December 31, 2016 because your average household income of $2,346.50 per month was below the allowable income limit of $3,271.00.

On May 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 supports the following findings of fact:

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

2) Your household's Medicaid coverage through Ulster County Department of Social Services ended effective October 31, 2016.

3) You submitted your initial application to NYSOH on November 22, 2016.

4) On November 22, 2016, you submitted to NYSOH four earnings statements reflecting that you had received from your employment: (1) $1,080.00 on September 21, 2016, (2) $1,015.88 on October 5, 2016, (3) $951.75 on October 19, 2016 and (4) $1,005.75 on November 2, 2016. The constituted your earnings from work performed from September 21, 2016 to October 29, 2016.

5) On December 9, 2016, NYSOH requested that you send additional income documentation for you and your youngest child by December 11, 2016 and for your two oldest children by December 26, 2016.

6) On December 12, 2016, you submitted to NYSOH two additional earnings statements reflecting that you had received from [redacted]: (1) $945.00 on November 16, 2016 and (2) $756.00 on November 30, 2016.

7) On December 28, 2016, you submitted to NYSOH two additional earnings statements reflecting that you had received from [redacted]: (1) $1,039.50 on December 14, 2016, and (2) $948.38 on December 28, 2016.

8) You resubmitted to NYSOH all earnings statements you previously provided on January 4, 2017, as well as a letter confirming your children did not have any income. The only difference was that the name of your employer was not cut off. These documents were verified as acceptable proof of income on January 6, 2017.

9) You and your children were found eligible for Medicaid on January 6, 2017.

10) You and your children were subsequently found eligible for retroactive Medicaid coverage between November 1, 2016 and December 31, 2016.

11) You selected an MMC plan for you and your children on January 9, 2017.

12) You testified that you were seeking for your family's MMC plan coverage to begin effective November 1, 2016, rather than February 1, 2017, since your child incurred extensive medical expenses associated with a hospital and follow-up medical visits during November 2016.

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 $28,440.00 for a five-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 federal poverty level (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 $28,440.00 for a five-person household (81 Fed. Reg. 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)).

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 issue is whether NYSOH properly determined that your and your children's enrollment your MMC plan was effective no earlier than February 1, 2017.

The record reflects that your family's Medicaid coverage through Ulster County Department of Social Services ended effective October 31, 2016.

You testified, and your NYSOH account reflects, that you updated your application on November 22, 2016 and attested to annual household income of $25,974.00. However, NYSOH again requested income documentation to confirm the eligibility for you and your children.

The record reflects that on November 22, 2016 you submitted to NYSOH four earnings statements reflecting that you had received from your employer: (1) $1,080.00 on September 21, 2016, (2) $1,015.88 on October 5, 2016, (3) $951.75 on October 19, 2016 and (4) $1,005.75 on November 2, 2016.

However, NYSOH issued a notice on December 9, 2016 stating that the income documents you provided were insufficient to confirm the eligibility of you and your children. You were requested to provide additional income documentation for you and your youngest child by December 11, 2016 and for your two oldest children by December 26, 2016. The notice did not explain why the documents were insufficient, or that you needed to submit documents with the name of your employer included.

The record further reflects that between December 12, 2017 and December 28, 2016 you provided four additional earning statements reflecting that you had received (1) $945.00 on November 16, 2016, (2) $756.00 on November 30, 2016, (3) $1,039.50 on December 14, 2016, and (4) $948.38 on December 28, 2016.

You ultimately resubmitted all earning statements previously submitted to NYSOH on January 4, 2017, with the name of your employer included. These documents were verified as acceptable proof of income on January 5, 2017. Because of this finding by NYSOH, you and your children were found eligible for Medicaid, effective January 1, 2017, and were eligible to enroll in an MMC plan. The record reflects that you selected an MMC plan on January 9, 2017, which provided you and your children an MMC plan coverage start date of February 1, 2017.

We find, however, that NYSOH failed to provide you with the proper notice as to what was deficient in the documentation submitted on November 22, 2016. Had it done so, you would have known to submit the appropriate documentation in a timely manner.

The documents you provided to NYSOH on January 4, 2017 were accepted as valid proof on income, and they contained the same income information as had been submitted on November 22, 2016. Had you been properly notified of the specific deficiency in this evidence there was ample time for you to have provided further documentation before December 15, 2016.

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.

We find there is sufficient evidence that your MMC should be deemed to have been selected on December 15, 2016. Therefore, the January 10, 2017 enrollment notice is MODIFIED to state that your and your children's MMC plan coverage began effective January 1, 2017.

Your case is RETURNED to NYSOH to effectuate the changes to you and your MMC plan coverage as referenced above.

Decision

The January 10, 2017 enrollment notice is MODIFIED to state that you and your children's MMC plan coverage began effective January 1, 2017.

Your case is RETURNED to NYSOH to effectuate the changes to you and your MMC plan coverage as referenced above.

Effective Date of this Decision: June 27, 2017

How this Decision Affects Your Eligibility

The effective date of your and your children'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 10, 2017 enrollment notice is MODIFIED to state that you and your children's MMC plan coverage began effective January 1, 2017.

Your case is RETURNED to NYSOH to effectuate the changes to you and your MMC plan coverage as referenced above.

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 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.

(Urdu)اردو

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).