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

Notice of Decision

Decision Date: February 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023759

On January 22, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 17, 2017 discontinuance and disenrollment notices and the October 27, 2017 eligibility determination.

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: February 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023759

Issues

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

> Did NY State of Health (NYSOH) properly determine that you and your child's enrollment in your Medicaid Managed Care plan ended effective October 31, 2017?
>
> Did NYSOH properly determine that you were eligible for an Essential Plan with a $20.00 monthly premium and your child was eligible for Child Health Plus with a $9.00 monthly premium, effective December 1, 2017?

Procedural History

On November 26, 2016, NYSOH issued a notice of eligibility determination stating that you and your child were eligible for Medicaid, effective November 1, 2016. You both subsequently enrolled in Medicaid Managed Care plans.

On September 3, 2017, NYSOH issued a notice that it was time to renew your health insurance. That notice stated that, based on information from federal and state sources, NYSOH could not determine whether you and your child would qualify for financial help paying for your health coverage, and that you needed to update your account by October 15, 2017 or you might lose the financial assistance you were currently receiving.

No updates were made to your account by October 15, 2017.

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On October 16, 2017, NYSOH redetermined your eligibility.

On October 17, 2017, NYSOH issued an eligibility determination notice stating that you and your child were not eligible for Medicaid, Child Health Plus, or to receive tax credits or cost-sharing reductions to help pay for the cost of insurance. You also could not enroll in a qualified health plan at full cost. This was because you had not responded to the renewal notice and had not completed your renewal within the required time frame. Your eligibility ended October 31, 2017.

Also on October 17, 2017, NYSOH issued a disenrollment notice stating that you and your child's coverage in your Medicaid Managed Care plan was ending effective October 31, 2017.

On October 26, 2017, NYSOH received your updated application for health insurance wherein you attested to a household income of $26,800.00. That day a preliminary eligibility determination was prepared regarding that application, stating you were eligible for an Essential Plan with a $20.00 monthly premium and your child was eligible for Child Health Plus with a $9.00 monthly premium, both effective December 1, 2017.

Also on October 26, 2017, you spoke to NYSOH's Account Review Unit and appealed you and your child's disenrollment from your Medicaid Managed Care plan.

On October 27, 2017, NYSOH issued an eligibility redetermination notice stating that you were eligible for an Essential Plan with a $20.00 monthly premium and your child was eligible for Child Health Plus with a $9.00 monthly premium, effective December 1, 2017.

On January 22, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was left open until January 29, 2018 for you to provide income documentation.

On January 29, 2018, NYSOH's Appeals Unit received a fax requesting "a few more days" to provide income documentation. The request was granted.

On February 5, 2018, NYSOH's Appeals Unit received a fax containing income documentation which was made part of the record as Appellant's Exhibit #1. The record is now closed.

Findings of Fact

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

1) NYSOH records reflect that you and your son were determined eligible for Medicaid, effective November 1, 2016.

2) NYSOH records reflect that a renewal notice was issued to you on September 3, 2017. The notice directed you to update your account by October 15, 2017 or you and your child might lose the financial assistance you were currently receiving.

3) You testified, and the record reflects, that you receive your notices from NYSOH by regular mail.

4) You testified that you did not receive any notices telling you that you needed to update your application to renew you and your child's Medicaid Managed Care plan coverage.

5) You testified that you did not know that you needed to update your account until you received the October 17, 2017 disenrollment notice.

6) The record reflects that on October 26, 2017 NYSOH received your updated application for health insurance.

7) No notices sent to you at the address listed on your NYSOH account have been returned as undeliverable.

8) You testified that you are appealing you and your child's disenrollment from your Medicaid Managed Care plan, effective October 31, 2017.

9) During the hearing, you testified that you also were seeking to appeal you and your child's eligibility determination dated October 27, 2017. The Hearing Officer allowed you to provide testimony and income documentation on this issue.

10) You testified that the October 27, 2017 eligibility determination finding you eligible for an Essential Plan with a $20.00 monthly premium and your child eligible for Child Health Plus with a $9.00 monthly premium, effective December 1, 2017, was incorrect because it was based on an incorrect expected 2017 annual income.

11) You testified that when you contacted NYSOH to update your application on October 26, 2017, that you attested to a household income for 2017 of $26,800.00 consisting of in income from your

current employer, [redacted] and from your former employer [redacted].

12) You testified that you worked for [redacted] during January 2017 and earned approximately $1,800.00 during that time.

13) You testified that you began working for [redacted] on [redacted]. You testified that you are paid $12.00 per hour and work forty hours per week. You testified that you expect to earn $25,000.00 annually.

14) You testified that you incorrectly attested to an annual expected 2017 income from [redacted] of $25,000.00 and did not factor in that you would not make $25,000.00 annually because you did not work for [redacted] during January 2017. You testified your annual income for 2017 was closer to $25,000.00.

15) The Hearing Officer asked you to provide income documentation by January 29, 2018 or the record would be closed and the determination would rely on the information contained in your NYSOH account.

16) On February 5, 2018 you provided the following: a pay stub from [redacted] with a pay date of December 5, 2017 in the amount of $553.80; a pay stub from [redacted] with a pay date of December 12, 2017 in the amount of $730.95; a pay stub from [redacted] with a pay date of December 19, 2017 in the amount of $610.80; a pay stub from [redacted] with a pay date of December 26, 2017 in the amount of $501.75 with a "year to date" total of $26,608.67; and a pay stub from [redacted] reflecting "year to date" gross earnings for 2017 of $2,820.97.

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

Applicable Law and Regulations

<u>Medicaid Renewal</u>

In general, NYSOH must review Medicaid eligibility once every twelve months or "whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility" (42 CFR § 435.916(a)(1), (d)). NYSOH must make its "redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency,

including but not limited to information accessed through any data bases accessed by the agency” (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates provided by the individual (45 CFR §155.335(h)).

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 Managed Care (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, N.Y. Soc. Serv. Law §364-j(1)(c); 18 NYCRR § 360-10.3(h)).

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 2016 FPL, which is $16,020.00 for a two-person household (81 Federal Register 4036).

Legal Analysis

The issue under review is whether NYSOH properly determined that you and your child’s enrollment in your Medicaid Managed Care plan ended effective October 31, 2017.

You and your child were originally found eligible for Medicaid effective November 1, 2016.

Generally, NYSOH must redetermine a qualified individual's eligibility for Medicaid once every 12 months without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency. NYSOH's September 3, 2017 renewal notice stated that there was not enough information to determine whether you and your child were eligible to continue your financial assistance for health insurance, and that you needed to supply additional information by October 15, 2017, or you and your child's financial assistance might end.

Because there was no timely response to this notice, you and your child's coverage in your Medicaid Managed Care plan ended effective October 31, 2017.

You testified that you did not receive any notice from NYSOH telling you that you needed to update the information in your NYSOH account. You testified, and your NYSOH account confirms, that you elected to receive notifications by regular mail. However, there is no evidence in the record that any of the notices that were sent to your mailing address were returned as undeliverable.

Therefore, the record reflects that NYSOH properly notified you of your annual renewal and that information in your NYSOH account needed to be updated to ensure you and your child's enrollment in your health plan and eligibility for financial assistance would continue.

Therefore, NYSOH's October 17, 2017 discontinuance and disenrollment notices are AFFIRMED as they properly ended you and your child's coverage in your Medicaid Managed Care plan on October 31, 2017.

The second issue under review is whether NYSOH properly determined that you were eligible for an Essential Plan with a $20.00 monthly premium and your child was eligible for Child Health Plus with a $9.00 monthly premium, effective December 1, 2017.

On October 27, 2017, NYSOH issued an eligibility redetermination notice stating that you were eligible for an Essential Plan with a $20.00 monthly premium and your child was eligible for Child Health Plus with a $9.00 monthly premium, effective December 1, 2017.

NYSOH records reflect that the October 27, 2017 eligibility determination was based on an annual household income of $26,800.00. You testified that this amount was incorrect and that you made less in 2017.

You testified that you had two employers in 2017. You testified that you worked for [redacted] during January 2017 and that you worked for [redacted] from February 2, 2017 throughout the end of 2017.

The record reflects that you submitted a pay stub from [redacted] reflecting "year to date" gross earnings for 2017 of $2,820.97 and a pay stub from [redacted] dated December 26, 2017 reflecting a "year to date" total of $26,608.67. therefore, your annual household income for 2017 is $29,429.64.

As such, the October 27, 2017 eligibility determination was based on incorrect information and is RESCINDED.

Your case is RETURNED to NYSOH to recalculate you and your child's eligibility for financial assistance based on a two-person household, living in Westchester County, NY, with a 2017 household income of $29,429.64, effective December 1, 2017.

Decision

The October 17, 2017 discontinuance and disenrollment notices are AFFIRMED.

The October 27, 2017 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to recalculate you and your child's eligibility for financial assistance based on a two-person household, living in Westchester County, NY, with a 2017 household income of $29,429.64, effective December 1, 2017.

Effective Date of this Decision: February 16, 2018

How this Decision Affects Your Eligibility

The end date of you and your child's Medicaid Managed Care plan is October 31, 2017.

Your case is RETURNED to NYSOH to recalculate you and your child's eligibility for financial assistance based on a two-person household, living in Westchester County, NY, with a 2017 household income of $29,429.64, effective December 1, 2017.

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).

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 17, 2017 discontinuance and disenrollment notices are AFFIRMED.

The October 27, 2017 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to recalculate you and your child's eligibility for financial assistance based on a two-person household, living in Westchester County, NY, with a 2017 household income of $29,429.64, effective December 1, 2017.

The end date of you and your child's Medicaid Managed Care plan is October 31, 2017.

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.

(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.

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