STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: February 26, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025101

[redacted]

On January 23, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 1, 2017 eligibility determination notice, December 6, 2017 disenrollment notice, and December 27, 2017 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
  PO 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: February 26, 2018

NY State of Health Account ID: [redacted]
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Issue

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

> Did NY State of Health (NYSOH) properly determine that enrollment in a Medicaid Managed Care (MMC) plan for you and your child was effective February 1, 2018?

Procedural History

On November 17, 2016, NYSOH issued an eligibility determination notice, stating that you were eligible to enroll in Medicaid, effective November 1, 2016. You were subsequently enrolled in an MMC plan effective January 1, 2017.

On September 3, 2017, NYSOH issued a renewal notice, advising you that NYSOH could not determine whether you would qualify for financial assistance for the upcoming coverage year, and that you needed to update your application by October 15, 2017.

On September 27, 2017 you updated your account, listing your annual household income as $29,200.00. You were found eligible to enroll in the Essential Plan with a $20.00 monthly premium, based on this income, effective November 1, 2017. You enrolled in the Essential Plan; however, you later cancelled this coverage before it went into effect.

On October 30, 2017, you updated your application twice. In the first application, you listed your annual household income as $38,000.00, which entitled you to enroll in a qualified health plan (QHP) and to receive advance payments of the

premium tax credit. In the second, you listed annual income as $25,500.00, which led to eligibility to enroll in the Essential Plan.

On November 30, 2017, you updated your application again, listing your annual household income as $26,000.00. That same day, NYSOH prepared a preliminary eligibility determination, stating you were eligible to enroll in the Essential Plan, effective January 1, 2018.

Also on November 30, 2017, you spoke to NYSOH's Account Review Unit and appealed this eligibility determination, insofar as you were found eligible for the Essential Plan, instead of Medicaid.

On December 1, 2017, NYSOH issued an eligibility determination notice, stating that you were eligible to enroll in the Essential Plan, effective January 1, 2018, and your child was eligible to enroll in a Child Health Plus plan.

Also on December 1, 2017, NYSOH issued a notice confirming your enrollment in the Essential Plan, effective November 1, 2017.

On December 5, 2017 you updated your application, and on December 6, 2017, NYSOH issued an eligibility determination notice, stating that you needed to provide documentation to confirm the income in your application before an eligibility determination could be issued.

On December 15, 2017, you submitted a copy of a "payment summary" from [redacted]. On December 19, 2017, NYSOH issued a notice advising you that the documentation was insufficient to determine your eligibility.

After income documentation was submitted, on December 23, 2017, NYSOH issued an eligibility determination notice, stating that you were eligible for Medicaid, effective December 1, 2017, and your child was eligible for Medicaid effective January 1, 2018. This eligibility was based on annual household income of $6,000.00 per year. You were also found eligible for retroactive Medicaid assistance for November 2017.

On December 23, 2017, NYSOH issued a notice confirming your enrollment in an MMC plan, effective February 1, 2018.

On January 23, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed thereafter.

Findings of Fact

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

1) You testified that you want notices sent to you at [redacted], [redacted] The hearing officer advised you that you would need to contact NYSOH directly to formally change the address on your account.

2) After you filed your appeal, you and your child were subsequently found eligible for Medicaid. At the hearing, you amended your appeal to request your enrollment in your MMC plan begin on November 1, 2017.

3) Your eligibility for November 2017 was first determined through your September 27, 2017 application, at which time you were found eligible to enroll in the Essential Plan based on annual income of $29,200.00. Although you initially enrolled in the Essential Plan effective November 1, 2017, you cancelled that coverage before it went into effect.

4) You next updated your application (twice) on October 30, 2017, and you were found eligible for the Essential Plan, effective December 1, 2017.

5) You next updated your account on November 30, 2017, and you were again found eligible for the Essential Plan, effective January 1, 2018. You appealed that same day.

6) On December 15, 2017, you submitted a copy of a "payment summary" from [redacted] It included payments for "billing period" covering the months of September and October 2017, but the payments were not made until October 18, 2017 and December 1, 2017, nor does the document include year-to-date information or sufficiently make clear what the document represented. There is also no information regarding the second source of income you testified to.

7) On December 22, 2017 and December 27, 2017, you submitted additional income documentation. NYSOH subsequently found you eligible for Medicaid.

8) You testified that you would be filing your tax return as head of household with one qualifying dependent. Your relevant applications listed expected annual household incomes between $25,500.00 and $38,000.00. You testified that your earnings for 2017 would probably be around $28,000.00.

9) You also testified that you were on medical leave from your primary employment as of November 27, 2017; since that time your only income has been from a job [redacted]. You have applied for disability benefits.

You estimated your annual income as of December 5, 2017 to be $6,000.00.

10) According to your account, NYSOH did not receive any income documentation for you until December 15, 2017.

11) You were found eligible for retroactive Medicaid assistance for November 2017.

12) According to your account, you selected an MMC plan on December 26, 2017. You testified that you had selected an MMC in December 2017, but were not quite sure when.

13) You testified you were seeking to backdate your enrollment in your MMC plan to November 1, 2017, because you have outstanding copays from that month.

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), 42 CFR § 435.945).

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) 42 CFR § 435.952).

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 September 27, 2017 application, that was the 2016 FPL, which is $16,020.00 for a two-person household (81 Federal Register 4036).

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, *see* www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf).

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 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)).

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 September 27, 2017 application, that was the 2017 FPL, which is $16,240.00 for a two-person household (82 Federal Register 8831, 8832).

Enrollment in a Qualified Health Plan

The effective date of coverage by a QHP 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)). 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)).

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/downloads/ny-blueprint.pdf).

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)).
Medicaid – Effective Dates of Coverage

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 under review is whether NYSOH properly determined your enrollment in your MMC plan was effective February 1, 2018.

You were sent a renewal notice on September 3, 2017, advising you that NYSOH could not determine your eligibility for financial assistance and that you needed to update your application.

You updated your application on September 23, 2017, and listed expected annual earnings of $29,200.00. NYSOH relied on the income you entered and determined your eligibility based on this amount.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income

that is between 138% and 200% of the FPL for the applicable family size. On the date of your September 27, 2017 application, the relevant FPL was $16,020.00 for a two-person household. Since an annual household income of $29,200.00 is 182.27% of the 2016 FPL, NYSOH properly found you eligible for the Essential Plan, with a $20.00 monthly premium at that time.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $16,240.00 for a two-person household. Since $29,200.00 is 179.80% of the 2017 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

Financial eligibility for Medicaid for applicants can also be based on current monthly household income and family size. However, although you have subsequently been found eligible to receive retroactive Medicaid assistance for November 2017, there was no evidence in the file at the time of your September 27, 2017 application to support such a finding then.

Pursuant to regulations, NYSOH must request data that will allow NYSOH to verify the household's income. 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.

No documentary evidence regarding your income was submitted to NYSOH until December 15, 2017. The evidence submitted at that time was insufficient for NYSOH to determine your eligibility, either on an annual or monthly basis. It did not cover both of your sources of income and it did not document any earnings from September 2017.

You did not submit income documentation considered to be sufficient until on or after December 22, 2017.

According to your account, you were found eligible for Medicaid on or after December 23, 2017 and you selected an MMC plan.

Pursuant to the regulations, the date on which a Medicaid Managed Care plan can take effect depends on the day a plan is selected 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 evidence establishes that NYSOH did not receive satisfactory income documentation for your household until at least December 22, 2017. Even if you had been allowed to select an MMC plan that day, the earliest it could have become effective was on the first day of the second following month; that is, on February 2, 2018, because the plan selection would not have occurred until after the fifteenth day of the month.

Therefore, the December 27, 2017 enrollment confirmation notice stating you were enrolled in a Medicaid Managed Care plan, effective February 1, 2018, was correct and is AFFIRMED.

Decision

The December 1, 2017 eligibility determination notice, December 6, 2017 disenrollment notice were correct and are AFFIRMED.

The December 27, 2017 enrollment confirmation notice stating you were enrolled in a Medicaid Managed Care plan, effective February 1, 2018, was correct and is AFFIRMED.

Effective Date of this Decision: February 26, 2018

How this Decision Affects Your Eligibility

Your Medicaid Managed Care plan coverage became effective on February 1, 2018.

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
  PO Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The December 1, 2017 eligibility determination notice, December 6, 2017 disenrollment notice were correct and are AFFIRMED.

The December 27, 2017 enrollment confirmation notice stating you were enrolled in a Medicaid Managed Care plan, effective February 1, 2018, was correct and is AFFIRMED.

Your Medicaid Managed Care plan coverage became effective on February 1, 2018.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

[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).