



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

Notice of Decision

Decision Date: April 27, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000013953

[REDACTED]

Dear [REDACTED]

On April 5, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 15, 2016 eligibility determination and enrollment confirmation notices.

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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DEPARTMENT OF HEALTH
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Decision

Decision Date: April 27, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000013953



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 newborn child's Medicaid Managed Care plan (Healthfirst) began October 1, 2016?

Procedural History

On September 14, 2016, you updated your NYSOH application to add your newborn child to your account.

On September 15, 2016, NYSOH issued an eligibility determination notice stating that your newborn child was conditionally eligible for Medicaid Fee for Service coverage, effective September 1, 2016.

Also on September 15, 2016, NYSOH issued a notice of enrollment confirmation stating that your newborn child was enrolled in a Medicaid Managed Care plan (Healthfirst), effective October 1, 2016.

On December 10, 2016, you updated your application with NYSOH.

On December 11, 2016, NYSOH issued an eligibility determination stating that your newborn child was enrolled in a Medicaid Managed Care plan (Healthfirst), effective October 1, 2016.

On December 12, 2016, you spoke to NYSOH's Account Review Unit and appealed the September 15, 2016 eligibility determination and enrollment confirmation notices insofar as they began your newborn child's enrollment in her Medicaid Managed Care plan (Healthfirst) as of October 1, 2016 and not September 1, 2016.

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 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 the only issue under appeal is that you are seeking a start date for your newborn child's Medicaid Managed Care plan (Healthfirst) of September 1, 2016.
- 2) You testified that on September 14, 2016 your NYSOH application was updated to indicate that your child was born on [REDACTED]
- 3) You testified that your newborn child's Medicaid Managed Care plan coverage should have started in the month that she was born.
- 4) The enrollment history tab in your NYSOH application indicates that your newborn child's eligibility for Medicaid Fee for Service was made effective as of September 1, 2016.
- 5) You testified that you selected your newborn child's Medicaid Managed Care plan (Healthfirst) on September 14, 2016 and that her coverage was effective October 1, 2016.
- 6) You testified that you incurred a bill from your newborn child's pediatrician from September 20, 2016 in the amount of \$115.00. You testified that your provider does not accept Medicaid Fee for Service.
- 7) You testified that the hospital bills from the birth of your newborn child from September 2016 were paid through your Medicaid Fee for Service coverage.

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

Applicable Law and Regulations

Medicaid for Children

A child who is under one year of age 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 223% of the FPL for the applicable family size (42 CFR § 435.118(c); New York Department of Social Services Administrative Directive 13ADM-03).

Medicaid Managed Care Plan Effective Date

An individual is eligible for Medicaid Fee for Service 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 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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your newborn child's Medicaid Managed Care plan (Healthfirst) was effective October 1, 2016.

You testified that on September 14, 2016 your NYSOH application was updated to indicate that your child was born on September 13, 2016. On September 15, 2016, NYSOH issued an eligibility determination notice stating that your newborn child was eligible for Medicaid Fee for Service coverage, effective September 1, 2016. You testified that your newborn child's Medicaid Managed Care plan coverage should have started in the month your child was born.

An individual is eligible for Medicaid Fee for Service coverage effective on the first day of the month if an individual was eligible any time during that month. Therefore, NYSOH correctly determined that your newborn child's eligibility for Medicaid Fee for Service was effective as of September 1, 2016.

You testified that you selected your newborn child's Medicaid Managed Care plan (Healthfirst) on September 14, 2016. On September 15, 2016, NYSOH issued a notice of enrollment confirmation stating that your newborn child was enrolled in a Medicaid Managed Care plan, effective October 1, 2016.

Generally, the date on which a Medicaid Managed Care plan can take effect depends on the day a person selects the plan for enrollment. Enrollments received before the fifteenth day of the month are effective the first day of the following month.

On September 14, 2016, you selected a Medicaid Managed Care plan for your newborn child, so it should have taken effect on the first day of the following month; that is, on October 1, 2016.

Therefore, the September 15, 2016 eligibility determination and enrollment confirmation notices are AFFIRMED because they properly began your newborn child's Medicaid Fee for Service coverage on September 1, 2016 and Medicaid Managed Care plan coverage on October 1, 2016.

Decision

The September 15, 2016 eligibility determination is AFFIRMED.

The September 15, 2016 enrollment confirmation is AFFIRMED.

Effective Date of this Decision: April 27, 2017

How this Decision Affects Your Eligibility

Your newborn child was eligible for Medicaid Fee for Service coverage, effective September 1, 2016.

Your newborn child's enrollment in her Medicaid Managed Care plan was effective as of October 1, 2016.

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.

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).

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 September 15, 2016 eligibility determination is AFFIRMED.

The September 15, 2016 enrollment confirmation is AFFIRMED.

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Your newborn child was eligible for Medicaid Fee for Service coverage, effective September 1, 2016

Your newborn child's enrollment in her Medicaid Managed Care plan was effective as of October 1, 2016.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



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 مجاناً.

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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&btumi ama wo obi a okyer& 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 کرم 1-855-355-5777 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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