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

Notice of Decision

Decision Date: March 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014306

[redacted]

Dear [redacted]

On March 6, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 23, 2016 eligibility determination and December 24, 2016 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: March 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014306

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Issues

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

> Did NY State of Health (NYSOH) provide a timely determination of your household's Medicaid eligibility as of December 23, 2016?
>
> Did NY State of Health properly determine that your household's Medicaid Managed Care plan began February 1, 2017?

Procedural History

On November 29, 2016, NY State of Health (NYSOH) received your application for financial assistance with your health insurance.

On November 30, 2016, NYSOH issued a notice stating more information was needed to make a determination. The notice explained the income documentation you provided NYSOH did not match what was obtained from state and federal data sources. You were asked to submit income documentation for your household by December 14, 2016.

You uploaded income documentation on December 6, 2016.

On December 7, 2016, NYSOH issued a notice stating more information was needed to make a determination. The notice explained the income documentation you provided NYSOH did not match what was obtained from state and federal data sources. You were asked to submit income documentation for your household by December 14, 2016.

You uploaded income documentation on December 13, 2016.

On December 13, 2016, NYSOH issued a notice stating more information was needed to make a determination. The notice explained the income documentation you provided NYSOH did not match what was obtained from state and federal data sources. You were asked to submit income documentation for your household by December 29, 2016. You were also asked to provide proof of your Third Party Health insurance by December 27, 2016.

On December 21, 2016, NYSOH verified the paystubs and income documentation you uploaded and a new application was submitted on your behalf.

On December 21, 2016, NYSOH invalidated your proof of Third Party Health insurance.

On December 22, 2016, NYSOH issued a notice stating more information was needed to make a determination. The notice explained the documentation you provided NYSOH did not match what was obtained from state and federal data sources. You were asked to submit proof of your Third Party Health insurance by January 11, 2017.

On December 22, 2016, NYSOH issued an eligibility determination notice finding your household conditionally eligible for Medicaid effective November 1, 2016. The determination was based on the condition that you provide proof of your household's Third Party Health Insurance by January 11, 2017. The determination was based on your attested household income of $25,180.00.

On December 23, 2016, NYSOH issued an eligibility determination notice based on your December 22, 2016 application finding your household eligible for Medicaid effective December 1, 2016.

On December 23, 2016, you selected a Medicaid Managed Care plan.

Also on December 23, 2016, you contacted the NYSOH Account Review Unit and requested an appeal of the start date of your household's Medicaid Managed Care plan, requesting that it begin January 1, 2017 and not February 1, 2017.

On December 24, 2016, an enrollment confirmation notice was issued confirming your selection of a Medicaid Managed Care plan on December 23, 2016. The notice confirmed your household's enrollment in a plan starting February 1, 2017.

On March 6, 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, and the record reflects, that you are appealing the enrollment start date of your household's Medicaid Managed Care plan.

2) In your application submitted on November 29, 2016 you attested to a household annual income of $26,180.00. You testified this amount was correct at the time.

3) In your application submitted on December 22, 2016 you attested to a household annual income of $25,180.00. You testified this amount was correct.

4) Your application states you will be filing your 2016 taxes as married filing jointly and will claim two dependents on that tax return. You testified this was correct.

5) On December 6 and December 13, 2016, you submitted documentation of your paystubs and Unemployment Insurance Benefits statement to NYSOH for verification of the income stated in your November 29, 2016 application.

6) On December 21, 2016, your paystubs and Unemployment Insurance Benefits statement were verified as acceptable proof of income.

7) The record reflects NYSOH invalidated your proof of your Third Party Health Insurance on December 21, 2016.

8) You testified you lost your employment effective [redacted].

9) You testified you continued your household's health insurance with "COBRA" until December 31, 2016.

10) The record reflects that you selected a Medicaid Managed Care plan on December 23, 2016.

11) You testified that you want your Medicaid Managed Care plan to begin on January 1, 2017 because you incurred medical costs in the amount of $317.78 in the month of January 2017.

12) NYSOH records show your household was enrolled in Medicaid Fee-for-Service for November 1, 2016 through January 31, 2017.

13) You testified you did not have your NY benefits card for Medicaid at the time you received medical services in January, 2017, and did not provide the physician your Medicaid card as a result. You were not sure whether the physician you received medical services from accepts Medicaid Fee-for-Service.

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

Applicable Law and Regulations

Medicaid

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 2010,13 ADM-03(III)(F)).

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).

Timely Notice of Medicaid Eligibility

When an individual applies for insurance through NYSOH, NYSOH must determine that person's eligibility promptly and without undue delay (45 CFR § 155.310(e)(1); 42 CFR § 435.1200(b)(3)(iii)).

To assess whether an eligibility determination was untimely, NYSOH must base the time period from the date of application to the date NYSOH notifies the

applicant of its decision (45 CFR § 155.310(e)(2)). However, if the applicant submits an incomplete application or there is not sufficient information for NYSOH to make an eligibility determination, then NYSOH must notify that applicant that more information is needed to complete the application (45 CFR § 155.310(k)(1)).

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the application (42 CFR § 435.912).

Third Party Health Insurance

A person who has primary medical or health care coverage available from or under a third-party insurance provider is not permitted to enroll into a Medicaid Managed Care plan (NY Social Services Law (NY SSL) § 364-j(3)(e)(xx); Medicaid Managed Care Model Contract (Appendix H-6), effective 3/1/2014 – 2/28/2019). However, they will remain eligible for fee-for-service Medicaid with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, or failing to provide a valid social security number (NY SSL § 366(4)(c)).

Legal Analysis

The first issue is whether NYSOH provided you with timely determination of your household's Medicaid eligibility as of December 23, 2016.

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.

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.

You updated your NYSOH account on November 29, 2016. The income amount that was entered into this application did not match federal and state data sources. As a result, NYSOH asked that you submit additional documentation to confirm your income.

You uploaded income documentation on December 6, 2016 in the form of your spouse's paystubs. You then uploaded proof of your income from Unemployment Insurance Benefits on December 13, 2016.

NYSOH verified that documentation as acceptable proof of income on December 21, 2016.

Therefore, your application was considered complete as of December 13, 2016 for purposes of issuing an eligibility determination.

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the completed application. To assess whether an eligibility determination was untimely, NYSOH must base the time period from the date of the completed application to the date NYSOH notifies the applicant of its decision.

NYSOH issued an eligibility determination notice on December 23, 2016 that stated your household was eligible for Medicaid effective December 1, 2016. Since NYSOH issued an eligibility determination 10 days from the date your application was considered complete, the December 23, 2016 eligibility determination was timely.

The second issue is whether NYSOH properly determined that your household's enrollment in your Medicaid Managed Care plan was effective February 1, 2017.

The record reflects that you contacted NYSOH on December 23, 2016 and enrolled into a Medicaid Managed Care plan that day.

The date on which a Medicaid Managed Care 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.

Since the December 23, 2016 eligibility determination notice was timely issued, you were able to select a Medicaid Managed Care plan as of December 23, 2016. Your plan would therefore properly take effect on the first day of the next month following after December; that is, on February 1, 2017.

Therefore, the December 24, 2016 enrollment confirmation notice stating that your household's enrollment in your Medicaid Managed Care plan would be effective February 1, 2017, was correct and must be AFFIRMED.

Decision

The December 23, 2016 eligibility determination was timely and is AFFIRMED.

The December 24, 2016 enrollment confirmation notice is AFFIRMED.

Effective Date of this Decision: March 24, 2017

How this Decision Affects Your Eligibility

This decision does not change your household's eligibility.

Your household's enrollment in your Medicaid Managed Care plan is February 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 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 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 December 23, 2016 eligibility determination was timely and is AFFIRMED.

The December 24, 2016 enrollment confirmation notice is AFFIRMED.

This decision does not change your household's eligibility.

Your household's enrollment in their Medicaid Managed Care plan is February 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।

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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.

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.

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