



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

## Notice of Decision

Decision Date: April 10, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000014769

[REDACTED]

Dear [REDACTED],

On April 4, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 28, 2016 eligibility determination and December 30, 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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## Decision

Decision Date: April 10, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000014769

[REDACTED]

## Issues

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

Did NY State of Health provide a timely determination of your Medicaid eligibility as of December 1, 2016?

Did NY State of Health properly determine that your Medicaid Managed Care plan began February 1, 2017?

## Procedural History

On June 30, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan, effective August 1, 2016.

On July 28, 2016, NYSOH issued a notice of enrollment confirming your enrollment in an Essential Plan with a plan enrollment start date of July 1, 2016.

On December 1, 2016, NYSOH received your updated application for financial assistance with your health insurance, wherein you indicated a change in your income due to a change in the amount of hours worked.

Also on December 1, 2016, you uploaded income documentation to your NYSOH account.

On December 2, 2016, NYSOH issued a notice stating more information was needed to make a determination. The notice explained the income information

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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 16, 2016.

On December 27, 2016, NYSOH verified the paystubs you uploaded as documentation and a new application was submitted on your behalf.

On December 28, 2016, NYSOH issued an eligibility determination notice finding you eligible for Medicaid effective December 1, 2016.

On December 29, 2016, you selected a Medicaid Managed Care plan.

On December 30, 2016, an enrollment confirmation notice was issued confirming your selection of a Medicaid Managed Care plan on December 29, 2016. The notice confirmed your enrollment in a plan starting February 1, 2017.

On January 11, 2017, you contacted the NYSOH Account Review Unit and requested an appeal of the start date of your Medicaid Managed Care plan, requesting that it begin January 1, 2017.

On April 4, 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 your enrollment start date of your Medicaid Managed Care plan.
- 2) According to your NYSOH account, NYSOH received your updated application for financial assistance on December 1, 2016.
- 3) You testified that you were pregnant in December of 2016.
- 4) The application that you submitted on December 1, 2016 does not indicate that you were pregnant.
- 5) On December 1, 2016, you submitted documentation of your income in the form of a letter from your employer to NYSOH for verification of the income stated in your December 1, 2016 application.
- 6) On December 27, 2016, the letter from your employer was verified as acceptable proof of income.

- 7) The record reflects that you selected a Medicaid Managed Care plan on December 29, 2016.
- 8) You testified that you want your Medicaid Managed Care plan to begin on January 1, 2017 because you have outstanding medical bills for January 2017 which are not covered by Fee-For Service Medicaid.

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 2010,13ADM-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). NYSOH must provide Medicaid applicants notice of their eligibility determination within 30 days from the date of the application if the applicant is pregnant or a child (18 NYCRR 360-2.4(a(3))).

## **Legal Analysis**

The first issue is whether NYSOH's provided you with timely determination of your Medicaid eligibility as of December 1, 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 December 1, 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.

On December 1, 2016, you uploaded a copy of your paystubs and on December 27, 2016 NYSOH verified those paystubs as acceptable proofs of income.

Therefore, your application was considered complete as of December 1, 2016 for purposes of issuing an eligibility determination.

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days, and pregnant Medicaid applicants notice of their eligibility determination within 30 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 28, 2016 that stated you were eligible for Medicaid effective December 1, 2016. Since NYSOH issued an eligibility determination 27 days from the date your application was considered complete, the December 28, 2016 eligibility determination was timely.

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

The record reflects that you contacted NYSOH on December 29, 2016 and enrolled into a Medicaid Managed Care plan.

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 28, 2016 eligibility determination notice was timely issued, you were able to select a Medicaid Managed Care plan as of December 28, 2016. Your plan would therefore properly take effect on the first day of the second month following after December 2016; that is, on February 1, 2017.

Therefore, the December 30, 2016 enrollment confirmation notice stating that your enrollment in your Medicaid Managed Care plan would be effective February 1, 2017, was correct and must be AFFIRMED.

## **Decision**

The December 28, 2016 eligibility determination notice was timely is AFFIRMED.

The December 30, 2016 enrollment confirmation notice is AFFIRMED.

**Effective Date of this Decision:** April 10, 2017

## **How this Decision Affects Your Eligibility**

This decision does not affect your eligibility.

Your enrollment in your Medicaid Managed Care plan is effective February 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

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- By fax: 1-855-900-5557

## **Summary**

The December 28, 2016 eligibility determination notice was timely is AFFIRMED.

The December 30, 2016 enrollment confirmation notice is AFFIRMED.

This decision does not affect your eligibility.

Your enrollment in your Medicaid Managed Care plan is effective 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:**



## 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।

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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 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&etumi ama wo obi a okyerE 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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