



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

## Notice of Decision

Decision Date: April 28, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000015204

[REDACTED]

Dear [REDACTED]

On April 24, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 16, 2016 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  
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 28, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000015204



## 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 youngest child's enrollment in her Medicaid Managed Care (MMC) plan was effective December 1, 2016?

## Procedural History

On November 22, 2015, NYSOH issued a notice of eligibility determination, based on your November 16, 2015 application, stating that your spouse was eligible for the Essential Plan, effective January 1, 2016. She was subsequently enrolled into an Essential Plan, with coverage beginning January 1, 2016.

On October 19, 2016, NYSOH issued a renewal notice stating that it was time to renew your NYSOH coverage for 2017. The notice directed you to update your NYSOH application by December 15, 2016 so that your household's eligibility for financial assistance in 2017 could be determined.

On November 14, 2016, you updated your NYSOH account, and added your youngest child to your application for financial assistance.

On November 15, 2016, NYSOH issued a notice of eligibility determination stating that your youngest child was eligible for Medicaid, effective November 1, 2016.

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On November 16, 2016, NYSOH issued a notice of enrollment in the plan you selected on November 15, 2016, stating that your youngest daughter was enrolled in an MMC plan, and that her coverage would start on December 1, 2016.

On January 26, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your youngest child's enrollment in her MMC plan, insofar as it did not begin October 1, 2016.

On April 24, 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 support the following findings of fact:

- 1) You testified that your spouse gave birth to your youngest child on [REDACTED].
- 2) Your NYSOH account reflects that your spouse's coverage at the time she gave birth was through the Essential Plan, and you testified that this was correct.
- 3) You testified that you did not update your NYSOH application at any point to reflect that your spouse was pregnant.
- 4) You testified that you waited until November 14, 2016 to update your NYSOH application and add your youngest child because you were waiting for her birth certificate and Social Security number.
- 5) You testified that you had contacted NYSOH in early November 2016 to apply on behalf of your daughter, but were told that you would need the birth certificate and Social Security number.
- 6) You testified that, though the hospital bills for your youngest child's delivery were covered, you have medical bills from October and November 2016 for her pediatrician, who does not take Medicaid.
- 7) You testified that the outstanding medical bills add up to approximately \$760.00 or \$780.00.
- 8) You testified that you have not tried submitting these bills to Medicaid, as the doctor told you that they do not accept Medicaid.

- 9) You testified that you want your youngest child's MMC plan coverage to begin on the date of her birth so that these medical bills from October and November 2016 can be covered.

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 federal poverty level (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 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)).

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; see 42 USC § 1315; § 364-j(1)(c); 18 NYCRR § 360-10.3(h)).

### Newborn Child – Effective Date of Coverage for Medicaid

Medicaid coverage must be provided to a child born to a woman who has been determined eligible and is receiving Medicaid on the date of the child's birth (42 CFR § 435.117(a), N.Y. Soc. Serv. Law § 366-g(3)). Additionally, Medicaid MMCs are contractually obligated to provide coverage to eligible newborns from the date of birth (Medicaid Managed Care Model Contract (Appendix H-3(a), effective 3/1/2014 – 2/28/2019).

## **Legal Analysis**

The issue under review is whether NYSOH properly determined that your youngest child's enrollment in her MMC plan was effective December 1, 2016.

You testified that you contacted NYSOH on November 14, 2016 to add your youngest child to your NYSOH application, and your NYSOH account reflects that you selected an MMC plan for her on November 15, 2016.

The date on which an MMC 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.

On November 15, 2016, you selected an MMC plan for your youngest child, so it properly took effect on the first day of the month following November; that is, on December 1, 2016.

Though MMC plan enrollments are sometimes made retroactive to the date of birth for a newborn, your spouse would have to have been eligible for, and receiving, Medicaid on the date of your child's birth in order for your child's enrollment to be backdated. If you had reported your spouse's pregnancy to NYSOH, her eligibility would have been redetermined, and she may have become eligible for Medicaid. However, since her pregnancy was not reported, and she remained in the Essential Plan through her labor and delivery, her newborn was not eligible for a backdate of her MMC plan start date.

Therefore, the November 16, 2016 enrollment confirmation notice, stating that your youngest child's enrollment in her MMC plan would be effective December 1, 2016, was correct and must be AFFIRMED.

REMINDER – It is your obligation to report any changes that may affect your, or a member of your household's, eligibility, within 30 days of such change. This is stated in each eligibility determination notice under the heading, "Reporting Changes during the year." Pregnancy is included in the list of changes which you are obligated to report to NYSOH.

## **Decision**

The November 16, 2016 enrollment confirmation notice is AFFIRMED.

**Effective Date of this Decision:** April 28, 2017

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

This decision does not change your youngest child's eligibility.

The effective date of your youngest child's MMC plan enrollment is December 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.

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 November 16, 2016 enrollment confirmation notice is AFFIRMED.

This decision does not change your youngest child's eligibility.

The effective date of your youngest child's MMC plan enrollment is December 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&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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