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

Notice of Decision

Decision Date: May 17, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015230

[redacted]

Dear [redacted]

On May 2, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 23, 2017 eligibility determination and February 25, 2017 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
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Albany, NY 12211

Decision

Decision Date: May 17, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015230

[redacted]

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 Medicaid eligibility as of February 23, 2017?
>
> Did NYSOH properly determine that your Medicaid Managed Care plan began April 1, 2017?

Procedural History

On December 30, 2016, NYSOH received your application for financial assistance with your health insurance. This application listed three different sources of anticipated income.

Also on December 30, 2016, you submitted one paystub dated December 5, 2016.

On December 31, 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 January 14, 2017.

On January 6, 2017, you submitted one paystub dated November 18, 2016, an invoice dated October 31, 2016 for $200.00, and an invoice dated December 28, 2016 for $200.00.

On January 10, 2017, NYSOH invalidated that documentation as insufficient proof of income.

On January 12, 2017, you submitted two paystubs dated December 20, 2016 and January 5, 2017.

On January 23, 2017, NYSOH invalidated those paystubs as insufficient proof of income.

On January 26, 2017, NYSOH received your application for financial assistance with your health insurance. This application listed one source of anticipated income.

Also on January 26, 2017, you uploaded one paystub dated January 20, 2017.

Finally, on January 26, 2017, you contacted the NYSOH Account Review Unit and requested an appeal of the timeliness of NYSOH's determination of your eligibility.

On January 27, 2017, 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 February 10, 2017.

On February 6, 2017, NYSOH invalidated the paystub submitted on January 26, 2017 as insufficient proof of income.

On February 7, 2017, NYSOH issued a notice stating that the documentation you had submitted was insufficient to prove your income.

On February 10, 2017, you submitted paystubs dated January 5, 2017, January 20, 2017, and February 3, 2017.

On February 22, 2017, NYSOH verified the paystubs you uploaded as documentation and a new application was submitted on your behalf.

On February 23, 2017, NYSOH issued an eligibility determination notice was issued finding you eligible for Medicaid effective February 1, 2017.

On February 24, 2017, you enrolled in a Medicaid Managed Care plan.

On February 25, 2017, an enrollment confirmation notice was issued confirming your selection of a Medicaid Managed Care plan on February 24, 2017. The notice confirmed your enrollment in a plan starting April 1, 2017.

On May 2, 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 Medicaid Managed Care plan.

2) According to your NYSOH account, NYSOH received your application for financial assistance on December 30, 2016. You testified, and the record reflects, that this application listed three different sources of anticipated income.

3) You testified that you have only one source of expected income for 2017.

4) You submitted income documentation on December 30, 2016, January 6, 201, January 12, 2017, and January 26, 2017. NYSOH invalidated all documents as insufficient proof of the three sources of income listed in your December 30, 2016 application.

5) On January 26, 2017, you updated your application for financial assistance. This application reflected one source of anticipated income.

6) On February 10, 2017, you submitted documentation of your paystubs to NYSOH for verification of the income stated in your January 26, 2017 application.

7) On February 22, 2017, your paystubs were verified as acceptable proof of income.

8) The record reflects that you selected a Medicaid Managed Care plan on February 24, 2017.

9) You testified that you have no outstanding medical bills.

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).

Legal Analysis

The first issue is whether NYSOH's provided you with timely determination of your Medicaid eligibility as of February 23, 2017.

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 30, 2016. This application listed three sources of anticipated income. The income amount that was entered 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 testified that you have only one source of expected income for 2017. Therefore, the December 30, 2016 application is incorrect as submitted and cannot be considered.

On December 31, 2016, January 6, 2017, January 12, 2017 and January 26, 2017, you uploaded documentation regarding your income and on January 10, 2017, January 23, 2017 and February 6, 2017 NYSOH properly invalidated that documentation as insufficient proof of the income listed in your December 30, 2016 application.

You updated your NYSOH account on January 26, 2017. This application listed one source of anticipated income, and you testified that this is correct. The income amount that was entered this application did not match federal and state data sources. As a result, NYSOH asked that you to submit additional documentation to confirm your income.

On February 10, 2017, you submitted paystubs dated January 5, 2017, January 20, 2017, and February 3, 2017 and on February 22, 2017, NYSOH verified that documentation as sufficient proof of income.

Therefore, your application was considered complete as of February 10, 2017 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 February 23, 2017 that stated you were eligible for Medicaid effective February 1, 2017. Since NYSOH issued an eligibility determination 13 days from the date your application was considered complete, the February 23, 2017 eligibility determination was timely.

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

The record reflects that you contacted NYSOH on February 24, 2017 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 February 23, 2017 eligibility determination notice was timely issued, you were able to select a Medicaid Managed Care plan as of February 23, 2017. Your plan would therefore properly take effect on the first day of the next month following February 23, 2017; that is, on April 1, 2017.

Therefore, the February 25, 2017 enrollment confirmation notice stating that your enrollment in your Medicaid Managed Care plan would be effective April 1, 2017, was correct and must be AFFIRMED.

Decision

The February 23, 2017 eligibility determination was timely is AFFIRMED.

The February 25, 2017 enrollment confirmation notice is AFFIRMED.

Effective Date of this Decision: May 17, 2017

How this Decision Affects Your Eligibility

This decision does not affect your eligibility.

Your enrollment in your Medicaid Managed Care plan is April 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 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 February 23, 2017 eligibility determination was timely is AFFIRMED.

The February 25, 2017 enrollment confirmation notice is AFFIRMED.

This decision does not affect your eligibility.

Your enrollment in your Medicaid Managed Care plan is April 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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