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

Notice of Decision

Decision Date: May 15,2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015410

[redacted]

Dear [redacted],

On April 26, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 22, 2017, enrollment 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: May 15,2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015410

[redacted]

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 you, your spouse, and children were enrolled in a Medicaid Managed Care (MMC) plan with an enrollment start date of March 1, 2017?

Procedural History

On December 14, 2016, you submitted a financial assistance application for your family through NYSOH.

On December 15, 2016, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal data sources and more information was needed to confirm the information in your application. The notice directed you to submit income documentation by December 29, 2016.

Also on December 15, 2016, you uploaded additional income documentation to your account (*see* Documents [redacted]).

On January 9, 2017, your NYSOH account was systemically updated.

On January 10, 2017, NYSOH issued an eligibility determination notice stating that you, your spouse, and children were eligible to purchase a qualified health plan at full cost effective as of February 1, 2017.

On January 17, 2017, you updated your NYSOH account.

On January 18, 2017, NYSOH issued a notice stating in part that the income information in your application did not match what NYSOH received from state and federal data sources and more information was needed to confirm the information in your application. The notice directed you to submit income documentation by February 1, 2017.

On January 22, 2017, you uploaded additional income documentation to your account ([redacted]).

On January 26, 2017, NYSOH issued a notice stating that the documentation received does not confirm the information in your application. The notice directed to submit additional proof of income by February 1, 2017.

On February 1, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as your family's eligibility for financial assistance through NYSOH had not been determined.

On February 6, 2017, you uploaded additional income documentation to your account (*see* Document [redacted]).

On February 16, 2017, your NYSOH account was systemically updated.

Also on February 16, 2017, you uploaded additional income documentation to your account (*see* Document [redacted]).

On February 17, 2017, NYSOH issued an eligibility determination notice stating that you and your family were eligible for Medicaid effective as of January 1, 2017.

On February 22, 2017, NYSOH issued a plan enrollment notice confirming that, as of February 21, 2017, you, your spouse, and children were enrolled in a MMC plan with an enrollment start date of March 1, 2017.

On April 26, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing and the record was closed at the end of the proceeding.

Findings of Fact

A review of the record supports the following findings of fact:

1) You testified that you are appealing your family's MMC plan enrollment start date.

2) According to your NYSOH account and testimony, you are applying for health insurance through NYSOH for yourself, your spouse, and nine children.

3) You testified that you were enrolled in Medicaid coverage through Rockland County Department of Social Services through December 31, 2016.

4) According to your NYSOH account, your initial application was submitted on December 14, 2016.

5) According to your December 14, 2016 application, you attested to an expected annual household income of $22,500.00. You reported income of: $750.00 monthly from [redacted]; $2,300.00 quarterly from [redacted]; $2,500.00 yearly in taxable interest, and $150.00 monthly from rental, royalties, partnerships, [redacted], and trusts.

6) On December 15, 2016, NYSOH issued a notice stating that additional income information was needed to confirm the information in your application. The notice stated that you must report all the income for your household and provided a list of acceptable documentation (*see* Document [redacted]).

7) On December 15, 2016, you submitted a letter from the [redacted] stating that you are expected to be compensated $2,300.00 quarterly or $9,200.00 annually (*see* Document [redacted].

8) On December 15, 2016, you submitted two earnings statements from [redacted] for the pay periods of 11/01/2016 – 11/16/2016 and 11/16/2016 – 11/30/2016. Each statement indicates that you were issued $375.00 (*see* Document [redacted]).

9) On January 22, 2017, you submitted a statement from your [redacted] account from 12/1/2016 – 12/31/2016. The statement indicates an estimated annual income of $2,526.00 (*see* Document [redacted]).

10) On February 16, 2017, you submitted a letter from the [redacted]. The letter states that you are in a partnership and receive a monthly distribution of $150.00 (*see* Document [redacted]).

11) According to your NYSOH account, the income documentation submitted to your account was determined to be valid on February 16, 2017.

12) According to your NYSOH account and testimony, you, your spouse, and children have been enrolled in a MMC plan with an effective date of March 1, 2017.

13) You testified that you want your MMC plan to be effective January 1, 2017, to cover medical expenses that were incurred in that month.

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

Applicable Law and Regulations

Medicaid – 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).

MMC Enrollment Start Date

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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your, your spouse, and children's MMC plan should have an enrollment start date of March 1, 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 by giving the applicant the opportunity to submit satisfactory documentary evidence.

On December 14, 2016, you submitted an application for financial assistance through NYSOH. You attested to an expected annual household income of $22,500.00 based on income from: [redacted]; [redacted]; taxable interest, and rental, royalties, partnerships, [redacted], and trusts.

The household income that you attested to in your application did not match federal and state data sources. As a result, NYSOH issued you a notice on December 15, 2016, directing you to submit additional of proof of income to NYSOH to confirm your family's eligibility for financial assistance. The notice stated that you must report all the income for your household and provided a list of acceptable documentation (*see* Document [redacted]).

On December 15, 2016, you submitted a letter from the [redacted] stating that you are expected annual income, and two biweekly earnings statements from [redacted] (*see* Documents [redacted]; [redacted]). On January 22, 2017, you submitted a statement from [redacted] account indicating your estimated annual taxable interest (*see* Document [redacted]). On February 16, 2017, you submitted a letter from a letter from the [redacted] stating your monthly partnership income (*see* Document [redacted]). That same day, NYSOH was able to validate your household income based on the totality of these income documents.

The date on which a MMC plan can take effect depends on the day a person selects the plan for enrollment. A plan that is selected between the first day and fifteenth day of a month goes into effect on the first day of the following month. A plan that is selected from the sixteenth day of the month and the end of the month goes into effect on the first day of the second following month.

The record reflects that you, your spouse, and children were enrolled in MMC plan effective March 1, 2017. You testified that you want your family's MMC plan was effective January 1, 2017 to cover medical bills that have been incurred.

The record reflects that on February 16, 2017, the income documentation submitted to your account was sufficient to confirm your attestation and determined to be valid. Therefore, NYSOH had sufficient information to render an eligibility determination as of that date.

The income documentation to verify your attestation needed to be submitted to NYSOH by December 15, 2016, to have your MMC plan be effective January 1, 2017. Therefore, you and your family were not eligible to be enrolled in MMC plan for the month of January 2016.

The February 22, 2017, NYSOH issued a plan enrollment notice confirming that you, your spouse, and children were enrolled in a MMC plan with an enrollment start date of March 1, 2017 is AFFIRMED.

Decision

The February 22, 2017, plan enrollment notice is AFFIRMED.

Effective Date of this Decision: May 15,2017

How this Decision Affects Your Eligibility

Your, your spouse's, and children's MMC plan enrollment start date is March 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 22, 2017, plan enrollment notice is AFFIRMED.

Your, your spouse's, and children's MMC plan enrollment start date is March 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.

□□□□□ (Bengali)

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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 नि:शुल्क 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)

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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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