



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

## Notice of Decision

Decision Date: June 07, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000016046

[REDACTED]

Dear [REDACTED],

On May 25, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 22, 2017 plan 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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DEPARTMENT OF HEALTH  
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## Decision

Decision Date: June 07, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000016046

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

## Procedural History

On December 14, 2016, an application for financial assistance was submitted for your family.

On December 15, 2016, NYSOH issued a notice stating that the income information in your application does 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.

On December 30, 2016, income documentation that was faxed to NYSOH was uploaded to your account (see Documents [REDACTED]; and [REDACTED]).

On January 4, 2017, your NYSOH account was updated.

On January 5, 2017, NYSOH issued a notice stating that the income information in your application does not match what NYSOH received from state and federal data sources and more information was needed to confirm the information in your

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application. The notice directed you to submit income documentation for you and your spouse by January 13, 2017 and January 19, 2017.

On January 30, 2017, your NYSOH account was updated.

On January 31, 2017, NYSOH issued a notice stating that the income information in your application does 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 for you and your spouse by January 28, 2017 and February 14, 2017.

On February 17, 2017, your NYSOH account was systemically updated.

On February 18, 2017, NYSOH issued an eligibility determination notice stating in part that you and your spouse were eligible for Medicaid effective as of February 1, 2017.

On February 21, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal relative to your and your spouse's MMC plan enrollment start date.

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

On May 25, 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 proceeding.

## **Findings of Fact**

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

- 1) You testified that you want your and your spouse's MMC plan to have an effective date of January 1, 2017.
- 2) According to your December 14, 2016 NYSOH application, you attested to two sources of income for you and your spouse respectively: Unemployment Insurance benefits and [REDACTED].
- 3) On December 15, 2016, NYSOH issued a notice directing you and your spouse to submit additional income documentation. The notice providing a list of acceptable documentation, including: paycheck stubs for the last 4 weeks; printout of recipient's account information from

NYS Department of Labor website; and a letter from your previous employer with a termination date (see [REDACTED]).

- 4) On December 15, 2016, you faxed the following documentation to NYSOH;
  - (a) A letter from your employer, stating that you were laid off as of 12/3/2016 and would return to work 5/1/2017 weather permitting;
  - (b) Your Official Record of Benefit Payment History from the NYS Department of Labor's website;
  - (c) Weekly earnings statements from your spouse's employer, with the check dates of: November 17, 2016; November 23, 2016; December 1, 2016, and December 8, 2016  
  
(see Documents [REDACTED]; [REDACTED]; uploaded 12/30/2016).
- 5) You testified that you were informed by NYSOH in January 2017 that the documentation you provided was invalid.
- 6) According to your NYSOH account, on January 11, 2017, the income documentation was determined to be invalid because you "submitted 4 outdated weekly pay stubs."
- 7) According to your NYSOH account, you enrolled in a MMC plan on February 21, 2017.
- 8) You testified that you and your spouse incurred medical expenses in January 2017 and want the MMC plan to cover those costs.

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).

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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).

### 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)).

The enrollment period was extended to December 17, 2016 for individuals to enroll in a health plan for coverage starting January 1, 2017 (NY State of Health Deadline Extended! New Yorkers Now Have Until December 17 to Enroll in or Renew Health Insurance Coverage Beginning January 1, 2017, [https://www.health.ny.gov/press/releases/2016/2016-12-15\\_renew\\_health\\_insurance\\_coverage.htm](https://www.health.ny.gov/press/releases/2016/2016-12-15_renew_health_insurance_coverage.htm)).

## **Legal Analysis**

The issue under review is whether NYSOH properly determined that you and your spouse were enrolled in a MMC plan with an enrollment start date of April 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 two sources of income for you and your spouse, Unemployment Insurance benefits.

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 eligibility for financial assistance. The notice providing an acceptable documentation list including: paycheck stubs for the last 4 weeks; printout of recipient's account information from NYS Department of Labor

website; and a letter from your previous employer with a termination date (see Document [REDACTED]).

On December 15, 2016, you faxed: (1) A letter from your employer, [REDACTED] stating that you were laid off as of 12/3/2016 and would return to work 5/1/2017 weather permitting; (2) Your Official Record of Benefit Payment History from the NYS Department of Labor's website; and (3) weekly earnings statements from your spouse's employer, with the check dates of: November 17, 2016; November 23, 2016; December 1, 2016, and December 8, 2016 (see Documents [REDACTED]).

The record reflects that on January 11, 2017, the income documentation was determined to be invalid by NYSOH because you "submitted 4 outdated weekly pay stubs." However, the record supports that your spouse's four most recent pay stubs were sent to NYSOH on December 15, 2016. Therefore, NYSOH had sufficient information to render an eligibility determination as of that date.

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.

If you had selected a MMC plan on December 15, 2016, the plan enrollment start date would have been on the first day of the first month following December 15, 2016; that is, on January 1, 2017.

Therefore, the February 22, 2017, enrollment notice is MODIFIED to state that you and your spouse were enrolled in a MMC plan with an enrollment start date of January 1, 2017.

Your case is RETURNED to NYSOH to enroll you and your spouse in a MMC plan with an effective date of January 1, 2017, and to notify you accordingly.

## **Decision**

The February 22, 2017, enrollment notice is MODIFIED to state that you and your spouse were enrolled in a MMC plan with an enrollment start date of January 1, 2017.

Your case is RETURNED to NYSOH to enroll you and your spouse in a MMC plan with an effective date of January 1, 2017, and to notify you accordingly.

**Effective Date of this Decision:** June 07, 2017

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

Your and your spouse's MMC plan enrollment start date is January 1, 2017.

NYSOH will enroll you and your spouse in your MMC plan as of January 1, 2017 and notify you once it has been done.

## **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 February 22, 2017, enrollment notice is MODIFIED to state that you and your spouse were enrolled in a MMC plan with an enrollment start date of January 1, 2017.

Your case is RETURNED to NYSOH to enroll you and your spouse in a MMC plan with an effective date of January 1, 2017, and to notify you accordingly.

Your and your spouse's MMC plan enrollment start date is January 1, 2017.

NYSOH will enroll you and your spouse in your MMC plan as of January 1, 2-017 and notify you once it has been done.

## **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**

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).

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 مجانًا.

### **বাংলা (Bengali)**

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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### **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&btumi 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.

### **שׂוּדִישׁ (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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