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

Notice of Decision

Decision Date: June 29, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016425

[redacted]

Dear [redacted],

On June 9, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 23, 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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Decision

Decision Date: June 29, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016425

[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 your newborn child's enrollment in their Medicaid Managed Care plan was effective March 1, 2017?

Procedural History

On January 12, 2017, NYSOH received your application in which you added your newborn child (child) and requested financial assistance with health insurance on behalf of your child and spouse. On January 18, 2017, you updated that application.

On January 12, 2017 and again on January 18, 2017, NYSOH made preliminary eligibility determinations finding the information provided on your application regarding your spouse and child did not match what NYSOH obtained from state and federal data sources and, until you provided documents to prove their respective incomes, their eligibility could not be determined.

On January 19, 2017 and again on January 25, 2017, NYSOH issued eligibility determination notices stating that you were no longer eligible for Medicaid; however, your coverage would continue until March 31, 2017. The notices also instructed you that, to confirm eligibility for financial assistance for your spouse and child, addition income documentation regarding your household's income

was needed by February 2, 2017, as well as your child's proof of citizenship and a valid Social Security number by April 18, 2017.

On January 25, 2017, NYSOH issued a notice requesting additional information to confirm eligibility for members of your household: (1) Proof of income by February 2, 2017; and (2) Proof of your child's citizenship and a valid Social Security number by April 18, 2017. The notice further stated that, if you miss the due date, NYSOH will not be able to determine your family members; eligibility for health coverage.

Also on January 25, 2017, a similar notice was issued requesting income documentation to confirm your family members' eligibility for retroactive Medicaid.

On February 3, 2017, NYSOH issued an eligibility determination notice that in part stated your spouse was eligible for Medicaid, effective February 1, 2017, and your child was conditionally eligible for Medicaid as of January 1, 2017.

Also on February 3, 2017, NYSOH issued a plan enrollment notice confirming in part that your spouse and child were enrolled in a Medicaid Managed Care plan effective March 1, 2017, based on your February 2, 2017 plan selection for them.

On February 23, 2017, NYSOH issued the following notices:

An eligibility determination that in part stated your spouse remained eligible for Medicaid effective February 1, 2017, and your child remained conditionally eligible for Medicaid, effective February 1, 2017;

An eligibility determination that in part stated your spouse was eligible for Medicaid retroactively from November 1, 2016 through January 31, 2017, because your monthly household income of $1,430.00 is at or below the allowable monthly income limit of $2,319.00; and

A plan enrollment notice confirming your spouse and child's enrollment in a Medicaid Managed Care plan, effective March 1, 2017.

On March 1, 2017, you contacted NYSOH's Account Review Unit and appealed the start date of your spouse and child's enrollment start dates of March 1, 2017 in their Medicaid Managed Care plan insofar as coverage did not begin January 1, 2017.

On June 9, 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) According to your testimony, your spouse had a separate account with NYSOH [redacted]), under which she had health insurance coverage through Medicaid Managed Care plans from January 1, 2016 through December 31, 2017.

2) According to both your and your spouse's NYSOH accounts, your child's date of birth is [redacted] and they had Medicaid Fee-For-Service as of January 1, 2017, [redacted].

3) In your spouse's NYSOH account, your child's enrollment in Medicaid was terminated on January 12, 2017, the same day you submitted your first application in your NYSOH account for health insurance on their behalf.

4) According to your NYSOH account, your child's Medicaid Fee-For-Service in your account was made effective January 1, 2017, conditioned upon certain proof, with coverage in their Medicaid Managed Care plan with UnitedHealthcare Community Plan to begin March 1, 2017, based on your February 2, 2017 plan selection.

5) According to your NYSOH account, your spouse had coverage with Medicaid Fee-For-Service, retroactive to January 1, 2017, and coverage in Medicaid Managed Care Plan with UnitedHealthcare Community Plan as of March 1, 2017, based on your February 2, 2017 plan selection.

6) You testified that you want your child's Medicaid Managed Care plan to begin on January 1, 2017, because his [redacted] doctor does not accept Medicaid Fee-For-Service and you cannot afford to pay the doctor yourself.

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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that the Medicaid Managed Care enrollment date for your spouse and child was effective March 1, 2017.

The record reflects that your child's enrollment in Medicaid Fee-For-Service was made conditionally effective January 1, 2017, and your spouse's eligibility for financial assistance was pending proof of income to confirm her eligibility. The record further reflects that, despite there being two separate accounts for you and your spouse, your child was determined conditionally eligible for Medicaid as of the [redacted]; that is, January 1,2017, such that there is no error in his eligibility.

According to your NYSOH account, your application was deemed complete on February 2, 2017, and you selected a Medicaid Managed Care plan for your spouse and child that same day. Your spouse was also determined eligible for retroactive Medicaid in the month of January 2017, such that she had no gap in health insurance coverage.

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.

On February 2, 2017, you selected a Medicaid Managed Care plan for your spouse and child, so it properly took effect on the first day of the month following after February 2, 2017; that is, on March 1, 2017.

Therefore, the February 3, 2017 plan enrollment notice stating that your spouse and child's enrollment in their Medicaid Managed Care plan would be effective March 1, 2017, was correct and must be AFFIRMED.

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).

Decision

The February 3, 2017 plan enrollment notice is AFFIRMED.

Effective Date of this Decision: June 29, 2017

How this Decision Affects Your Eligibility

This decision does not change your spouse or child's eligibility.

Your spouse and child each had health insurance coverage under Medicaid Fee-For-Service from January 1, 2017 through February 28, 2017.

The effective date of their Medicaid Managed Care plan 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

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).

- 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 3, 2017 plan enrollment notice is AFFIRMED.

This decision does not change your spouse or child's eligibility.

Your spouse and child each had health insurance coverage under Medicaid Fee-For-Service from January 1, 2017 through February 28, 2017.

The effective date of their Medicaid Managed Care plan 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:

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)

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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।

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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