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

Notice of Decision

Decision Date: July 18, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016464

[redacted]

Dear [redacted]

On June 13, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 23, 2016, eligibility redetermination notice, and February 7, 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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nystateofhealth
The Official Health Plan Marketplace

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

Decision

Decision Date: July 18, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016464

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health properly disenroll your youngest son from his Medicaid Managed Care plan, effective January 1, 2017?
>
> Did NY State of Health properly determine your youngest son's enrollment in a Medicaid Managed Care plan began March 1, 2017?

Procedural History

On August 18, 2016, NY State of Health (NYSOH) received your youngest [redacted] application for financial assistance.

On August 19, 2016, NYSOH issued a notice of eligibility determination stating that your youngest [redacted] was conditionally eligible for Medicaid effective August 1, 2016. His eligibility was based on the condition you provide proof of [redacted] Citizenship Status and Social Security number by November 16, 2016.

Also on August 19, 2016, an enrollment confirmation notice was issued confirming your youngest [redacted] enrollment in a Medicaid Managed Care plan effective October 1, 2016.

No documentation was received by NYSOH by November 16, 2016.

On November 22, 2016, NYSOH redetermined your youngest [redacted] eligibility for financial assistance.

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On November 23, 2016, NYSOH issued a notice of eligibility determination stating that your youngest [redacted] was no longer eligible for Medicaid. The notice stated this was because you did not provide the information to confirm [redacted] Citizenship Status and Social Security number. The notice further stated NYSOH was unable to validate your youngest [redacted] Social Security number and Citizenship Status. The notice stated his eligibility would end effective January 1, 2017.

On November 27, 2016, NYSOH issued a cancellation notice stating your youngest [redacted] Medicaid Managed Care plan was cancelled effective December 31, 2016. The notice stated this was because [redacted] was no longer eligible to remain enrolled in health insurance through NYSOH.

On January 27, 2017, your youngest [redacted] eligibility for financial assistance was redetermined.

On January 28, 2017, an eligibility determination notice was issued stating your youngest [redacted] was eligible for Medicaid, effective January 1, 2017.

On February 6, 2017, your youngest [redacted] was enrolled in a Medicaid Managed Care plan with a start date of March 1, 2017.

On February 7, 2017, NYSOH issued an enrollment notice confirming your youngest [redacted] enrollment in a Medicaid Managed Care plan, effective March 1, 2017.

On March 2, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that enrollment notice insofar as you wanted your youngest [redacted] enrollment in a Medicaid Managed Care plan to start January 1, 2017.

On June 13, 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 submitted an application for your youngest [redacted] for financial assistance on August 18, 2016.

2) Your August 18, 2016, application states you were in the process of applying for your youngest [redacted] Social Security number.

3) The August 18, 2016, application states your youngest [redacted] is a U.S. Citizen.

4) Your youngest [redacted] was born on [redacted].

5) You testified you were made aware of your youngest [redacted] disenrollment from his Medicaid Managed Care plan in January 2017. You testified you were not sure who or what agency informed you, but you had received a call.

6) You testified you do not remember receiving a notice dated August 19, 2016 requesting proof of your youngest [redacted] Social Security number and Citizenship Status by November 16, 2016.

7) The record supports and you testified you receive your notices via regular U.S. Mail.

8) You testified your address is correct.

9) The record shows the August 19, 2016 notice is addressed to your current address.

10) Your NYSOH account shows no notices have been returned to NYSOH as undeliverable.

11) You testified you are seeking your youngest [redacted] enrollment in a Medicaid Managed Care plan to start January 1, 2017.

12) You testified you incurred medical bills in the amount of approximately $390.00 during the months of January, and February, 2017 as your youngest child's doctor does not accept Medicaid fee for service.

13) NYSOH received the Social Security number for your youngest [redacted] on January 27, 2017.

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 at least one year of age but younger than nineteen 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 154% of the FPL for the

applicable family size (42 CFR § 435.118(c); New York Department of Social Services Administrative Directive 13ADM-03).

Generally, applicants determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, even if they lose Medicaid eligibility because of any changes or updates they make to their NYSOH account. For example, even if income increases above the Medicaid limit allowed for the household size, the insured will remain covered under Medicaid for a 12-month period. This 12-month period is referred to as "continuous coverage" and is set based on the start date of the original Medicaid eligibility determination or the date of a subsequent Medicaid eligibility determination based on modified adjusted gross income (NY Social Services Law § 366(4)(c)).

An individual will be enrolled or remain in their Medicaid plan with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, failing to provide a valid social security number, or having third party health insurance (NY Social Services Law § 366(4)(c)).

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 of Social Security Number

NYSOH must review an applicant's Social Security Number (SSN) when applying for Medicaid, as well as case records for those already enrolled to determine whether they contain a beneficiary's SSN, or in the case of families, each family member's SSN. If the case record does not contain the required SSN's, the agency must require the beneficiary to furnish them (42 CFR §§ 435.910, 435.920 (a)(b)).

Legal Analysis

The issue under review is whether NYSOH properly disenrolled your youngest [redacted] from his Medicaid Managed Care plan, effective January 1, 2017.

After receiving your youngest [redacted] application for financial assistance with [redacted] health insurance on August 18, 2016, NYSOH issued a notice of eligibility determination on August 19, 2016, stating [redacted] was conditionally eligible for Medicaid effective August 1, 2016.

His eligibility was based on the condition you provide proof of [redacted] Citizenship Status and Social Security number by November 16, 2016. You then enrolled [redacted] in a Medicaid Managed Care plan which began October 1, 2016.

NYSOH did not receive the requested Social Security number and Citizenship documentation by November 16, 2016.

Generally, applicants determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, even if they lose Medicaid eligibility because of any changes or updates they make to their NYSOH account. An individual will be enrolled or remain in their Medicaid plan with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, failing to provide a valid social security number, or having third party health insurance

NYSOH must review an applicant's Social Security number when applying for Medicaid. When NYSOH finds an individual's Social Security number is not valid or cannot determined, it will redetermine the applicant's eligibility using available information.

Your youngest [redacted] eligibility was redetermined on November 22, 2016, and the next day NYSOH issued a notice of eligibility determination stating that your youngest [redacted] was no longer eligible for Medicaid effective January 1, 2017, as NYSOH was unable to validate your youngest [redacted] Social Security number and Citizenship Status.

You testified you do not remember receiving a notice dated August 19, 2016, requesting you to provide documentation confirming your youngest [redacted] Social Security number and Citizenship Status by November 16, 2016.

The record shows, and you testified you receive all of your notices from NYSOH via regular U.S. Mail. No notices in your account have been returned to NYSOH as undeliverable. Additionally, you confirmed your correct address which is on the August 19, 2016 notice.

Therefore, it is determined NYSOH provided you adequate and appropriate notice of the need to show proof of your child's Social Security number and Citizenship Status by November 16, 2016.

The November 23, 2016, eligibility redetermination notice finding your youngest [redacted] no longer eligible for Medicaid for failing to provide proof of [redacted] SSN and Citizenship Status effective January 1, 2017 is AFFIRMED.

The second issue is whether NYSOH properly determined that your youngest [redacted] enrollment in the Medicaid Managed Care plan was effective March 1, 2017.

Your youngest [redacted] eligibility for enrollment in a Medicaid Managed Care plan was redetermined on January 27, 2017, where [redacted] was then found eligible for Medicaid effective January 1, 2017. A plan was selected for [redacted] on February 6, 2017, and [redacted] was 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.

On February 6, 2017, you selected a Medicaid Managed Care plan, so it properly took effect on the first day of the month following February; that is, on March 1, 2017.

Therefore, the February 7, 2017, enrollment confirmation notice stating that your youngest son's enrollment in [redacted] Medicaid Managed Care plan would be effective March 1, 2017, was correct and must be AFFIRMED.

Decision

The November 23, 2016 eligibility redetermination notice is AFFIRMED.

The February 7, 2017 enrollment confirmation notice is AFFIRMED.

Effective Date of this Decision: July 18, 2017

How this Decision Affects Your Eligibility

Your youngest [redacted] was eligible for Medicaid Fee For Service effective January 1, 2017.

Your youngest [redacted] enrollment in his Medicaid Managed Care plan began 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 November 23, 2016 eligibility redetermination notice is AFFIRMED.

The February 7, 2017 enrollment confirmation notice is AFFIRMED.

Your youngest [redacted] was eligible for Medicaid Fee For Service effective January 1, 2017.

Your youngest [redacted] enrollment in his Medicaid Managed Care plan began 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]

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 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)

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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