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: AP000000016955

[redacted]

Dear [redacted],

On June 21, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 18, 2017 eligibility determination notice and April 1, 2017 enrollment confirmation 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
P.O. Box 11729
Albany, NY 12211

# Decision

Decision Date: June 29, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016955

[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, your spouse's, and your youngest child's enrollment in your Medicaid Managed Care plan was effective April 1, 2017?

## Procedural History

On December 5, 2016, NYSOH sent you a notice advising you that your, your spouse's, and your youngest child's coverage through your Local Department of Social Services (LDSS) was ending on February 28, 2017. The notice further advised you that you would need to update your NYSOH account between January 16, 2017 and February 15, 2017.

On January 17, 2017, you submitted an application for financial assistance for your household.

On January 18, 2017, NYSOH issued a notice of eligibility determination, based on the January 17, 2017 application, stating that you, your spouse, and your youngest child were eligible to purchase a qualified health plan at full cost through NYSOH, effective February 1, 2017. This was because federal and state data sources show that you, your spouse, and your youngest child were already enrolled in Medicaid, Child Health Plus, or another program.

On March 8, 2017, you updated your household's application for financial assistance.

On March 9, 2017, NYSOH issued a notice of eligibility determination, based on your March 8, 2017 application, stating that you, your spouse, and your youngest child were eligible for Medicaid, effective March 1, 2017.

Also on March 9, 2017, NYSOH issued a notice of enrollment in the plan you selected on March 8, 2017, stating that you were enrolled in a Medicaid Managed Care plan, and that your, your spouse's, and your youngest child's coverage would start on April 1, 2017.

On March 17, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your, your spouse's, and your youngest child's enrollment in your Medicaid Managed Care plan, insofar as it did not begin March 1, 2017.

On June 21, 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 that you want your, your spouse's, and your youngest child's Medicaid Managed Care plan to begin on March 1, 2107 because you have outstanding medical bills for that month that are not covered by Fee-For Service Medicaid.

2) The record reflects that on December 5, 2016, NYSOH sent you a notice advising you that you would need to contact NYSOH between January 16, 2017 and February 15, 2017 in order to submit an application for health insurance, as your, your spouse's, and your youngest child's coverage through LDSS was ending on February 28, 2017.

3) You submitted an application to NYSOH for financial assistance on January 17, 2017.

4) Your NYSOH account reflects that as of the January 17, 2017 application, you, your spouse, and your youngest child were enrolled in Medicaid through your LDSS. Your NYSOH account further indicates that at the time of your January 17, 2017 application, NYSOH was aware that your, your spouse's, and your youngest child's coverage through your LDSS would terminate as of February 28, 2017.

5) You testified that no one in your household was incarcerated in 2017.

6) You testified that the members of your household have all maintained residence in NY throughout 2017.

7) The record reflects, that you selected your Medicaid Managed Care Plan on March 8, 2017, and that your enrollment was effective on April 1, 2017.

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)).

A person who has primary medical or health care coverage available from or under a third-party insurance provider is not permitted to enroll into a Medicaid Managed Care plan (NY SSL § 364-j(3)(e)(xx); Medicaid Managed Care Model Contract (Appendix H-6), effective 3/1/2014 – 2/28/2019). However, they will remain eligible for fee-for-service Medicaid with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, or failing to provide a valid social security number (NY SSL § 366(4)(c)).

## Legal Analysis

The issue is whether NYSOH properly determined that your, your spouse's, and your youngest child's enrollment in your Medicaid Managed Care plan was effective April 1, 2017.

On December 5, 2016, NYSOH issued a notice advising you that you would need to contact NYSOH between January 16, 2017 and February 15, 2017 as your household's coverage through your LDSS would end on February 28, 2017.

The record reflects that on January 17, 2017, you contacted NYSOH and submitted an application for financial assistance with health insurance.

As a result of this application, you, your spouse, and your youngest child were found eligible to purchase a qualified health plan at full cost through NYSOH. This was because federal and state data sources showed that you, your spouse, and your youngest child were already enrolled in Medicaid.

There is no indication in the record that you, your spouse, or your youngest child would have been ineligible for Medicaid or to enroll in a Medicaid Managed Care plan for any other reason at the time of your January 17, 2017 application.

Although the system showed that you, your spouse, and your youngest child were enrolled in Medicaid through your LDSS as of the date of your January 17, 2017 application, the system also showed that your, your spouse's, and your youngest child's Medicaid coverage through your LDSS would end on February 28, 2017.

Therefore, the January 18, 2017 eligibility determination is MODIFIED to reflect that you, your spouse, and your youngest child were eligible for Medicaid, effective March 1, 2017.

The date on which a Medicaid Managed Care plan can take effect depends on the day a person selects the plan for enrollment.

Had you, your spouse, and your youngest child been properly found eligible for Medicaid in the January 18, 2017 eligibility determination, you would have been able to select a Medicaid Managed Care plan as early as January 18, 2017.

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.

Had you been permitted to select a Medicaid Managed Care plan on January 18, 2017, so it would have taken effect on the first day of the second month following after January 2017; that is, on March 1, 2017.

Therefore, the March 9, 2017 enrollment confirmation notice is MODIFIED to reflect that your, your spouse's, and your youngest child's enrollment in your Medicaid Managed Care plan was effective March 1, 2017.

Your case is RETURNED to NYSOH to enroll you, your spouse, and your youngest child in your Medicaid Managed Care plan as of March 1, 2017.

## Decision

The January 18, 2017 eligibility determination is MODIFIED to reflect that you, your spouse, and your youngest child were eligible for Medicaid, effective March 1, 2017.

The March 9, 2017 enrollment confirmation notice is MODIFIED to reflect that your, your spouse's, and your youngest child's enrollment in your Medicaid Managed Care plan was effective March 1, 2017.

Your case is RETURNED to NYSOH to enroll you, your spouse, and your youngest child in your Medicaid Managed Care plan as of March 1, 2017.

## Effective Date of this Decision: June 29, 2017

## How this Decision Affects Your Eligibility

Your, your spouse's, and your youngest child's enrollment in your Medicaid Managed Care should have been effective as of March 1, 2017.

Your case is being sent back to NYSOH to enroll you, your spouse, and your youngest child in your Medicaid Managed Care plan as of 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:

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 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 January 18, 2017 eligibility determination is MODIFIED to reflect that you, your spouse, and your youngest child were eligible for Medicaid, effective March 1, 2017.

The March 9, 2017 enrollment confirmation notice is MODIFIED to reflect that your, your spouse's, and your youngest child's enrollment in your Medicaid Managed Care plan was effective March 1, 2017.

Your, your spouse's, and your youngest child's enrollment in your Medicaid Managed Care should have been effective as of March 1, 2017.

Your case is RETURNED to NYSOH to enroll you, your spouse, and your youngest child in your Medicaid Managed Care plan as of 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.

**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।

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).

**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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