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

Notice of Decision

Decision Date: August 1, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017022

[redacted]

Dear [redacted]

On June 30, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 17, 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).

This page intentionally left blank.

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).

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

Decision

Decision Date: August 1, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017022

[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 adult child's enrollment in a Medicaid Managed Care plan was effective March 1, 2017?

Procedural History

On October 6, 2016, NYSOH sent you a notice stating that it was time to renew your coverage. The notice advised you of the steps you needed to take before your and your adult child's (child's) Medicaid coverage through the Niagara County Department of Social Services ended on December 31, 2016.

On December 6, 2016, NYSOH issued a notice, based on your December 5, 2016 application, stating that the income information in your application did not match what the NYSOH received from state and federal data sources. That notice further stated that proof of current income was needed by December 20, 2016 to confirm your eligibility.

On January 9, 2017, NYSOH received via regular mail your submission of a statement from the Social Security Administration regarding your current monthly benefits (*see* Document [redacted]). This document was uploaded to your account on January 26, 2017 and validated on February 3, 2017.

On February 4, 2017, NYSOH issued an eligibility determination notice, based on the February 3, 2017 updated application, stating that you and your child remained eligible for Medicaid, effective February 1, 2017. The notice stated that

the type of Medicaid coverage you were eligible for did not require or allow you to enroll in a health plan. The notice further stated that you needed to pick a plan for your child.

On February 17, 2017, NYSOH issued a plan enrollment notice confirming the Medicaid Managed Care plan you selected on February 10, 2017 for your child and that his coverage would start on March 1, 2017.

On March 20, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your child's enrollment in his Medicaid Managed Care plan, insofar as it did not begin January 1, 2017.

On June 30, 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 NYSOH account, you submitted an application to NYSOH for financial assistance on December 5, 2016.

2) You testified that you are disabled and cannot log into a computer and do not have access to a facsimile device and, therefore you conduct all your transactions over the telephone.

3) According to your NYSOH account and your testimony, on January 5, 2017, you mailed to NYSOH a copy of your Social Security benefit statement, dated December 12, 2016.

4) According to your NYSOH account, this document was received on January 9, 2017, uploaded to your account on January 26, 2017, and verified on February 3, 2017.

5) According to your NYSOH account, NYSOH updated your income on February 3, 2017 from $13,376.40 to $14,664.00 based on your full monthly Social Security benefit of $1,222.00.

6) According to your NYSOH account, based upon the updated February 3, 2017 application, you and your child were found eligible for Medicaid, effective February 1, 2017.

7) According to your NYSOH account and your testimony, you selected your child's Medicaid Managed Care Plan on February 10, 2017, and that his enrollment was effective on March 1, 2017.

8) You testified that you want your child's Medicaid Managed Care plan to begin on January 1, 2017 because he had [redacted], [redacted], and [redacted] in the month of January 2017.

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

Applicable Law and Regulations

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).

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 your child's enrollment in his Medicaid Managed Care plan was effective 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 including giving the applicant the opportunity to submit satisfactory documentary evidence.

You submitted an application for health insurance to NYSOH on December 5, 2016. The income amount that was entered into this application did not match information received from federal and state data sources. As such, NYSOH instructed you to additional documentation to confirm your household income.

You testified that you are disabled and cannot log onto a computer and that you do not have access to a facsimile machine. Therefore, on January 5, 2017 you sent a copy of the December 12, 2016 Social Security benefit statement by regular mail to NYSOH. The record indicates that this document was received by NYSOH on January 9, 2017, uploaded to your account on January 26, 2017, and validated on February 3, 2017. For purposed of an eligibility determination, the application is considered complete as of the date it was validated. In your case, that is as of February 3, 2017.

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the completed application. To assess whether an eligibility determination was untimely, NYSOH must base the time-period from the date of the completed application to the date NYSOH notifies the applicant of its decision.

On February 3, 2017, NYSOH updated your income based on the validated Social Security benefit statement and issued an eligibility determination on February 4, 2017. The eligibility determination issued February 4, 2017 stated that you and your child remained eligible for Medicaid effective February 1, 2017.

Since NYSOH issued an eligibility determination one day from the date your original application was considered complete, the February 4, 2017 eligibility determination was timely.

The issue turns to whether your child's Medicaid Managed Care plan properly began as of March 1, 2017.

The record reflects you selected a Medicaid Managed Care plan for your child on February 10, 2017.

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.

Since you selected your child's Medicaid Managed Care plan on February 10, 2017, it properly took effect on the first day of the month following February 2017; that is, on March 1, 2017.

Therefore, the February 17, 2017 plan enrollment notice confirming that your child's enrollment in his Medicaid Managed Care plan would be effective March 1, 2017, was correct and must be AFFIRMED.

Decision

The February 17, 2017 plan enrollment notice is AFFIRMED.

Effective Date of this Decision: August 1, 2017

How this Decision Affects Your Eligibility

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

You and your child were eligible for Medicaid as of February 1, 2017.

The effective date of your child's 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

- 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

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 mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The February 17, 2017 plan enrollment notice is AFFIRMED.

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

You and your child were eligible for Medicaid and as of February 1, 2017.

The effective date of your child's 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:

[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)

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).

□□□ □□ □□□□□□□□□□□□□ □□□□ □□□ □□□□□ □□□□□ □□□ □□□□□□□□□□ □□□□□□□□ □□ □□□□□, □□□□□□□□ □□□ 1-855-355-5777 □□□□□□ □□ □□□□□ □□□□ □□ □□□□□□ □□□ □□□□ □□□□□□□□□□ □□□□ □□□□□□ □□□□ □□□□□□ □□□□ □□□□□

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)

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).

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.

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).