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

# Notice of Decision

Decision Date: August 14, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017829

[redacted]

Dear [redacted],

On July 25, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 18, 2016 eligibility determination and November 18, 2016 enrollment confirmation notices.

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: August 14, 2017

NY State of Health Account ID: [redacted]
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[redacted]

## Issues

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

> Was your appeal of NY State of Health's (NYSOH) November 18, 2016 eligibility determination notice and November 18, 2016 enrollment confirmation notice timely?
>
> Did NYSOH provide a timely determination of your Medicaid eligibility as of November 18, 2016?
>
> Did NYSOH properly determine that your Medicaid Managed Care plan began January 1, 2017?

## Procedural History

On September 28, 2016, NYSOH received your application for financial assistance with your health insurance.

On September 29, 2016, NYSOH issued a notice stating more information was needed to make a determination. The notice explained the income information you provided NYSOH did not match what was obtained from state and federal data sources. You were asked to submit income documentation for your household by October 13, 2016.

On October 13, 2016, you submitted income documentation.

On October 25, 2016, NYSOH issued a notice stating that the income documentation you submitted did not confirm the information in your application. You were directed to send additional proof of income by November 11, 2016.

On November 2, 2016, an application for financial assistance with health insurance was run on your behalf.

On November 3, 2016, NYSOH issued an eligibility determination notice stating that if qualified for a special enrollment period, you were eligible to purchase a qualified health plan at full cost.

Also on November 3, 2016, NYSOH issued a notice stating more information was needed to make a determination. The notice explained the income information you provided NYSOH did not match what was obtained from state and federal data sources. You were asked to submit income documentation for your household by November 12, 2016.

On November 15, 2016 NYSOH received copies of your paystubs.

On November 17, 2016, NYSOH received your application for health insurance.

On November 18, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective November 1, 2016.

Also on November 18, 2016, NYSOH issued an enrollment confirmation notice, stating that you were enrolled in a Medicaid Managed Care plan effective January 1, 2017.

On April 6, 2017, you contacted the NYSOH Account Review Unit and requested an appeal of the start date of your Medicaid Managed Care plan, requesting that it begin on December 1, 2016.

On July 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 hearing.

## Findings of Fact

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

1) You testified, and the record reflects, that you are appealing your enrollment start date of your Medicaid Managed Care plan.

2) According to your NYSOH account, NYSOH received an application for financial assistance on September 28, 2016.

3) On October 13, 2016, you uploaded paystubs to your NYSOH account:
    a. dated September 2, 2016 for a gross $51.21
    b. dated September 16, 2016, which was not legible
    c. dated September 30, 2016 for a gross $512.06

4) On November 11, 2016, NYSOH received additional paystubs:
    a. dated September 16, 2016 for a gross $279.31
    b. dated September 30, 2016 for a gross $512.06
    c. dated October 14, 2016 for a gross $512.05
    d. dated October 28, 2016 for a gross $516.71

5) On November 17, 2016, your paystubs were verified as acceptable proof of income.

6) The record reflects that you selected a Medicaid Managed Care plan on November 17, 2016.

7) The record reflects that you contacted NYSOH on January 3, 2017 regarding your enrollment start date, but an appeal was not created. (Complaint Tracking [redacted] and [redacted])

8) You testified that you want your Medicaid Managed Care plan to begin on December 1, 2016 because you have outstanding medical bills for services rendered in December 2016.

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

## Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR §155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

However, where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe as determined by NYSOH that failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal (45 CFR §155.520(d)(2)(i)(D)).

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 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).

## Legal Analysis

The first issue under review is whether your appeal of NYSOH's November 18, 2016 eligibility determination and November 18, 2016 disenrollment notice was timely.

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of the notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of your enrollment start date as stated in the November 18, 2016 eligibility determination and November 18, 2016 disenrollment notice, an appeal should have been filed by January 17, 2017.

Although your appeal was untimely on its face, the record reflects that you called NYSOH on January 3, 2017 regarding your enrollment start date. You credibly testified that you spoke with a representative at that time and that you were not informed that you could appeal until April 2017.

As you originally contacted NYSOH within sixty (60) days of the November 18, 2016 eligibility determination and November 18, 2016 disenrollment notice regarding your enrollment start date, your failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal.

The second issue is whether NYSOH's provided you with timely determination of your Medicaid eligibility as of November 18, 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.

An application for health insurance was submitted on September 28, 2016. The income amount that was entered into this application did not match federal and state data sources. As a result, NYSOH asked that you submit additional documentation to confirm your income.

On October 13, 2016, you uploaded a copy of your paystubs, however one of the paystubs were illegible. As a result, on October 24, 2016 NYSOH invalidated those paystubs as acceptable proofs of income. You submitted additional documentation on November 15, 2016 and NYSOH verified that documentation on November 17, 2016 as acceptable proofs of income.

Therefore, your application was considered complete as of November 17, 2016 for purposes of issuing an eligibility determination.

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.

NYSOH issued an eligibility determination notice on November 18, 2016 that stated you were eligible for Medicaid effective November 1, 2016. Since NYSOH issued an eligibility determination 7 days from the date your application was considered complete, the November 18, 2016 eligibility determination was timely.

The second issue is whether NYSOH properly determined that your enrollment in your Medicaid Managed Care plan was effective January 1, 2017.

The record reflects that you contacted NYSOH on November 17, 2016 and 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.

Since the November 18, 2016 eligibility determination notice was timely issued, you were able to select a Medicaid Managed Care plan as of November 18, 2016. Your plan would therefore properly take effect on the first day of the second month following after November 18, 2016; that is, on January 1, 2017.

Therefore, the November 18, 2016 enrollment confirmation notice stating that your enrollment in your Medicaid Managed Care plan would be effective January 1, 2017, was correct and must be AFFIRMED.

## Decision

The November 18, 2016 eligibility determination was timely and is AFFIRMED.

The November 18, 2016 enrollment confirmation notice is AFFIRMED.

## Effective Date of this Decision: August 14, 2017

## How this Decision Affects Your Eligibility

This decision does not affect your eligibility.

Your enrollment in your Medicaid Managed Care plan is January 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 18, 2016 eligibility determination was timely and is AFFIRMED.

The November 18, 2016 enrollment confirmation notice is AFFIRMED.

This decision does not affect your eligibility.

Your enrollment in your Medicaid Managed Care plan is January 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।

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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 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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