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

Notice of Decision

Decision Date: September 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018652

[redacted]

[redacted],

On August 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 25, 2017 plan enrollment and May 1, 2017 eligibility determination 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: September 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018652

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly determine that your child's enrollment in a Medicaid Managed Care (MMC) plan was effective June 1, 2017?
>
> Did NYSOH properly determine that your Medicare Part B monthly premiums should be reimbursed, effective April 1, 2017?

Procedural History

According to your NYSOH account, while your child was found eligible for and enrolled in Medicaid as of May 1, 2016 and her coverage continued through April 30, 2017, your Medicaid Fee-For-Service coverage through NYSOH was terminated as of May 31, 2016.

On March 24, 2017, you updated your child's application and submitted a new application for yourself.

On March 25, 2017, NYSOH issued a notice, based on your March 24, 2017 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 April 8, 2017, to confirm your and your child's eligibility.

Also on March 25, 2017, NYSOH issued a disenrollment notice stating your child's MMC plan was terminated effective April 30, 2017.

On April 4, 2017, you submitted proof of income to NYSOH; which was subsequently validated on April 12, 2017 ([redacted]).

On April 13, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective April 1, 2017 and your child was eligible for Medicaid, effective May 1, 2017. That notice also stated that you must pick a health plan for your child and that you will receive confirmation once you do.

On April 25, 2017, NYSOH issued a plan enrollment notice, based on your April 24, 2017 plan selection, confirming your child's enrollment in an MMC plan, effective June 1, 2017.

On May 1, 2017, NYSOH issued an eligibility determination notice that you are eligible to receive reimbursement for your monthly Medicare Part B premiums from NYSOH effective April 1, 2017.

On May 3, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal of the plan enrollment notice insofar as it began your child's MMC plan on June 1, 2017, and not May 1, 2017.

On August 14, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, your request to amend the appeal to include an appeal of NYSOH's failure to reimburse you for your Medicare premiums beginning December 2016 through April 2017 was granted and testimony was received. The record was developed at the hearing and was 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 applied for health insurance for yourself and your child through NYSOH on March 24, 2017. You were required to submit proof of income to confirm your and your child's eligibility.

2) According to your NYSOH account, you submitted a statement from the Social Security Administration on April 4, 2017 showing that you were receiving $861.80 in benefits per month. This documentation was validated by NYSOH on April 12, 2017.

3) According to your NYSOH account, based upon your April 12, 2017 updated application, you were determined eligible for Medicaid as of April 1, 2017 and your child was found eligible as of May 1, 2017.

4) According to your NYSOH account, you selected an MMC plan for your child on April 24, 2017, and she was enrolled in that plan as of June 1, 2017. You were unable to select a plan for yourself because you were already enrolled in Medicare.

5) You testified that you want your child's MMC plan to begin on May 1, 2017 because, although you do not have medical bills for that month, you turned in your paperwork on time and you want her MMC plan backdated on principal.

6) You further testified that you also want your Medicare premiums reimbursed by NYSOH for the months of December 2016 through April 2017. Since May 2017, your premiums have been reimbursed.

7) According to a telephone call record, dated May 30, 2017, you received reimbursement for two months of premiums in May 2017. This indicates that you did receive premium reimbursement for the month of April 2017 and May 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)). MMC 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)).)(c); 18 NYCRR § 36010.3(h)).

Payment of Medicare part B premiums will be made by the Medicaid program if a recipient is:

(1) enrolled in a voluntary insurance program under Medicare part B;

(2) receiving cash grants as an eligible recipient of public assistance;

(3) receiving chronic care in a medical institution;

(4) receiving care in a public home; or

(5) a qualified Medicare beneficiary

(18 NYCRR § 360-7.8(b)).

“The [Medicaid] program will pay the Medicare part B monthly premiums for a qualified Medicare beneficiary beginning with the month following the month he or she applies for [Medicaid] payment of these amounts” (18 NYCRR § 3607.8(b)(5)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your child's MMC plan began June 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 updated your child's NYSOH account application and applied for financial assistance on March 24, 2017. Since the income amount that was entered into this application did not match federal and state data sources, NYSOH requested that you submit additional documentation to confirm your and your child's household income.

On April 4, 2017, you submitted proof of income to NYSOH; which was subsequently validated on April 12, 2017 ([redacted]). Therefore, your child's application should have been considered complete as of that date for purposes of determining your child's eligibility for financial assistance.

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 April 13, 2017, one day from the date your child's original March 24, 2017 application was considered complete. Therefore, the April 13, 2017 eligibility determination notice was timely.

The issue turns to whether your child's MMC plan properly began as of June 1, 2017.

The record reflects you selected a MMC plan for your child on April 24, 2017.

The date on which a MMC 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 goes into effect on the first day of the following month. A plan that is selected after the fifteenth day of a month goes into effect on the first day of the second following month.

Since you selected your child's MMC plan on April 24, 2017, it properly took effect on the first day of the second month following April 2017; that is, on June 1, 2017.

Therefore, NYSOH's April 25, 2017 plan enrollment notice is correct and must be AFFIRMED.

The second issue is whether NYSOH properly determined that your Medicare Part B monthly premiums should be reimbursed, effective April 1, 2017.

You testified that you want your Medicare premiums reimbursed by NYSOH for the months of December 2016 through April 2017.

An individual is eligible to have their Medicaid Part B premiums paid by Medicaid if they meet the criteria under 18 NYCRR § 360-7.8(b). On May 1, 2017, the Marketplace issued an eligibility determination notice that you are eligible to receive reimbursement of Medicare Part B premiums effective April 1, 2017.

An individual is eligible to have their monthly Medicare part B premiums reimbursed through Medicaid the month after they apply. Since the record reflects that you initially applied for Medicaid for yourself on March 24, 2017, the effective date of your premium reimbursement properly took effect on April 1, 2017.

Therefore, the NYSOH's May 1, 2017 eligibility determination notice is correct and must be AFFIRMED.

Decision

The April 25, 2017 plan enrollment notice is AFFIRMED.

The May 1, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: September 26, 2017

How this Decision Affects Your Eligibility

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

The effective date of your child's MMC plan is June 1, 2017.

The effective date of your Medicaid part B premium reimbursements is April 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

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).

Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The April 25, 2017 plan enrollment notice is AFFIRMED.

The May 1, 2017 eligibility determination notice is AFFIRMED.

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

The effective date of your child's MMC plan is June 1, 2017.

The effective date of your Medicaid part B premium reimbursements is April 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.

□□□ (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.

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).

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।

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.

(Urdu) اردو

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)

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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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