



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

Notice of Decision

Decision Date: February 06, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000024270

[REDACTED]

[REDACTED]

On January 4, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 11, 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).

This page intentionally left blank.



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

Decision

Decision Date: February 06, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000024270

[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 enrollment in your Medicaid Managed Care plan was effective December 1, 2017?

Procedural History

On December 7, 2016, NYSOH issued a notice of eligibility determination, stating that you were eligible for Medicaid, effective November 1, 2016.

On December 9, 2016, NYSOH issued a notice of enrollment, stating that you were enrolled in a Medicaid Managed Care plan (Empire), and that your coverage would start on January 1, 2017.

On September 4, 2017, NYSOH issued a renewal notice stating that you no longer qualified for Medicaid, Child Health Plus, the Essential Plan or for tax credits because federal and state sources showed that your household income was over \$47,520.00. The notice directed you to select a new health plan before October 15, 2017. The eligibility was effective November 1, 2017.

On September 17, 2017, NYSOH issued a disenrollment notice stating that coverage under your Medicaid Managed Care plan was ending effective October 31, 2017.

On October 6, 2017, you updated your NYSOH account attesting to an annual income of \$0.00.

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).

On October 7, 2017, NYSOH issued a notice stating that the income in your application did not match information NYSOH received from state and federal sources. The notice directed you to provide proof of income by October 21, 2017.

On October 10, 2017, you uploaded proof of income.

On October 11, 2017, NYSOH issued an eligibility determination stating that you were eligible for Medicaid, effective November 1, 2017. The notice directed you to select a health plan.

On November 10, 2017, you selected a health plan. On that date, a preliminary eligibility determination was prepared stating that your Medicaid Managed Care plan, would begin December 1, 2017.

Also on November 10, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your enrollment in your Medicaid Managed Care plan, insofar as it did not begin November 1, 2017.

On November 11, 2017, NYSOH issued a notice of enrollment, stating that you were enrolled in a Medicaid Managed Care plan (Empire), and that your coverage would start on December 1, 2017.

On January 4, 2018, 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) On December 7, 2016, NYSOH issued a notice of eligibility determination, stating that you were eligible for Medicaid, effective November 1, 2016. You subsequently enrolled into a Medicaid Managed Care plan (Empire).
- 2) On September 4, 2017, NYSOH issued a renewal notice stating that you no longer qualified for Medicaid, Child Health Plus, the Essential Plan or for tax credits because federal and state sources show that your household income was over \$47,520.00. The notice directed you to select a health plan before October 15, 2017. The eligibility was effective November 1, 2017.
- 3) On September 17, 2017, NYSOH issued a disenrollment notice stating that coverage under your Medicaid Managed Care plan was ending effective October 31, 2017.

- 4) On October 6, 2017, you updated your NYSOH account attesting to an annual income of \$0.00.
- 5) On October 7, 2017, NYSOH issued a notice stating that the income in your application did not match what NYSOH received from state and federal sources. The notice directed you to provide proof of income by October 21, 2017.
- 6) On October 10, 2017, you uploaded proof of income which was verified that day.
- 7) On October 11, 2017, NYSOH issued an eligibility determination stating that you were eligible for Medicaid, effective November 1, 2017. The notice directed you to select a health plan.
- 8) You testified that you disregarded the October 11, 2017 notice advising you to select a health plan because you believed that you would be enrolled in your previous health plan, Empire.
- 9) You testified that when you realized that you did not have health insurance coverage during November 2017 you contacted NYSOH on November 10, 2017.
- 10) You testified, and the record reflects, that you selected your Medicaid Managed Care Plan on November 10, 2017, and that your enrollment was effective on December 1, 2017.
- 11) You testified that you want your Medicaid Managed Care plan to begin on November 1, 2017 because you incurred a medical bill during November 2017 which was not covered by your Medicaid fee for service coverage.

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

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).

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 is whether NYSOH properly determined that your enrollment in a Medicaid Managed Care plan was effective December 1, 2017.

On December 7, 2016, NYSOH issued a notice of eligibility determination, stating that you were eligible for Medicaid, effective November 1, 2016. You subsequently enrolled into a Medicaid Managed Care plan (Empire).

On September 4, 2017, NYSOH issued a renewal notice stating that you no longer qualified for Medicaid, Child Health Plus, the Essential Plan or for tax credits because federal and state sources show that your household income was over \$47,520.00. The notice directed you to select a health plan before October 15, 2017. The eligibility was effective November 1, 2017.

On October 6, 2017, you updated your NYSOH account attesting to an annual income of \$0.00. On October 7, 2017, NYSOH issued a notice stating that the income in your application did not match information NYSOH received from state and federal sources. The notice directed you to provide proof of income by October 21, 2017.

On October 10, 2017, you uploaded proof of income which was verified that day. On October 11, 2017, NYSOH issued an eligibility determination stating that you were eligible for Medicaid, effective November 1, 2017. The notice directed you to select a health plan.

You testified that you disregarded the October 11, 2017 notice advising you to select a health plan because you believed that you would be enrolled in your previous health plan, Empire.

You testified that when you realized that you did not have health insurance coverage during November 2017 you contacted NYSOH on November 10, 2017.

You testified that you contacted NYSOH on November 10, 2017 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.

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).

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 November 10, 2017, you selected a Medicaid Managed Care plan, so it properly took effect on the first day of the following month; that is, on December 1, 2017.

Therefore, the November 11, 2017 enrollment confirmation notice stating that your enrollment in your Medicaid Managed Care plan would be effective December 1, 2017, was correct and must be AFFIRMED.

Decision

The November 11, 2017 enrollment confirmation notice is AFFIRMED.

Effective Date of this Decision: February 06, 2018

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

The effective date of your Medicaid Managed Care plan is December 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 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).

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 11, 2017 enrollment confirmation notice is **AFFIRMED**.

This decision does not change your eligibility.

The effective date of your Medicaid Managed Care plan is December 1, 2017.

Legal Authority

We are issuing this determination in accordance with 45 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).

A Copy of this Decision Has Been Provided To:



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 مجاناً.

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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&etumi ama wo obi a okyerε 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 کرم 1-855-355-5777 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.

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).