STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: December 15, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP28671346

[redacted]

[redacted]

On November 2, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's alleged failure to issue a timely eligibility determination for the Medicaid eligibility for you and your children.

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
  PO 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(b).

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: December 15, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP28671346

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health (NYSOH) fail to provide a timely eligibility determination for the Medicaid eligibility for you and your children?

Procedural History

On May 8, 2017, NYSOH issued a notice advising you that you and your children's Medicaid coverage through [redacted] would end effective July 31, 2017. You were requested to access your NYSOH account between June 16, 2017 and July 15, 2017 to complete the renewal process for anyone who needs health coverage.

Between June 16, 2017 and August 8, 2017, your account was accessed three times to verify your address details, but an application was not processed completed or processed during that time.

On or about August 28, 2017, you spoke to NYSOH's Account Review Unit and appealed that you and your children had not found eligible for Medicaid, effective August 1, 2017 due to system defects within NYSOH.

On September 19, 2017, NYSOH redetermined your household's eligibility for financial assistance with health insurance.

On September 22, 2017, NYSOH issued a notice stating that you did not qualify for health coverage through NYSOH. This was because federal and state data sources showed that you were receiving Medicare.

On September 28, 2017, NYSOH received an update to your application for financial assistance with health insurance. In response to this application, NYSOH prepared a preliminary eligibility determination stating that you and your children were eligible for Medicaid, effective September 1, 2017. This preliminary eligibility determination also stated that you qualified for retroactive Medicaid during the month of August 2017.

On September 29, 2017, NYSOH issued an enrollment notice stating confirming your selection of a Medicaid Managed Care (MMC) plan for your younger child as of September 28, 2017. The notice stated that your younger child's MMC plan coverage would begin effective November 1, 2017. The notice further stated that you and your older child's type Medicaid coverage did not require or allow you to select an MMC plan at that time.

On October 1, 2017, NYSOH issued an eligibility determination notice stating that you and your children remained eligible for Medicaid, effective September 1, 2017.

On October 13, 2017, NYSOH took independent action to update your account details to reflect that your children's Medicaid coverage was backdated to begin August 1, 2017, and that your younger child's MMC plan coverage was also backdated to begin August 1, 2017.

On November 2, 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.

On November 21, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid between August 1, 2017 and August 31, 2017.

Findings of Fact

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

1) You testified that since NYSOH took independent action to backdate your account details to reflect that your children's Medicaid coverage began effective August 1, 2017, and your younger child's MMC plan coverage also began effective August 1, 2017, you withdrew your appeal with respect to their eligibility.

2) You testified that you were now seeking an appeal solely to request that your Medicaid coverage be backdated to August 1, 2017, so that you

could submit claims for bills during that time, and to seek reimbursement for your Medicaid Part B premium incurred during that month.

3) You testified, and your NYSOH account reflects, that you and your children were enrolled in Medicaid coverage through Oneida County Department of Social Services, and that such coverage ended effective July 31, 2017.

4) You testified that you are enrolled in Medicare.

5) You testified that you received NYSOH's May 8, 2017 notice requesting that you update your account between June 16, 2017 and July 15, 2017 so that your household's eligibility could be determined.

6) You testified, and your NYSOH account reflects, that you attempted to update your application at least three times between June 16, 2017 and August 8, 2017, but were unable to complete an application because you had been "locked out."

7) Your NYSOH account reflects that a [redacted] had been filed on your behalf to resolve the issue. You testified that there had been no resolution regard this defect until your application had been updated on or about September 28, 2017 with the assistance of a NYSOH representative.

8) Based on the information contained in your September 28, 2017 application, you and your children were found eligible for Medicaid, effective September 1, 2017.

9) Your children's eligibility for Medicaid was subsequently backdated to begin effective August 1, 2017, and your younger child's MMC plan coverage was also backdated to begin effective August 1, 2017.

10) Based on the information contained in your September 28, 2017 application, you were found eligible for retroactive Medicaid between August 1, 2017 and August 31, 2017. You were issued an eligibility determination notice regarding this finding on November 21, 2017.

11) You testified during your hearing that you were continuing the appeal solely to submit claims for medical expenses you incurred during August 2017, and to seek reimbursement for your Medicare Part B premium incurred for coverage during the month of August 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)).

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)).

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).

NYSOH must provide Medicaid applicants who are at least one year of age but younger than nineteen notice of their eligibility determination within 30 days of

the date of the application if the household income does not exceed 138% of the federal poverty level (18 NYCRR §360-2.4(a)(3)(ii)).

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 issue under review is whether NYSOH failed to provide a timely eligibility determination for the Medicaid eligibility for you and your children.

You testified during the hearing that you had been seeking for you and your children’s Medicaid coverage to begin effective August 1, 2017. However, you also testified that NYSOH had already taken independent action to backdate your

account details to reflect that your children's Medicaid coverage began effective August 1, 2017, so you withdrew your appeal with respect to their eligibility.

Accordingly, NYSOH Appeals Unit will not review their eligibility.

You testified that you were now seeking an appeal solely to request that your Medicaid coverage also be backdated to August 1, 2017, so that you could submit claims for bills during that time, and to seek reimbursement for your Medicaid Part B premium incurred during that month.

The record reflects that on November 21, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for retroactive Medicaid coverage between August 1, 2017 and August 31, 2017. Accordingly, since you were subsequently found eligible for retroactive Medicaid coverage effective August 1, 2017, your appeal is now moot and we will not address your eligibility for Medicaid.

Since you were determined eligible for retroactive Medicaid during the month of August 2017, your case is RETURNED to Plan Management to assist you in submitting a claim to have your Medicare Part B premium paid for coverage during August 2017 reimbursed, if this has not already occurred.

Decision

Since you were subsequently found eligible for retroactive Medicaid coverage between August 1, 2017 and August 31, 2017, your appeal is now moot and we will not address your eligibility for Medicaid.

Your case is RETURNED to Plan Management to assist you in submitting a claim to have your Medicare Part B premium paid for coverage during August 2017 reimbursed, if this has not already occurred.

Effective Date of this Decision: December 15, 2017

How this Decision Affects Your Eligibility

You and your children's Medicaid coverage through NYSOH began effective August 1, 2017.

Your younger child's MMC plan coverage also began effective August 1, 2017.

Your case is being sent back to Plan Management to assist you in submitting a claim to have your Medicare Part B premium paid for coverage during August 2017 reimbursed, if this has not already occurred.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the 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
  PO Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

Since you were subsequently found eligible for retroactive Medicaid coverage between August 1, 2017 and August 31, 2017, your appeal is now moot and we will not address your eligibility for Medicaid.

You and your children's Medicaid coverage through NYSOH began effective August 1, 2017.

Your younger child's MMC plan coverage also began effective August 1, 2017.

Your case is being referred to Plan Management to assist you in submitting a claim to have your Medicare Part B premium paid for coverage during August 2017 reimbursed, if this has not already occurred.

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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