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

Notice of Decision

Decision Date: March 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013421

[redacted]

Dear [redacted]

On February 22, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 20, 2016 disenrollment 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: March 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013421

[redacted]

Issue

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

> Did NY State of Health properly determine that your enrollment in a Medicaid Managed Care (MMC) plan terminated on December 31, 2016?

Procedural History

On October 15, 2015, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective October 1, 2015.

That same day, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in an MMC plan through United Healthcare, effective November 1, 2015.

On October 8, 2016, NYSOH issued a renewal notice stating that it was time to renew your health coverage for the next year. The notice stated that you needed to update your application by November 15, 2016, or the financial assistance you were currently receiving might end.

On October 19, 2016, your NYSOH account was updated.

On October 20, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective January 1, 2017. The notice further stated that, because you had other full benefit health insurance or Medicare, you could not enroll in an MMC plan.

That same day, NYSOH issued a disenrollment notice stating that your MMC coverage would end effective December 31, 2016 because you have other full benefit health insurance or Medicare, and could not enroll in an MMC plan.

On November 21, 201, 2016, you spoke to NYSOH's Account Review Unit and appealed, because you wanted Medicaid to pay your Medicare part B premiums for the months of November and December 2016, when you were still enrolled in your MMC plan.

On February 22, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and kept open for fifteen days at the end of the hearing so that you could submit a letter that you stated you received from your United Healthcare MMC plan showing that your coverage terminated as of October 31, 2016. No documentation was received by the Appeals Unit, and the record closed at the end of the fifteen-day period.

Findings of Fact

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

1) You testified, and your NYSOH account reflects, that you were receiving Medicaid and were enrolled in a United Healthcare MMC plan.

2) You testified that you began receiving Social Security Disability less than two years ago.

3) You testified that you were not aware that you would become eligible for Medicare so quickly, as you have not been receiving Social Security Disability for two years, but that your disability onset date was backdated.

4) You testified that you became eligible for Medicare as of November 1, 2016.

5) You testified that you notified NYSOH multiple times in October 2016 that you were becoming eligible for Medicare, as you had many questions about what this would do to your coverage.

6) You testified that you did not use your MMC coverage in November or December 2016.

7) You testified that you received a letter from United Healthcare informing you that your MMC coverage ended on October 31, 2016, so you do not understand why NYSOH is stating that it ended on December 31, 2016.

8) You testified that Medicaid began paying your Medicare premium as of January 1, 2017, but that you had to pay for it yourself in November and December 2016.

9) You testified that you are looking to have your premium reimbursement backdated to so that you can be reimbursed for the premiums you paid in November and December 2016.

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

Applicable Law and Regulations

Medicaid

Medicaid can be provided through the Marketplace to adults who: (1) Are age 19 or older and under age 65; (2) Are not pregnant; (3) Are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act; (4) Are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part; and (5) Have a household modified adjusted gross income that is at or below 138% of the federal poverty level (FPL) for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

In an analysis of Medicaid eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR § 435.4). On the date of your application, that was the 2013 FPL, which is $11,490.00 for a one-person household (79 Federal Register 3593, 3593). Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits can be based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

Medicaid Premium Reimbursement

A person may be eligible for Medicaid reimbursement of health insurance premiums paid if the payment of those premiums is cost-effective and so reduces the cost of providing Medicaid services (*see* NYS Social Services Law § 367a(b), 18 NYCRR § 360-7.5, GIS 02 MA/019). Cost-effectiveness may be determined by comparing what it would cost Medicaid to provide coverage to the cost of the premiums for the health insurance policy.

Payment of Medicare part B premiums will be made by Medicaid if a Medicaid recipient is a qualified Medicare beneficiary, pursuant to 18 NYCRR § 360-7.7(g).

Payment of the part B premium begins in the month following the month in which the qualified Medicare beneficiary applies for Medicaid payment of the premiums (18 NYCRR § 360-7.8(b)(5)).

Medicaid Managed Care Plans

Generally, with regard to enrollment in a MMC plan, Medicaid recipients, except for those who are eligible for an exemption or an exclusion, must enroll in a MMC plan (18 NYCRR § 360-10.4(a)).

An individual dually eligible for Medicaid and benefits under the federal Medicare program may be required to enroll into a MMC plan (NY Soc. Serv. Law § 364-j(3)(e)(i)).

The MMC program excludes from enrollment consumers who receive Medicare benefits. Once Medicare coverage is gained the recipient must be disenrolled from their MMC plan as soon as possible (GIS 11 MA/025).

Legal Analysis

The issue under review is whether NYSOH properly determined that your enrollment in an MMC plan ended on December 31, 2016.

According to the October 15, 2015 eligibility determination notice, you were eligible for Medicaid as of October 1, 2015. Also on October 15, 2015, NYSOH issued an enrollment notice confirming your enrollment in an MMC plan.

A person who is Medicaid eligible generally must enroll in a MMC plan. However, the MMC program excludes from enrollment consumers who receive Medicare benefits. Once Medicare coverage is gained the recipient must be disenrolled from their MMC plan as soon as possible.

Your NYSOH account contains a notice dated October 20, 2016 stating that you were to be disenrolled from your MMC plan because you were enrolled in full benefit health insurance or Medicare. According to your testimony, you began receiving Medicare in November 2016. Further, you testified that you notified NYSOH repeatedly in October 2016 that you were going to be receiving Medicare as of November 1, 2016.

Since, according to your testimony, you were eligible for Medicare benefits as of November 1, 2016, and NYSOH was made aware of this before October 20, 2016 (the date of the disenrollment notice), NYSOH should have disenrolled you from your MMC plan effective October 31, 2016 instead.

Therefore, the October 20, 2016 disenrollment notice is MODIFIED to state that you are disenrolled from your MMC plan effective October 31, 2016.

According to your testimony, you want to be reimbursed for Medicare part B premiums for November and December 2016. Since your MMC enrollment should have ended as of October 31, 2016, your case is RETURNED to NYSOH to determine your eligibility for Medicaid reimbursement of your Medicare part B premium for the months of November and December 2016.

Decision

The October 20, 2016 disenrollment notice is MODIFIED to state that your enrollment in your MMC plan was terminated effective October 31, 2016.

Your case is RETURNED to NYSOH to disenroll you from your MMC plan effective October 31, 2016 and to determine your eligibility for Medicaid reimbursement of your Medicare Part B premium for the months of November and December 2016.

Effective Date of this Decision: March 28, 2017

How this Decision Affects Your Eligibility

You are disenrolled from your MMC plan as of October 31, 2016.

Your case is being sent back to NYSOH to determine your eligibility for Medicaid reimbursement of your Medicare part B premium for the months of November and December 2016.

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 October 20, 2016 disenrollment notice is MODIFIED to state that your enrollment in your MMC plan was terminated effective October 31, 2016.

Your case is RETURNED to NYSOH to disenroll you from your MMC plan effective October 31, 2016 and to determine your eligibility for Medicaid reimbursement of your Medicare Part B premium for the months of November and December 2016.

You are disenrolled from your MMC plan as of October 31, 2016.

Your case is being sent back to NYSOH to determine your eligibility for Medicaid reimbursement of your Medicare part B premium for the months of November and December 2016.

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.

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।

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 महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क 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.

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).