



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

Notice of Decision

Decision Date: June 21, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000015255

[REDACTED]

Dear [REDACTED]

On May 15, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 27, 2017 enrollment 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: June 21, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000015255

[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 family's Medicaid Managed Care plan was effective March 1, 2017?

Procedural History

On December 1, 2016, NY State of Health (NYSOH) issued an eligibility determination notice, based on your November 30, 2016 application, stating your family was eligible for Medicaid, effective December 1, 2016.

Also on December 1, 2016, NYSOH issued an enrollment notice, based on your November 30, 2016 plan selection, stating that your family was enrolled in a Medicaid Managed Care plan, effective January 1, 2017.

On December 7, 2016, NYSOH issued a disenrollment notice stating in part that your family's Medicaid Managed Care plan would be terminated effective January 1, 2017. This was because your family had other (full benefit) health insurance.

On January 13, 2017, you submitted a letter, dated December 1, 2016, regarding your employer-sponsored health insurance stating in part that your family's employer-sponsored health insurance would begin, effective January 1, 2017 (see Document [REDACTED]).

On January 14, 2017, NYSOH issued an eligibility determination notice stating your family remained eligible for Medicaid, effective January 1, 2017. That notice further stated that the type of Medicaid coverage your family was eligible for does not require or allow any of you to enroll in a Medicaid Managed Care plan.

On January 24, 2017, you submitted a letter, dated January 24, 2017, from your employer stating in part that you do not have any medical coverage through them (see Document [REDACTED]).

On January 26, 2017, NYSOH issued an eligibility determination notice stating your family remained eligible for Medicaid, effective January 1, 2017. That notice stated that you must pick a health plan.

On January 27, 2017, NYSOH issued a plan enrollment notice, based on your January 26, 2017 plan selection, confirming your family was enrolled in a Medicaid Managed Care plan, effective March 1, 2017.

Also on January 27, 2016, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination insofar as your family's Medicaid Managed Care plan did not begin on January 1, 2017.

On May 15, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was held open until June 14, 2017 to allow you to submit proof of the date you requested termination and the actual termination date of your family's employer-sponsored health insurance.

As of June 14, 2017, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day. This Decision is based on the record as developed at the time of the hearing.

Findings of Fact

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

- 1) According to your NYSOH account, your family was determined eligible for Medicaid effective December 1, 2016.
- 2) According to your NYSOH account, when NYSOH reran your application for health insurance on December 6, 2016, your family was disenrolled from your Medicaid Managed Care plan as of January 1, 2017. This was because at the time of your application, the system showed that your family was covered by employer-sponsored health insurance.

- 3) You testified that you advised your employer that you wanted to try the employer-sponsored health coverage beginning January 2017, but the employer mistakenly enrolled your family and started taking money out of your paycheck to cover your health insurance in November 2016. You further testified that this issue was resolved and you were refunded the money paid out in November 2016.
- 4) On January 13, 2017, you submitted a letter from your employer to NYSOH that states your family's employer-sponsored health coverage began on January 1, 2017.
- 5) On January 24, 2017, you submitted a letter from your employer to NYSOH that states your family does not have employer-sponsored health coverage through them. According to your NYSOH account and your testimony, you were then able to select a Medicaid Managed Care plan.
- 6) You testified that, once you realized that with the employer-sponsored coverage you would be receiving medical bills that you had to process through that coverage, you told your employer not to bother with the employer-sponsored insurance.
- 7) According to your NYSOH account, on January 26, 2017, you selected a Medicaid Managed Care plan, which began effective March 1, 2017.
- 8) You testified that you want your Medicaid Managed Care plan reinstated to January 1, 2017, because you have medical bills due that are not covered by insurance.

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 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);

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).

18 NYCRR § 360-10.3(h), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

A Medicaid recipient who has primary medical or health care coverage available from a Third-Party payor may be required to enroll with a managed care program when the payment of the premium or cost sharing amounts would be cost-effective, as determined by the local social services district (NY Soc. Serv. Law § 364-j(3)(e)(xx)).

Third Party Health Insurance

A person who has primary medical or health care coverage available from or under a third-party insurance provider is not permitted to enroll into a Medicaid Managed Care plan (NY SSL § 364-j(3)(e)(xx); Medicaid Managed Care Model Contract (Appendix H-6), effective 3/1/2014 – 2/28/2019). However, they will remain eligible for fee-for-service Medicaid with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, or failing to provide a valid social security number (NY SSL § 366(4)(c)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your family's enrollment in a Medicaid Managed Care plan was effective March 1, 2017.

In the December 1, 2016 eligibility determination notice, your family remained eligible for Medicaid, effective January 1, 2017. On November 30, 2016, you selected a Medicaid Managed Care plan, effective January 1, 2017, as is documented by the December 1, 2016 plan enrollment notice.

Generally, when an individual is eligible for Medicaid through NYSOH, they are required to enroll in a Medicaid Managed Care plan. Applicants determined eligible will be enrolled or remain in their Medicaid Managed Care plan with limited exceptions, including entering prison or another facility that provides medical care, moving out of state, having active third-party health insurance, or failing to provide a valid Social Security number.

On December 6, 2016, NYSOH redetermined your household's eligibility for financial assistance with health insurance. On December 7, 2016, NYSOH issued a disenrollment notice advising that your family's coverage in their Medicaid Managed Care plan would be terminated as of January 1, 2017, because the system showed that your family had full benefit employer-sponsored health insurance.

When NYSOH determines that a person has active coverage in a health insurance plan outside of NYSOH, that person is not eligible to enroll or remain enrolled in a Medicaid Managed Care plan.

You testified that you advised your employer that you wanted to try the employer-sponsored health coverage beginning January 2017, but the employer mistakenly enrolled your family and started taking money out of your paycheck to cover your health insurance in November 2016.

On January 13, 2017 and January 24, 2017, you submitted conflicting letters from your employer to NYSOH stating respectively that your employer-sponsored health coverage began on January 1, 2017, and you don't have employer-sponsored health coverage through them.

During the hearing, the Hearing Officer held the record open until June 14, 2017 to allow you time to submit proof of the date you requested to terminate your employer-sponsored health coverage and the actual termination date of your employer-sponsored health coverage. As of June 14, 2017, no documents were received and the record lacks such evidence. Thus, these factors are not considered in this Decision.

Based upon the December 1, 2016 letter you submitted, NYSOH properly determined that as of January 1, 2017, you were covered by employer-sponsored health insurance and were unable to select a Medicaid Managed Care Plan. Therefore, the December 7, 2016 disenrollment notice was correct and AFFIRMED.

Likewise, the January 14, 2017 eligibility determination notice stating that your family was eligible for Medicaid, effective January 1, 2017, and the type of Medicaid coverage your family was eligible for does not require or allow any of you to enroll in a Medicaid Managed Care plan, was correct and is AFFIRMED.

Upon receipt of the January 24, 2017 letter stating that you did not have employer-sponsored health insurance, you were then able to select a Medicaid Managed Care plan. This was because as of that date, your application was complete.

According to your NYSOH account, on January 26, 2017 you enrolled your family 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.

On January 26, 2017, you selected a Medicaid Managed Care plan, so it properly took effect on the first day of the second month following January 2017; that is, on March 1, 2017.

Therefore, the January 27, 2017 plan enrollment notice confirming your family's enrollment in a Medicaid Managed Care plan was effective March 1, 2017, was correct and must be AFFIRMED.

Decision

The December 7, 2016 disenrollment notice is AFFIRMED.

The January 14, 2017 eligibility determination notice is AFFIRMED.

The January 27, 2017 plan enrollment notice is AFFIRMED.

Effective Date of this Decision: June 21, 2017

How this Decision Affects Your Eligibility

This decision does not change your family's eligibility.

Your family was eligible for Medicaid Fee-For-Service as of January 1, 2017, which would be secondary to any other health insurance your family had.

The effective date of your family's Medicaid Managed Care plan is March 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.

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).

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 December 7, 2016 disenrollment notice is **AFFIRMED**.

The January 14, 2017 eligibility determination notice is **AFFIRMED**.

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).

The January 27, 2017 plan enrollment notice is AFFIRMED.

This decision does not change your family's eligibility.

Your family was eligible for Medicaid Fee-For-Service as of January 1, 2017, which would be secondary to any other health insurance your family had.

The effective date of your family's Medicaid Managed Care plan is March 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:



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 okyerE 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).

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).