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

Notice of Decision

Decision Date: July 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015373

[redacted]

Dear [redacted],

On July 17, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 20, 2017 eligibility determination notice, January 20, 2017 disenrollment notice and March 2, 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).

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Decision

Decision Date: July 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015373

[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 you were no longer eligible to remain enrolled in your Medicaid Managed Care plan as of January 31, 2017?

Procedural History

On March 16, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible for Medicaid, effective March 1, 2016.

On March 19, 2016, NYSOH issued a notice of enrollment stating that you were enrolled in a Medicaid Managed Care plan, effective May 1, 2016.

On December 3, 2016, NYSOH issued a notice that it was time to renew your health insurance for the upcoming coverage year. That notice stated that based on information from state and federal data sources, NYSOH could not make a decision about whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by January 15, 2016 or you might lose the financial assistance you were currently receiving.

No updates were received by January 15, 2017 and NYSOH redetermined your eligibility for financial assistance with health insurance.

On January 20, 2017, NYSOH issued an eligibility determination notice stating that you are not eligible for Medicaid, Child Health Plus, the Essential Plan, to

receive tax credits or cost-sharing reductions to help pay for the cost of insurance, or to purchase a qualified health plan, effective February 1, 2017. You also could not enroll in a qualified health plan at full cost. This was because you had not responded to the renewal notice and had not completed your renewal within the required time frame.

Also on January 20, 2017, NYSOH issued a notice of disenrollment, stating that your enrollment in your Medicaid Managed Care plan would end on January 31, 2017. This was because you were no longer eligible to enroll in health insurance through NYSOH.

On January 31, 2017, NYSOH received your updated application for health insurance. The day, a preliminary determination was prepared stating that the income information you provided did not match what had been obtained from state and federal data sources and that an eligibility determination could not be made until you provided income documentation.

Also on January 31, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were not enrolled in a Medicaid Managed Care plan as of February 1, 2017. You also requested Aid to Continue at that time. That day, an incident [redacted], was created in response to your Aid to Continue request.

On February 5, 2017, you submitted income documentation to NYSOH for verification.

On March 1, 2017, NYSOH redetermined your eligibility for financial assistance and reinstated your Medicaid Managed Care plan as of February 1, 2017.

On March 2, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective March 1, 2017.

Also on March 2, 2017, NYSOH issued a notice of enrollment stating that you were reenrolled into your Medicaid Managed Care plan, effective February 1, 2017.

Finally, on March 2, 2017, your written request for an expedited appeal was uploaded to your NYSOH account.

On March 13, 2017, your request for an expedited appeal was denied because your re-enrollment in a Medicaid Managed Care plan had been backdated to February 1, 2017 and as such you had no gap in Medicaid Managed Care plan coverage.

On April 5, 2017, NYSOH issued a notice of telephone hearing to inform you that your hearing was scheduled for May 10, 2017 [redacted].

On May 10, 2017, a Hearing Officer from NYSOH's Appeals Unit placed three phone calls to the telephone number that was listed on the notice of telephone hearing but the Hearing Officer was unable to reach you.

On May 12, 2017, NYSOH's Appeals Unit issued a notice of dismissal for failure to appear.

On May 23, 2017, your written request to vacate the May 12, 2017 dismissal was uploaded to your NYSOH account.

On June 5, 2017, a secondary written request to vacate the May 12, 2017 dismissal was uploaded to your NYSOH account.

Also on June 5, 2017, your request to vacate the May 12, 2017 dismissal was vacated and your hearing was rescheduled.

On July 17, 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.

Findings of Fact

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

1) You testified, and your NYSOH account reflects, that you receive your notices from NYSOH by regular mail.

2) You testified that you may have received the December 3, 2016 renewal notice telling you that you needed to update your account.

3) No notices sent to you at the mailing address listed on your NYSOH account have been returned as undeliverable.

4) You testified that you contacted NYSOH on January 31, 2017 to update your account and were advised at that time that you needed to submit income documentation.

5) You testified that you filed an appeal on January 31, 2017. You also testified that you requested Aid to Continue at that time.

6) On January 31, 2017, an incident [redacted] was created in response to your appeal request. That incident indicates that you were initially appealing your pending Medicaid status, and seeking to enroll in a Medicaid Managed Care plan as of February 1, 2017.

7) The Evidence Packet [redacted] contains an appeal summary. A note within that appeal summary at page 3 of the Evidence Packet reads as follows, "03/1/2017 – The consumer renewed on the last day [redacted] had coverage (1/31/17) so should not have had a gap in coverage. Fixing coverage instead of granting ATC [Aid to Continue] by enrolling back into MMC plan and backdating to 2/1/17 so no gap in coverage".

8) You testified that you were without coverage during the month of February 2017, and were unable to seek medical treatment during that month because you could not afford to pay medical expenses out of pocket.

9) You testified that you have no medical bills for February 2017.

10) You testified that you wanted to pursue the appeal, because you initially had a gap in coverage and were not granted Aid to Continue, and you now wish to appeal the failure of NYSOH to grant you Aid to Continue.

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

Applicable Law and Regulations

Medicaid Renewal

In general, NYSOH must review Medicaid eligibility once every twelve months or "whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility" (42 CFR § 435.916(a)(1), (d)). NYSOH must make its "redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency" (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates provided by the individual (45 CFR §155.335(h)).

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 Managed Care (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, N.Y. Soc. Serv. Law §364-j(1)(c); 18 NYCRR § 360-10.3(h)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were no longer eligible to remain enrolled in your Medicaid Managed Care plan as of January 31, 2017.

You were found eligible for Medicaid, effective March 1, 2016.

On December 3, 2016, NYSOH sent you a renewal notice stating that there was not enough information to determine whether you were eligible to continue your financial assistance for health insurance, and that you needed to supply additional information by January 15, 2017, or your financial assistance might end.

There was no response to this renewal notice and on January 20, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid because you had not responded to the renewal notice and had not completed your renewal within the required time frame. As a result, you were disenrolled from your Medicaid Managed Care plan as of January 31, 2017.

On January 31, 2017, you updated your NYSOH account but an eligibility determination was unable to be made that day until you submitted documentation to confirm your income.

Also on January 31, 2017, you filed an appeal insofar as you were no longer enrolled into a Medicaid Managed Care plan as of February 1, 2017. That day, you also requested Aid to Continue pending the outcome of your appeal.

However, on March 1, 2017, NYSOH redetermined your eligibility for financial assistance and reinstated your Medicaid Managed Care plan as of February 1, 2017. According to a note in the evidence packet this was because “[You] renewed on the last day [you] had coverage (1/31/17) so should not have had a gap in coverage. Fixing coverage instead of granting ATC [Aid to Continue] by enrolling back into MMC plan and backdating to 2/1/17 so no gap in coverage”.

On March 2, 2017, NYSOH issued a notice of enrollment confirming that you were enrolled in your Medicaid Managed Care plan, as of February 1, 2017.

Since it is evident from the record that NYSOH has conceded that your enrollment in your Medicaid Managed Care plan should have begun as of February 1, 2017, a discussion of the merits of your case is not necessary

because you had no gap in your Medicaid Managed Care plan which was the basis of your initial appeal request.

Therefore, the January 20, 2017 eligibility determination and disenrollment notices terminating your coverage in your Medicaid Managed Care plan as of January 31, 2017 are RESCINDED.

The March 2, 2017 enrollment notice, which stated that you were enrolled in your Medicaid Managed Care plan, effective February 1, 2017, is AFFIRMED.

During the hearing, you testified that you wanted to pursue the appeal, because you initially had a gap in coverage and were not granted Aid to Continue, and you now wish to appeal the failure of NYSOH to grant you Aid to Continue. However, as stated above NYSOH voluntarily backdated your enrollment in your Medicaid Managed Care plan to February 1, 2017 in lieu of granting you Aid to Continue to ensure that you did not have a gap in your Medicaid Managed Care plan coverage.

Therefore, the issue of whether or not you should have been granted Aid to Continue as of February 1, 2017 is rendered moot as you were granted the relief you were requesting—your Medicaid Managed Care plan effective February 1, 2017.

Decision

The January 20, 2017 eligibility determination notice is RESCINDED.

The January 20, 2017 enrollment confirmation notice is RESCINDED.

The March 2, 2017 enrollment notice is AFFIRMED.

Effective Date of this Decision: July 24, 2017

How this Decision Affects Your Eligibility

Your eligibility for Medicaid and your enrollment in your Medicaid Managed Care plan began on February 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
  Albany, NY 12211

- By fax: 1-855-900-5557

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).

Summary

The January 20, 2017 eligibility determination notice is RESCINDED.

The January 20, 2017 enrollment confirmation notice is RESCINDED.

The March 2, 2017 enrollment notice is AFFIRMED.

Your eligibility for Medicaid and your enrollment in your Medicaid Managed Care plan began on February 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:

[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 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.

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