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

NOTICE OF DISMISSAL

Decision Date: June 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015428

[redacted]

Dear [redacted],

On April 26, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 18, 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).

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

Decision

Decision Date: June 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015428

[redacted]

Issue

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

> Does NY State of Health (NYSOH) have the authority to determine whether you were properly auto-enrolled in a Medicaid Managed Care plan, rather than eligible to remain enrolled in Medicaid fee-for-service coverage, effective February 1, 2017?

Procedural History

On December 6, 2016, NYSOH issued an eligibility determination notice based on an application received as of December 5, 2016. The notice stated that you remained eligible for Medicaid, effective December 1, 2016. The notice also advised you to select a Medicaid Managed Care (MMC) plan, and if you did not choose one, one would be chosen for you.

On January 12, 2017, NYSOH issued an enrollment notice confirming your enrollment in an MMC plan as of January 11, 2017. The notice stated that your MMC plan coverage would begin effective February 1, 2017.

On January 17, 2017, NYSOH received a revised application for health insurance.

On January 18, 2017, NYSOH issued an eligibility determination notice stating that you were no longer eligible for Medicaid; however, your Medicaid coverage would remain in effect until February 28, 2017. This was because certain individual who qualified for Medicaid get coverage for 12 continuous months from

the date they were last determined eligible. This eligibility determination was effective January 1, 2017.

On January 28, 2017, NYSOH received a revised application for health insurance.

On January 29, 2017, NYSOH issued an eligibility determination based on the information contained in the January 28, 2017 application. The notice stated that you were eligible for Medicaid, effective March 1, 2017. The notice also advised you to select an MMC plan, and if you did not choose one, one would be chosen for you.

On February 1, 2017, NYSOH received a revised application in which you attested that you were not seeking financial assistance. In response to this application, NYSOH prepared a preliminary eligibility determination stating that you were eligible to enroll in a qualified health plan (QHP) at full cost.

Also on February 1, 2017, NYSOH received a further revised application in which you attested that you were seeking financial assistance. In response to this application, NYSOH prepared a preliminary eligibility determination stating that you were eligible for Medicaid, effective March 1, 2017

Finally, on February 1, 2017, you spoke to NYSOH's Account Review Unit and appealed your enrollment in an MMC during February 2017 insofar as you were seeking to remain enrolled in Medicaid fee-for-service coverage during that month and thereafter.

On February 2, 2017, NYSOH issued an eligibility redetermination notice stating that you were eligible for Medicaid, effective March 1, 2016. The notice also advised you to select an MMC plan, and if you did not choose one, one would be chosen for you.

On March 12, 2017, NYSOH issued an enrollment notice confirming your enrollment in an MMC plan as of March 11, 2016. The notice stated that your MMC plan coverage would begin effective April 1, 2017.

On April 26, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing closed at the end of the hearing.

Findings of Fact

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

1) You were found eligible for Medicaid, effective January 1, 2017.

2) You were auto-enrolled in an MMC plan as of January 11, 2017, and your MMC plan coverage started effective February 1, 2017.

3) You testified that you were instructed by a NYSOH representative to switch your application type from seeking financial assistance to one in which you were not seeking financial assistance, to force your disenrollment from your MMC plan effective February 28, 2017.

4) After your initial revision to your application on February 1, 2017, you were found eligible to enroll in a QHP at full cost effective March 1, 2017. Accordingly, your MMC plan coverage ended effective February 28, 2017.

5) You further testified that you were instructed by a NYSOH representative to switch your application to seeking financial assistance after you had been disenrolled from your MMC plan.

6) You submitted an additional application on February 1, 2017, in which you were seeking financial assistance. You were found eligible for Medicaid, effective March 1, 2017, and were enrolled in Medicaid fee-for-service coverage effective March 1, 2017.

7) You testified that you were seeking to be removed from your MMC plan and remain enrolled in Medicaid fee-for-service coverage during the month of February 2017 and through the rest of the year.

8) You testified that you were seeking to be removed from your MMC plan, and remain enrolled in Medicaid fee-for-service, because the only Medicaid plan your doctors located in [redacted] and [redacted] mutually accepted was 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

Valid Appeal Requests

An applicant has the right to appeal to the Appeals Unit of NYSOH: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) a failure by NYSOH to provide timely notice of an eligibility determination 45 CFR § 155.505; and (4) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by the Marketplace (45 CFR § 155.520(b)(2); 18 NYCRR § 358-3.5(b)(1)).

Legal Analysis

The issue under review is whether NYSOH has the authority to determine whether you were properly auto-enrolled in a MMC plan, rather than eligible to remain enrolled in Medicaid fee-for-service coverage, effective February 1, 2017.

The record reflects that after updating your application on December 5, 2016, NYSOH found that you remained eligible for Medicaid, effective December 1, 2016. An eligibility determination notice issued on December 6, 2016 stated that in addition to you having been found eligible for Medicaid, you would need to select an MMC plan, and if you did not choose one, one would be chosen for you.

The record further reflects that on January 11, 2017, you were auto-enrolled in an MMC plan, with coverage to begin effective February 1, 2017.

On February 1, 2017, you submitted two separate applications: one in which you were seeking financial assistance, and one in which you were not seeking financial assistance. The result of these changes to your application caused a temporary disenrollment of your MMC plan, effective February 28, 2017.

The record reflects that you were subsequently found eligible for Medicaid, and auto-enrolled in an MMC effective April 1, 2017.

You testified that you were seeking to retroactively terminate your MMC plan coverage to February 1, 2017, and to remain enrolled in Medicaid fee-for-service coverage for the remainder of 2017.

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) a failure by the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (4) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

According to NYSOH's records, your appeal was filed to dispute NYSOH's having enrolled you in an MMC plan once you had been found eligible for Medicaid. However, the Appeals Unit of NYSOH has no authority to waive any requirement for an individual to enroll in an MMC plan; only the Office of

Temporary and Disability Assistance (OTDA) is authorized to grant a request to opt out of this requirement.

Accordingly, your appeal of the January 18, 2017 enrollment notice is DISMISSED.

Decision

Your appeal of the January 18, 2017 enrollment notice is DISMISSED as unappealable through NYSOH.

Effective Date of this Decision: June 13, 2017

How this Decision Affects Your Eligibility

This does not change your current eligibility through NYSOH.

However, you may request to opt out of the requirement that your child enroll in a Medicaid Managed Care plan through ODTA. To make such a request through OTDA, you can call 800-342-3334 to speak with a customer service representative, send a written request by fax to 518-473-6735, or visit the OTDA website and fill out an electronic form at http://otda.ny.gov/hearings.

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

Your appeal of the January 18, 2017 enrollment notice is DISMISSED as unappealable through NYSOH.

This does not change your current eligibility through NYSOH.

However, you may request to opt out of the requirement that your child enroll in a Medicaid Managed Care plan through ODTA. To make such a request through OTDA, you can call 800-342-3334 to speak with a customer service representative, send a written request by fax to 518-473-6735, or visit the OTDA website and fill out an electronic form at http://otda.ny.gov/hearings.

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Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

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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।

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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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