



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

Notice of Decision

Decision Date: July 6, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000016971

[REDACTED]

Dear [REDACTED],

On June 30, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 27, 2016 plan disenrollment notice, and March 18, 2017 plan 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: July 6, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000016971

[REDACTED]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

Was your appeal of NY State of Health's October 27, 2016 plan disenrollment notice timely?

Did NY State of Health properly determine that your child's enrollment in his Medicaid Managed Care plan ended September 30, 2016?

Procedural History

On July 2, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination, based on your July 1, 2016 application, stating that your child was eligible for Medicaid, for a limited time, effective July 1, 2016. This notice directed you to submit your child's social security number, and proof of [REDACTED] citizenship by September 29, 2016.

Also on July 2, 2016, NYSOH issued a plan enrollment notice confirming your child was enrolled in a Medicaid Managed Care plan, and that [REDACTED] coverage would start on August 1, 2016.

On October 27, 2016, NYSOH issued a plan disenrollment notice stating that your child was disenrolled from [REDACTED] Medicaid Managed Care plan, effective September 30, 2016. This notice stated that this was because your child had other full benefit health insurance or Medicare.

On February 28, 2017, you uploaded a one- page document to your NYSOH account.

On March 17, 2017, an updated application for health insurance was submitted on your behalf. That day a preliminary eligibility determination was issued stating that your child remained eligible for Medicaid, effective March 1, 2017. Your child was also enrolled into a Medicaid Managed Care plan that day with a start date of May 1, 2017.

Also on March 17, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your child's enrollment in a Medicaid Managed Care plan, insofar as it did not begin October 1, 2016.

On March 18, 2017, NYSOH issued an eligibility determination, based on your March 17, 2017 application, stating that your child remained eligible for Medicaid, effective March 1, 2017.

Also on March 18, 2017, NYSOH issued a plan enrollment notice, based on your March 17, 2017 plan selection, confirming your child's enrollment in [REDACTED] Medicaid Managed Care plan, effective May 1, 2017.

On June 30, 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 added your newborn child to your account on July 1, 2016, and an application was run for financial assistance.
- 2) You testified, and the record reflects, that you selected your child's Medicaid Managed Care Plan on July 1, 2016, and that your child's enrollment was effective on August 1, 2016.
- 3) You testified, and the record reflects, that your child was disenrolled from [REDACTED] Medicaid Managed Care plan on September 30, 2016 because NYSOH stated that [REDACTED] had other full benefit health insurance.
- 4) You testified that you were told by NYSOH to get a letter from your [REDACTED] health insurance company stating that your child was never on [REDACTED] policy, and that your child's coverage would be backdated.

- 5) You testified that it took you some time to receive the letter from your [REDACTED] health insurance company because the health insurance company only issued the letter after several attempts of you requesting it.
- 6) On February 28, 2017, you uploaded a letter to your NYSOH account from your [REDACTED] health insurance company stating that your child has never been added as an active dependent on your [REDACTED] health insurance policy.
- 7) You testified that your child has never had health insurance through any other provider, except [REDACTED] Medicaid coverage through NYSOH.
- 8) You testified, and the record reflects, that you reenrolled your child into a Medicaid Managed Care Plan on March 17, 2017, and that [REDACTED] enrollment was effective on May 1, 2017.
- 9) You testified that you want your child's Medicaid Managed Care plan to begin on October 1, 2016 because [REDACTED] doctor does not accept straight Medicaid and [REDACTED] has unpaid medical bills from the months [REDACTED] was disenrolled from [REDACTED] Medicaid Managed Care plan.

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 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) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) 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 NYSOH (45 CFR 155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

Medicaid

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

Medicaid and 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 first issue under review is whether your appeal of NYSOH's October 27, 2016 plan disenrollment notice was timely.

The record reflects that you first contacted NYSOH to file a complaint about the termination of your child's Medicaid Managed Care plan on March 17, 2017. The record indicates that a formal appeal was filed on that day.

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of the termination of your child's Medicaid Managed Care Plan as stated in the October 27, 2016 plan disenrollment notice, an appeal should have been filed on or around December 26, 2016. The record reflects that your appeal was filed on March 17, 2017, which is well beyond the 60-day deadline.

However, you testified that you had contacted NYSOH before filing the appeal and after receiving the October 27, 2016 plan disenrollment notice and were told that if you submitted a letter from your [REDACTED] health insurance company stating

that your [REDACTED] was never added to [REDACTED] policy that your child's coverage would be backdated. You further testified that it took you some time to get a letter from your [REDACTED] health insurance company because the representatives told you that they would submit a request, but were unsure if a letter stating that your child was never on your [REDACTED] insurance could be issued. It wasn't until you were told by NYSOH that it would not be backdated that you filed the appeal.

It is reasonable to infer that you filed your appeal within a reasonably short time of learning that your child's coverage would not be backdated. Therefore, your appeal was timely filed.

The second issue is whether NYSOH properly determined that your child's enrollment in [REDACTED] Medicaid Managed Care plan ended effective September 30, 2016.

The record reflects that you added your newborn child to your NYSOH account on July 1, 2016, and [REDACTED] was determined eligible for Medicaid, effective July 1, 2017. On July 1, 2016, you also enrolled your child into a Medicaid Managed Care plan, effective August 1, 2016.

On October 27, 2016, NYSOH issued a plan disenrollment notice stating that your child was disenrolled from [REDACTED] Medicaid Managed Care plan, effective September 30, 2016. This notice stated that this was because your child had other full benefit health insurance or Medicare.

On February 28, 2017, you uploaded a letter from your [REDACTED] health insurance company which stated that your child was never added as an active dependent on your [REDACTED] health insurance policy.

Generally, when an individual is eligible for Medicaid through NYSOH they are required to enroll in a Medicaid Managed Care plan. However, when a person has active coverage in a health insurance plan outside of NYSOH, they are not eligible to enroll in a Medicaid Managed Care plan.

You testified, and submitted supporting documentation, that your child has never had any other health insurance coverage, except for [REDACTED] Medicaid coverage through NYSOH.

As noted above, your child was disenrolled from [REDACTED] Medicaid Managed Care plan, effective September 30, 2016 due to there being third-party health information on [REDACTED] account. However, the record reflects that this was in error, and your child should have never been disenrolled from [REDACTED] Medicaid Managed Care plan.

Therefore, the October 27, 2016 plan disenrollment notice was issued in error and must be RESCINDED.

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).

Your case is being RETURNED to NYSOH to enroll your child back into his Medicaid Managed Care plan as of October 1, 2016, and to notify you accordingly.

Since your child should have never been disenrolled from [REDACTED] Medicaid Managed Care plan; therefore, the March 18, 2017 enrollment confirmation notice stating that your child's enrollment in [REDACTED] Medicaid Managed Care plan would be effective May 1, 2017, is MODIFIED to stated that your child's enrollment in [REDACTED] Medicaid Managed Care plan would be effective October 1, 2016.

Decision

The October 27, 2016 plan disenrollment notice is RESCINDED.

Your case is being RETURNED to NYSOH to enroll your child back into [REDACTED] Medicaid Managed Care plan as of October 1, 2016, and to notify you accordingly.

The March 18, 2017 plan enrollment notice is MODIFIED to stated that your child's enrollment in [REDACTED] Medicaid Managed Care plan would be effective October 1, 2016.

Effective Date of this Decision: July 6, 2017

How this Decision Affects Your Eligibility

NYSOH improperly terminated your child's enrollment in a Medicaid Managed Care plan.

Your child will be reenrolled into [REDACTED] Medicaid Managed Care plan as of October 1, 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

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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 27, 2016 plan disenrollment notice is **RESCINDED**.

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).

NYSOH improperly terminated your child's enrollment in a Medicaid Managed Care plan.

Your case is being RETURNED to NYSOH to enroll your child back into [REDACTED] Medicaid Managed Care plan as of October 1, 2016, and to notify you accordingly.

The March 18, 2017 plan enrollment notice is MODIFIED to stated that your child's enrollment in [REDACTED] Medicaid Managed Care plan would be effective October 1, 2016.

Your child will be reenrolled into [REDACTED] Medicaid Managed Care plan as of October 1, 2016.

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 مجاناً.

বাংলা (Bengali)

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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 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. y&b&tumi 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.

שׂוֹדִיִּשׁ (Yiddish)

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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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