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

Notice of Decision

Decision Date: August 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017478

[redacted]

Dear [redacted]

On July 17, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 25, 2017 disenrollment notice, March 25, 2017 eligibility redetermination notice and March 30, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: August 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017478

[redacted]

Issue

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

> Did NY State of Health (NYSOH) properly determine that your enrollment in your Medicaid Managed Care plan was effective May 1, 2017?

Procedural History

On October 25, 2016, NYSOH issued a notice of eligibility determination, based on your October 24, 2016 application, stating that you were eligible for Medicaid, effective October 1, 2016.

Also on October 25, 2016, NYSOH issued a notice of enrollment in the plan you selected on October 24, 2016, stating that you were enrolled in a Medicaid Managed Care plan, and that your coverage would start on December 1, 2016.

On March 24, 2017, NYSOH redetermined your eligibility.

On March 25, 2017, NYSOH issued an eligibility redetermination notice stating that you were not eligible for Medicaid, Child Health Plus, the Essential Plan, to receive advance premium tax credits or to purchase a qualified health plan through NYSOH because you had Medicaid coverage through your local Department of Social Services.

Also, on March 25, 2017, NYSOH issued a notice of disenrollment stating that your Medicaid Managed Care plan coverage would end effective March 31, 2017.

On March 29, 2017, you updated your NYSOH application and were determined eligible for Medicaid, effective April 1, 2017. Also on that date, you selected a plan for enrollment in a Medicaid Managed Care plan.

Also, on March 29, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your enrollment in your Medicaid Managed Care plan, insofar as it began on May 1, 2017 and not on April 1, 2017.

On March 30, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective April 1, 2017.

Also on March 30, 2017, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in a Medicaid Managed Care plan, effective May 1, 2017.

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 submitted an application to NYSOH for financial assistance on October 24, 2016.

2) You were determined eligible for Medicaid, effective October 1, 2016.

3) You selected a Medicaid Managed Care plan on October 24, 2016, and was enrolled in a Medicaid Managed Care plan, effective December 1, 2016.

4) In your NYSOH account under "Account Notes" on March 24, 2017, it states "Did a LSC and marked [redacted] as not applying due to [redacted] request – has coverage with LDSS under [redacted]

5) Based on the March 24, 2017 actions taken by NYSOH, you were determined no longer eligible for enrollment in your Medicaid Managed Care plan, effective March 31, 2017, due to NYSOH making a determination that you had Medicaid coverage through the local Department of Social Services.

6) There is no evidence in your NYSOH account or otherwise that indicates during March 2017 that you had Medicaid coverage through a local Department of Social Services.

7) On March 25, 2017, NYSOH issued an eligibility determination stating that you were not eligible for health insurance through NYSOH because you had Medicaid coverage through a local Department of Social Services.

8) You were disenrolled from your Medicaid Managed Care plan, effective March 31, 2017.

9) On March 29, 2017, you updated your NYSOH application and were determined eligible for Medicaid, effective April 1, 2017.

10) Also on March 29, 2017, you selected a plan for enrollment in a Medicaid Managed Care plan.

11) On March 30, 2017, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in a Medicaid Managed Care plan, effective May 1, 2017.

12) You testified that you had Medicaid Fee-for-Service coverage from NYSOH during April 2017.

13) You testified that you were incorrectly disenrolled from your Medicaid Managed Care plan, effective March 31, 2017.

14) You testified that you did not believe that you had Medicaid coverage through a local Department of Social Services during April or May 2017.

15) You testified that you want your Medicaid Managed Care plan to begin on April 1, 2017 because you incurred a medical bill during April 2017 which was not covered by Medicaid fee-for-Service.

16) You testified that beginning in June 2017 that you began receiving Medicaid coverage through the [redacted] Department of Social Services.

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

Legal Analysis

The issue is whether NYSOH properly determined that your enrollment in a Medicaid Managed Care plan was effective May 1, 2017.

You submitted an application to NYSOH for financial assistance on October 24, 2016 resulting in you being determined eligible for Medicaid, effective October 1, 2016. You selected a Medicaid Managed Care plan on October 24, 2016, and was enrolled in a Medicaid Managed Care plan, effective December 1, 2016.

On March 24, 2017, NYSOH determined that you were no longer eligible for enrollment in a Medicaid Managed Care plan, effective March 31, 2017, due to NYSOH finding that you had Medicaid coverage through the local Department of Social Services. However, there is no evidence in your NYSOH account or otherwise that indicates during March 2017 that you had Medicaid coverage through a local Department of Social Services. You testified that you did not believe that you had Medicaid coverage through a local Department of Social Services during April 2017 or May 2017.

As there is no evidence that you were enrolled in Medicaid coverage through a local Department of Social services during March 2017, you should not have been disenrolled from your Medicaid Managed Care plan, effective March 31, 2017.

Subsequently, on March 29, 2017, you updated your NYSOH application and were determined eligible for Medicaid, effective April 1, 2017. Also on that date you selected a plan for enrollment in a Medicaid Managed Care plan and on March 30, 2017, NYSOH issued a notice of enrollment confirmation stating that

you were enrolled in a Medicaid Managed Care plan, effective May 1, 2017. You testified that you want your Medicaid Managed Care plan to begin on April 1, 2017 because you incurred a medical bill during April 2017 which was not covered by Medicaid fee-for-Service.

As stated above, you were incorrectly disenrolled from your Medicaid Managed Care Plan, effective March 31, 2017. There is no indication in the records of NYSOH or otherwise reflecting that you had Medicaid coverage through a local Department of Social Services.

Therefore, the March 30, 2017 enrollment confirmation notice stating that your enrollment in your Medicaid Managed Care plan would be effective May 1, 2017, was incorrect and is RESCINDED. Accordingly, the March 25, 2017 eligibility redetermination and disenrollment notices are also RESCINDED. Your case is being RETURNED to NYSOH to reinstate your coverage in your Medicaid Managed Care plan for the month of April 2017.

Decision

The March 25, 2017 disenrollment notice is RESCINDED.

The March 25, 2017 eligibility redetermination notice is RESCINDED.

The March 30, 2017 enrollment confirmation notice is RESCINDED.

Your case is being RETURNED to NYSOH to reinstate your coverage in your Medicaid Managed Care plan for the month of April 2017.

Effective Date of this Decision: August 24, 2017

How this Decision Affects Your Eligibility

Your case is being RETURNED to NYSOH to reinstate your coverage in your Medicaid Managed Care plan for the month of April 2017.

The effective date of your Medicaid Managed Care plan is April 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.

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).

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):

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- 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

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Summary

The March 25, 2017 disenrollment notice is RESCINDED.

The March 25, 2017 eligibility redetermination notice is RESCINDED.

The March 30, 2017 enrollment confirmation notice is RESCINDED.

Your case is being RETURNED to NYSOH to reinstate your coverage in your Medicaid Managed Care plan for the month of April 2017.

The effective date of your Medicaid Managed Care plan is April 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)

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).

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।

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 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 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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