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

# NOTICE OF DISMISSAL – INVALID APPEAL REQUEST

Notice Date: August 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017857

[redacted]

Dear [redacted]

On November 25, 2014, NY State of Health (NYSOH) received your updated application for financial assistance with insurance indicating that you were pregnant and expecting one child with a due date of [redacted].

On November 26, 2014, you uploaded two documents to your NYSOH account.

On November 27, 2014, NYSOH issued an eligibility determination stating, in part, that you were conditionally eligible for Medicaid, effective November 1, 2014. This notice also directed you to submit income documentation by December 12, 2014.

On December 1, 2014, NYSOH validated your income documentation and an updated application was submitted on your behalf.

On December 2, 2014, NYSOH issued an eligibility determination stating, in part, that you remained eligible for Medicaid, effective December 1, 2014. This notice further directed you to select a health plan for enrollment.

On December 9, 2014, NYSOH issued a plan enrollment notice, based on your December 3, 2014 plan selection, confirming your enrollment in a Medicaid Managed Care plan, effective January 1, 2015.

On June 4, 2015, the system ran an updated application for financial assistance on your family's behalf.

On June 6, 2015, NYSOH issued a plan disenrollment notice stating that your coverage in your Medicaid Managed Care plan would end effective June 30, 2015.

On June 10, 2015, you added your newborn child to your NYSOH account and submitted an updated application for financial assistance with health insurance. That application was also updated to include your employer sponsored health insurance information.

On April 7, 2017, you filed an appeal. The appeal notes dated April 7, 2017 stated that the reason for your appeal was the denial of retroactive Medicaid benefits for the month of June 2015 (See Incident [redacted]).

On August 15, 2017 you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. You testified that you filed the appeal because you would like your Medicaid Managed Care plan coverage to be retroactively terminated for the months that you had third party health insurance, and you would like your account to reflect that you had fee-for-service Medicaid during that time, specifically for the month of June 2015.

You testified that you were pregnant and [redacted]. The medical bills you incurred during the month of June 2015 were all paid through your Medicaid Managed Care plan; however, you testified that in early April 2017 you started to receive medical bills from your doctor's office for services rendered in June 2015. You testified that after calling the insurance company, you were told that your Medicaid Managed Care plan had retroactively revoked payments for services that were provided to you during the time that you had third party health insurance.

Therefore, through this appeal you are seeking your NYSOH account to reflect that you had fee-for-service Medicaid and not your Medicaid Managed Care plan so that your doctor's office can bill fee-for-service Medicaid as your secondary insurance for services rendered during the month of June 2015.

## Why Your Appeal Request Is Not Valid

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 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)).

After hearing your testimony, your appeal was requested to dispute what type of Medicaid coverage you were eligible for in the month of June 2015. You testified that you are requesting that your account be updated to reflect that you were ineligible for a Medicaid Managed Care plan, and eligible for fee-for-service Medicaid in June 2015. This issue relates to what type of Medicaid coverage you were entitled to, which is not an issue that NYSOH's Appeals Unit is authorized to address. Therefore, NYSOH's Appeals Unit must dismiss your appeal.

However, we will REFER your case to NYSOH's Application Support for review of the billing issues that have occurred on your account due to being enrolled into third party health insurance and a Medicaid Managed Care plan during the month of June 2015.

Additionally, you may have appeal options through the Office of Temporary and Disability Assistance (ODTA). You can contact OTDA and request a fair hearing:

Online: https://errswebnet.otda.ny.gov/errswebnet/erequestform.aspx

By Mail: NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
P.O. Box 1930
Albany, NY 12201-1930

By Fax: 518-473-6735

By Phone: 1 (800) 342-3334

## How does this Dismissal Affect Your Eligibility?

This Decision does not affect your current eligibility.

Your case has been REFERRED to NYSOH's Application Support for review of the billing issues that have occurred on your account due to being enrolled in third party health insurance and a Medicaid Managed Care plan during the same time frame.

You may have additional options outside of NYSOH's Appeals Unit, such as through your local Department of Social Service office.

## If You Think Your Appeal Should Not Be Dismissed

If you think your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. In that writing, you must explain why you think this dismissal should be vacated and if your issue differs from the one discussed above.

If you ask us in writing to vacate this dismissal, NYSOH's Appeals Unit will review your request and send you a decision on that request.

If we deny your request to vacate this dismissal, we will tell you that in writing.

If you do not respond to this notice within 30 days, your appeal will remain dismissed. No further action will be taken on it by NYSOH.

## Appeal Identification Number

When communicating with NYSOH about this appeal, please reference Appeal Identification Number and the Account ID at the top of this notice.

## How to Contact NYSOH

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

## Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.530.

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).

## A Copy of this Notice of Dismissal 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 1-855-355-5777번으로 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.

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).

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।

**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.

**(Urdu)**اردو

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۔

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**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.