



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

NOTICE OF DISMISSAL – INVALID APPEAL REQUEST

Notice Date: October 5, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000019643

[REDACTED]

Dear [REDACTED]

On February 8, 2017, an application for financial assistance was submitted to NY State of Health (NYSOH).

On February 25, 2017, NYSOH issued an eligibility determination notice stating that your youngest child remained eligible for Medicaid, effective February 1, 2017.

Also on February 25, 2017, NYSOH issued a plan enrollment notice stating that your youngest child was enrolled in a Medicaid Managed Care plan, effective April 1, 2017.

On June 8, 2017, you and your domestic partner (your youngest child's mother) contacted NYSOH and filed an appeal insofar as your youngest child was required to enroll in a Medicaid Managed Care plan.

On September 8, 2017, during your telephone hearing with a Hearing Officer from NYSOH's Appeals Unit, you authorized your domestic partner to appear on your behalf. Your domestic partner testified that she was disputing your youngest child's enrollment because, at the time she enrolled him, she was not aware that many of his medical services were not covered through his Medicaid Managed Care plan. She requested, instead, that your youngest child be enrolled in fee-for-service Medicaid so that his medical services could be covered.

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).

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) 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)).

According to NYSOH's records, your appeal was filed to dispute your youngest child's enrollment in a Medicaid Managed Care plan once he was redetermined eligible for Medicaid.

However, the Appeals Unit of NYSOH has no authority to waive any requirement for an individual to enroll in a Medicaid Managed Care plan; only the Office of Temporary and Disability Assistance (OTDA) is authorized to grant a request to opt out of this requirement.

How does this Dismissal Affect Your Eligibility?

This decision does not change your youngest child's 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 OTDA. 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 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.

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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.

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A Copy of this Notice of Dismissal Has Been Provided To



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