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

Notice of Decision

Decision Date: November 7, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021554

[redacted]

Dear [redacted],

On October 26, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 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 NY State of Health 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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Decision Date: November 7, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021554

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Issues

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

> Did NY State of Health (NYSOH) properly determine that your Medicaid Managed Care (MMC) plan had an enrollment start date of October 1, 2017?
>
> Whether you are eligible to be reimbursed for the medical expenses that were incurred in the months of May and June 2017?

Procedural History

On July 23, 2017, you submitted an application for financial assistance through NYSOH.

Also on July 23, 2017, you uploaded additional documentation to your account (*see* Documents [redacted]).

On July 24, 2017, NYSOH issued a notice stating that your July 23, 2017 application had been reviewed; however, the income information in your application did not match what NYSOH received from state and federal data sources. The notice directed you to submit proof of your current household income by August 7, 2017.

On July 25, 2017, NYSOH issued a notice stating that the documentation received did not confirm the information in your application. The notice directed you to submit additional income documentation by August 22, 2017.

On July 31, 2017, you uploaded additional documentation to your account (*see* Documents [redacted]; and [redacted] was uploaded on August 3, 2017).

On August 1, 2017, your NYSOH account was systemically updated.

On August 2, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid as of July 1, 2017.

On August 7, 2017, you updated your NYSOH account.

On August 8, 2017, NYSOH issued a notice stating that your July 23, 2017, application had been reviewed; however, the income information in your application did not match what NYSOH received from state and federal data sources. The notice directed you to submit proof of your current household income by August 22, 2017.

On August 9, 2017, you uploaded additional documentation to your NYSOH account (*see* Documents [redacted]).

Also on August 9, 2017, your NYSOH account was updated.

On August 10, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for a tax credit up to $233.00 per month, effective September 1, 2017.

On August 11, 2017, you uploaded additional documentation to your account (*see* Documents [redacted].

On August 12, 2017, NYSOH issued you an eligibility determination notice stating that you were eligible for Medicaid as of September 1, 2017.

On August 17, 2017, you spoke with NYSOH's Account Review and requested an appeal relative to the enrollment start date of your MMC plan.

On August 18, 2017, NYSOH issued a plan enrollment notice confirming that as of August 17, 2017, you were enrolled in a MMC plan with an enrollment start date of October 1, 2017.

On September 15, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid from May 1, 2017, through June 30, 2017.

On October 26, 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 proceeding.

Findings of Fact

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

1) According to your NYSOH account and testimony, you are applying for health insurance for yourself.

2) You testified that you want your MMC plan to have an enrollment start date of September 1, 2017, and Medicaid to cover your expenses in the months of May 2017 and June 2017.

3) According to your July 23, 2017 application, you indicated that you wanted help paying for medical bills from the last three months.

4) On August 2, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid without any conditions, effective July 1, 2017 (*see* Document [redacted]).

5) According to your NYSOH account: (1) on August 7, 2017, your eligibility could not be determined, and (2) on August 9, 2017, you were determined eligible to receive tax credits.

6) You testified that you contacted NYSOH on August 10, 2017, and informed the representative that you wanted to enroll in the Fidelis Care MMC plan. The representative stated that they would make a note in your file.

7) According to your NYSOH account, you were enrolled in a MMC plan on August 17, 2017.

8) On September 15, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid from May 1, 2017, through June 30, 2017 (*see* Document [redacted]).

9) You testified that you submitted proof of medical expenses from May 2017 and June 2017 to NYSOH; however, on October 17, 2017, you were issued a notice stating that additional proof of payment was needed.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Medicaid Eligibility

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

Medicaid Continuous Coverage:

Most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, unless the adult loses Medicaid eligibility because of citizenship status, lack of state residence, or failure to provide a valid social security number, before the end of a twelve-month period. This twelve-month period is referred to as “continuous coverage,” and is set based on the start date of the original Medicaid eligibility determination or the date of a subsequent Medicaid eligibility determination based on modified adjusted gross income (*see* 42 CFR § 435.916(a); N.Y. Soc. Serv. Law § 366(4)(c)).

MMC Enrollment Start Date

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)).

Appealable Issues

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)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your MMC plan should have an enrollment start date of October 1, 2017.

On August 2, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid without any conditions, effective July 1, 2017 (*see* Document [redacted]).

Generally, once individuals are determined eligible for Medicaid, they are guaranteed 12 months of Medicaid coverage, even if the adult loses Medicaid eligibility because of any changes or updates they make to their NYSOH account. This twelve-month period is based on the effective date of the Medicaid eligibility determination and is known as “continuous coverage.”

The record reflects that your NYSOH account was updated on August 7, 2017, and August 9, 2017. Based on those updates, your NYSOH account no longer reflected that you were eligible for Medicaid. You credibly testified that you contacted NYSOH on August 10, 2017, and informed the representative that you wanted to enroll in the Fidelis Care MMC plan. However, on August 10, 2017, your NYSOH account reflected that you were eligible to receive tax credits.

Notwithstanding these updates, you were determined eligible for Medicaid as of July 1, 2017, such that you were entitled to remain in Medicaid for 12 continuous months, absent any disqualifying event; none of which pertain to you. Therefore, the August 10, 2017 eligibility determination notice is RESCINDED.

The date on which enrollment in a MMC plan can take effect depends on the day a person selects the plan for enrollment. A plan that is selected from the first day to and including the fifteenth day of a month will go into effect on the first day of the following month. A plan that is selected on or after the sixteenth day of the month will go into effect on the first day of the second following month.

The record supports that you selected a MMC plan on August 17, 2017. However, if your NYSOH account properly reflected that you were eligible for Medicaid on August 10, 2017, you would have been enrolled in a MMC plan as of that date.

Therefore, the August 18, 2017 plan enrollment notice is MODIFED to state that you were enrolled in a MMC plan with an enrollment state date of September 1, 2017.

The second issue under review is whether you are eligible to be reimbursed for the medical expenses that were incurred in the months of May 2017 and June 2017.

On September 15, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid from May 1, 2017, through June 30, 2017 (*see* Document [redacted]).

You testified that you submitted proof of medical expenses that were incurred in the months of May 2017and June 2017 to NYSOH; however, on October 17, 2017, you were issued a notice from NYSOH stating that additional proof of payment was needed.

NYSOH Appeals Unit only has the authority to review issues related to the following: (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 to provide timely notice of an eligibility determination and (5) a denial of a special enrollment period.

The Appeals Unit does not have the authority to review whether an individual should be reimbursed for specific medical expenses. We cannot reach the merits as to whether you are entitled to be reimbursed for those expenses. Therefore, your request for reimbursement for the medical expenses for the months of May and June 2017 is DISMISSED as a non-appealable issue.

Your case is REFERRED to New York State Department of Health, Office of Health Insurance Programs, Stakeholder Relations and Exchange Support to facilitate the possible reimbursement for the medical expenses that were incurred in the months of May 2017 and June 2017.

Decision

The August 10, 2017 eligibility determination notice is RESCINDED.

The August 18, 2017 plan enrollment notice is MODIFED to state that you were enrolled in a MMC plan with an enrollment state date of September 1, 2017.

The issue regarding the reimbursement for the medical expenses for the months of May and June 2017 is DISMISSED as a non-appealable issue.

Your case is REFERRED to New York State Department of Health, Office of Health Insurance Programs, Stakeholder Relations and Exchange Support to investigate and facilitate the possible reimbursement for the medical expenses that were incurred in the months of May 2017 and June 2017.

Effective Date of this Decision: November 7, 2017

How this Decision Affects Your Eligibility

You were entitled to 12 months of continuous Medicaid coverage as of July 1, 2017.

Your case is being sent back to NYSOH to effectuate your MMC plan enrollment start date to September 1, 2017. NYSOH will notify you once this has been done.

Any issues regarding reimbursement of medical expenses incurred in May 2017 and June 2017 are not properly before NYSOH's Appeals Unit. However, in this regard, your case is being referred to New York State Department of Health, Office of Health Insurance Programs, Stakeholder Relations and Exchange Support to investigate and facilitate the possible reimbursement of those medical expenses.

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 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).

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 August 10, 2017 eligibility determination notice is RESCINDED.

The August 18, 2017 plan enrollment notice is MODIFED to state that you were enrolled in a MMC plan with an enrollment state date of September 1, 2017.

The issue regarding the reimbursement for the medical expenses for the months of May and June 2017 is DISMISSED as a non-appealable issue.

Your case is REFERRED to New York State Department of Health, Office of Health Insurance Programs, Stakeholder Relations and Exchange Support to investigate and facilitate the possible reimbursement for the medical expenses that were incurred in the months of May 2017 and June 2017.

You were entitled to 12 months of continuous Medicaid coverage as of July 1, 2017.

Your case is being sent back to NYSOH to effectuate your MMC plan enrollment start date to September 1, 2017. NYSOH will notify you once this has been done.

Any issues regarding reimbursement of medical expenses incurred in May 2017 and June 2017 are not properly before NYSOH's Appeals Unit. However, in this regard, your case is being referred to New York State Department of Health, Office of Health Insurance Programs, Stakeholder Relations and Exchange

Support to investigate and facilitate the possible reimbursement of those medical expenses.

Legal Authority

We are sending you this notice in accordance with 45 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).

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.

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 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.

(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۔

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.

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).

(Yiddish) אידיש

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.

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).