



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

## Notice of Decision

Decision Date: December 08, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000022070

[REDACTED]

[REDACTED]

On November 8, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 17, 2017 discontinuance and disenrollment notices, and the September 2, 2017 eligibility determination and enrollment notices.

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.

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## Decision

Decision Date: December 08, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000022070

[REDACTED]

## 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 eligibility for and enrollment in your Medicaid Managed Care plan ended as of August 31, 2017?

Did NYSOH properly determine that your eligibility for and enrollment in your Essential Plan was effective October 1, 2017?

## Procedural History

On September 13, 2016, NYSOH received your application for financial assistance with health insurance.

On September 14, 2016, NYSOH issued an eligibility determination notice, based on your September 13, 2016 application, stating that you were eligible for Medicaid, effective September 1, 2016.

Also on September 14, 2016, NYSOH issued an enrollment confirmation notice, confirming your selection of a Medicaid Managed Care plan, with an enrollment start date of October 1, 2016.

On July 2, 2017, NYSOH issued a notice that it was time to renew your health insurance for the upcoming coverage year. That notice stated that based on information from federal and state sources, NYSOH could not make a decision about whether you would qualify for financial help paying for your health

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coverage, and that you needed to update your account by August 15, 2017 or you might lose the financial assistance you were currently receiving.

No updates were received by August 15, 2017 and NYSOH redetermined your eligibility for financial assistance with health insurance.

On August 17, 2017, NYSOH issued a discontinuance notice stating that effective September 1, 2017, you were no longer eligible for health insurance through NYSOH because you did not respond to the renewal notice and did not complete your renewal within the required time frame.

Also on August 17, 2017, NYSOH issued a disenrollment notice stating that your enrollment in your Medicaid Managed Care plan would end effective August 31, 2017 because you were no longer eligible to enroll in health insurance through NYSOH.

On September 1, 2017, NYSOH received your updated application for health insurance. That day, a preliminary eligibility determination was prepared stating that you were eligible for the Essential Plan and you had selected a plan for enrollment.

Also on September 1, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your Essential Plan, insofar as you were not covered for the month of September 2017.

On September 2, 2017, NYSOH issued a notice of eligibility determination, stating that you were eligible to enroll in the Essential Plan, effective October 1, 2017.

Also on September 2, 2017, NYSOH issued an enrollment notice confirming your selection of your Essential Plan, with a plan enrollment start date of October 1, 2017.

On November 8, 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 were determined eligible for Medicaid effective September 1, 2016.
- 2) You testified that you receive your notices from NYSOH by regular mail.

- 3) You testified that you did not receive any notices in the mail telling you that you needed to update your application in order to renew your eligibility.
- 4) No notices sent to you at the mailing address listed on your NYSOH account have been returned as undeliverable.
- 5) You testified that you did not know that you needed to update your account until you received the cancellation notice.
- 6) The record reflects that on September 1, 2017 NYSOH received your updated application for health insurance.
- 7) You reenrolled into an Essential Plan on September 1, 2017.
- 8) You testified that you are seeking to have coverage for the month of September 2017.

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

## **Applicable Law and Regulations**

### Medicaid Renewal

In general, NYSOH must review Medicaid eligibility once every twelve months or “whenever it receives information about a change in a beneficiary’s circumstances that may affect eligibility” (42 CFR § 435.916(a)(1), (d)). NYSOH must make its “redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual’s account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency” (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates provided by the individual (45 CFR §155.335(h)).

### Essential Plan

For individuals seeking enrollment in an Essential Plan, New York State has elected to follow the same rules that NYSOH uses in determining effective dates

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for individuals seeking enrollment in qualified health plans (NY Social Services Law § 369-gg(4)(c); New York's Basic Health Plan Blueprint, p. 16, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/basic-health-program.html>).

The effective date of coverage by an Essential Plan is determined by the date on which an applicant selects a plan for enrollment. For individuals who are eligible for enrollment, NYSOH must generally ensure that coverage is effective the first day of the following month for selections received by NYSOH from the first to the fifteenth of any month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(i); see also 42 CFR § 600.320). For selections received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(ii)).

## **Legal Analysis**

The first issue under review is whether NYSOH properly determined that your eligibility for and enrollment in your Medicaid Managed Care plan terminated effective August 31, 2017.

You were originally found eligible for Medicaid effective September 1, 2016.

Generally, NYSOH must redetermine a qualified individual's eligibility for Medicaid once every 12 months without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency. NYSOH's July 2, 2017 renewal notice stated that there was not enough information to determine whether you were eligible to continue your financial assistance for health insurance, and that you needed to supply additional information by August 15, 2017, or your financial assistance might end.

Because there was no timely response to this notice, you were terminated from your Medicaid Managed Care plan effective August 31, 2017.

You testified that you did not receive any notice from NYSOH telling you that you needed to update the information in your NYSOH account. You testified, and your NYSOH account confirms, that you elected to receive notifications by regular mail. However, there is no evidence in the record that any of the notices that were sent to your mailing address were returned as undeliverable.

Therefore, the record reflects that NYSOH properly notified you of your annual renewal and that information in your NYSOH account needed to be updated in order to ensure your enrollment in your health plan and eligibility for financial assistance would continue.

Since your 12 months of Medicaid eligibility had expired and you were properly notified that you were required to renew your eligibility, the August 17, 2017 discontinuance and disenrollment notices finding you no longer eligible for Medicaid as of August 31, 2017 are AFFIRMED.

The second issue is whether NYSOH properly determined that your enrollment in the Essential Plan was effective as of October 1, 2017.

On September 1, 2017, you updated the information in your NYSOH account and submitted a request to enroll in an Essential Plan.

The date on which the Essential 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 goes into effect on the first day of the following month. A plan that is selected after the fifteenth day of a month goes into effect on the first day of the second following month.

Since you selected your Essential Plan on September 1, 2017, it must take effect on the first day of the following after September; that is, on October 1, 2017.

Therefore, NYSOH's September 2, 2017 eligibility determination notice and enrollment confirmation notice are AFFIRMED because they properly began your eligibility for and enrollment in the Essential Plan on October 1, 2017.

## **Decision**

The August 17, 2017 discontinuance notice is AFFIRMED.

The August 17, 2017 disenrollment notice is AFFIRMED.

The September 2, 2017 eligibility determination notice is AFFIRMED.

The September 2, 2017 enrollment confirmation notice is AFFIRMED.

**Effective Date of this Decision:** December 08, 2017

## **How this Decision Affects Your Eligibility**

This decision does not change your eligibility.

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 enrollment in your Medicaid Managed Care plan ended as of August 31, 2017.

The effective date of your Essential Plan is October 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.

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 fax: 1-855-900-5557

## **Summary**

The August 17, 2017 discontinuance notice is AFFIRMED.

The August 17, 2017 disenrollment notice is AFFIRMED.

Your enrollment in your Medicaid Managed Care plan ended as of August 31, 2017.

The September 2, 2017 eligibility determination notice is AFFIRMED.

The September 2, 2017 enrollment confirmation notice is AFFIRMED.

The effective date of your Essential Plan is October 1, 2017.

This decision does not change your eligibility.

## **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)

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।

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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. ye&btumi ama wo obi a okyerε 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.

## **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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