



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
PO Box 11729  
Albany, NY 12211

## Notice of Decision

Decision Date: December 14, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000022868



On November 22, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 28, 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  
PO 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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## Decision

Decision Date: December 14, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000022868

[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 children's enrollment in the UnitedHealthcare Medicaid Managed Care plan was effective November 1, 2017?

### Procedural History

On December 15, 2016, NYSOH issued a notice of eligibility determination, stating that your children were eligible to enroll in a Child Health Plus (CHP) plan, effective January 1, 2017.

On August 28, 2017, you updated your application for you and your children. In your application, you requested retroactive assistance with your own medical bills for the three months preceding your application.

On August 29, 2017, NYSOH issued a notice of eligibility determination, stating that your children were eligible for Medicaid, effective September 1, 2017. The notice also directed you to select a plan for yourself and your children.

Also on August 29, 2017, NYSOH issued a notice of eligibility determination, stating that you, [REDACTED] were eligible for retroactive Medicaid assistance for June 2017.

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Also on August 29, 2017, NYSOH issued a notice, stating that your children's coverage in their UnitedHealthcare Community Child Health Plus plan would end on August 31, 2017.

On August 30, 2017, NYSOH issued a notice of enrollment, stating that you had selected a Medicaid Managed Care plan for yourself, and that your coverage under that plan would start on October 1, 2017. The notice also advised you that you still needed to select a plan for your children, and that if you did not choose a plan, one would be chosen for you.

On September 12, 2017, NYSOH issued a notice of enrollment, stating that you and your children were enrolled in a Medicaid Managed Care plan through Healthfirst, effective October 1, 2017.

On September 27, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your children's enrollment in your preferred Medicaid Managed Care plan, UnitedHealthcare of New York, Inc., insofar as it did not begin on October 1, 2017.

Also on September 27, 2017, you changed your election for your children's Medicaid Managed Care plan, and on September 28, 2017, NYSOH issued a notice of enrollment, stating that your children's Medicaid Managed Care plan had been changed to UnitedHealthcare of New York, Inc., effective November 1, 2017.

On November 22, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit, after you waived your right to 15 days written notice of the hearing. The record was developed and closed at the end of the hearing.

## **Findings of Fact**

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

- 1) You updated your application for health insurance and financial assistance for your family on August 28, 2017. Your children had previously been eligible for coverage through Child Health Plus.
- 2) You and your children were found eligible for Medicaid, effective September 1, 2017, as documented in the notice of eligibility determination issued on August 29, 2017. You were advised to enroll your family in a plan; however, you selected a plan only for yourself.
- 3) In a notice issued on August 29, 2017, you were advised that your children's coverage through UnitedHealthcare would end effective August 31, 2017.

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- 4) A notice was sent to you on August 30, 2017, confirming that you had selected a Medicaid Managed Care Plan for yourself, which would be effective October 1, 2017, but that you had not selected a plan for your children.
- 5) On September 11, 2017, your children were automatically added to the Medicaid Managed Care plan you had previously selected for yourself, Healthfirst. On September 12, 2017, NYSOH issued a notice confirming this selection.
- 6) You testified that when you updated your application online yourself on August 28, 2017, you thought you were updating the application only for yourself. You thought that your children would remain enrolled in their Child Health Plus plan. You also testified that you knew your children could not be enrolled both in a Child Health Plus plan and a Medicaid Managed Care plan at the same time, which is why you did not select a plan for them.
- 7) You testified that you did not recall receiving any notice telling you that your children were being disenrolled from their Child Health Plus coverage, and that you think you might have received a notice directing you to pick a Medicaid Managed Care plan for your children.
- 8) You testified that you were first aware that your children had been enrolled in the Healthfirst Medicaid Managed Care plan when you received the confirmation of the enrollment. Your children's doctor did not accept that plan, and you have bills from September that have not been covered by fee-for-service Medicaid.
- 9) You first tried to correct your children's coverage around September 27, 2017, at which time you changed the enrollment to UnitedHealthcare, effective November 1, 2017.
- 10) In your appeal, you requested that coverage under your children's new Medicaid Managed Care plan, UnitedHealthcare, begin on October 1, 2017.

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 children's enrollment in the UnitedHealthcare Medicaid Managed Care plan was effective November 1, 2017.

The Appeals Unit finds that multiple notices were sent to you, advising you that you had to select a Medicaid Managed Care plan for your children, and that their coverage through Child Health Plus would end August 31, 2017.

You testified, and your account confirms, that you updated your application on August 28, 2017. Although you testified that you thought your children could remain enrolled in their Child Health Plus plan, you also testified that you did not select a Medicaid Managed Care plan for your children when you selected one for yourself, because you knew they could not be enrolled in both at the same time.

Given the numerous notices sent to you regarding the need to select a plan for your children, and your own testimony, the Appeals Unit finds that you were given proper notice of the need to select a plan and you failed to do so.

In any event, your children were eligible for Medicaid fee-for-service coverage effective September 1, 2017, and when you failed to select a Medicaid Managed Care plan for them, NYSOH enrolled your children in the same plan as you were enrolled in, with coverage effective October 1, 2017. You elected to change that coverage on September 27, 2017, and the change could not become effective until November 1, 2017.

Your children had some form of coverage at all times.

The date on which a Medicaid Managed Care 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.

On September 27, 2017, you selected a Medicaid Managed Care plan for your children, so it properly took effect on the first day of the second month following September 2017; that is, on November 1, 2017.

Therefore, the September 28, 2017 enrollment confirmation notice stating that your children's enrollment in the UnitedHealthcare Medicaid Managed Care plan would be effective November 1, 2017 was correct and must be AFFIRMED.

## **Decision**

The September 28, 2017 enrollment confirmation is AFFIRMED.

**Effective Date of this Decision:** December 14, 2017

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

This decision does not change your eligibility.

The effective date of your children's UnitedHealthcare Medicaid Managed Care plan is November 1, 2017.

## **If You Disagree with this Decision (Appeal Rights)**

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your appeal was decided, the 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):**

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  
PO Box 11729  
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- By fax: 1-855-900-5557

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## **Summary**

The September 28, 2017 enrollment confirmation is AFFIRMED.

This decision does not change your eligibility.

The effective date of your children's UnitedHealthcare Medicaid Managed Care plan is November 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:**



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. يمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

### **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 महत्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई महत 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 yε tow krataa a ho hia. Sε wo hia εho nkyerεkyerεmu a, yε sre wo, frε 1-855-355-5777. yεbεtumi ama wo obi a ɔkyerε 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)

דאָן איז אַויכטיגער דָּאָקְומָעָנט. אויב אַיר דָּאָרְפְּט הַילָּפָע עַס צָו פָּאָרְשְׁטִין, בִּיטָּע רְופָט 1-855-355-5777. מִיר קָעָנָען אַיְר גַּעַבְן אַדְלָמָעָטְשָׁר פֿרִי פֿון אַפְּצָאַל אַיְן דִּי שְׁפָרָאַךְ וְאַוְסָא אַיר רְעָדֶט.