



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

## Notice of Decision

Decision Date: November 24, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000018971 and AP000000022872

[REDACTED]

Dear [REDACTED],

On November 17, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's May 16, 2017 eligibility determination and September 21, 2017 plan 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.

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

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NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000018971 and AP000000022872

[REDACTED]

## Issues

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

Was your appeal of the NY State of Health's (NYSOH) May 16, 2017 eligibility determination notice timely?

Did NYSOH properly enroll your ward in a Medicaid Managed Care (MMC) plan with an enrollment start date of November 1, 2017?

## Procedural History

On May 15, 2017, you submitted an application for financial assistance through NYSOH.

On May 16, 2017, NYSOH issued an eligibility determination notice stating in relevant part that your ward was eligible for Child Health Plus with a \$0.00 monthly premium, effective June 1, 2017.

Also on May 16, 2017, NYSOH issued a plan enrollment notice confirming, in relevant part, that as of May 15, 2017, your ward was enrolled in a Child Health Plus plan with an enrollment start date of June 1, 2017.

On September 20, 2017, your NYSOH account was updated.

On September 21, 2017, NYSOH issued a plan enrollment notice confirming in relevant part that your ward was enrolled in an MMC plan with an enrollment start date of November 1, 2017.

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Also on September 21, 2017, NYSOH issued a disenrollment notice stating that your ward's coverage through Child Health Plus would end as of September 30, 2017.

On September 27, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal relative to: (1) the amount of financial assistance your ward was determined eligible to receive as of May 16, 2017; and (2) the enrollment start date of your ward's MMC plan.

On September 30, 2017, NYSOH issued an eligibility determination notice stating in relevant part that your ward was eligible for Medicaid, effective October 1, 2017.

On November 17, 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) According to your NYSOH account and testimony, you are the legal guardian of a [REDACTED] minor.
- 2) You testified that, on May 15, 2017, the NYSOH representative incorrectly included your income when calculating your ward's eligibility for financial assistance. Since your income was included, your ward was not determined eligible for Medicaid.
- 3) According to your NYSOH account, on May 16, 2017, your ward was determined eligible for Child Health Plus with a \$0.00 monthly premium.
- 4) According to your NYSOH account and testimony, you requested to appeal the May 16, 2017 eligibility determination on September 27, 2017.
- 5) You testified that your ward's orthodontist does not accept Child Health Plus. Therefore, you incurred medical bills in the month of August 2017.
- 6) According to your NYSOH account, your ward was enrolled in an MMC plan on September 20, 2017, with an enrollment start date of November 1, 2017.

- 7) You testified that you want your ward to be enrolled in an MMC plan as of August 1, 2017, to cover the medical expenses that were incurred in that month.

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

## **Applicable Law and Regulations**

### Valid Appeal Requests

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 NYSOH to provide timely notice of an eligibility determination; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505, 45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH (45 CFR § 155.520(b)(2); 18 NYCRR § 358-3.5(b)(1)).

### 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)).

## **Legal Analysis**

The first issue under review is whether your appeal of NYSOH's May 16, 2017, eligibility determination notice was timely.

Individual applicants and enrollees must request a hearing within sixty days of the date stated on the notice of eligibility determination.

On May 16, 2017, NYSOH issued notice stating that your ward was eligible for Child Health Plus with a \$0.00 monthly premium, effective as of June 1, 2017.

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).

The record reflects that you requested to appeal this eligibility determination on September 27, 2017.

For an appeal to be timely on the issue of NYSOH May 16, 2017, eligibility determination notice, an appeal requested should have been made before July 15, 2017. According to the credible evidence in the record, you did not contact NYSOH to file a complaint or appeal your ward's eligibility for financial assistance until September 27, 2017.

Since your request to appeal the May 16, 2017 eligibility determination notice was not timely, the appeal is DISMISSED.

The second issue under review is whether NYSOH properly enrolled your ward in an MMC plan with an enrollment start date of November 1, 2017.

The date on which 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 available record supports that your ward was enrolled in an MMC plan on September 20, 2017. Since the MMC plan was selected September 20, 2017, it properly took effect on the first day of the second following month; that is, November 1, 2017.

Therefore, the September 21, 2017 plan enrollment notice is AFFIRMED.

## **Decision**

Your appeal of the May 16, 2017 eligibility determination notice was untimely and therefore, is DISMISSED.

The September 21, 2017 plan enrollment notice is AFFIRMED.

**Effective Date of this Decision:** November 24, 2017

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

Your ward was enrolled in an MMC plan with an enrollment start date of November 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):**

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

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).

P.O. Box 11729  
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- By fax: 1-855-900-5557

## **Summary**

Your appeal of the May 16, 2017 eligibility determination notice was untimely and therefore, is DISMISSED.

The September 21, 2017 plan enrollment notice is AFFIRMED.

Your ward was enrolled in an MMC plan with an enrollment start date of November 1, 2017.

## **Legal Authority**

We are sending you this notice 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.

### **বাংলা (Bengali)**

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).

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 नि:शुल्क 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 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye bɛtumi ama wo obi a okyerɛ 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 דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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