



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

Notice of Decision

Decision Date: December 20, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000023057

[REDACTED]

Dear [REDACTED]

On December 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 28, 2017 eligibility determination notice and October 4, 2017 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
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(b).

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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DEPARTMENT OF HEALTH
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Decision

Decision Date: December 20, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000023057

[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 enrollment in a Medicaid Managed Care plan terminated effective July 31, 2017?

Did NYSOH properly determine that your enrollment in a Medicaid Managed Care resumed effective November 1, 2017?

Procedural History

On May 10, 2017, NY State of Health (NYSOH) issued an eligibility determination notice stating that you were eligible for Medicaid effective May 1, 2017.

Also on May 10, 2017, NYSOH issued an enrollment notice confirming your enrollment in a Medicaid Managed Care (MMC) plan, with a plan enrollment start date of June 1, 2017.

On June 27, 2017, NYSOH redetermined your household's eligibility for financial assistance with health insurance.

On June 28, 2017, NYSOH issued an eligibility redetermination notice stating that you would remain eligible for Medicaid, effective August 1, 2017, however, you were unable to select an MMC plan as the system was showing that you had other full benefit health insurance or Medicare.

On September 28, 2017, NYSOH received a facsimile containing a letter issued by [REDACTED], dated September 27, 2017, stating that that your health insurance coverage through [REDACTED] ended effective September 1, 2017.

On September 30, 2017, NYSOH redetermined your household's eligibility for financial assistance with health insurance.

On October 1, 2017, NYSOH issued an eligibility redetermination notice stating that you were eligible for Medicaid effective September 1, 2017.

On October 4, 2017, NYSOH issued an enrollment notice confirming your enrollment in an MMC plan as of October 3, 2017, with such coverage beginning November 1, 2017. You spoke to NYSOH's Account Review Unit and appealed the start date of your enrollment in your MMC plan, insofar as your enrollment did not begin September 1, 2017.

On December 14, 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 testified, and your account confirms, that you were determined eligible for Medicaid effective May 1, 2017
- 2) The record reflects that on May 9, 2017, you selected an MMC plan, with such coverage beginning June 1, 2017.
- 3) You testified, and your NYSOH account confirms, that on July 31, 2017 you were disenrolled from your MMC plan because the system determined that you had active third-party health insurance.
- 4) You testified that you had insurance through your prior employer, but believed that it had ended at the time of your employment, around March 2017.
- 5) On September 27, 2017, you provided to NYSOH through facsimile a letter from [REDACTED] stating that you had coverage through them until September 1, 2017.
- 6) The record indicates that the third-party health insurance was removed from the system on September 29, 2017.

- 7) You testified that you were without a MMC plan during the month of September 2017 and incurred extensive medical bills because of your [REDACTED].
- 8) You testified, and your NYSOH account reflects, that you selected a MMC plan on October 3, 2017.
- 9) You testified that you were seeking for your MMC plan coverage to begin no later than September 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 that individual was eligible at 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 18 NYCRR § 360-10.3(h),; Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13 ADM-03(III)(F)).

Third Party Health Insurance

A person who has primary medical or health care coverage available from or under a third-party insurance provider is not permitted to enroll into a Medicaid Managed Care plan (NY SSL § 364-j(3)(e)(xx); Medicaid Managed Care Model Contract (Appendix H-6), effective 3/1/2014 – 2/28/2019). However, they will remain eligible for fee-for-service Medicaid with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, or failing to provide a valid social security number (NY SSL § 366(4)(c)).

Legal Analysis

The first issue for review is whether NYSOH properly determined that your enrollment in your MMC plan was terminated effective July 31, 2017.

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In the May 10, 2017 eligibility determination notice, you were found eligible for Medicaid, effective May 1, 2017. On May 9, 2017, you selected an MMC plan, effective June 1, 2017, as is documented by the May 10, 2017 enrollment notice.

Generally, when an individual is eligible for Medicaid through NYSOH they are required to enroll in a MMC plan. Applicants determined eligible will be enrolled or remain in their Medicaid plan with limited exceptions, including entering prison or another facility that provides medical care, moving out of state, or failing to provide a valid Social Security number.

On June 27, 2017, NYSOH redetermined your household's eligibility for financial assistance with health insurance. On June 28, 2017, NYSOH issued an eligibility redetermination notice advising that you while you remained eligible for Medicaid, you were no longer eligible to remain enrolled in your MMC because you had full benefit health insurance or Medicare.

When NYSOH determines that a person has active coverage in a health insurance plan outside of NYSOH, that person is not eligible to enroll or remain enrolled in a MMC plan.

You testified, and your NYSOH account reflects, that on September 27, 2017, you provided to NYSOH through facsimile a letter from [REDACTED] [REDACTED] stating that you had coverage through them from until September 1, 2017.

Therefore, NYSOH correctly cancelled your coverage in your MMC plan effective July 31, 2017 due to your having third party health insurance, since that coverage was in effect during the time you were receiving Medicaid coverage from NYSOH.

Accordingly, the June 28, 2017 eligibility determination notice terminating your coverage your MMC plan, effective July 31, 2017, is AFFIRMED.

The second issued under review is whether NYSOH properly determined that your MMC plan coverage resumed, effective November 1, 2017.

You testified, and your NYSOH account reflects, that you contacted NYSOH on October 3, 2017 and enrolled into an MMC plan.

The date on which an 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.

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On October 3, 2017, you selected a MMC plan, so it properly took effect on the first day of the month following October 3, 2017; that is, on November 1, 2017.

Therefore, the October 4, 2017 enrollment notice stating that your enrollment in your MMC plan would be effective November 1, 2017, was correct and must be AFFIRMED.

Decision

The June 28, 2017 eligibility determination notice is AFFIRMED.

The October 4, 2017 enrollment notice is AFFIRMED.

Effective Date of this Decision: December 20, 2017

How this Decision Affects Your Eligibility

You were disenrolled from your MMC plan coverage effective July 31, 2017.

You reenrolled in your MMC plan coverage effective November 1, 2017.

You remained eligible for Medicaid Fee-For-Service coverage between August 1, 2017 and October 31, 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 case 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

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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 calling the Customer Service Center at 1-855-355-5777
- By mail at:
NY State of Health Appeals
PO Box 11729
Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The June 28, 2017 eligibility determination notice is **AFFIRMED**.

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The October 4, 2017 enrollment notice is AFFIRMED.

You were disenrolled from your MMC plan coverage effective July 31, 2017.

You reenrolled in your MMC plan coverage effective November 1, 2017.

You remained eligible for Medicaid Fee-For-Service coverage between August 1, 2017 and October 31, 2017.

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 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 דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.