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

Notice of Decision

Decision Date: May 29, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027715

[redacted]

Dear [redacted]

On May 1, 2018, you and your representative appeared by telephone at a hearing on your appeal of NY State of Health's April 25, 2017 discontinuance and disenrollment notices under account [redacted]

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 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(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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nystateofhealth
The Official Health Plan Marketplace

STATE OF NEW YORK
DEPARTMENT OF HEALTH
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Decision

Decision Date: May 29, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027715

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Was your appeal of the April 25, 2017 discontinuance and disenrollment notices issued under account [redacted] timely?

Procedural History

On January 19, 2017, NYSOH issued an eligibility determination notice under account [redacted] stating you were conditionally eligible for Medicaid, effective January 1, 2017. The notice directed you to submit proof of your citizenship status and Social Security number by April 18, 2017 or you might lose your insurance or receive less help paying for your coverage.

Also on January 19, 2017, NYSOH issued an enrollment notice, under account [redacted] stating you were enrolled in a Medicaid Managed Care plan, effective February 1, 2017.

On March 10, 2017, NYSOH issued an eligibility determination notice, under account [redacted] stating you remained conditionally eligible for Medicaid, effective March 1, 2017. The notice directed you to submit proof of your Social Security number by April 18, 2017 or you might lose your insurance or receive less help paying for your coverage.

On April 24, 2017, NYSOH systematically redetermined your eligibility under account [redacted]

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On April 25, 2017, NYSOH issued a discontinuance notice, under account [redacted] stating you were no longer eligible for health insurance through NYSOH, effective June 1, 2017, because you did not provide proof of your Social Security number to confirm your eligibility by the deadline.

Also on April 25, 2017, NYSOH issued a disenrollment notice, under account [redacted] stating your Medicaid Managed Care plan coverage would end on May 31, 2017, because you were no longer eligible to enroll in the plan.

On November 29, 2017, account [redacted] was created.

On November 30, 2017 and December 15, 2017, NYSOH issued eligibility determination notices in account [redacted] stating the income information in your applications did not match information received from state and federal data sources. The notices directed you to submit proof of your income or NYSOH would not be able to determine your eligibility for health insurance.

On January 3, 2018, NYSOH issued an eligibility determination notice in account [redacted] stating you were eligible for Medicaid, effective November 1, 2017.

On January 13, 2018, NYSOH issued an enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective February 1, 2018.

On January 24, 2018, you spoke to NYSOH's Account Review Unit and appealed the June 1, 2017 discontinuance of your prior coverage insofar as you were not covered for the months of June through October 2017.

On May 1, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit wherein you orally authorized [redacted] to represent you at the hearing. The record was developed during the hearing and closed thereafter.

Findings of Fact

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

1) According to NYSOH records, both accounts [redacted] and [redacted] both now inactive, were created in your name on or about January 9, 2017.

2) No notices were issued under [redacted]

3) Your representative testified that he initially tried to set up a NYSOH account for you in January 2017, but he was having issues, so he went to a navigator who applied on your behalf.

4) According to inactive account [redacted] an initial application was submitted on your behalf on January 18, 2017. That application indicated you were in the "process of applying for a Social Security number."

5) Your representative testified that he did not know why the application indicated you did not have a Social Security number, because you did.

6) According to NYSOH records, you were determined conditionally eligible for Medicaid, under inactive account [redacted] effective January 1, 2017, pending receipt of proof confirming your citizenship status and Social Security number.

7) On April 24, 2017, NYSOH systematically redetermined your eligibility and found you ineligible for health insurance through NYSOH, purportedly because NYSOH had not received proof of your Social Security number.

8) You were disenrolled from your Medicaid Managed Care plan, effective May 31, 2017.

9) According to NYSOH records you had elected to receive communication from NYSOH for account [redacted] electronically.

10) Your representative testified that he had listed his own email address on your account.

11) Your representative testified that he never received an email alert regarding the April 25, 2017 discontinuance or disenrollment notices, nor did he receive a paper copy.

12) Your representative testified that neither you nor he were aware you had been disenrolled from your Medicaid coverage until you went to the doctor at the end of September 2017.

13) Your representative testified that he created a new account for you in November 2017 to renew your coverage.

14) According to NYSOH records, account [redacted] was created on November 29, 2017 and an updated application for health insurance was submitted on your behalf that day.

15) You were placed in a pending Medicaid status with proof of your income requested prior to NYSOH determining your eligibility for health insurance.

16) On January 2, 2018, NYSOH verified your documentation and found you eligible for Medicaid, under account [redacted] effective November 1, 2017.

17) On January 24, 2018, an appeal was filed on your behalf, under account [redacted] regarding the gap in your coverage from June to November 2017.

18) Your representative testified that you are his tax dependent and that he incurred a tax penalty for you being uninsured for a portion of 2017.

19) Your representative testified that you are seeking reinstatement in your Medicaid coverage for June 2017 through October 2017.

20) On February 13, 2018, NYSOH issued a notice stating your appeal request was not valid, because it had been requested more than 60 days after the date of the eligibility determination notice.

21) On February 23, 2018, a letter from you was posted to your NYSOH account [redacted] requesting to continue with your appeal. That letter indicated that you could not have requested an appeal within the 60-day limitation, because you never received an eligibility determination notice. That letter further stated that you "only found out [your] coverage was dropped when [you] attempted to see [your] primary physician at the end of September 2017."

22) Your representative testified that an appeal was not requested on your behalf until January 2018, because "it took a while to figure out."

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) a failure by NYSOH to provide timely notice of an eligibility determination 45 CFR § 155.505; and (4) 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)).

Individual applicants and enrollees must request a hearing within sixty (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)).

Legal Analysis

The sole issue under review is whether your appeal of the April 25, 2017 discontinuance and disenrollment notices, issued in account [redacted] was timely.

According to NYSOH records, on April 25, 2017, NYSOH issued a disenrollment notice and a discontinuance notice stating that you were no longer eligible for health insurance through NYSOH, effective June 1, 2017, and that your Medicaid Managed Care plan coverage would end on May 31, 2017. You appealed the termination of your Medicaid coverage.

Pursuant to the above cited regulations, individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of the May 31, 2017 termination of your Medicaid coverage, as stated in the April 25, 2017 discontinuance and disenrollment notices, an appeal should have been filed by Monday, June 26, 2017. The record reflects that the appeal in this matter was not filed until January 24, 2018, long after the 60-day timeframe in which to appeal the April 25, 2017 notices had passed.

It is noted that your representative testified you did not receive any email alerts regarding the April 25, 2017 discontinuance or disenrollment notices, nor did you receive a paper copy of either of those notices. Additionally, the letter you submitted in February 2018 stated that because you never received any notice of the termination of your coverage, you were unable to request an appeal within the 60-day time frame.

However, as your representative testified, and your February 2017 letter concedes, you became aware at the end of September 2017 that your Medicaid coverage had been terminated. Notwithstanding, the evidence establishes you did not request an appeal of the termination of your coverage until January 24, 2018, four months later. Thus, it is concluded that even if you did not receive the April 25, 2017 notices, and even if that would have been enough to extend the deadline in which to file an appeal, you knew in September 2017 that your

coverage had been terminated and you failed to appeal that termination within a reasonable time thereafter.

Since the evidence establishes that you did not appeal the April 25, 2017 discontinuance or disenrollment notices within the 60-day regulatory time frame or even within a reasonable time after learning of the disenrollment, there has been no timely appeal regarding the discontinuance of your Medicaid coverage effective May 31, 2017; therefore, your appeal must be DISMISSED.

Decision

Your appeal of the April 25, 2017 discontinuance and disenrollment notices in account [redacted] was untimely, and is DISMISSED.

Effective Date of this Decision: May 29, 2018

How this Decision Affects Your Eligibility

This decision does not change your enrollment dates.

The Appeals Unit will not review the merits of the termination of your Medicaid coverage effective May 31, 2017, because there has been no timely appeal of that termination.

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
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

Your appeal of the April 25, 2017 discontinuance and disenrollment notices in account [redacted] was untimely, and is DISMISSED.

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).

This decision does not change your enrollment dates.

The Appeals Unit will not review the merits of the termination of your Medicaid coverage effective May 31, 2017, because there has been no timely appeal of that termination.

Legal Authority

We are sending you this notice 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. يُمكننا 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।

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).

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.

اردو (Urdu)

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.

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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