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

Notice of Decision

Decision Date: May 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028030

[redacted]

Dear [redacted]

On March 15, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 9, 2017 eligibility determination.

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

Decision

Decision Date: May 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000028030

[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 you were eligible to purchase a qualified health plan at full cost as of December 9, 2017?

Procedural History

On December 8, 2017, you submitted an application for financial assistance for health insurance.

On December 9, 2017, NYSOH issued an eligibility determination notice, based on the December 8, 2017 application, stating in part, that you were eligible to purchase a qualified health plan at full cost through NYSOH, effective January 1, 2018. The notice stated that you were not eligible for Medicaid because you were qualified for coverage on another NYSOH account.

On January 30, 2018, you spoke to NYSOH's Account Review Unit and appealed the December 9, 2018 eligibility determination notice.

On April 16, 2018, you submitted an updated application for financial assistance for health insurance.

On April 17, 2018, NYSOH issued an eligibility determination notice, based on the April 16, 2018 updated application, stating in part, that you were eligible for Medicaid, effective April 1, 2018.

Also on April 17, 2018, NYSOH issued an enrollment notice confirming your April 16, 2018 plan selection, stating that that your enrollment in a Medicaid Managed Care plan would start June 1, 2018.

Findings of Fact

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

1) You testified and the record reflects that at the time of your December 8, 2017 application you were still listed as a household member on your mother's NYSOH account, [redacted]

2) On December 8, 2017, through your mother's account, you had active Medicaid coverage and were enrolled in a Medicaid Managed Care plan.

3) According to your testimony and the record reflects, that your Medicaid Managed Care plan on the other account terminated on December 31, 2017.

4) According to your NYSOH account, you submitted an updated application for financial assistance with health insurance on April 16, 2018 and were determined eligible for Medicaid, effective April 1, 2018.

5) According to your NYSOH account, you selected a Medicaid Managed Care plan on April 16, 2018 with your enrollment in that plan starting June 1, 2018.

6) According to notes associated with your NYSOH account, dated April 16, 2018, you indicated that you are satisfied with the result of that update and no longer wished to continue your appeal.

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

Applicable Law and Regulations

<u>Application Process and Notice of Eligibility Determination</u>

NYSOH must accept an application and make an eligibility determination for an applicant seeking an eligibility determination, at any time during the year (45 CFR § 155.310(c)).

When an individual applies for insurance through NYSOH, NYSOH must determine that person's eligibility promptly and without undue delay (45 CFR § 155.310(e)(1); 42 CFR § 435.1200(b)(3)(iii)).

Any required notice issued by NYSOH must include an explanation of the action referenced in the notice, including the effective date of the action, and the factual and legal basis for such action (45 CFR § 155.230(a)).

Legal Analysis

The issue under review is whether NYSOH properly determine that you were eligible to purchase a qualified health plan at full cost as of December 9, 2017.

On December 8, 2017 you submitted an application for financial assistance with health insurance to NYSOH. At that time, you were still on your mother's NYSOH account, [redacted] On December 8, 2017 you had active Medicaid coverage and were enrolled in a Medicaid Managed Care plan through your mother's account. Your coverage in that Medicaid Managed Care plan terminated on December 31, 2017. Due to this duplicate coverage, you were determined eligible to purchase a qualified health plan at full cost.

On April 16, 2018, you submitted an updated application for financial assistance to NYSOH. On April 17, 2018, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid effective April 1, 2018 and that your Medicaid Managed Care plan would start June 1, 2018. Notes associated with your NYSOH account dated April 16, 2018 indicate that you were satisfied with this result and that you no longer wanted to continue your appeal.

Therefore, since the issue regarding your eligibility for financial assistance is no longer in contention according to NYSOH and your account, it is not necessary to address the factual merits of your appeal request on this issue.

Decision

The issue of your eligibility for health coverage through NYSOH was resolved by the April 17, 2018 eligibility determination notice stating that you were eligible for Medicaid, effective June 1, 2018 and the corresponding enrollment notice stating that your Medicaid Managed Care plan would start June 1, 2018.

NYSOH Appeals Unit will not review the December 12, 2017 eligibility determination notice as the issue is now resolved.

Effective Date of this Decision: May 10, 2018

How this Decision Affects Your Eligibility

You are eligible for Medicaid effective April 1, 2018.

Your enrollment in a Medicaid Managed Care plan will start on June 1, 2018.

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 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

The issue of your eligibility for health coverage through NYSOH was resolved by the April 17, 2018 eligibility determination notice stating that you were eligible for Medicaid, effective June 1, 2018 and the corresponding enrollment notice stating that your Medicaid Managed Care plan would start June 1, 2018.

NYSOH Appeals Unit will not review the December 12, 2017 eligibility determination notice as the issue is now resolved.

You are eligible for Medicaid effective April 1, 2018.

Your enrollment in a Medicaid Managed Care plan will start on June 1, 2018.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

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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