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

Notice of Decision

Decision Date: October 3, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP19993

[redacted]

Dear [redacted],

On September 21, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 17, 2017 disenrollment notice and the May 2, 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
  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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Issues

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

> Is your appeal of the March 17, 2017 disenrollment notice timely?
>
> Did NY State of Health (NYSOH) properly determine that your reenrollment in your Medicaid Managed Care plan was effective no earlier than June 1, 2017?

Procedural History

On May 27, 2016, NYSOH issued a notice of eligibility determination stating you were eligible for Medicaid, effective May 1, 2016.

On June 6, 2016, NYSOH issued a notice of enrollment confirming you were enrolled in a Medicaid Managed Care plan, effective July 1, 2016.

On June 27, 2016 and again on August 5, 2016, NYSOH issued eligibility determination notices, based on systematic eligibility redeterminations, stating you were no longer eligible for Medicaid, but your coverage would be continued to April 30, 2017. The June 27, 2016 notice directed you to submit proof of your income by July 11, 2016. Both notices directed you to update the information in your application between March 16, 2017 and April 15, 2017, so your eligibility for 2017 could be determined.

On March 3, 2017, NYSOH issued a notice stating it was time to renew your health insurance for 2017. That notice stated that you were eligible to buy a

health plan at full cost, and no longer eligible for Medicaid, effective May 1, 2017, because you failed to comply with Medicaid rules. The notice directed you to update your account and select a new plan by April 15, 2017 to continue your coverage.

On March 17, 2017, NYSOH issued a disenrollment notice stating your Medicaid Managed Care plan coverage would end on April 30, 2017, because you were no longer eligible to enroll in the plan.

There is no record of an updated application or health plan selection submitted on your behalf prior to April 15, 2017.

On May 1, 2017, NYSOH received your updated application for health insurance.

On May 2, 2017, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective May 1, 2017.

On May 2, 2017, an enrollment notice was issued confirming you selected a Medicaid Managed Care plan on May 1, 2017 and the effective date of that enrollment was June 1, 2017.

On June 26, 2017, you spoke to NYSOH's Account Review Unit and appealed the disenrollment of your Medicaid Managed Care plan for the month of May 2017.

On September 21, 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 support the following findings of fact:

1) You testified, and the record reflects, that you receive your notices from NYSOH by regular mail.

2) You testified that you received the March 3, 2017 renewal notice and you attempted to update your application online shortly thereafter.

3) You testified that you realized your updated online application had not been properly submitted when you receive the March 17, 2017 disenrollment notice indicating your Medicaid Managed Care plan was ending on April 30, 2017, because you were no longer eligible for the plan.

4) There is no evidence in your account of any updated applications submitted on your behalf between May 6, 2016 and May 1, 2017.

5) You were disenrolled from your Medicaid Managed Care plan, effective May 1, 2017.

6) According to your account, an updated application was submitted on your behalf on May 1, 2017. You were determined eligible for fee-for-service Medicaid, effective May 1, 2017.

7) Your account confirms that you selected a new Medicaid Managed Care plan on May 1, 2017 and the coverage through that plan became effective on June 1, 2017.

8) You testified you did not contact NYSOH until May 1, 2017 to complete your updated application, because you were distracted with various family obligations in the months of March and April 2017.

9) You testified you are seeking to have your Medicaid Managed Care plan coverage backdated to May 1, 2017, because you have outstanding medical bills for that month and your providers do not accept fee-for-service Medicaid.

10) According to your account, you were disenrolled from your Medicaid Managed Care plan for the month of July 2017 due to a discrepancy in your mailing address. Your account confirms that you were reenrolled in the same plan for August 2017 and NYSOH backdated that enrollment to July 2017, so there was no gap in Medicaid Managed Care plan coverage for that month.

11) You testified you are only appealing your coverage for the month of May 2017.

12) According to your account, the first record of you contesting your coverage for the month of May 2017 was on June 26, 2017 when the formal appeal in this matter was filed.

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; and (4) 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)).

Medicaid Renewal

In general, NYSOH must review Medicaid eligibility once every twelve months or "whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility" (42 CFR § 435.916(a)(1), (d)). NYSOH must make its "redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency" (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates provided by the individual (45 CFR §155.335(h)).

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 Managed Care (MMC) 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, N.Y. Soc. Serv. Law §364-j(1)(c); 18 NYCRR § 360-10.3(h)).

Legal Analysis

The first issue under review is whether your appeal of the March 17, 2017 disenrollment notice was timely.

NYSOH issued a disenrollment notice on March 17, 2017 stating your coverage through your Medicaid Managed Care plan would end on April 30, 2017, because you were no longer eligible to enroll in the Plan. You appealed insofar as you were not covered by a Medicaid Managed Care plan in the month of May 2017. However, pursuant to the above cited regulations, applicants must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH to be reviewable by the Appeals Unit.

For an appeal to have been timely on the issue of the April 30, 2017 termination of your Medicaid Managed Care plan coverage, as stated in the March 17, 2017 disenrollment notice, an appeal should have been filed no later than May 16, 2017. There is no evidence in the record that you contacted NYSOH prior to June 26, 2017 to contest your coverage for the month of May 2017. According to your account, a formal appeal was not filed on your behalf until June 26, 2017, after the 60-day period in which to appeal the March 17, 2017 disenrollment notice had passed. Thus, there is no justification for tolling the regulatory deadline to appeal.

As such, there has been no timely appeal of the March 17, 2017 disenrollment notice and your appeal of the April 30, 2017 termination of your Medicaid Managed Care plan coverage is DISMISSED.

The second issue under review is whether NYSOH properly determined your reenrollment in your Medicaid Managed Care plan was effective no earlier than June 1, 2017.

Although you testified you started an application online in March 2017 to renew your coverage for 2017, there is no record in your account that NYSOH received a completed application until May 1, 2017. You testified, and your account confirms that you selected to reenroll in the same Medicaid Managed Care plan over the phone on May 1, 2017.

According to the regulations, 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 goes into effect on the first day of the following month. A plan that is selected after the fifteenth day of a month goes into effect on the first day of the second following month.

Since you selected your Medicaid Managed Care plan on May 1, 2017, it properly became effective on the first day of the following after; that is, on June 1, 2017.

Therefore, NYSOH's May 2, 2017 enrollment confirmation notice stating your coverage through your Medicaid Managed Care plan became effective on June 1, 2017 is correct and is AFFIRMED.

Decision

Your appeal of the March 17, 2017 disenrollment notice is DISMISSED.

The May 2, 2017 enrollment confirmation notice is AFFIRMED.

Effective Date of this Decision: October 3, 2017

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

The Appeals Unit will not review your April 30, 2017 disenrollment from your Medicaid Managed Care plan, because you did not appeal within the necessary time frame.

The effective date of your Medicaid Managed Care plan reenrollment is June 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
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

Your appeal of the March 17, 2017 disenrollment notice is DISMISSED.

The May 2, 2017 enrollment confirmation notice is AFFIRMED.

This decision does not change your eligibility.

The Appeals Unit will not review your April 30, 2017 disenrollment from your Medicaid Managed Care plan, because you did not appeal within the necessary time frame.

The effective date of your Medicaid Managed Care plan reenrollment is June 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:

[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)

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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 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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