



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

## Notice of Decision

Decision Date: April 7, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Numbers: AP000000010336  
AP000000010340

[REDACTED]

Dear [REDACTED],

On March 2, 2017, you and your authorized representative, [REDACTED], appeared by telephone at a hearing on your appeal of NY State of Health's December 18, 2015 disenrollment 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 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.

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  
P.O. Box 11729  
Albany, NY 12211

## Decision

Decision Date: April 7, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000010336  
AP000000010340

[REDACTED]

## Issue

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

Did New York State of Health (NYSOH) properly terminate your spouse's Medicaid Fee-For-Service (FFS) coverage, effective January 31, 2016?

## Procedural History

On April 17, 2015, NYSOH issued an eligibility determination notice, in relevant part, that your spouse was eligible for Medicaid, effective as of April 1, 2015.

On April 18, 2015, NYSOH issued an enrollment notice, in relevant part, that your spouse "[did] not need to pick a health plan."

On December 15, 2015, your NYSOH account was updated.

On December 16, 2015, NYSOH issued an eligibility determination notice, in relevant part, that your spouse was no longer eligible for Medicaid. However, their Medicaid coverage would continue until March 31, 2016. The notice specified that your spouse was eligible for Medicaid because certain individuals who have been determined eligible for Medicaid remain eligible for benefits for twelve continuous months based on the date they were determined eligible.

Also on December 16, 2015, your NYSOH account was updated.

On December 18, 2015, NYSOH issued a disenrollment notice stating, in relevant part, that your spouse's Medicaid FFS coverage would be discontinued as of January 31, 2016.

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On June 17, 2016, you spoke with NYSOH's Account Review Unit and requested to appeal the date that your spouse was disenrolled from their MA FFS, and the date that your and your daughter's MMC coverage ended. Based on that request, Account Review created two separate appeals, AP000000010336 and AP000000010340.

On March 2, 2017, you had a telephone hearing, with the assistance of your authorized representative, with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was left open to allow the Hearing Officer to request the recording of the December 16, 2015 between your navigator and NYSOH representative.

On March 16, 2017, the recording of the December 16, 2015 conversation between your navigator and the NYSOH representative was provided to NYSOH's Appeals Unit. That recording will be referred to as "Appellant Exhibit A" and has been incorporated into the record. The record is now complete and closed.

## **Findings of Fact**

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

- 1) During the hearing your authorized representative clarified that you are only appealing the date that your spouse was disenrolled from their MA FFS.
- 2) According to your NYSOH account and testimony, your spouse was enrolled in MA FFS, effective April 1, 2015.
- 3) According to your NYSOH account and testimony, on December 16, 2015, NYSOH issued you an eligibility determination notice stating that your spouse's Medicaid coverage would continue until March 31, 2016 (see [REDACTED]).
- 4) On December 16, 2015, your navigator, [REDACTED], contacted NYSOH on your behalf. During that conversation, your navigator stated that only you and your daughter were seeking Medicaid through NYSOH. The NYSOH representative stated that your spouse was no longer eligible for Medicaid and needed to contact the Local Department of Social Services (LDSS) to apply for Medicaid (Appellant Exhibit A).
- 5) On December 16, 2015, your NYSOH account was updated to reflect that your spouse was "Not Applying for Health Coverage" through NYSOH.

- 6) You testified that you did not instruct the navigator to change your account to reflect that your spouse was not applying for health coverage through NYSOH.
- 7) You testified that you found out that your spouse's Medicaid FFS would be discontinued January 31, 2016, when you received the December 18, 2015 disenrollment notice from NYSOH.
- 8) You testified that you submitted a complaint regarding the early termination of your spouse's MA FFS on March 1, 2016 (Complaint # [REDACTED]).
- 9) You testified that your spouse was receiving assistance paying their Medicare Part B premiums before their Medicaid FFS was discontinued. Your spouse did not receive reimbursement of their Medicare Part B premiums in January, February, and March 2016.
- 10) You testified that your spouse lost their favorable rate with their Univera insurance plan because the MA FFS ended three months early.
- 11) You testified that your spouse's eligibility in the Extra Help Program through the Social Security Administration (SSA) ended three months early because your spouse's MA FFS coverage ended three months early.
- 12) You testified that you are seeking to be reimbursed for the increase in copayments for January, February, and March 2017 because the Extra Help Program ended three months early.
- 13) You testified you want your spouse's MA FFS to end March 31, 2016.

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

## **Applicable Law and Regulations**

### MAGI Medicaid

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

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In general, to qualify for MAGI-based Medicaid through NYSOH, you must also be one of the following:

- An adult aged 19-64 who is not eligible for Medicare Part A or Part B,
- A pregnant woman or infant,
- A child aged 1-18, or
- A parent or caretaker relative

(45 CFR § 155.305(c); N.Y. Soc. Serv. Law § 366(1)(b)).

Caretaker relative is a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care (42 CFR § 435.4).

Dependent child is under the age of 18, or is age 18 and a full-time student in secondary school, if before attaining age 19 the child may reasonably be expected to complete such school or training (42 CFR § 435.4).

### Non-MAGI Medicaid

If an individual does not fall into one of these categories, he or she may still be eligible for non-MAGI-based Medicaid coverage through their Local Department of Social Services or the New York City Human Resources Administration (see N.Y. Soc. Serv. Law § 366(1)(c)).

### Medicaid Continuous Coverage:

Most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, unless the adult loses Medicaid eligibility because of citizenship status, lack of state residence, or failure to provide a valid social security number, before the end of a twelve-month period. This twelve-month period is referred to as "continuous coverage," and is set based on the start date of the original Medicaid eligibility determination or the date of a subsequent Medicaid eligibility determination based on modified adjusted gross income (see 42 CFR § 435.916(a); N.Y. Soc. Serv. Law § 366(4)(c)).

### Reimbursement for Out-of-Pocket Expenses

Generally, Medicaid payments are made to providers which furnished the services (18 NYCRR § 360-7.5(a)(1)). However, Medicaid recipients or their representatives may be reimbursed when, through no fault of their own:

- (a) an erroneous Medicaid eligibility determination is reversed (whether the reversal is due to the state or local agency discovering its own error or is the result of a fair hearing decision or court order), or the state or local

agency fails to determine Medicaid eligibility within the applicable time periods; and

(b) an erroneous eligibility determination or the delay in determining eligibility caused the recipient or the recipient's representative to pay for medically necessary services which otherwise would have been paid for by the Medicaid program.

18 NYCRR §360-7.5(a)(3)(i).

## **Legal Analysis**

The issue under review is whether NYSOH properly ended your spouse's MA FFS effective January 31, 2016.

On April 17, 2015, NYSOH issued an eligibility determination notice stating that your spouse was eligible for Medicaid, effective as of April 1, 2015.

Generally, once individuals are determined eligible for Medicaid, they are guaranteed 12 months of Medicaid coverage, even if the adult loses Medicaid eligibility because of any changes or updates they make to their NYSOH account. This twelve-month period is based on the effective date of the Medicaid eligibility determination.

The record reflects that your navigator contacted NYSOH on December 16, 2015. During that conversation, your navigator gave the NYSOH representative the impression that your spouse was no longer applying for Medicaid through NYSOH. Therefore, the representative updated your account to reflect that your spouse was no longer seeking health insurance through NYSOH. Based on the update to your NYSOH account, NYSOH issued a disenrollment notice stating that your spouse's Medicaid FFS coverage would be discontinued as of January 31, 2016.

However, you credibly testified you did not instruct the navigator to change your account to reflect that your spouse was not applying for health coverage through NYSOH before the end of their twelve months of eligibility.

When your spouse's Medicaid FFS coverage terminated on January 31, 2016, the twelve-month period of Medicaid eligibility that was effective on April 1, 2015, had not expired. Therefore, the December 18, 2015 disenrollment notice is **RESCINDED**.

Your case is **RETURNED** to NYSOH to reinstate your spouse's MA FFS through the end of their twelve-month eligibility period. Therefore, NYSOH will reinstate your spouse's MA FFS through March 31, 2016.

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You testified that because your spouse's MA FFS coverage ended prematurely: (1) Your spouse did not receive reimbursement of their Medicare Part B premiums in January, February, and March 2016; (2) Your spouse's eligibility in the Extra Help Program through the SSA ended three months early; and (3) Your spouse lost their favorable rate with their Univera insurance plan for three months.

Your case will be REFERRED to New York State Department of Health, Office of Health Insurance Programs, Stakeholder Relations and Exchange Support to facilitate the possible reimbursement for the out-of-pocket expenses that resulted from the discontinuance of your spouse's MA FFS coverage.

## **Decision**

The December 18, 2015 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your spouse's MA FFS through March 31, 2016.

Your case will be REFERRED to New York State Department of Health, Office of Health Insurance Programs, Stakeholder Relations and Exchange Support to facilitate the possible reimbursement of the out-of-pocket expenses regarding the discontinuance of your spouse's MA FFS coverage.

**Effective Date of this Decision:** April 7, 2017

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

Your spouse was eligible for MA FFS through NYSOH until March 31, 2016.

## **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

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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**

The December 18, 2015 disenrollment notice is **RESCINDED**.

Your case is **RETURNED** to NYSOH to reinstate your spouse's MA FFS through the end of their twelve-month eligibility period, March 31, 2016.

Your case will be **REFERRED** to New York State Department of Health, Office of Health Insurance Programs, Stakeholder Relations and Exchange Support to

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facilitate the possible reimbursement of the out-of-pocket expenses regarding the discontinuance of your spouse's MA FFS coverage.

Your spouse was eligible for MA FFS through NYSOH until March 31, 2016.

### **Legal Authority**

We are sending you this notice in accordance with 45 CFR § 155.545.

**A Copy of this Decision Has Been Provided To:**

[REDACTED]

[REDACTED]

## 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&etumi ama wo obi a okyerE 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.

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