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

Notice of Decision

Decision Date: March 29, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013604

[redacted]

Dear [redacted]

On March 3, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 17, 2016 eligibility determination notice and November 23, 2016 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
  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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Decision

Decision Date: March 29, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013604

[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 your enrollment in your Medicaid Managed Care plan ended effective July 31, 2016?
>
> Did NYSOH properly determine that your reenrollment in your Medicaid Managed Care plan resumed effective no earlier than January 1, 2017?

Procedural History

On February 11, 2015, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid effective February 1, 2016. You subsequently enrolled in a Medicaid Managed Care (MMC) plan, effective April 1, 2015.

On June 15, 2016, NYSOH issued a notice that it was time to renew your health insurance. That notice stated that, based on information from federal and state sources, NYSOH could not make a decision about whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by July 15, 2016 or you might lose the financial assistance you were currently receiving.

No updates were made to your account by July 15, 2016.

On July 17, 2016, NYSOH issued an eligibility redetermination notice stating that NYSOH redetermined your eligibility on July 16, 2016, and you were no longer qualified to enroll in coverage through NYSOH because mail that was sent to you

by NYSOH was returned as undeliverable. The notice stated that your eligibility would end July 31, 2016

Also on July 17, 2016, NYSOH issued a disenrollment notice stating that your MMC plan coverage would end effective July 31, 2016. This was because you were no longer eligible to enroll in health insurance through NYSOH.

On August 22, 2016, NYSOH received two updates to your application for health insurance. This application reflected an update to your mailing address from [redacted] to [redacted]"

On August 23, 2016, NYSOH issued a notice stating that you might be eligible for health insurance; however, more information was required to confirm your eligibility. This notice requested that you provide income documentation by September 5, 2016 in order to confirm the information you provided in your application was accurate.

No income documents were received by NYSOH by September 5, 2016.

On November 2, 2016, NYSOH received (1) a facsimile that included a letter issued to you by [redacted], dated October 20, 2016, stating that your employment ended as of October 12, 2016, and (2) four earning statement issued to you by [redacted] between October 5, 2016 and October 26, 2016. These documents were ultimately verified on November 16, 2016.

On November 18, 2016, NYSOH received an update to your application based on the information available in your account as of November 16, 2016.

On November 19, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective November 1, 2016.

On November 23, 2016, NYSOH issued an enrollment notice confirming your selection of an MMC plan as of November 22, 2016. The notice stated that your MMC plan coverage would begin effective January 1, 2017.

On November 29, 2016, you spoke to NYSOH's Account Review Unit and appealed your disenrollment from your MMC plan as of July 31, 2016, and your reenrollment in that MMC plan insofar as it began effective January 1, 2017.

On March 3, 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 the record reflects, that you have lived in New York State continuously since you first applied for health insurance through NYSOH.

2) You testified that you always reported address changes to NYSOH by speaking with a NYSOH representative over the phone.

3) The record reflects that, since January 2015, your residential and mailing address and the dates they were in effect were as follows:

   a. January 2015 to August 21, 2016
   [redacted]

   b. August 22, 2016 to November 15, 2016:
   [redacted]

   c. November 16, 2016 to present:
   [redacted]

4) You testified that you did not receive the renewal notice issued to you by NYSOH on June 15, 2016 until sometime during December 2016, when mail was finally forwarded to your new address by the USPS.

5) You testified that you believed that you moved to your intermediate address at [redacted] prior to June 15, 2016.

6) You testified that you believed that you had informed both NYSOH and USPS of your move to [redacted] prior to August 22, 2016.

7) Your MMC plan coverage was terminated effective July 31, 2016.

8) You provided income documentation on November 2, 2016, which was ultimately verified by NYSOH on November 16, 2016.

9) You were redetermined eligible for Medicaid on November 18, 2016, and reenrolled in your MMC plan effective January, 1 2017.

10) The June 15, 2016 renewal notice and July 17, 2016 eligibility determination notice were returned to NYSOH as undeliverable.

11) You testified that you want your Medicaid Managed Care plan to begin on August 1, 2016 because you incurred medical expenses relating to your [redacted] appointment that were not covered.

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

Applicable Law and Regulations

Medicaid for Adults between the Ages of 19 and 65

Medicaid through NYSOH can be provided 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 federal poverty level (FPL) for the applicable family size (42 CFR §§ 435.119(b), 435.911(b)(1), 435.603(d)(4); NY Social Services Law § 366(1)(b)).

Most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage even if they lose Medicaid eligibility because of any changes or updates they make to their NYSOH account. For example, even if income increases above the Medicaid limit allowed for the household size, the insured will remain covered under Medicaid for a 12-month period. This 12-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 (NY Social Services Law § 366(4)(c)).

An individual will be enrolled or remain in their Medicaid plan with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, failing to provide a valid social security number, or having third party health insurance (NY Social Services Law § 366(4)(c)).

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, NY Social Services Law § 364-j(1)(c); 18 NYCRR § 360-10.3(h)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your enrollment in your MMC plan ended effective July 31, 2016.

You were originally found eligible for Medicaid effective February 1, 2015. The record reflects that your enrollment in an MMC began effective April 1, 2015.

On August 1, 2016, the June 15, 2016 renewal notice was returned to NYSOH because the post office was unable to forward it to another address. Likewise, on September 8, 2016 the July 17, 2016 eligibility determination notice was returned to NYSOH because the post office was unable to forward it to another address.

Generally, an individual remains eligible for Medicaid for 12 continuous months unless the person becomes otherwise ineligible. If a person lacks state residence or is unable to prove state residence during those 12 months they become ineligible for Medicaid and continuous coverage.

You testified that you provided to both NYSOH and the USPS, prior to your August 22, 2016 application update, your most recent address, which at that time was [redacted] However, the credible record of evidence reflects that you did not provide an updated mailing address to NYSOH until August 22, 2016. Accordingly, we find that you did not provide to NYSOH the necessary information to issue the June 15, 2016 renewal and July 17, 2016 eligibility determination notices to your current mailing address, and were thereafter returned to NYSOH, which ultimately led to your disenrollment as of July 31, 2016.

Therefore, the June 15, 2016 renewal and July 17, 2016 eligibility determination notices were properly issued to the most recent address contained within your account.

Accordingly, the July 17, 2016 eligibility determination notice is AFFIRMED.

The second issue is whether NYSOH properly determined that your reenrollment in your MMC plan resumed effective no earlier than January 1, 2017.

The record shows that on November 2, 2016, you provided income documentation to NYSOH, including: (1) a facsimile that included a letter issued to you by [redacted] dated October 20, 2016, stating that your

employment ended as of October 12, 2016, and (2) four earning statement issued to you by [redacted] between October 5, 2016 and October 26, 2016. These documents were ultimately verified on November 16, 2016 as acceptable proof of your income.

The record further shows that on November 18, 2016, your NYSOH application was updated to reflect your eligibility for Medicaid, effective November 1, 2016. You later selected an MMC plan on November 22, 2016.

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.

However, since the credible evidence of record provides that you provided the necessary income documentation, as requested by NYSOH, on November 2, 2016, you would have been found eligible for Medicaid as of that date and eligible to select an MMC.

Since we may reasonably infer that you would have selected an MCM plan on November 2, 2016, the first day of your presumed eligibility for Medicaid, it must take effect on the first day of the following after November 2016; that is, on December 1, 2016.

Therefore, NYSOH's November 23, 2016 enrollment notice is MODIFIED to stated that your MMC plan reenrollment began effective December 1, 2016.

Your case is RETURNED to NYSOH to effectuate the above changes to your account.

Decision

The July 17, 2016 eligibility determination notice is AFFIRMED.

The November 23, 2016 enrollment notice is MODIFIED to stated that your MMC plan reenrollment began effective December 1, 2016.

Your case is RETURNED to NYSOH to effectuate the above changes to your account.

Effective Date of this Decision: March 29, 2017

How this Decision Affects Your Eligibility

Your MMC plan coverage ended effective July 31, 2016.

The effective date of your reenrollment in your MMC plan is December 1, 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 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 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).

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 July 17, 2016 eligibility determination notice is AFFIRMED.

The November 23, 2016 enrollment notice is MODIFIED to stated that your MMC plan reenrollment began effective December 1, 2016.

Your case is RETURNED to NYSOH to effectuate the above changes to your account.

Your MMC plan coverage ended effective July 31, 2016.

The effective date of your reenrollment in your MMC plan is December 1, 2016.

Legal Authority

We are issuing this determination 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।

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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 महत्त्वपूर्ण 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 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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