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

Notice of Decision

Decision Date: April 24,2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013618

[redacted]

Dear [redacted],

On March 2, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 10, 2016 eligibility redetermination, November 21, 2016 cancellation, and November 24, 2016 enrollment confirmation notices.

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.

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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).

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

Decision

Decision Date: April 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013618

[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 no longer eligible to remain enrolled in your Medicaid Managed Care (MMC) plan effective November 30, 2016?

Procedural History

On June 3, 2016, NYSOH issued an eligibility determination notice stating that, effective June 1, 2016, you were eligible for Medicaid because your household income of $10,400.00 was at or below the allowable income limit.

On June 4, 2016, NYSOH issued an enrollment notice confirming your enrollment in a MMC plan, with an enrollment start date of July 1, 2016.

On August 1, 2016, NYSOH received your updated application for health insurance; specifically, your income information was updated to $25,272.00.

On August 2, 2016, NYSOH issued an eligibility redetermination notice stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until May 31, 2017, because certain individuals determined eligible for Medicaid remain eligible for benefits for 12 continuous months from the date that they were determined eligible. This eligibility was effective as of August 1, 2016.

On August 25, 2016, you contacted NYSOH and updated your mailing address.

On August 26, 2016, NYSOH issued an eligibility redetermination notice stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until May 31, 2017, because certain individuals determined eligible for Medicaid remain eligible for benefits for 12 continuous months from the date that they were determined eligible. This eligibility was effective as of August 1, 2016. This notice was mailed to the new address on your NYSOH account.

Also on August 26, 2016, NYSOH issued an enrollment notice confirming your enrollment in a MMC, with a plan enrollment start date of July 1, 2016. This notice was also mailed to the new address.

On November 10, 2016, NYSOH issued an eligibility redetermination notice based on information recently received, stating that you were newly eligible to purchase a qualified health plan (QHP) at full cost, effective December 1, 2016. There was no indication in the notice as to what the recently received information was or why you were no longer eligible for Medicaid.

Also on November 10, 2016, and on November 21, 2016, NYSOH issued disenrollment notices stating that your MMC plan would end effective November 30, 2016.

On November 23, 2016, NYSOH received your updated application for health insurance. That day, a preliminary eligibility redetermination was prepared finding you eligible for advance premium tax credit (APTC) of up to $368.00 per month, and eligible for cost-sharing reductions (CSR), effective January 1, 2017. NYSOH did not issue a corresponding eligibility redetermination notice reflecting this preliminary finding.

On November 24, 2016, NYSOH issued an enrollment notice confirming your November 23, 2016 enrollment in a silver-level QHP, with your coverage and the application of your APTC to begin on January 1, 2017.

On November 29, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as your enrollment in Medicaid had been discontinued as of November 30, 2016.

On March 2, 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 that you are appealing the disenrollment from your MMC plan effective November 30, 2016.

2) You testified that you have a gap in health insurance coverage for the month of December 2016, but there are no medical bills that were incurred during that month.

3) You testified that you receive all your notices from NYSOH by regular mail.

4) According to your NYSOH account and your testimony, you will be filing your 2016 taxes as single and will not claim any dependents.

5) According to your NYSOH account you were initially found eligible for Medicaid on June 2, 2016, with an effective date of June 1, 2016.

6) You testified that you received a raise in wages and you updated your application for financial assistance on August 1, 2016.

7) According to your NYSOH account and your testimony, you updated your mailing address to [redacted] on August 25, 2016.

8) According to your NYSOH account, updated eligibility redetermination and enrollment confirmation notices dated August 26, 2016 were mailed by NYSOH to the new address.

9) According to your NYSOH account, the August 26, 2016 notices were returned to NYSOH by the post office marked as undeliverable as addressed. These the documents were stamped as “RETURN MAIL” on September 8, 2016.

10) According to your NYSOH account, the two returned notices were scanned into your account on November 9, 2016 and November 11, 2016 respectively (*see* Documents [redacted] and [redacted]).

11) You testified that the address on each returned mail document was correct and you have no idea why the post office returned those two pieces of mail.

12) You testified that subsequent notices mailed to you by NYSOH at the same address have been delivered without problem.

13) According to your NYSOH account events tab, your mailing address was marked as “invalid” on November 9, 2016 and your eligibility was re-run by the system at that time, resulting in you being redetermined eligible to purchase a QHP at full cost, effective December 1, 2016, as stated in the November 10, 2016 eligibility redetermination notice. This notice did not state a reason why your Medicaid eligibility was being terminated.

14) According to your NYSOH account and your testimony, you contacted NYSOH on November 23, 2016 and updated your account and a preliminary eligibility redetermination was prepared finding you eligible for APTC of $368.00 and cost sharing reductions, effective January 1, 2017. At that time, you enrolled in a silver-level QHP with a plan start date and APTC applied to the monthly premium effective January 1, 2017.

15) You testified that you would like to be placed back into your MMC plan as of December 1, 2016 and have the premiums you paid for your silver-level QHP refunded.

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 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 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)).

Continuous Coverage

Generally, 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)).

State Residence

Individuals are ineligible for medical assistance unless he or she is a resident of NY State (NY SSL § 366(d)(1)).

Timely Notice Concerning Adverse Actions

NYSOH must give Medicaid beneficiaries timely and adequate notice of proposed action to terminate, discontinue, or suspend their eligibility or to reduce or discontinue services they may receive under Medicaid (42 CFR §435.917 (a)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were no longer eligible to remain enrolled in your MMC plan effective November 30, 2016.

You were found eligible for Medicaid effective June 1, 2016, based on the application you submitted on June 2, 2016. You enrolled into a MMC plan that day with a start date of July 1, 2016.

On August 1, 2016, you updated your application for financial assistance because you received an increase in wages where you were employed. This update increased your annual household income to $25,272.00, which is above the Medicaid limit.

Under New York State law, once a person is eligible for Medicaid, that eligibility continues for 12 months, even if the household income rises above 138% of the FPL. This provision is called “continuous coverage.”

Based on this updated income information in the August 1, 2016 application, NYSOH issued an eligibility redetermination stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until May 31, 2017, because of the 12-month continuous coverage provision. Therefore,

the August 2, 2016 eligibility redetermination notice was proper and is AFFIRMED.

On August 25, 2016, you contacted NYSOH and updated your address to [redacted]. This resulted in NYSOH redetermining your eligibility and mailing updated eligibility redetermination and enrollment confirmation notices on August 26, 2016 to this new address. You were again correctly found eligible to receive continuous coverage under Medicaid until May 31, 2017 and remained enrolled in your MMC plan, such that the August 26, 2016 eligibility redetermination and enrollment confirmation notices are AFFIRMED.

For reasons not known to you and which were not your fault, the post office returned the two notices dated August 26, 2016 to NYSOH. These notices were stamped “Returned Mail” by NYSOH on September 8, 2016 and uploaded to your account on November 9, 2016 and November 11, 2016 respectively.

As a result of receiving the returned notices, NYSOH marked your address as invalid on November 9, 2016 and, as such, your state residency was deemed no longer valid.

This change in residency status also resulted in NYSOH’s system re-running your eligibility and, on November 10, 2016, issuing an eligibility redetermination notice stating you were eligible for a QHP at full cost and that you were not eligible for coverage through the Essential Plan because of your income level. The notice did not provide you with a reason why your Medicaid coverage was ending. Further, because your address being marked invalid and your state residency was no longer verifiable, you were disenrolled from your MMC coverage effective November 30, 2016.

You credibly testified that the address listed on the August 26, 2016 notices was correct and that subsequent notices mailed to that same address have been delivered by the post office.

Therefore, it is reasonable to conclude that the August 26, 2016 notices were correctly addressed and returned to NYSOH as undeliverable by the post office due to no fault of your own. It is also reasonable to concluded that you were disenrolled from your MMC plan due to this error.

Therefore, the November 10, 2016 eligibility redetermination notice and the November 10, 2016 and November 21, 2016 disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to reinstate your MMC plan effective December 1, 2016.

NYSOH will facilitate the reimbursement of silver-level QHP premiums you have paid since January 2017 to the implementation of this decision.

Decision

The August 2, 2016 and August 26, 2016 eligibility redeterminations and enrollment confirmation notices are AFFIRMED.

The November 10, 2016 eligibility redetermination notice is RESCINDED.

The November 10, 2016 and November 21, 2016 disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to reinstate your MMC plan effective December 1, 2016. NYSOH will facilitate a reimbursement of premium amounts for the silver-level QHP you have paid from January 2017 to the implementation of this decision.

Effective Date of this Decision: April 24, 2017

How this Decision Affects Your Eligibility

You should not have been disenrolled from your MMC plan as of November 30, 2016 because, through no fault of your own, notices were incorrectly returned by the post office to NYSOH marked as undeliverable.

Your case is being sent back to NYSOH to reinstate you into your MMC plan as of December 1, 2016.

Your Medicaid coverage, which began on June 1, 2016, continues until May 31, 2017, barring subsequent changes in your eligibility.

NYSOH will facilitate the return of any premiums you have paid for your silver-level QHP from January 2017 to the implementation of this decision.

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

The August 2, 2016 and August 26, 2016 eligibility redeterminations and enrollment confirmation notices are AFFIRMED.

The November 10, 2016 eligibility redetermination notice is RESCINDED.

The November 10, 2016 and November 21, 2016 disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to reinstate your MMC plan effective December 1, 2016. NYSOH will facilitate a reimbursement of premium amounts for the silver-level QHP you have paid from January 2017 to the implementation of this decision.

You should not have been disenrolled from your MMC plan as of November 30, 2016 because, through no fault of your own, notices were incorrectly returned by the post office to NYSOH marked as undeliverable.

Your case is being sent back to NYSOH to reinstate you into your MMC plan as of December 1, 2016.

Your Medicaid coverage, which began on June 1, 2016, continues until May 31, 2017, barring subsequent changes in your eligibility.

NYSOH will facilitate the return of any premiums you have paid for your silver-level QHP from January 2017 to the implementation of this decision.

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.

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).