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

Notice of Decision

Decision Date: April 07, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014115

[redacted]

Dear [redacted],

On March 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 1, 2016 disenrollment notice, December 6, 2016 redetermination notice, and 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: April 07, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014115

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Issues

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

> Did NY State of Health (NYSOH) properly disenrolled you from your Medicaid Managed Care plan effective November 30, 2016?
>
> Did NYSOH properly determine that your enrollment in your Essential Plan was effective January 1, 2017?

Procedural History

On January 13, 2016, NYSOH issued a notice of eligibility determination based on your January 12, 2016 application stating that you were eligible for Medicaid effective January 1, 2016.

You were subsequently enrolled in a Medicaid Managed Care plan effective March 1, 2016.

On October 10, 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 November 15, 2016 or you might lose the financial assistance you were currently receiving.

On October 31, 2016, NYSOH received your updated application for financial assistance. That same day you uploaded your income documentation.

On November 1, 2016, NYSOH issued a notice stating the income information in your application does not match what NYSOH received from state and federal data sources. The notice requested more information to confirm the information in your application by providing proof of your income by November 15, 2016.

On November 1, 2016, a disenrollment notice was issued terminating your Medicaid Managed Care plan effective November 30, 2016.

On November 11, 2016, a notice was issued stating the documentation NYSOH reviewed does not confirm the information in your application. The notice asked you send in more proof of your income by November 30, 2016.

On November 15, 2016, NYSOH received your additional income documentation.

On December 6, 2016, NYSOH issued an eligibility redetermination notice stating that you were eligible to enroll in the Essential Plan for a limited time effective January 1, 2017. The notice required that you provide proof of your income by March 5, 2017.

Also on December 6, 2016 NYSOH issued an enrollment confirmation notice stating that you were enrolled in the Essential Plan, effective January 1, 2017.

On December 19, 2016, you spoke to NYSOH's Account Review Unit and appealed the enrollment insofar as it began your Essential plan on January 1, 2017 and not December 1, 2016.

On March 28, 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 are seeking insurance for yourself.

2) You testified you will be filing your 2016 taxes as single and will claim no dependents.

3) Your January 12, 2016 application states your annual household income was $16,152.00.

4) Your December 5, 2016 application states your household income was $17,000.00 annually.

5) The record supports your income documentation you provided was determined invalid by NYSOH on November 10, 2016.

6) You testified that you did not know that you had been disenrolled from your Medicaid Managed Care plan until you were told by your physician's office that you no longer had active coverage with your health plan. You were unsure of the exact date of this.

7) On October 31, 2016 NYSOH received your updated application for health insurance.

8) The record reflects you have not moved in 2016, you testified this was correct.

9) You testified, and the record reflects, that you selected your Essential Plan 2 on December 5, 2016, and that your enrollment was effective on January 1, 2017.

10) No notices sent to you at the address listed on your NYSOH account have been returned as undeliverable.

11) You testified that you want your Medicaid Managed Care plan to continue through to December 31, 2016 or to have your Essential Plan backdated to December 1, 2016.

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

Applicable Law and Regulations

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)).

Continuous Coverage

Most applicants determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage offered through Medicaid Managed Care, even if the adult loses Medicaid eligibility because of any changes or updates they make to their 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 any subsequent Medicaid eligibility determination based on modified adjusted gross income (*see* 42 CFR § 435.916; NY Social Services Law (NY SSL) § 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)).

Essential Plan Effective Date

For individuals seeking enrollment in an Essential Plan, New York State has elected to follow the same rules that NYSOH uses in determining effective dates for individuals seeking enrollment in qualified health plans (NY Social Services Law § 369-gg(4)(c); New York’s Basic Health Plan Blueprint, p. 16, as approved January 2016; *see* https://www.medicaid.gov/basic-health-program/basic-health-program.html).

The effective date of coverage by an Essential Plan is determined by the date on which an applicant selects a plan for enrollment. For individuals who are eligible for enrollment, NYSOH must generally ensure that coverage is effective the first day of the following month for selections received by NYSOH from the first to the fifteenth of any month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(i); *see also* 42

CFR § 600.320). For selections received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(ii)).

Legal Analysis

The first issue is whether NYSOH properly disenrolled you from your Medicaid Managed Care plan effective November 30, 2016.

You were originally found eligible for Medicaid effective January 1, 2016. You then enrolled into a Medicaid Managed Care plan with a start date of March 1, 2016.

Generally, NYSOH must redetermine a qualified individual's eligibility for Medicaid once every 12 months 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. NYSOH's October 10, 2016 renewal notice stated that there was not enough information to determine whether you were eligible to continue your financial assistance for health insurance, and that you needed to supply additional information by November 15, 2016, or your financial assistance might end.

You then updated your application on October 31, 2016 and provided proof of your income. As a result of the update, NYSOH issued a November 1, 2016 disenrollment notice terminating your enrollment in your Medicaid Managed Care plan as of November 30, 2016.

However, most applicants determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage offered through Medicaid Managed Care, even if the adult loses Medicaid eligibility because of any changes or updates they make to their 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 except in limited circumstances described above. 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 any subsequent Medicaid eligibility determination based on modified adjusted gross income.

Since you were determined eligible for Medicaid effective January 1, 2016, your eligibility would continue for 12 months until December 31, 2016 regardless of whether your income increased above the Medicaid limit.

Therefore, the November 1, 2016, disenrollment notice terminating your enrollment in your Medicaid Managed Care plan effective November 30, 2016

was improper and is MODIFIED to state that your plan ended effective December 31, 2016.

Your case is RETURNED to NYSOH to ensure your Medicaid Managed Care plan is reinstated for the month of December, 2016.

The second issue is whether NYSOH properly determined that your enrollment in the Essential Plan 2 was effective January 1, 2017

You testified, and the record indicates, that you submitted your completed NYSOH application on December 5, 2016 after submitting additional income documentation. You were found eligible for the Essential Plan 2 as of January 1, 2016 and enrolled into a plan that same day.

The date on which enrollment in an Essential 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 from the sixteenth day of the month to the end of the month goes into effect on the first day of the second following month.

Because on December 5, 2016, you selected an Essential Plan, your enrollment properly took effect on the first day of the first month following December; that is, on January 1, 2017.

Therefore, the December 6, 2016 eligibility determination and enrollment confirmation notices stating that your eligibility for and enrollment in the Essential Plan was effective January 1, 2017, are correct and must be AFFIRMED.

Decision

The November 1, 2016, disenrollment notice is MODIFIED to state that your Medicaid Managed Care plan ended effective December 31, 2016.

Your case is RETURNED to NYSOH to ensure your Medicaid Managed Care plan is reinstated for the month of December, 2016.

The December 6, 2016 eligibility determination and enrollment confirmation notices are AFFIRMED.

Effective Date of this Decision: April 07, 2017

How this Decision Affects Your Eligibility

Your Medicaid Managed Care plan ended December 31, 2016.

The effective date of your Essential Plan is January 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

The November 1, 2016, disenrollment notice is MODIFIED to state that your Medicaid Managed Care plan ended effective December 31, 2016.

Your case is RETURNED to NYSOH to ensure your Medicaid Managed Care plan is reinstated for the month of December, 2016.

The December 6, 2016 eligibility determination and enrollment confirmation notices are AFFIRMED.

Your Medicaid Managed Care plan ended December 31, 2016.

The effective date of your Essential Plan is January 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)

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 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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