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

Notice of Decision

Decision Date: May 19, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014991

[redacted]

Dear [redacted],

On April 12, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 7, 2016 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 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: May 19, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014991

[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 and your spouse's enrollment in a Medicaid Managed Care plan terminated effective June 1, 2016?

Procedural History

On April 28, 2016, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible for Medicaid, effective April 1, 2016.

Also on April 28, 2016, NYSOH issued a notice of enrollment confirming you and your spouse's enrollment in a Medicaid Managed Care plan, with a plan enrollment start date of June 1, 2016.

On December 6, 2016, NYSOH redetermined your household's eligibility for financial assistance with health insurance.

On December 7, 2016, NYSOH issued a disenrollment notice stating that you and your spouse's enrollment in your Medicaid Managed Care plan ended June 1, 2016 and you would remain eligible for Medicaid, effective June 1, 2016. The notice stated that you were unable to select a Medicaid Managed Care plan, as the system was showing that you had other full benefit health insurance or Medicare.

Also, on December 7, 2016, NYSOH issued an enrollment confirmation notice stating that the type of Medicaid coverage you and your spouse were eligible for did not require you to enroll in a health plan.

That same day, NYSOH issued an eligibility redetermination notice stating that you and your spouse remained eligible for Medicaid, effective January 1, 2017, because your household income of $31,698.39 was at or below the allowable income limit of $33,534.00.

On December 14, 2016, you uploaded a letter from Empire Blue Cross Blue Shield showing that your coverage through them was cancelled as of June 1, 2016.

On December 22, 2016, NYSOH issued an eligibility redetermination notice stating that you and your spouse remained eligible for Medicaid, effective December 1, 2016.

On December 30, 2016, you updated the income information in your NYSOH account from $31,698.39 to $51,308.79.

On December 31, 2016, NYSOH issued a notice of redetermination stating that you and your spouse were no longer eligible for Medicaid, however your Medicaid coverage would be continued until November 30, 2017. The eligibility was effective December 1, 2016.

On January 20, 2017, you spoke to NYSOH's Account Review Unit and appealed the December 7, 2016 disenrollment notice, insofar as you and your spouse were disenrolled from your Medicaid Managed Care plan, effective June 1, 2016.

On April 12, 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 your account confirms, that you and your spouse were determined eligible for Medicaid effective April 1, 2016, and you and your spouse enrolled in a Medicaid Managed Care plan effective June 1, 2016.

2) You testified, and your account confirms, that on December 7, 2016 you and your spouse were retroactively disenrolled from your Medicaid Managed Care plan, effective June 1, 2016, because the system determined that you had active third-party health insurance.

3) You testified that you had insurance through Empire Blue Cross Blue Shield until June 1, 2016.

4) On December 14, 2016, you uploaded a letter from Empire Blue Cross Blue Shield showing that your coverage through them was cancelled as of June 1, 2016.

5) You testified that you spoke to a representative from NYSOH who advised that when NYSOH confirmed your third-party health insurance end date, your Medicaid Managed Care plan coverage would be retroactively reinstated to June 1, 2016.

6) On December 30, 2016, you updated the income information in your NYSOH account from $31,698.39 to $51,308.79.

7) On December 31, 2016, NYSOH issued a notice stating that you and your spouse were no longer eligible for Medicaid, however your Medicaid coverage would be continued until November 30, 2017.

8) The record indicates that the third-party health insurance was removed from the system on December 30, 2016.

9) The record does not contain any information from NYSOH regarding where they obtained the information that you were enrolled in third-party health insurance.

10) You testified that you were without a Medicaid Managed Care plan from June 2016 through December 2016, during which you incurred medical bills.

11) You testified that your doctors do not accept Medicaid Fee-for-Service coverage.

12) You testified that you are seeking that you and your spouse's Medicaid Managed Care plan coverage be reinstated, effective June 1, 2016.

13) You testified that you are not appealing NYSOH's determination that you and your spouse were covered under the policy of Medicaid continuous coverage, effective 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

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if that individual was eligible at any time during that month (42 CFR § 435.915(b); Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

Medicaid Managed Care 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; *see* 18 NYCRR § 360-10.3(h),; Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13 ADM-03(III)(F)).

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 Marketplace 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)).

Third Party Health Insurance

A person who has primary medical or health care coverage available from or under a third-party insurance provider is not permitted to enroll into a Medicaid Managed Care plan (NY SSL § 364-j(3)(e)(xx); Medicaid Managed Care Model Contract (Appendix H-6), effective 3/1/2014 – 2/28/2019). However, they will remain eligible for fee-for-service Medicaid with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, or failing to provide a valid social security number (NY SSL § 366(4)(c)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you and your spouse's enrollment in your Medicaid Managed Care plan was terminated effective June 1, 2016 because you had full benefit health insurance or Medicare

In the April 27, 2016 notice of eligibility determination, you and your spouse were found eligible for Medicaid, effective April 1, 2016 and were enrolled in a Medicaid Managed Care plan, effective June 1, 2016, as documented by the April 28, 2016 notice of enrollment confirmation.

Generally, when an individual is eligible for Medicaid through NYSOH, they are required to enroll in a Medicaid Managed Care plan. Applicants determined eligible will be enrolled or remain in their Medicaid Managed Care plan with limited exceptions, including entering prison or another facility that provides medical care, moving out of state, or failing to provide a valid Social Security number.

On December 6, 2016, NYSOH redetermined your household's eligibility for financial assistance with health insurance. On December 7, 2016, NYSOH issued a disenrollment notice advising that you and your spouse's coverage in your Medicaid Managed Care plan would be terminated as of June 1, 2016 because you had full benefit health insurance or Medicare.

When NYSOH determines that a person has active coverage in a health insurance plan outside of NYSOH, that person is not eligible to enroll or remain enrolled in a Medicaid Managed Care plan.

However, you credibly testified that your coverage under your private health insurance ended on June 1, 2016 and submitted documentation from your private health insurance confirming that your coverage ended June 1, 2016.

Therefore, when NYSOH cancelled you and your spouse's coverage in a Medicaid Managed Care plan due to your having third party health insurance, you did not, in fact, have third party health insurance. The information relied upon by NYSOH in making the determination to terminate your coverage under your Medicaid Managed Care plan was incorrect.

Accordingly, the December 7, 2016 disenrollment notice terminating you and your spouse's coverage under your Medicaid Managed Care plan, effective June 1, 2016, is RESCINDED.

Decision

The December 7, 2016 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you and your spouse into your Medicaid Managed Care plan effective June 1, 2016.

Effective Date of this Decision: May 19, 2017

How this Decision Affects Your Eligibility

NYSOH improperly disenrolled you and your spouse from your Medicaid Managed Care plan.

Your case is being sent back to reinstate you and your spouse into your Medicaid Managed Care plan as of June 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 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 7, 2016 disenrollment notice is RESCINDED.

NYSOH improperly disenrolled you and your spouse from your Medicaid Managed Care plan.

Your case is being sent back to reinstate you and your spouse into your Medicaid Managed Care plan as of June 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:

[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)

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).

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)

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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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