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

Notice of Decision

Decision Date: June 30, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016030

[redacted]

Dear [redacted]

On May 24, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 21, 2016 disenrollment notice, January 20, 2017 eligibility determination notice and the January 21, 2017 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: June 30, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016030

[redacted]

Issue

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

> Did NY State of Health properly determine that your enrollment in a Medicaid Managed Care plan terminated effective November 30, 2016?

Procedural History

On March 5, 2016, NY State of Health (NYSOH) issued an eligibility determination notice stating that you were eligible for Medicaid effective March 1, 2016. See [redacted].

On March 5, 2016, NYSOH issued a notice of enrollment confirming your enrollment in a Medicaid Managed Care plan, with a plan enrollment start date of March 1, 2016. See [redacted]

On September 16, 2016, your spouse was added to your NYSOH account and an application was submitted for financial assistance with health insurance. See [redacted].

On September 17, 2016, NYSOH issued an eligibility determination notice stating you were conditionally eligible for Medicaid, effective November 1, 2016. The notice asked that you provide proof of your Citizenship Status and Social Security Number by December 15, 2016. See [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).

On November 11, 2016, NYSOH issued an eligibility determination notice stating you were newly conditionally eligible to purchase a qualified health plan at full cost effective December 1, 2016. The notice asked that you provide proof of your Citizenship Status and Social Security Number by December 15, 2016. See [redacted].

On November 11, 2016, NYSOH you were added to your spouse's account ([redacted]) and an application was submitted on your behalf for financial assistance.

On November 12, 2016, an eligibility determination notice was issued stating you were conditionally eligible for Medicaid effective December 1, 2016. You were asked to provide proof of your and your spouse's income by November 26, 2016, and proof of your Citizenship Status and Social Security number by February 9, 2017. See [redacted].

On November 12, 2016, NYSOH received a copy of your U.S. birth certificate and letter of separation from your employer in [redacted].

On November 21, 2016, NYSOH issued a disenrollment notice stating your Medicaid Managed Care plan would end effective November 30, 2016. The notice stated this was because you were no longer eligible to enroll in your current health plan. See [redacted].

On December 2, 2016, a NYSOH representative invalidated your Citizenship documentation. See [redacted].

On December 3, 2016, NYSOH issued a notice stating the documentation that was reviewed does not confirm the information in your application. You were asked to provide proof of your Citizenship Status and Social Security Number by February 9, 2017. See [redacted].

On December 3, 2016, NYSOH issued an eligibility determination notice stating your spouse was eligible for Medicaid, and you were conditionally eligible for Medicaid, effective December 1, 2016. The notice asked that you provide proof of your Citizenship Status and Social Security number by February 9, 2017. See [redacted].

On December 6, 2016, NYSOH issued an enrollment notice confirming your and your spouse's enrollment on December 5, 2016 in a Medicaid Managed Care plan starting January 1, 2017. See [redacted].

On December 8, 2016, NYSOH received a copy of your U.S. Passport. See [redacted]

On December 10, 2016, NYSOH issued a disenrollment notice terminating your enrollment in your Medicaid Managed Care plan effective January 1, 2017. See [redacted]

Also on December 10, 2016, NYSOH issued an enrollment notice confirming your spouse's enrollment in a Medicaid Managed Care plan starting January 1, 2017, the notice also stated you needed to pick a health plan. See [redacted].

On December 27, 2016, NYSOH received a copy of your Social Security Card. See [redacted].

On January 20, 2017, NYSOH issued an eligibility determination notice based on your updated application on January 19, 2017 stating you and your spouse remained eligible for Medicaid. Your spouse was eligible for Medicaid effective January 1, 2017, and you were eligible for Medicaid effective February 1, 2017. See [redacted].

Also on January 20, 2017, NYSOH issued a notice stating you were eligible for Medicaid September 1, 2016 through November 30, 2016 because your monthly household income of $0.00 was at or below the monthly income limit of $3,747.00. See [redacted].

On January 21, 2017, NYSOH issued an enrollment notice confirming your and your spouse's enrollment on January 20, 2017. The notice stated your spouse's Medicaid Managed Care plan would start January 1, 2017, and your plan would start March 1, 2017. See [redacted].

On February 21, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your enrollment in your Medicaid Managed Care plan, insofar as your enrollment did not begin December 1, 2016. See [redacted].

On May 24, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open up to 15 days, to allow you to submit supporting documents.

On May 24, 2017, NYSOH received a two-page fax which was incorporated into the record as (Appellant's Exhibit 1).

Findings of Fact

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

1) You testified, and your account confirms, that you were determined eligible for Medicaid effective March 1, 2016 under [redacted].

2) The record shows you were enrolled in a Medicaid Managed Care plan starting March 1, 2016 under [redacted].

3) You had two accounts with NYSOH, [redacted] and [redacted].

4) The record reflects your account [redacted]. was made inactive and you were placed on your spouse's account [redacted].

5) On November 11, 2016, a notice was issued from NYSOH stating you needed to provide proof of your Citizenship Status and Social Security Number by December 15, 2016 under [redacted].

6) You testified, and your account confirms, that on November 30, 2016 you were disenrolled from your Medicaid Managed Care plan under [redacted].

7) You testified you were married in June, 2016, and changed your last name to take your husband's last name.

8) On December 27, 2016, NYSOH received a copy of your Social Security Card with your new last name on it. See [redacted].

9) You testified that you were without a Medicaid Managed Care plan during December, 2016, January 2017, and February 2017, and incurred medical bills.

10) On May 24, 2017, NYSOH received a two-page fax showing a letter from your Medicaid Managed Care plan dated December 7, 2016 stating your Medicaid Managed Care plan would start January 1, 2017 (See Appellant's Exhibit 1, pg. 2).

11) The record indicates that you were reenrolled into a Medicaid Managed Care plan on January 20, 2017 for a March 1, 2017 start date.

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)).

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)).

Presumptive Eligibility for Pregnant Women

In New York State, presumptive eligibility for Medicaid is a means of immediately providing Medicaid coverage for prenatal care services pending a full Medicaid eligibility determination. A pregnant woman does not need to provide documentation of income for the presumptive eligibility determination. Pregnant women are also not required to document citizenship/immigration status for presumptive eligibility or for ongoing Medicaid eligibility. Citizenship/immigration status is not an eligibility requirement for a pregnant woman throughout her pregnancy and for 2 months after the month in which the pregnancy ends (N.Y. Soc. Serv. Law § 366 (4)(b)). Medicaid pays providers during the presumptive eligibility period for care provided to pregnant women; however, as a matter of Medicaid Program policy, labor and delivery services are excluded from payment.

Verification of Social Security Number

NYSOH must review an applicant’s Social Security Number (SSN) when applying for Medicaid, as well as case records for those already enrolled to determine whether they contain a beneficiary’s SSN, or in the case of families, each family member’s SSN. If the case record does not contain the required SSN’s, the agency must require the beneficiary to furnish them (42 CFR §§ 435.910, 435.920 (a)(b)).

Citizenship Verification

If an applicant attests to citizenship, status as a national, or lawful presence, and NYSOH is unable to verify such attestation, NYSOH must provide the applicant with notice of the inconsistency. NYSOH must then provide the applicant with 90 days to provide satisfactory documentary evidence, from the date the notice of inconsistency is received by the applicant. Notice is considered received 5 days after the date on the notice, unless the applicant demonstrates that he or she did not receive the notice within the 5-day period (42 CFR § 600.345, 45 CFR § 155.315(c)(3), (f)(2)(i)).

Medicaid Effective Date for Enrollments

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)).

Legal Analysis

The issue for review is whether NYSOH properly determined that your enrollment in your Medicaid Managed Care plan was terminated effective November 30, 2016.

You were found fully eligible for Medicaid effective March 1, 2016 and were enrolled in a Medicaid Managed Care plan with an effective date of March 1, 2016 under [redacted].

You testified that you were married in June, 2016, and changed your last name to take your husband's last name. On September 16, 2016, your spouse was added to your NYSOH account [redacted]) and an application was submitted for financial assistance with health insurance. As a result of this new application, you were found conditionally eligible for Medicaid and were asked to provide proof of your Citizenship Status and SSN by December 15, 2016.

NYSOH must review an applicant's SSN when applying for Medicaid, as well as case records for those already enrolled to determine whether they contain a

beneficiary's SSN. It is assumed that NYSOH was requesting this documentation in order to confirm your SSN with the new name.

Prior to the December 15, 2016 deadline, on November 21, 2016, NYSOH issued a disenrollment notice stating your Medicaid Managed Care plan would end effective November 30, 2016.

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." 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. A review of the record supports that the only information that changed in the September 16, 2016 application was to add your spouse to the account. Since this is not a disaqualifying event and because there is no indication that your SSN changed or would have changed as a result of your last name changing, you should have remained fully eligible for Medicaid and remained enrolled in your Medicaid Managed Care plan under [redacted].

Accordingly, the November 21, 2016, disenrollment notice under [redacted] is RESCINDED.

Generally, NYSOH Appeals Unit would return your case to NYSOH to reinstate your coverage. However, your account, [redacted] is now inactive.

On November 11, 2016, NYSOH you were added to your spouse's account ([redacted]) and an application was submitted on your behalf for financial assistance. As a result, you were asked to produce proof of your income, citizenship status, and SSN under [redacted]. You provided sufficient documentation and your application was resubmitted on January 19, 2017 under [redacted].

On January 20, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid effective February 1, 2017. You were subsequently reenrolled into a Medicaid Managed Care plan with a start date of March 1, 2017.

Since you should have remained enrolled in your Medicaid Managed Care plan in [redacted] until the end of your 12 months continuous coverage, your coverage in your spouse's account should be backdated in accordance with the continuous coverage you should have had in your now inactive account.

Therefore, the January 20, 2017 eligibility determination notice and the January 21, 2017 enrollment confirmation notice in [redacted] are MODIFIED to

state that you were eligible for and enrolled in a Medicaid Managed Care plan, effective December 1, 2016.

Decision

The November 21, 2016, disenrollment notice in [redacted] is RESCINDED.

The January 20, 2017 eligibility determination notice and the January 21, 2017 enrollment confirmation notice in [redacted] are MODIFIED to state that you were eligible for and enrolled in a Medicaid Managed Care plan, effective December 1, 2016.

Your case is RETURNED to NYSOH to reinstate your Medicaid Managed Care plan effective December 1, 2016 through February 28, 2017.

Effective Date of this Decision: June 30, 2017

How this Decision Affects Your Eligibility

NYSOH improperly disenrolled you from your Medicaid Managed Care plan.

Your case is being sent back to reinstate your Medicaid Managed Care plan as of December 1, 2016, through February 28, 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 21, 2016, disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid Managed Care plan effective December 1, 2016 through February 28, 2017.

NYSOH improperly disenrolled you from your Medicaid Managed Care plan.

Your case is being sent back to reinstate your Medicaid Managed Care plan as of December 1, 2016, through February 28, 2017.

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).

Legal Authority

We are issuing this determination in accordance with 45 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).

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 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.

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).