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

Notice of Decision

Decision Date: September 05, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Numbers: AP000000016755

[redacted]

Dear [redacted],

On July 21, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 14, 2017 discontinuance and disenrollment 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 NY State of Health 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.

This page intentionally left blank.

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: September 05, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Numbers: AP000000016755

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly end your Medicaid Managed Care (MMC) plan, effective February 1, 2017?
>
> Did NYSOH properly terminate your Medicaid Fee-For-Service (FFS) coverage, effective January 31, 2017?

Procedural History

On July 3, 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 qualified for financial help paying for health coverage, and that you needed to update your account between July 16, 2016 and August 15, 2016 to complete your renewal.

On August 8, 2016, your NYSOH account was updated.

On August 9, 2016, NYSOH issued an eligibility determination notice stating that you remained eligible for Medicaid, effective as of September 1, 2016,.

Also on August 9, 2016, NYSOH issued a plan enrollment notice confirming that on August 8, 2016, you enrolled in a MMC plan with an enrollment start date of November 1, 2015.

On December 30, 2016, NYSOH issued a disenrollment notice stating that on December 29, 2016, you requested to end your MMC coverage, and your coverage would end on December 31, 2016.

On January 12, 2017, NYSOH issued a plan enrollment notice confirming that on January 11, 2017, you were enrolled in a MMC plan with an enrollment start date of February 1, 2017. The notice stated that you were enrolled into this plan because you did not select a health plan.

On January 13, 2017, your NYSOH account was updated.

On January 14, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for financial assistance or to enroll in health insurance because you no longer want to remain covered through NYSOH.

On January 14, 2017, NYSOH issued a disenrollment notice stating that on January 13, 2017, you requested to end your MMC coverage, and your coverage would end on February 1, 2017.

On March 9, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal relative to the end date of your Medicaid FFS and MMC plan coverages.

On July 21, 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 dates that your Medicaid FFS coverage and MMC plans ended.

2) According to your NYSOH account, on August 8, 2016, you were determined eligible for Medicaid and enrolled in a MMC plan.

3) According to your NYSOH account and testimony, on December 29, 2016, you accessed your account and deleted your MMC enrollment.

4) According to your NYSOH account, on January 11, 2017, you were automatically assigned a MMC plan.

5) According to your NYSOH account and testimony, on January 13, 2017, you contacted NYSOH and changed your status to “Not Applying for Health Coverage” because you have “MEC outside of NYSOH.”

6) You testified that you were enrolled in employer-sponsored insurance effective January 1, 2017.

7) You testified that you want your MA FFS coverage and MMC plan to end effective December 31, 2016.

8) According to the enrollment history in your NYSOH account, you were not enrolled in a MMC plan as of December 31, 2016,.

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

Applicable Law and Regulations

Medicaid - Eligibility

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 FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

Medicaid Continuous Coverage:

Most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage. This twelve-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 (*see* 42 CFR § 435.916(a); N.Y. Soc. Serv. Law § 366(4)(c)).

In the following situations, individuals are not entitled to receive continuous coverage:

- Unable to locate;
- Death;
- Consumer requests to have his/her Medicaid closed;

- Failure to provide or cooperate in obtaining a Social Security Number, if otherwise required;
- Failure to provide documentation of citizenship after the reasonable opportunity period;
- Moved out of State;
- Coverage established under MAGI in error;
- Undocumented pregnant women (only get 60 days post-partum);
- Failure to comply with absent parent (IV-D) requirements; and
- Individuals receiving treatment in a setting where Medicaid eligibility is not available

(*see* 42 CFR § 435.916(a); N.Y. Soc. Serv. Law § 366(4)(c); GIS 15 MA/22).

MMC Enrollment

The United States Department of Health and Human Services has granted the State of New York a waiver pursuant to Section 1115 of the Social Security Act to permit the operation of a demonstration waiver program for Managed Care Programs in which certain eligible Medicaid recipients are subject to mandatory enrollment.

A "Managed Care Program" is a statewide program in which Medicaid recipients enroll on a voluntary or mandatory basis to receive Medicaid Services, including from a managed care provider. Individuals shall select a MMC plan at the time of application for Medicaid. If the individual does not choose a plan, the individual shall be automatically assigned a plan (N.Y. Soc. Serv. Law §§ 364-j(1)(c), 364-j(4)(f)(i)).

NYSOH is responsible for processing routine disenrollment requests to take effect on the first day of the following month if the request is made before the fifteenth day of the month. In no event shall the effective date of disenrollment be later than the first day of the second month after the month in which an enrollee requests a disenrollment (Medicaid Managed Care Model Contract (Appendix H-7(a)(iii), effective 3/1/2014 – 2/28/2019).

Legal Analysis

The first issue under review is whether NYSOH properly ended your Medicaid FFS coverage effective January 31, 2017.

On August 8, 2016, you submitted a financial assistance application through NYSOH. Based on that application, you were determined eligible for Medicaid, effective September 1, 2016.

Generally, once adults are determined eligible for Medicaid, they are guaranteed 12 months of Medicaid coverage, even if the adult loses Medicaid eligibility because of any changes or updates they make to their NYSOH account. This twelve-month period is based on the effective date of the Medicaid eligibility determination. Under certain circumstances, including a request by the enrollee to end their Medicaid coverage, the continuous coverage may end.

You testified that you accessed your account on December 29, 2016, to end your health insurance through NYSOH because your employer-sponsored insurance was to become effective January 1, 2017. The record reflects that you deleted your MMC plan enrollment; however, your account still reflected that you were applying for health insurance through NYSOH.

The record supports that, on January 13, 2017, you contacted NYSOH and your account was updated to reflect that you were "Not Applying for Health Coverage" through NYSOH. Since it was properly documented that you were no longer seeking health insurance through NYSOH as of January 13, 2017, NYSOH properly ended your Medicaid FFS coverage effective January 31, 2017.

Therefore, the January 14, 2017, eligibility determination notice is AFFIRMED.

The second issue under review is whether NYSOH properly ended your MMC plan effective February 1, 2017.

On August 9, 2016, you re-enrolled in a MMC plan through NYSOH. As stated above, you deleted your MMC enrollment on December 29, 2016; however, your account still reflected that you were applying for health insurance through NYSOH. Therefore, you were still enrolled in MA FFS coverage.

Generally, Medicaid recipients must enroll in a MMC plan. If the individual does not select a plan, the individual shall be automatically assigned a plan.

On January 12, 2017, NYSOH issued an enrollment notice confirming that as of January 11, 2017, you were enrolled in a MMC plan with an enrollment start date of February 1, 2017. The notice states, "[y]ou have been enrolled into this plan because you did not select a health plan" (*see* Document [redacted]).

NYSOH must process requests by enrollees to disenroll them from their MMC plan. The disenrollment must be effectuated the first day of the following month, if the request is made before the fifteenth day of the month.

On January 13, 2017, your account was updated to reflect that you were "Not Applying for Health Coverage," and your MMC enrollment was deleted. Since your enrollment was deleted as of January 13, 2017, NYSOH properly ended your MMC plan coverage effective February 1, 2017.

Therefore, the January 14, 2017 disenrollment notice is AFFIRMED.

Your NYSOH account reflects that your MMC plan coverage was terminated effective December 31, 2016. Since you terminated your MMC plan before the coverage was effective February 1, 2017, you were no longer enrolled in a MMC plan as of December 31, 2016.

Decision

The January 14, 2017 eligibility determination notice is AFFIRMED.

The January 14, 2017 disenrollment notice is AFFIRMED.

Effective Date of this Decision: September 05, 2017

How this Decision Affects Your Eligibility

You were enrolled in Medicaid FFS coverage through NYSOH until January 31, 2017.

You were enrolled in a MMC plan through NYSOH until December 31, 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 January 14, 2017 eligibility determination notice is AFFIRMED.

The January 14, 2017 disenrollment notice is AFFIRMED.

You were enrolled in Medicaid FFS coverage through NYSOH until January 31, 2017.

You were enrolled in a MMC plan through NYSOH until December 31, 2016.

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.

□□□□□ (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).

□□□ □□ □□□□□□□□□□□□□ □□□□ □□□ □□□□□ □□□□□ □□□ □□□□□□□□□□ □□□□□□□□□ □□ □□□□□, □□□□□□□□ □□□ 1-855-355-5777 □□□□□□□ □□ □□□□□ □□□□ □□ □□□□□□□ □□□ □□□□ □□□□□□□□□□□ □□□□□ □□□□□□□ □□□□□ □□□□□□□ □□□□□ □□□□□□

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)

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).

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).