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

Notice of Decision

Decision Date: August 23, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017546

[redacted]

Dear [redacted],

On July 13, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 16, 2017 eligibility determination and 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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Decision

Decision Date: August 23, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017546

[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 Medicaid and your Medicaid Managed Care plan through NYSOH because mail sent to you was returned as undeliverable?

Procedural History

On September 10, 2016, NYSOH issue a notice of eligibility determination stating that you remained eligible for Medicaid coverage of inpatient hospital services only, effective September 1, 2016. This was because NYSOH received information that shows that you are currently incarcerated in [redacted].

On December 19, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for full Medicaid, effective December 1, 2016.

On December 29, 2016, NYSOH issued an enrollment notice, confirming your enrollment in Empire BlueCross BlueShield HealthPlus (Empire BCBS) as your Medicaid Managed Care (MMC) plan, with a start date of February 1, 2017.

NYSOH received by return mail a notice issued to you by NYSOH on December 19, 2016. This notice was posted to your NYSOH account on February 15, 2017, though reflects it was initially received by NYSOH on December 29, 2016.

On February 16, 2017, NYSOH issued an eligibility redetermination notice stating that you were not qualified to enroll in coverage through NYSOH because information was sent to you by mail at the mailing address in your account, and it was returned to NYSOH as undeliverable.

Also on February 16, 2017, NYSOH issued a disenrollment notice stating that your enrollment in your MMC plan was terminated effective February 28, 2017 because you were no longer eligible to enroll in health insurance through NYSOH.

On March 28, 2017, NYSOH received an update to your application for health insurance.

On March 29, 2017, NYSOH issued an eligibility determination notice based on the information contained in the March 28, 2017 application. The notice stated that you were found eligible to enroll in the Essential Plan with a $0.00 premium, effective May 1, 2017.

Also on March 29, 2017, NYSOH issued an enrollment notice confirming your selection of an Essential Plan as of March 28, 2017. The notice stated that your coverage under this Essential Plan would begin effective May 1, 2017.

On March 30, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal of the February 16, 2017 eligibility determination notice insofar as it caused you to experience a gap in coverage during the months of March and April 2017.

On July 13, 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 were initially found eligible for Medicaid coverage of inpatient hospital services as of September 1, 2016. This was later converted to full Medicaid eligibility, effective December 1, 2016. These eligibility determinations are not under review.

2) You testified that you were released from [redacted] on [redacted] 2016.

3) Your application was received on December 18, 2016, which included an apparent change of address to '[redacted]."

4) Based on the application submitted to NYSOH on December 18, 2016, you were found eligible for full Medicaid eligibility, effective December 1, 2016. You enrolled in Empire BCBS as your MMC on that same date, with such coverage beginning on February 1, 2017.

5) Your NYSOH account reflects that a notice mailed to you on December 19, 2017 was stamped as "Return Mail" on December 29, 2016. The notice was addressed as follows:

[redacted]

The returned notice was uploaded to your NYSOH account on February 15, 2017, along with an envelope with a label stating, "Return to Sender, Not Deliverable As Addressed, Unable to Forward."

6) You testified that you have never lived at that address, nor designated that address for the receipt of your mailings.

7) You testified that you only discovered that you had been disenrolled from your MMC plan coverage was when you received billings from your physicians during March 2017.

8) You testified, and your NYSOH account reflects, that you contacted NYSOH to re-enroll in coverage on March 28, 2017, and update your address to:

[redacted]

Because of the March 28, 2017 application, you were found eligible for coverage under the Essential Plan, effective May 1, 2017.

9) You testified that your disenrollment from Medicaid resulted in you having a gap in coverage during the months of March and April 2017.

10) You testified that because you did not have health insurance during March and April 2017, you had medical expenses that were not covered.

11) You testified that you are looking to have your MMC plan coverage reinstated for the months of March and April 2017 so that you can be reimbursed for those expenses.

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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your eligibility for, and enrollment in, your Medicaid and MMC plan coverage ended as of February 28, 2017 because mail sent to you by NYSOH was returned as undeliverable.

You were originally found eligible for Medicaid coverage of inpatient hospital services only, effective September 1, 2016. This was later converted to full

Medicaid eligibility, effective December 1, 2016, which coincided with your release from [redacted] on or about [redacted] 2016. These eligibility determinations are not at issue in this appeal.

Under New York State law, once a person is eligible for Medicaid, that eligibility continues for twelve months, with limited exceptions. This provision is called "continuous coverage." One of the exceptions to continuous coverage is a lack of NY State residence.

On February 15, 2017, NYSOH uploaded a copy of a December 19, 2016 notice that was sent to you and had been marked "Return Mail" on December 29, 2016. The notice was uploaded along with an envelope bearing a "Return to Sender" label. During the hearing, you testified that you have never lived at that address, nor designated that address for the receipt of your mailings. You further testified that after your release from [redacted] Facility, you have only resided at "[redacted]," so you are unaware of who provided NYSOH with the [redacted] address referenced in the December 19, 2016 eligibility determination notice.

After mail sent to you was returned to NYSOH, NYSOH determined that you were not eligible to enroll in coverage through NYSOH and discontinued your MMC plan. However, your credible testimony is that you lived continuously at the you have only resided at [redacted] since your release from [redacted]. Accordingly, we find that there is sufficient evidence that you should not have been disenrolled from your Medicaid and MMC plan coverage as of February 28, 2017.

As such, your enrollment in your Medicaid coverage and your MMC plan should not have been terminated as of February 28, 2017. Instead, your Medicaid and MMC coverage should continue for a 12-month period that began on December 1, 2016, so long as no there are no intervening events that make you ineligible.

Therefore, the February 16, 2017 eligibility determination and disenrollment notices are RESCINDED.

Furthermore, the March 29, 2017 eligibility determination notice finding you eligible for the Essential Plan is no longer supported by the record, and is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid coverage and your MMC enrollment as of March 1, 2017, so that there is no gap in your coverage.

Decision

The February 16, 2017 eligibility determination and disenrollment notices are RESCINDED.

The March 29, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid coverage and your MMC enrollment as of March 1, 2017, so that there is no gap in your coverage.

Effective Date of this Decision: August 23, 2017

How this Decision Affects Your Eligibility

Your Medicaid coverage, which began on December 1, 2016, should continue until November 30, 2017, so long as there are no intervening events that make you ineligible.

Your MMC coverage should not have been terminated as of February 28, 2017.

Your case is being sent back to NYSOH to reinstate your MMC plan coverage as of March 1, 2017.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services. 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 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 February 16, 2017 eligibility determination and disenrollment notices are RESCINDED.

The March 29, 2017 eligibility determination notice is RESCINDED.

Your MMC coverage should not have been terminated as of February 28, 2017.

Your case is being sent back to NYSOH to reinstate your MMC plan coverage as of March 1, 2017.

Legal Authority

We are sending you this notice 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.

□□□□□ (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).

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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).