



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

## Notice of Decision

Decision Date: August 21, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000018173

[REDACTED]

[REDACTED]

On August 15, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 25, 2017 eligibility determination 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 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: August 21, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000018173



## 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 your Medicaid Managed Care plan ended effective March 31, 2017?

## Procedural History

On February 1, 2017, NY State of Health (NYSOH) issued a notice stating that the income information in your application did not match what NYSOH received from state and federal data sources. The notice instructed you to provide proof of income before February 15, 2017 to confirm your eligibility.

On February 15, 2017, NYSOH issued an eligibility determination notice, based on your updated application, stating that you were eligible for Medicaid effective January 1, 2017.

On February 16, 2017, NYSOH issued a plan enrollment notice confirming your selection of a Medicaid Managed Care (MMC) Plan with an effective start date of March 1, 2017.

On March 25, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid, Child Health Plus, or to receive tax credits or cost-sharing reductions to help pay for the cost of insurance. You also could not enroll in a qualified health plan at full cost. This was because notices sent to you by NYSOH were returned to the Marketplace as undeliverable. Your eligibility ended March 25, 2017.

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Also on March 25, 2017, NYSOH issued a disenrollment notice stating that your coverage in your MMC plan would end on March 31, 2017. This was because you were no longer eligible to remain enrolled in health insurance through NYSOH.

On March 30, 2017, NYSOH issued an eligibility determination notice, based on your March 29, 2017 updated application, stating that you were eligible for Medicaid effective as of April 1, 2017.

Also on March 30, 2017, NYSOH issued a plan enrollment notice confirming your selection of a MMC plan and the effective date of that plan was May 1, 2017.

On April 19, 2017, you spoke to NYSOH's Account Review Unit and appealed the March 25, 2017 disenrollment notice insofar as your enrollment in your MMC plan ended on March 31, 2017, resulting in a lapse in MMC coverage for the month of April 2017.

On August 15, 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) According to your NYSOH account and your testimony, you initially applied for health insurance through NYSOH on January 31, 2017. On February 1, 2017, NYSOH issued a notice that was returned as undeliverable on February 17, 2017. Thus, you were terminated from your MMC Plan, effective April 1, 2017.
- 2) You testified that you realized that you were being disenrolled from your MMC plan when you received NYSOH's March 25, 2017 disenrollment notice in the mail.
- 3) According to your NYSOH account, on March 29, 2017, NYSOH received your updated application for health insurance. You selected your MMC plan that day and your enrollment was effective on May 1, 2017.
- 4) According to your NYSOH account and your testimony, on March 29, 2017, a NYSOH representative updated your address by changing "[REDACTED]" to "[REDACTED]" in your NYSOH account. You testified that "[REDACTED]" is the correct address and you are unsure why she changed it, but that the changed address is working nonetheless.

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- 5) According to your NYSOH account, no other notices have been returned as undeliverable to the address on file, including the notices delivered to the "[REDACTED]" address.
- 6) You testified that you have resided in the same address since October 2016 and have never had any issues with receiving your mail. You are unsure why your February 1, 2017 notice was returned to NYSOH.
- 7) According to your NYSOH account, the envelope in which your February 1, 2017 notice was returned to NYSOH states, "Return to Sender: Not Deliverable as Addressed."
- 8) You testified that you were told by a NYSOH representative that your coverage would not become effective until May 1, 2017 because you had notices that were returned to NYSOH as undeliverable.
- 9) You testified that you want your MMC plan reinstated for the month of May 2017 because you should not have a lapse in coverage for something that is not your fault. Additionally, you went to the doctor in April and, although you have not received any bills, you are unsure of what the doctor did about getting payment for the services rendered.

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 an individual was eligible 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)).

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; see 42 USC § 1315; § 364-j(1)(c); 18 NYCRR § 360-10.3(h), 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

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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)).

### State Residency Requirement

To be eligible for enrollment in a MMC plan through the New York State of Health, an applicant must be a resident of New York State (NY Public Health Law § 2510(6)).

## **Legal Analysis**

The issue under review is whether NYSOH properly determined that your enrollment in your MMC plan ended effective March 31, 2017.

You were originally found eligible for a MMC plan and enrolled effective March 1, 2017.

According to your NYSOH account, on February 1, 2017, NYSOH issued a notice that was returned to NYSOH as undeliverable on February 17, 2017. A review of the record reflects that this was the only notice returned as undeliverable despite several other notices being sent to the exact same address.

You were subsequently disenrolled under the returned mail rule on the basis that you did not meet the state residency requirement. As such, on March 25, 2017, NYSOH issued eligibility determination and disenrollment notices stating respectively that you were no longer eligible to enroll in Medicaid and your coverage in your MMC plan would end effective March 31, 2017.

The credible evidence of the record reflects that the February 1, 2017 notice was the only notice returned as undeliverable to NYSOH despite other notices being sent to the same mailing address. Additionally, the envelope on the return letter states, "Return to Sender: Not Deliverable as Addressed" indicating that the address on the envelope was incorrect when it was not.

Since it is reasonable to conclude that this notice was returned as undeliverable through no fault of your own, and quite possibly it was the result of an error of NYSOH or the United State Postal Service, it is also reasonable to conclude that your disenrollment from your MMC plan was in error.

Therefore, the March 25, 2017 eligibility determination and disenrollment notices must be RESCINDED.

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).

Your case is RETURNED to NYSOH to reinstate you in your MMC plan for the month of April 2017, and to notify you accordingly.

## **Decision**

The March 25, 2017 eligibility determination and disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to reinstate you in your MMC plan for the month of April 2017, and to notify you accordingly.

**Effective Date of this Decision:** August 21, 2017

## **How this Decision Affects Your Eligibility**

Your case is sent back to NYSOH to reinstate you in a MMC plan for the month of April 2017. NYSOH will notify you once this has been done.

## **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

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).

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 March 25, 2017 eligibility determination and disenrollment notices are **RESCINDED**.

Your case is **RETURNED** to NYSOH to reinstate you in your MMC plan for the month of April 2017, and to notify you accordingly.

Your case is sent back to NYSOH to reinstate you in a MMC plan for the month of April 2017. NYSOH will notify you once this has been done.

### **Legal Authority**

We are issuing this determination in accordance with 45 CFR § 155.545.

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**A Copy of this Decision Has Been Provided To:**



## **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.

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## বাংলা (Bengali)

এই নথি গুরুত্বপূর্ণ। আপনি যদি এটি বুঝতে সাহায্যের প্রয়োজন হয়, তবে দয়া করে 1-855-355-5777-এ কল করুন। আমরা আপনার ভাষায় একটি ব্যক্তিগত ব্যাচেলর প্রদান করতে 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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&btumi ama wo obi a okyerE kasa a woka no ase ama wo kwa a wontua hwee.

## (Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 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.

## אַײַדיש (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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