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

Notice of Decision

Decision Date: September 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018421

[redacted]

Dear [redacted],

On September 8, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 2, 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: September 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018421

[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 for Medicaid and your Medicaid Managed Care plan coverage, effective March 31, 2017?

Procedural History

On November 29, 2016, NYSOH issued a notice of eligibility determination stating that were eligible for Medicaid, effective December 1, 2016.

Also on November 29, 2016 NYSOH issued a notice of enrollment confirming your Medicaid Managed Care (MMC) plan selection on November 28, 2016, with a plan enrollment start date of January 1, 2017.

On December 21, 2016, NYSOH issued a notice confirming your request to change your mailing address to:

[redacted]

On January 3, 2017, NYSOH received an update to your application for health insurance.

On January 4, 2017, NYSOH issued a notice stating that you were no longer eligible for Medicaid. However, the notice further stated that your Medicaid

coverage would continue until November 30, 2017. This was because certain individual who qualified for Medicaid get coverage for twelve continuous months from the date they were last determined eligible. This eligibility determination was effective as of January 1, 2017. This notice was returned to NYSOH as undeliverable on January 23, 2017.

On March 2, 2017, NYSOH issued a notice of eligibility redetermination stating that you were not qualified to enroll through NYSOH as notices sent to you by U.S mail to the mailing address provided in your account were returned to NYSOH as undeliverable. The notice further stated that your eligibility would end effective March 31, 3017.

Also on March 2, 2017, NYSOH issued a disenrollment notice advising you that your enrollment in Medicaid and your MMC plan would end effective March 31, 2017 as you were no longer eligible to enroll in health insurance through NYSOH.

On March 8, 2017, NYSOH received an update to your application for health insurance.

On March 9, 2017, NYSOH issued an eligibility determination notice, based on the information contained in the March 8, 2017 application. The notice stated that you were eligible to enroll in a qualified health plan (QHP) at full cost. You were also found not eligible for Medicaid because you did not meet the income limits or other eligibility standard for this program.

Between March 31, 2017 and April 26, 2017, NYSOH received several application updates. In each case, NYSOH issued notices stating that the income information in your application does not match what NYSOH received from state and federal data sources. It requested that you provide additional income information to confirm your eligibility.

On April 26, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal March 2, 2017 eligibility determination and disenrollment notices insofar as you were seeking for your Medicaid and MMC plan coverage to be reinstated as of April 1, 2017.

On May 22, 2017, NYSOH redetermined your eligibility for health insurance.

On May 23, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in a QHP at full cost. You were also found not eligible for Medicaid because you did not meet the income limits or other eligibility standard for this program.

On June 16, 2017, NYSOH issued a notice confirming your request to change your mailing address to:

[redacted]

On September 8, 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 have lived in New York State continuously since your release from [redacted] during early 2016.

2) Your NYSOH account reflects that on December 21, 2016 you contacted NYSOH and updated your mailing address to [redacted].

3) You testified, and your NYSOH account reflects, that you lived at [redacted] until you moved to [redacted] on or about June 16, 2017.

4) The January 4, 2017 eligibility determination notice that was sent to the [redacted] was returned to NYSOH as undeliverable on January 23, 2017, but not posted to your NYSOH account until March 1, 2017.

5) You testified that you are seeking to be reenrolled into Medicaid and your Medicaid Managed Care plan, effective March 1, 2017 as you believe that your coverage should not have been cancelled and you should have been granted 12 months of continuous Medicaid coverage.

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

Applicable Law and Regulations

<u>Medicaid for Adults between the Ages of 19 and 65</u>

Medicaid through NYSOH can be provided 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); N.Y. Soc. Serv. Law § 366(1)(b)).

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)).

Under 42 CFR § 435.403 Medicaid must be provided to “eligible residents of the State” (42 CFR § 435.403(a)). A person shall not be eligible for Medicaid unless he or she is a resident of the state, or, while temporarily in the state, requires immediate medical care which is not otherwise available (N.Y. Soc. Serv. Law § 366(1)(d)(1)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were no longer eligible for Medicaid and your Medicaid Managed Care, effective March 31, 2017.

On November 29, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective December 1, 2016. Also on November 29, 2016, NYSOH issued an enrollment notice confirming your enrollment in a MMC plan, with a plan enrollment start date of January 1, 2017.

On January 3, 2017, NYSOH received an update to your application for health insurance. On January 4, 2017, NYSOH issued a notice stating that you were no longer eligible for Medicaid; however, your Medicaid coverage would continue until November 30, 2017 under “continuous coverage” guidelines. This notice was sent via regular mail to [redacted].

On January 23, 2017, the January 3, 2017 eligibility determination notice was returned to NYSOH because the post office was unable to forward them to another address. This returned document was posted to your NYSOH account on March 1, 2017.

On March 1, 2017, NYSOH issued a notice of eligibility redetermination stating that you were not qualified to enroll through NYSOH because you do not meet the income limits or other eligibility standards for these programs.

Generally, an individual remains eligible for Medicaid for twelve continuous months unless the person becomes otherwise ineligible. If a person lacks state residence or is unable to prove state residence during those twelve months they become ineligible for Medicaid and continuous coverage.

However, the record indicates that on December 21, 2016, the address information in your NYSOH account was updated. Your residential address and legal address were marked as [redacted].

As there is sufficient evidence in the record to conclude that you have continuously retained New York State residency, you were improperly disenrolled from Medicaid and your MMC plan effective March 31, 2017.

Therefore, the March 2, 2017 eligibility determination and disenrollment notices are RESCINDED.

Furthermore, the subsequent eligibility determinations issued on March 9, 2017 and May 23, 2017 are no longer supported by the record, and are also RESCINDED.

The case is RETURNED to NYSOH to facilitate your reenrollment into Medicaid and your MMC plan as of April 1, 2017.

Decision

The March 2, 2017 eligibility determination notice is RESCINDED.

The March 2, 2017 disenrollment notice is RESCINDED.

The March 9, 2017 and May 23, 2017 eligibility determination notices are RESCINDED.

The case is RETURNED to NYSOH to facilitate your reenrollment into Medicaid and your MMC plan as of April 1, 2017.

Effective Date of this Decision: September 13, 2017

How this Decision Affects Your Eligibility

Your Medicaid coverage should not have been terminated as of March 31, 2017

Your enrollment in your MMC plan should not have been terminated as of March 31, 2017.

NYSOH will reenroll you into Medicaid and your MMC plan as of April 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

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).

Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The March 2, 2017 eligibility determination notice is RESCINDED.

The March 2, 2017 disenrollment notice is RESCINDED.

The March 9, 2017 and May 23, 2017 eligibility determination notices are RESCINDED.

The case is RETURNED to NYSOH to facilitate your reenrollment into Medicaid and your MMC plan as of April 1, 2017.

Your Medicaid coverage should not have been terminated as of March 31, 2017

Your enrollment in your MMC plan should not have been terminated as of March 31, 2017.

NYSOH will reenroll you into Medicaid and your MMC plan as of April 1, 2017.

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.

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).

□□□□□ (Bengali)

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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)

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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.

(Yiddish) אידיש

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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