



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

## Notice of Decision

Decision Date: September 29, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000019390

[REDACTED]

Dear [REDACTED]

On August 30, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 15, 2017 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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DEPARTMENT OF HEALTH  
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## Decision

Decision Date: September 29, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000019390

[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 April 30, 2017?

## Procedural History

On January 31, 2017, NY State of Health (NYSOH) issued an eligibility determination notice stating that you were eligible for Medicaid effective January 1, 2017.

Also on January 31, 2017, NYSOH issued an enrollment confirmation notice, stating that you were enrolled in a Medicaid Managed Care plan, effective March 1, 2017.

On April 14, 2017, NYSOH redetermined your eligibility for financial assistance with health insurance.

On April 15, 2017, NYSOH issued a notice of eligibility redetermination stating that you would remain eligible for Medicaid, effective May 1, 2017. The notice also stated that the type of Medicaid coverage you were eligible for does not require or allow you to enroll in a health plan.

Also on April 15, 2017, NYSOH issued a disenrollment notice stating that your enrollment in your Medicaid Managed Care plan would end April 30, 2017, because NYSOH records show you had other health insurance or Medicare.

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On May 23, 2017, you uploaded a letter from [REDACTED] COBRA Administration showing that your coverage through them was cancelled as of March 31, 2017.

On May 26, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid effective May 1, 2017. The notice advised you to pick a health plan.

On May 30, 2017, you selected a Medicaid Managed Care plan for enrollment.

On May 31, 2017, NYSOH issued an enrollment confirmation notice stating that you were enrolled in a Medicaid Managed Care plan, effective July 1, 2017.

Also on May 31, 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 May 1, 2017.

On August 30, 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 September 14, 2017, to allow you to submit supporting documents.

On September 13, 2017, you submitted the requested documentation and it was entered into the record as Appellant's Exhibit #1. The record was closed that day.

## **Findings of Fact**

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

- 1) You testified that you are seeking enrollment in your Medicaid Managed Care plan effective May 1, 2017.
- 2) You testified, and your account confirms, that you were determined eligible for Medicaid effective January 1, 2017.
- 3) The record reflects that on January 30, 2017 you selected a Medicaid Managed Care plan.
- 4) You testified, and your account confirms, that on April 30, 2017 you were disenrolled from your Medicaid Managed Care plan because the system determined that you had active third-party health insurance.

- 5) You testified that you had insurance through COBRA until March 31, 2017, and that you currently have employer-sponsored coverage as of June 1, 2017.
- 6) On May 23, 2017, you uploaded a letter from COBRA stating that your coverage through them ended on March 31, 2017.
- 7) The record indicates that the Third-Party Health Insurance was removed from the system on May 25, 2017.
- 8) You testified that you were without a Medicaid Managed Care plan in May 2017 and incurred medical bills.
- 9) The record does not contain any information from NYSOH regarding where they obtained the information that you were enrolled in third party health insurance.
- 10) The record indicates that you were reenrolled into a Medicaid Managed Care plan on July 1, 2017, and you testified that you are currently covered under your new employer-sponsored insurance plan.
- 11) On September 13, 2017, you uploaded a screenshot of your [REDACTED] [REDACTED] which shows that your current employer-sponsored insurance coverage is active as of June 1, 2017.

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 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)).

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## Continuous Coverage

Most applicants determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage offered through Medicaid Managed Care, even if the adult loses Medicaid eligibility because of any changes or updates they make to their Marketplace 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 any subsequent Medicaid eligibility determination based on modified adjusted gross income (see 42 CFR § 435.916; NY Social Services Law (NY SSL) § 366(4)(c)).

## Third Party Health Insurance

A person who has primary medical or health care coverage available from or under a third-party insurance provider is not permitted to enroll into a Medicaid Managed Care plan (NY SSL § 364-j(3)(e)(xx); Medicaid Managed Care Model Contract (Appendix H-6), effective 3/1/2014 – 2/28/2019). However, they will remain eligible for fee-for-service Medicaid with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, or failing to provide a valid social security number (NY SSL § 366(4)(c)).

## **Legal Analysis**

The issue for review is whether NYSOH properly determined that your enrollment in your Medicaid Managed Care plan was terminated effective April 30, 2017.

In the January 31, 2017 notice of eligibility determination, you were found eligible for Medicaid, effective January 1, 2017. On January 30, 2017, you selected a Medicaid Managed Care plan, effective March 1, 2017, as is documented by the January 31, 2017 notice of enrollment confirmation.

Generally, when an individual is eligible for Medicaid through NYSOH they are required to enroll in a Medicaid Managed Care plan. Applicants determined eligible will be enrolled or remain in their Medicaid plan with limited exceptions, including entering prison or another facility that provides medical care, moving out of state, or failing to provide a valid Social Security number.

On April 14, 2017, NYSOH redetermined your household’s eligibility for financial assistance with health insurance. On April 15, 2017, NYSOH issued a disenrollment notice advising that your coverage in your Medicaid Managed Care plan would be terminated as of April 30, 2017 because you had full benefit health insurance or Medicare.

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).

When NYSOH determines that a person has active coverage in a health insurance plan outside of NYSOH, that person is not eligible to enroll or remain enrolled in a Medicaid Managed Care plan.

However, you credibly testified that your coverage under COBRA health insurance ended on March 31, 2017 and submitted documentation from your COBRA administrator confirming that your coverage ended March 31, 2017. You also testified that you have since become eligible for employer-sponsored coverage as of June 1, 2017. Based on your credible testimony and the record, you did not have third party or employer sponsored insurance in April or May 2017.

Therefore, when NYSOH cancelled your coverage in a Medicaid Managed Care plan due to your having third party health insurance, you did not, in fact, have third party health insurance and the information relied upon by NYSOH in making the determination to terminate your coverage under your Medicaid Managed Care plan was incorrect.

Accordingly, the April 15, 2017 disenrollment notice terminating your coverage under your Medicaid Managed Care plan, effective April 30, 2017 is **RESCINDED**.

You testified that you are seeking enrollment in your Medicaid Managed Care plan as of May 1, 2017. However, you testified and submitted documentation showing that you are covered by employer-sponsored coverage as of June 1, 2017, and are therefore not eligible to enroll in a Medicaid Managed Care plan as of that date. Your case is **RETURNED** to NYSOH to reinstate your Medicaid Managed Care plan for May 2017 only.

## **Decision**

The April 15, 2017 disenrollment notice is **RESCINDED**.

Your case is **RETURNED** to NYSOH to reinstate your Medicaid Managed Care plan for May 2017 only.

**Effective Date of this Decision:** September 29, 2017

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

NYSOH improperly disenrolled you from your Medicaid Managed Care plan.

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 being sent back to reinstate your Medicaid Managed Care plan for May 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

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).



- By mail at:  
NY State of Health Appeals  
P.O. Box 11729  
Albany, NY 12211
- By fax: 1-855-900-5557

## **Summary**

The April 15, 2017 disenrollment notice is RESCINDED.

NYSOH improperly disenrolled you from your Medicaid Managed Care plan.

Your case is RETURNED to NYSOH to reinstate your Medicaid Managed Care plan for May 2017 only.

## **Legal Authority**

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

**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 مجاناً.

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).

## **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।

## **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.

## **Twí (Twi)**

Krataa yi ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&etumi 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.

**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.