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

Notice of Decision

Decision Date: September 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019515

[redacted]

[redacted],

On September 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's May 27, 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 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).

This page intentionally left blank.

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

Decision

Decision Date: September 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019515

[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, your spouse, and six of your seven children's enrollment in a Medicaid Managed Care plan, and your daughter [redacted] enrollment in an Essential Plan, ended effective May 31, 2017?

Procedural History

On March 21, 2017, NYSOH issued an eligibility determination notice stating that you, your spouse, and six of your seven children were determined eligible for Medicaid, effective April 1, 2017. The notice also stated that your daughter, [redacted], was eligible for the Essential Plan, effective May 1, 2017.

Also, on March 21, 2017, NYSOH issued a notice of enrollment confirmation stating that you, your spouse and your six children were enrolled in a Medicaid Managed Care plan, effective May 1, 2017.

On April 8, 2017, NYSOH issued a notice of enrollment confirmation stating that your daughter, [redacted] was enrolled in an Essential Plan, effective May 1, 2017.

On May 27, 2017, NYSOH issued a notice of discontinuance stating that you, your spouse and your seven children were no longer eligible to receive health insurance through NYSOH, effective May 27, 2017, because notices regarding you, your spouse, and your seven children's eligibility and coverage sent to you by NYSOH were returned as undeliverable. This notice also stated that you

needed to update your mailing address so that you could remain eligible for health coverage through NYOSH.

Also on May 27, 2017, NYSOH issued a disenrollment notice stating that coverage in a Medicaid Managed Care plan for you, your spouse, and your six children would end on May 31, 2017. The notice also stated that your daughter, [redacted] was disenrolled from her Essential Plan, effective May 31, 2017.

On June 2, 2017, NYSOH received your updated application for financial assistance with health insurance. That day, a preliminary eligibility determination was prepared in response to that application, stating that you, your spouse, and your six children were determined eligible for Medicaid, effective June 1, 2017 and that your daughter [redacted] was eligible for an Essential Plan, effective July 1, 2017.

Also, on June 2, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as you, your spouse and your 6 children's Medicaid Managed Care plan started on July 1, 2017 and not June 1, 2017 and that your daughter [redacted] Essential Plan started on July 1, 2017 and not June 1, 2017.

On June 3, 2017, NYSOH issued an eligibility determination notice stating that you, your spouse, and your six children were determined eligible for Medicaid, effective June 1, 2017. The notice also stated that your daughter [redacted] was eligible for an Essential Plan, effective July 1, 2017.

Also on June 3, 2017, NYSOH issued an enrollment confirmation notice, based on your June 2, 2017 plan selection, confirming that you, your spouse and your six children were enrolled in a Medicaid Managed Care plan, effective July 1, 2017. The notice also stated that your daughter [redacted] was enrolled in an Essential Plan, effective July 1, 2017.

Also on June 3, 2017, NYSOH issued a notice stating that you changed your mailing address to [redacted]

On September 7, 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, and NYSOH records reflect, that you, your spouse, and six of your seven children were determined eligible for Medicaid, effective

April 1, 2017, and your daughter [redacted] was determined eligible for an Essential Plan, effective May 1, 2017.

2) You testified and NYSOH records confirm that you, your spouse, and six of your seven children and were enrolled in a Medicaid Managed Care plan, effective May 1, 2017. Your daughter [redacted] was enrolled in an Essential Plan, effective May 1, 2017.

3) NYSOH records reflect that you, your spouse, and your six children were subsequently disenrolled from your Medicaid Managed Care plans, effective May 31, 2017. Your daughter [redacted] was disenrolled from the Essential Plan, effective May 31, 2017.

4) You testified that you currently live at [redacted] and have lived at this address for the past 9 years.

5) You testified that you live in a building and that one of the residents of your building moved to [redacted].

6) You testified that a representative from the US Postal Service advised you that the US Post office incorrectly determined that you had moved to [redacted], and entered this as your address in their system.

7) Notices sent to you from NYSOH were addressed to [redacted], [redacted] and returned to sender (NYSOH) with a directive to forward to [redacted]

8) You testified that you did not receive notices from NYSOH through no fault of your own and that representatives of the US Post office acknowledged the error.

9) You testified that on June 2, 2017 you changed your mailing address with NYSOH to [redacted] due to the problems you were having receiving mail at your address [redacted]).

10) You testified that you incurred medical bills in June 2017 that were not covered by your Medicaid Fee-for-Service coverage.

11) You testified that you are seeking that you, your spouse, and your six children's enrollment in your Medicaid Managed Care plan be reinstated for the month of June 2017 and that your daughter [redacted] enrollment in her Essential Plan be reinstated for the month of June 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 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)).

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* 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)).

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

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)).

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR

§ 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

Legal Analysis

The issue under review is whether NYSOH properly determined that you, your spouse, and your six children's enrollment in your Medicaid Managed Care plans and your daughter [redacted] enrollment in her Essential Plan, ended effective May 31, 2017.

You, your spouse, and six of your seven children became eligible for Medicaid effective April 1, 2017. You, your spouse, and your six children were subsequently enrolled into a Medicaid Managed Care plan, effective May 1, 2017. Your daughter [redacted] was determined eligible for an Essential Plan, effective May 1, 2017 and her enrollment in an Essential Plan was effective May 1, 2017.

For an applicant to remain eligible for enrollment in a Medicaid Managed Care plan or the Essential Plan through NYSOH, they must meet both the financial and non-financial requirements. One of the non-financial requirements is that the applicant must be a New York State Resident.

Notices sent to you from NYSOH were addressed to [redacted] and returned to sender (NYSOH) with a directive to forward to [redacted].

As a result, you, your spouse, and your six children were subsequently disenrolled from your Medicaid Managed Care plans and your daughter [redacted] was disenrolled from her Essential Plan, because NYOSH received mail addressed to you that was undeliverable; therefore, the system assumed that you, your spouse, and your seven children no longer met the state residency requirement for enrollment through NYSOH.

As such, on May 31, 2017, NYSOH issued a discontinuance notice and a plan disenrollment notice, stating that you, your spouse, and your six children were no longer eligible to enroll in Medicaid, and that you, your spouse, and your six children's coverage in your Medicaid Managed Care plans would end effective May 31, 2017. It also stated that your daughter [redacted] no longer eligible to enroll in the Essential Plan and that her Essential Plan coverage would end May 31, 2017.

However, you testified that you currently live at [redacted] and have lived at this address for the past nine years. You testified that you live in a building and that one of the residents of your building moved to [redacted].

You testified that a representative from the US Postal service advised you that the US Post office incorrectly determined that your household moved to [redacted] and entered this as your address in their system.

Since the notices from NYSOH were returned as undeliverable despite your testimony that that you have not changed your address, it is reasonable to conclude that the notices were returned as undeliverable through no fault of your own, and was the result of an error of the United States Postal Service. As a result, it is reasonable to conclude that your and you, your spouse and six children's disenrollment from your Medicaid Managed Care plans as well as your daughter [redacted] disenrollment from an Essential Plan were in error.

Therefore, the May 27, 2017 discontinuance and disenrollment notices must be RESCINDED.

Your case is RETURNED to NYSOH to reinstate you, your spouse and your six children's coverage in your Medicaid Managed Care plan for the month of June 2017 and your daughter, [redacted] coverage in an Essential Plan for the month of June 2017.

Decision

The May 27, 2017 discontinuance notice is RESCINDED.

The May 27, 2017 disenrollment notice is RESCINDED.

Effective Date of this Decision: September 26, 2017

How this Decision Affects Your Eligibility

The May 27, 2017 discontinuance notice is RESCINDED.

The May 27, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you, your spouse and your six children's coverage in your Medicaid Managed Care plan for the month of June 2017 and your daughter [redacted] coverage in an Essential Plan for the month of June 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
- 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 May 27, 2017 discontinuance notice is RESCINDED.

The May 27, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you, your spouse and your six children's coverage in your Medicaid Managed Care plan for the month of June 2017 and your daughter [redacted] coverage in an Essential Plan for the month of June 2017.

Legal Authority

We are issuing this determination 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.

বাংলা (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).

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 महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क 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.

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).

(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.

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).