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

Notice of Decision

Decision Date: October 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020134

[redacted]

Dear [redacted],

On September 21, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 23, 2017 disenrollment notice, and July 1, 2017 eligibility determination 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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NY State of Health Account ID: [redacted]
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Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health properly determine you were no longer eligible to remain enrolled in Medicaid effective June 23, 2017?
>
> Did NY State of Health properly determine the type of Medicaid Coverage you were eligible for does not require or allow you to enroll in a health plan?

Procedural History

On December 16, 2016, NY State of Health (NYSOH) received your initial application for financial assistance.

On December 17, 2016, NYSOH issued a notice of eligibility determination stating you were eligible to enroll in the Essential Plan for a limited time, effective January 1, 2017. The notice requested you provide proof of your income by March 16, 2017.

On December 17, 2016, NYSOH issued a notice of enrollment stating your Essential Plan would start, effective January 1, 2017.

On January 24, 2017, NYSOH issued a notice stating your eligibility had been redetermined on January 23, 2017. The notice stated you were no longer eligible for health insurance through NYSOH. The notice stated this was because you

were sent notices by U.S. mail to a mailing address in your account and this information was returned as undeliverable.

On May 31, 2017, NYSOH received your updated application for financial assistance with your health insurance.

On June 1, 2017, NYSOH issued a notice stating you were eligible for Medicaid, effective May 1, 2017. The notice stated the type of Medicaid coverage you were eligible for does not require or allow you to enroll in a health plan.

On June 1, 2017, NYSOH issued a notice stating you were eligible for Medicaid for March 1, 2017 through April 30, 2017. The notice stated this was because your household monthly income of $1,040.00 is at or below the allowable monthly income limit of $1,387.00.

On June 1, 2017, NYSOH issued a notice stating it had received information form the U.S. Postal service that your address had changed. The notice requested you to update your address in your application and to make sure NYSOH has your current mailing and residential address. The notice stated coverage for you or your family may be impacted if your current address was not on file.

On June 23, 2017, NYSOH issued a notice stating your eligibility had been redetermined on June 22, 2017. The notice stated you were no longer eligible for health insurance through NYSOH effective June 23, 2017. The notice stated this was because you were sent notices by U.S. mail to mailing address in your account and this information was returned as undeliverable.

On June 29, 2017, you spoke to NYSOH's Account Review Unit and appealed the disenrollment from your Medicaid coverage effective June 23, 2017.

On July 1, 2017, NYSOH issued an eligibility determination notice based on your June 30, 2017 application stating you were eligible for Medicaid, effective June 23, 2017. The notice further stated the type of Medicaid coverage you are eligible for does not require or allow you to enroll in a health plan.

On September 21, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing you amended your appeal to include that you are unable to enroll in a Medicaid Managed Care plan based on the type of Medicaid coverage you are eligible for. The record was developed during the hearing and kept open 15 days for you to provide proof of the end date of your Medicaid Managed Care plan.

As of October 6, 2017, NYSOH's Appeals Unit did not receive the requested documentation. The record was closed that day.

Findings of Fact

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

1) You are seeking insurance for yourself.

2) You submitted an application for financial assistance on May 31, 2017, and were determined eligible for Medicaid effective May 1, 2017.

3) Notices that were sent to you by regular mail by NYSOH have been returned as undeliverable going back to July 21, 2015.

4) You testified you moved to your current address at the end of December 2016.

5) You testified you could not remember when you updated your NYSOH account with your new address.

6) You were disenrolled from Medicaid effective June 23, 2017.

7) Your NYSOH account indicates NYSOH reenrolled you into Medicaid, effective June 23, 2017.

8) You testified you were unaware your application counselor updated your account with your new address on June 29, 2017.

9) You testified you would like to be determined eligible to enroll in a Medicaid Managed Care plan.

10) You testified you had employer sponsored insurance which ended in February 2017.

11) You reside in [redacted], NY.

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 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)).

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 Social Services Law (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)).

Requirement for Individuals to Report Changes

NYSOH must require an applicant to report any change which may affect eligibility, such as citizenship status, incarceration, residency, household size, and income within 30 days of such change (45 CFR §155.330(b), 45 CFR §155.305, 42 CFR §435.403, 42 CFR §435.406, 42 CFR §425.603).

Legal Analysis

The first issue is whether NYSOH properly determined you were no longer eligible to remain enrolled in Medicaid effective June 23, 2017.

You were found eligible for Medicaid effective May 1, 2017. The record supports you were then disenrolled from Medicaid by notice on June 23, 2017. The notice that was issued stated you were no longer eligible for health insurance through NYSOH effective June 23, 2017, because you were sent notices by U.S. mail to mailing address in your account and this information was returned as undeliverable.

You testified you had moved to your current address at the end of December 2016, but you were unsure when you first notified NYSOH of your new address. The record shows your address was first updated to your current address by your Broker on June 29, 2017.

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. One triggering event which may result in a redetermination of an individual no longer eligible for Medicaid before the end of the 12-month period is if it is determined the individual lacks state residence.

On June 30, 2017, you were then redetermined eligible for Medicaid and reenrolled into Medicaid effective June 23, 2017, leaving no gap in coverage. A notice was issued on July 1, 2017 confirming this.

Since NYSOH conceded the issue of the disenrollment of your Medicaid Managed Care plan effective June 23, 2017, by reenrolling you into Medicaid effective June 23, 2017, a full analysis of the merits of your appeal request are not required for decision to be rendered on this issue.

The June 23, 2017 disenrollment notice is therefore RESCINDED.

The second issued under review is whether NYSOH properly determined the type of Medicaid coverage you were eligible for does not require or allow you to enroll in a health plan.

On July 1, 2017, you were again determined eligible for Medicaid, but this time effective June 23, 2017. The notice that was issued stated the type of Medicaid coverage you are eligible for does not require or allow you to enroll in a health plan.

Generally, when an individual is eligible for Medicaid through NYSOH they are required to enroll in a Medicaid Managed Care plan. However, when a person

has active coverage in a health insurance plan outside of NYSOH, they are not eligible to enroll in a Medicaid Managed Care plan.

You testified you did have employer sponsored health insurance which had ended in February 2017.

During your telephone hearing the Hearing Officer requested that you provide proof of the end of your employer sponsored health insurance ending in February 2017. At the end of the 15-day period no documentation was provided to NYSOH's Appeals Unit and therefore a determination on whether NYSOH's July 1, 2017 determination that you could not enroll in a health plan cannot be reached.

Therefore, absent evidence to the contrary, the July 1, 2017 eligibility determination notice was proper and is AFFIRMED.

If you wish to have your eligibility redetermined so that you may be found eligible to enroll in a Medicaid Managed Care plan, you will have to provide sufficient evidence to NYSOH of the end of your employer sponsored insurance.

Decision

The June 23, 2017 disenrollment notice is RESCINDED.

The July 1, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: October 13, 2017

How this Decision Affects Your Eligibility

You remain eligible for Medicaid Fee for Service effective June 23, 2017.

You were ineligible to enroll in a Medicaid Managed Care plan.

If you wish to have your eligibility redetermined so that you may be found eligible to enroll in a Medicaid Managed Care plan, you will have to provide sufficient evidence to NYSOH of the end of your employer sponsored insurance.

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
  Albany, NY 12211

- By fax: 1-855-900-5557

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).

Summary

The June 23, 2017 disenrollment notice is RESCINDED.

The July 1, 2017 eligibility determination notice is AFFIRMED.

You remain eligible for Medicaid Fee for Service effective June 23, 2017.

You were ineligible to enroll in a Medicaid Managed Care plan.

If you wish to have your eligibility redetermined so that you may be found eligible to enroll in a Medicaid Managed Care plan, you will have to provide sufficient evidence to NYSOH of the end of your employer sponsored insurance.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

[redacted]

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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)

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।

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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)

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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