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

Notice of Decision

Decision Date: November 27, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021630

[redacted]

Dear [redacted],

On November 10, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 12, 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 NY State of Health 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
Albany, NY 12211

Decision

Decision Date: November 27, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021630

[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 and your child were no longer eligible for Medicaid and properly terminate your Medicaid Managed Care (MMC) coverage on July 31, 2017?

Procedural History

On May 28, 2017, your NYSOH account was systemically updated.

On May 29, 2017, 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 submit proof of your household income by June 12, 2017, to confirm your eligibility.

Also on May 29, 2017, NYSOH issued a disenrollment notice stating that your Essential Plan coverage would end on June 30, 2017.

On June 2, 2017, NYSOH issued an eligibility determination notice stating that you and your child were eligible for Medicaid, effective June 1, 2017.

Also on June 2, 2017, NYSOH issued a plan enrollment notice confirming that, as of June 1, 2017, you both were enrolled in a MMC plan with an enrollment start date of July 1, 2017.

On June 14, 2017, NYSOH issued a plan enrollment notice confirming that you and your child were enrolled in a MMC plan with an enrollment start date of July 1, 2017.

On July 11, 2017, your account was systemically updated.

On July 12, 2017, NYSOH issued an eligibility determination notice stating, in relevant part, that you and your child were no longer qualified for Medicaid, effective July 12, 2017. The notice stated that information about your eligibility and coverage was sent by U.S. mail to the mailing address provided in your account. However, the information was returned to NYSOH as undeliverable.

Also on July 12, 2017, NYSOH issued a disenrollment notice stating that your and your child's MMC coverage would end on July 31, 2017.

On August 15, 2017, your account was updated.

On August 16, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan, effective September 1, 2017. Further, your child was determined eligible for Medicaid, effective as of August 1, 2017.

Also on August 16, 2017, NYSOH issued a plan enrollment notice confirming that, on August 15, 2017, you were enrolled in an Essential Plan and your child was enrolled in MMC plan with enrollment start dates of September 1, 2017.

On August 18, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as your and your child's Medicaid coverage was terminated as of July 31, 2017.

On November 10, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was left open to allow you to submit your current rental agreement to NYSOH's Appeals Unit.

On November 13, 2017, you faxed two-pages of documentation to NYSOH's Appeals Unit. That documentation was made part of the record as "Appellant Exhibit A." The record is now complete and closed.

Findings of Fact

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

1) According to your NYSOH account and testimony, you are applying for health insurance for yourself and your [redacted] child.

2) According to your NYSOH account, you and your child were determined eligible for Medicaid on June 2, 2017, and enrolled in a MMC, through Empire BlueCross BlueShield (Empire), with an enrollment start date of July 1, 2017.

3) According to your NYSOH account, your mailing address was:

   [redacted] from October 7, 2014, through June 13, 2017;

   [redacted] from June 13, 2017, through August 15, 2017;

   [redacted] from August 15, 2017 to the present.

4) On May 29, 2017, NYSOH issued notices regarding your eligibility for health insurance to the mailing address [redacted]. On June 2, 2017, the notices were stamped "RETURN to SENDER," and it indicated that your new address was [redacted].

5) According to your NYSOH account, on June 13, 2017, NYSOH updated your mailing address to [redacted]

6) On June 14, 2017, NYSOH issued a plan enrollment notice regarding your and your child's health insurance to the mailing address, [redacted]. The notice was returned to NYSOH as undeliverable on July 10, 2017 [redacted]

7) You testified that you had been using your [redacted] mailing address, [redacted].

8) You testified that your current residential address is [redacted], and has been your address since December 2016.

9) On November 13, 2017, you submitted your rental agreement to NYSOH's Appeals Unit. The agreement states that as of December 20, 2016, you were renting a [redacted], at [redacted] (*see* Appellant Exhibit A pg. 2).

10) You testified that you found out that your Medicaid coverage had been discontinued when refilling a prescription in August 2017.

11) You testified that you incurred medical expenses in the month of August 2017 because your health insurance coverage was discontinued.

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

Applicable Law and Regulations

Medicaid - Continuous Coverage

Most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, unless the adult loses Medicaid eligibility because of citizenship status, lack of state residence, or failure to provide a valid social security number, before the end of a twelve-month period. This twelve-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 (*see* 42 CFR § 435.916(a); N.Y. Soc. Serv. Law § 366(4)(c)).

Children under the age of 19 who are determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage. This twelve-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 (*see* 42 CFR § 435.926(c); N.Y. Soc. Serv. Law § 366(4)(b)(3)).

Medicaid - State Residency

NYSOH must provide Medicaid to eligible residents of the state of New York, including residents who are absent from the state (42 CFR § 435.403(a)).

For an individual who is age 21 or older, not living in an institution, and able to indicate intent, state residency is the state where the individual is living and, either: (1) where they intend to reside, including without a fixed address, or (2) has entered the state with a job commitment or is seeking employment (42 CFR § 435.403(h)(1)).

For an individual under the age of 21, who is not living in an institution, state residency is the state where: (1) they reside, including without a fixed address, or (2) the state residency of the parent or caretaker, with whom the individual resides (42 CFR § 435.403(i)(2)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you and your child were ineligible for Medicaid and ended your MMC plan, effective July 31, 2017.

On June 2, 2017, you and your child were determined eligible for Medicaid effective June 1, 2017, and enrolled in a MMC plan through Empire.

Generally, once individuals are determined eligible for Medicaid, they are guaranteed 12 months of Medicaid coverage, even if they lose Medicaid eligibility because of any changes in their household income. This twelve-month period is based on the start date of the original Medicaid eligibility determination. Exceptions to this rule include changes in citizenship status, lack of state residence, or failure to provide a valid social security number.

The record reflects that on May 29, 2017, NYSOH issued notices regarding your and your child's health insurance to the mailing address [redacted]). On June 2, 2017, the notices were returned to NYSOH, and the U.S. Postal Service stamped on the return envelope that your address was '[redacted]). However, since the mailing address stamped on the return envelope was not completely legible, NYSOH mistakenly updated your mailing address to be [redacted]

On June 14, 2017, NYSOH issued an enrollment notice regarding your and your child's health insurance to the mailing address, [redacted]. The notice was returned to NYSOH as undeliverable on July 10, 2017 [redacted]). Since that notice was returned to NYSOH as undeliverable, your Medicaid coverage was discontinued effective July 31, 2017.

You testified that your current residential and mailing addresses is [redacted] and has been since December 2016. On November 13, 2017, you submitted your rental agreement to NYSOH's Appeals Unit. The agreement states that as of December 20, 2016, you were renting a [redacted], at [redacted] (Appellant Exhibit A pg. 2).

When your MMC coverage was discontinued on July 31, 2017, the twelve-month period of Medicaid eligibility that began on June 1, 2017, had not expired. There is sufficient evidence in the record to conclude that you have continuously retained New York State residency and no other issue regarding your eligibility existed Therefore, the record does not contain any evidence that your eligibility

should have been discontinued before the end of your twelve-months of eligibility.

The July 12, 2017 eligibility determination and disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to reinstate your and your child's MMC plan as of August 1, 2017, and to notify you accordingly.

Decision

The July 12, 2017 eligibility determination is RESCINDED.

The July 12, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your and your child's MMC plan as of August 1, 2017, and to notify you accordingly.

Effective Date of this Decision: November 27, 2017

How this Decision Affects Your Eligibility

NYSOH incorrectly ended your and your child's Medicaid coverage effective July 31, 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
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The July 12, 2017 eligibility determination is RESCINDED.

The July 12, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your and your child's MMC plan as of August 1, 2017, and to notify you accordingly.

NYSOH incorrectly ended your and your child's Medicaid coverage effective July 31, 2017.

Legal Authority

We are sending you this notice in accordance with 45 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).

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.

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 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.

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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