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

Notice of Decision

Decision Date: December 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021807

[redacted]

[redacted]

On October 31, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 9, 2017 discontinuance and disenrollment notices, and the August 24, 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: December 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021807

[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 eligible for the Essential Plan and not Medicaid, effective October 1, 2017?

Procedural History

On February 1, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective January 1, 2017.

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

On February 13, 2017, the February 1, 2017 notices were returned to NYSOH as undeliverable.

On March 8, 2017, the returned mail was uploaded to your NYSOH account.

On March 9, 2017, NYSOH issued a discontinuance notice stating that effective March 9, 2017 you were no longer eligible for health insurance through NYSOH because notices were sent to you that were returned to NYSOH as undeliverable.

Also on March 9, 2017, NYSOH issued a disenrollment notice stating that your coverage in your Medicaid Managed Care plan would end on March 31, 2017

because you were no longer eligible to enroll in health insurance through NYSOH.

On March 25, 2017, the March 9, 2017 notices were returned to NYSOH as undeliverable.

On August 24, 2017, you updated your application for financial assistance. That day, a preliminary determination was prepared stating that you were eligible for the Essential Plan, effective October 1, 2017.

Also on August 24, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were not found eligible for Medicaid.

On August 26, 2017, NYSOH issued an eligibility determination notice, based on your August 24, 2017 application, stating that you were eligible to enroll in the Essential Plan, effective October 1, 2017. You were not eligible for Medicaid because your income was over the allowable income limit for that program.

On October 31, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open until November 14, 2017 to allow you time to submit documentation of your income. On November 14, 2017, NYSOH Appeals Unit received by fax your income documentation. The documentation was marked as Appellant's Exhibit 1 and the record was closed.

Findings of Fact

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

1) You were found eligible for Medicaid effective January 1, 2017.

2) The February 1, 2017 notices and March 9, 2017 notices were mailed to [redacted]

3) The mailing address listed in your account at the time of the February 1, 2017 notices and March 9, 2017 notices were issued was [redacted].

4) You testified that you reside at [redacted]

5) You were disenrolled from Medicaid and your Medicaid Managed Care plan effective March 31, 2017.

6) On August 24, 2017, you submitted an updated application for health insurance. That application stated that your annual household income is $20,800.00.

7) You testified that you do not make $20,800.00 a year and that you make closer to $15,000.00, maybe less.

8) You submitted a letter from your employer which states in the month of August 2017 you received $1,448.00 in gross pay and in the month of September 2017 you received $1,645.00 in gross pay.

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

Applicable Law and Regulations

Medicaid

Most individuals 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 eligible for the Essential Plan and not Medicaid, effective October 1, 2017.

You were found eligible for Medicaid effective January 1, 2017.

For an applicant to remain eligible for enrollment in a Medicaid Managed Care 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.

According to your NYSOH account, on February 1, 2017, NYSOH issued an eligibility determination and enrollment confirmation notices that were returned to NYSOH as undeliverable on February 13, 2017. You were subsequently disenrolled from your Medicaid Managed Care plan because NYOSH received mail addressed to you that was undeliverable; therefore, the system assumed that you no longer met the state residency requirement for enrollment in a Medicaid Managed Care plan.

As such, on March 9, 2017, NYSOH issued a discontinuance notice and a plan disenrollment notice, stating that you were no longer eligible to enroll in Medicaid and your Medicaid Managed Care plan would end, effective March 31, 2017. These notices were also returned as undeliverable to NYSOH on March 25, 2017.

However, the February 1, 2017 notices and March 9, 2017 notices were mailed to [redacted] The mailing address listed in your account at the time the February 1, 2017 notice sand March 9, 2017 notices was [redacted].

Based on the credible evidence of the record, 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 NYSOH for failing to include the apartment number that was correctly listed in your NYSOH account. As a result, your disenrollment from your Medicaid Managed Care plan was in error.

Therefore, the March 9, 2017 discontinuance and disenrollment notices are RESCINDED.

On August 24, 2017, you submitted an updated application for health insurance. That application stated that your annual household income is $20,800.00. As a result of this application, you were found eligible for the Essential Plan, effective October 1, 2017.

Under New York State law, once a person is eligible for Medicaid, that eligibility continues for 12 months, even if the household income rises above 138% of the FPL. This provision is called “continuous coverage.”

Credible evidence confirms that you were eligible for Medicaid effective January 1, 2017, and that even though your estimated annual income increased in your subsequent August 24, 2017 application, you remain eligible for and enrolled in Medicaid for the remainder of your 12-month eligibility period, until December 31,

2017. Since you were erroneously disenrolled from your initial Medicaid coverage for lack of state residence, the record supports no triggering event occurred which would have made you no longer eligible for Medicaid continuous coverage.

Therefore, the August 24, 2017 eligibility determination notice is RESCINDED.

Accordingly, your case is RETURNED to NYSOH to reinstate you into Medicaid and your Medicaid Managed Care plan, effective April 1, 2017 and to continue your Medicaid barring subsequent changes in eligibility until December 31, 2017.

Since your eligibility for continuous coverage Medicaid will expire on December 31, 2017, NYSOH is further directed to conduct outreach to you to assist you in updating your income information for coverage effective January 1, 2018.

Decision

The March 9, 2017 discontinuance and disenrollment notices are RESCINDED.

The August 24, 2017 eligibility determination notice is RESCINDED

Your case is RETURNED to NYSOH to reinstate you into Medicaid and your Medicaid Managed Care plan, effective April 1, 2017 and to continue your Medicaid barring subsequent changes eligibility until December 31, 2017.

Your case is also RETURNED so NYSOH can conduct outreach to you to assist you in updating your income information for coverage effective January 1, 2018 since your eligibility for continuous coverage Medicaid will expire on December 31, 2017.

Effective Date of this Decision: December 11, 2017

How this Decision Affects Your Eligibility

You should have remained eligible for Medicaid and a Medicaid Managed Care plan until December 31, 2017.

Your case is being sent back to NYSOH to reinstate you into your Medicaid Managed Care plan as of April 1, 2017.

NYSOH will assist you in updating your application for coverage effective January 1, 2018.

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

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Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The March 9, 2017 discontinuance and disenrollment notices are RESCINDED.

The August 24, 2017 eligibility determination notice is RESCINDED

Your case is RETURNED to NYSOH to reinstate you into Medicaid and your Medicaid Managed Care plan, effective April 1, 2017 and to continue your Medicaid barring subsequent changes eligibility until December 31, 2017.

You should have remained eligible for Medicaid and a Medicaid Managed Care plan until December 31, 2017.

Your case is being sent back to NYSOH to reinstate you into your Medicaid Managed Care plan as of April 1, 2017.

Your case is also RETURNED so NYSOH can conduct outreach to you to assist you in updating your income information for coverage effective January 1, 2018 since your eligibility for continuous coverage Medicaid will expire on December 31, 2017.

NYSOH will assist you in updating your application for coverage effective January 1, 2018.

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.

বাংলা (Bengali)

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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.

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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