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

Notice of Decision

Decision Date: October 26, 2017

NY State of Health Account ID [redacted]
Appeal Identification Numbers: AP000000021816

[redacted]

Dear [redacted],

On October 24, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 23, 2017 disenrollment and August 25, 2017 enrollment 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 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.

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Decision

Decision Date: October 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Numbers: AP000000021816

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly end your Medicaid Managed Care (MMC) plan, effective August 31, 2017?
>
> Did NYSOH properly enroll you in a MMC plan with an enrollment start date of October 1, 2017?

Procedural History

On October 17, 2016, NYSOH issued an eligibility determination notice stating that you remained eligible for Medicaid effective as of December 1, 2016, and were enrolled in an MMC plan as of that date.

On August 22, 2017, you updated your account.

On August 23, 2017, NYSOH issued an eligibility determination notice stating that you were newly eligible to purchase a qualified health plan at full cost, effective October 1, 2017.

Also on August 23, 2017, NYSOH issued a disenrollment notice stating that your MMC enrollment would end on August 31, 2017, because they were no longer eligible to be enrolled in that health plan.

On August 24, 2017, your NYSOH account was updated.

Also on August 24, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal insofar as you were not enrolled in a MMC plan during the month of September 2017.

On August 25, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective September 1, 2017.

Also on August 25, 2017, NYSOH issued a plan enrollment notice confirming that as of August 24, 2017, you were enrolled in a MMC plan with an enrollment start date of October 1, 2017.

On October 24, 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 that you requested the appeal because you were not enrolled in a MMC plan for the month of September 2017.

2) According to your NYSOH account, you were determined eligible for Medicaid and enrolled in an MMC plan, effective December 1, 2016.

3) You testified that you received a notice from NYSOH in mid-August 2017 stating that you may renew your Medicaid coverage early.

4) You testified that [redacted]" is your username through NYSOH.

5) According to your NYSOH account, on August 22, 2017, you accessed your account and changed your application from a "Financial Assistance" application to a "Non-Financial Assistance" application.

6) According to your NYSOH account, NYSOH presented the question: "Do you want help paying for health coverage?"

7) You testified that you found this question to be confusing.

8) According to your NYSOH account, your MMC plan was discontinued as of August 31, 2017.

9) According to your NYSOH account, on August 24, 2017, your application was changed from a "Non-Financial Assistance" application to "Financial Assistance" application, and you re-enrolled in an MMC plan.

10) You testified that you did not incur any medical expenses in September 2017.

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

Applicable Law and Regulations

General Eligibility for Financial Assistance

NYSOH must permit an applicant to request only an eligibility determination for enrollment in a qualified health plan through the NYSOH; however, NYSOH may not permit an applicant to request an eligibility determination for less than all insurance affordability programs (45 CFR § 155.310(b)).

Medicaid Eligibility

Medicaid can be provided through NYSOH 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 FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

Medicaid Continuous Coverage:

Most adults 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 § 435.916(a); N.Y. Soc. Serv. Law § 366(4)(c)).

In the following situations, individuals are not entitled to receive continuous coverage:

- Unable to locate;
- Death;
- Consumer requests to have his/her Medicaid closed;
- Failure to provide or cooperate in obtaining a Social Security Number, if otherwise required;

- Failure to provide documentation of citizenship after the reasonable opportunity period;
- Moved out of State;
- Coverage established under MAGI in error;
- Undocumented pregnant women (only get 60 days post-partum);
- Failure to comply with absent parent (IV-D) requirements; and
- Individuals receiving treatment in a setting where Medicaid eligibility is not available

(*see* 42 CFR § 435.916(a); N.Y. Soc. Serv. Law § 366(4)(c); GIS 15 MA/22).

MMC Disenrollment

NYSOH is responsible for disenrolling enrollees automatically upon death or loss of Medicaid eligibility. All such disenrollments will be effective at the end of the month in which the death or loss of eligibility occurs (Medicaid Managed Care Model Contract (Appendix H-7(a)(iv), effective 3/1/2014 – 2/28/2019).

Medicaid Managed Care – Effective Date

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)).

Legal Analysis

The first issue under review is whether NYSOH properly ended your MMC plan effective August 31, 2017.

You were determined eligible for Medicaid and enrolled in a MMC plan, effective December 1, 2016.

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 or updates they make to their NYSOH account. This twelve-month period is based on the effective date of the Medicaid eligibility determination. Under certain circumstances, including a request by the enrollee or their representative to end their Medicaid coverage, the continuous coverage may end.

When applying for health insurance through NYSOH, an applicant may only request enrollment in a qualified health plan; however, if an applicant requests an

eligibility determination for financial assistance, NYSOH must evaluate their eligibility for all the insurance affordability programs.

On August 22, 2017, you accessed your account and changed your application from a “Financial Assistance” application to a “Non-Financial Assistance” application. By selecting this type of application, you were no longer eligible for Medicaid or any other financial assistance program.

NYSOH must end an enrollee’s MMC coverage automatically upon death or loss of Medicaid eligibility. The enrollee’s coverage ends at the end of the month in which the death or loss of eligibility occurs. Since you were no longer eligible for Medicaid coverage as of August 22, 2017, your MMC plan properly ended August 31, 2017.

Therefore, the August 23, 2017, disenrollment notice is AFFIRMED.

The second issue under review is whether NYSOH properly determined that you were enrolled in a MMC plan with an enrollment start date of October 1, 2017.

The record reflects that you selected an MMC plan on August 24, 2017.

The date on which enrollment in a MMC plan can take effect depends on the day a person selects the plan for enrollment. A plan that is selected from the first day to and including the fifteenth day of a month will go into effect on the first day of the following month. A plan that is selected on or after the sixteenth day of the month will go into effect on the first day of the second following month.

Since the MMC plan was selected on August 24, 2017, the plan would properly take effect on the first day of the second month after August 24, 2017; that is, on October 1, 2017.

Therefore, the August 25, 2017 plan enrollment notice is AFFIRMED.

Decision

The August 23, 2017 disenrollment notice is AFFIRMED.

The August 25, 2017 plan enrollment notice is AFFIRMED.

Effective Date of this Decision: October 26, 2017

How this Decision Affects Your Eligibility

Your MMC plan ended on August 31, 2017.

You were re-enrolled in a MMC plan with an enrollment start date of October 1, 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:

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 calling the Customer Service Center at 1-855-355-5777
- By mail at:

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  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The August 23, 2017 disenrollment notice is AFFIRMED.

The August 25, 2017 plan enrollment notice is AFFIRMED.

Your MMC plan ended on August 31, 2017.

You were re-enrolled in a MMC plan with an enrollment start date of October 1, 2017.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

Getting Help in a Language Other than English

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 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 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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