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

Notice of Decision

Decision Date: November 3, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022212

[redacted]

Dear [redacted],

On October 26, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 31, 2017 discontinuance, and disenrollment notices, and the September 8, 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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Decision

Decision Date: November 3, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022212

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly determine that you and your three children's eligibility for and enrollment in a Medicaid Managed Care plan was terminated as of August 31, 2017?
>
> Did NYSOH properly determine that you and your children were not eligible for Medicaid effective October 1, 2017?

Procedural History

On December 8, 2016, NYSOH received your household's application for health insurance.

On December 9, 2016, NYOSH issued an eligibility determination stating that you and your three children were eligible for Medicaid, effective January 1, 2017.

Also on December 9, 2016, NYSOH issued a plan enrollment notice confirming that you and your three children were enrolled in a Medicaid Managed Care plan.

On August 25, 2017, a letter that was sent to from NYSOH was returned as undeliverable.

On August 31, 2017, NYSOH issued a notice of discontinuance stating that you and your three children were no longer eligible to receive health insurance through NYSOH, effective August 30, 2017, because notices regarding your

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 NYSOH.

Also on August 31, 2017, NYSOH issued a plan disenrollment notice confirming that you and your three children's Medicaid Managed Care plan would end on August 31, 2017.

On September 7, 2017, NYSOH received your updated application for financial assistance with health insurance. That day, a preliminary eligibility determination was prepared stating that you were eligible for up to $19.00 per month in advance premium tax credits, and your children were eligible to enroll in Child Health Plus each with a $30.00 per month premium.

Also on September 7, 2017, you spoke to NYSOH's Account Review Unit and appealed you and your three children's disenrollment from your Medicaid Managed Care plan.

On September 8, 2017, NYSOH issued an eligibility determination, based on your September 7, 2017 application, stating that you were eligible for up to $19.00 per month in advance premium tax credits, and that you your children were eligible to enroll in Child Health Plus each with a $30.00 monthly premium, effective October 1, 2017. The notice stated that you and your children were not eligible for Medicaid because your income was over the allowable income limit for that program.

On September 12, 2017, NYSOH issued a notice stating that you and your children were eligible for Medicaid for a limited time because you had been granted Aid to Continue until a decision was made on your appeal.

Also on September 12, 2017, NYSOH issued an enrollment confirmation notice stating that you and your children were enrolled in a Medicaid Managed Care plan effective September 1, 2017.

On October 26, 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) On December 8, 2016, you submitted an application for health insurance listing an annual household income of $10,400.00.

2) You and your children were enrolled into a Medicaid Managed Care plan effective January 1, 2017.

3) You and your children were subsequently disenrolled from your Medicaid Managed Care plan, effective August 31, 2017.

4) According to your NYSOH account, a letter entitled "Good News for Medicaid Enrollees" was returned as undeliverable on August 25, 2017. There is no date listed on this notice as to when it was issued to you.

5) The letter that was returned to NYSOH on August 25, 2017 was addressed to: [redacted]

6) The application that was submitted on December 8, 2016 lists a mailing, residence, and legal address of [redacted]. The ID proofed address was listed as [redacted]

7) You testified that you and your children have resided at the [redacted] address since May 2015 and that there was no reason why any notices should have been sent to the [redacted] address.

8) You testified that you are seeking to have you and your children reinstated in your Medicaid Managed Care plans for the remainder of your 12-month eligibility period.

9) On September 7, 2017, you submitted an application for financial assistance listing an annual household income of $62,400.00. You testified that you became employed on March 31, 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)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your and your three children’s eligibility for and enrollment in a Medicaid Managed Care plan was terminated as of August 31, 2017.

On December 8, 2016, you submitted an application for health insurance listing an annual household income of $10,400.00. As a result of this application, you and your children became eligible for Medicaid effective January 1, 2017. You and your children were subsequently enrolled into a Medicaid Managed Care plan.

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, a letter entitled “Good News for Medicaid Enrollees” was returned as undeliverable on August 25, 2017. There is no date listed on this notice as to when it was issued to you. You and your children were

subsequently disenrolled from your Medicaid Managed Care plans 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 August 31, 2017, NYSOH issued a discontinuance notice and a plan disenrollment notice, stating that you and your children were no longer eligible to enroll in Medicaid and your Medicaid Managed Care plans would end, effective August 31, 2017.

However, the letter that was returned to NYSOH as undeliverable on August 25, 2017 was addressed to [redacted]. Your account at that time had listed a mailing, residence, and legal address of [redacted]. The ID proofed address was listed as [redacted]. You credibly testified that you and your children have resided at the [redacted] since May 2015 and that there was no reason why any notices should have been sent to the [redacted] address.

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 issue the notice to the mailing address you had correctly listed in your NYSOH account. As a result, your and your children's disenrollment from your Medicaid Managed Care plan was in error.

Therefore, the August 31, 2017 discontinuance and disenrollment notices must be RESCINDED.

The second issue is whether NYSOH properly determined that you and your children were not eligible for Medicaid effective October 1, 2017.

On September 7, 2017, you submitted an application for financial assistance listing an annual household income of $62,400.00. You testified that you became employed on March 31, 2017. As a result of this application, you and your children were found not eligible for Medicaid because your income was over the allowable income limit for that program.

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 and your children were eligible for Medicaid effective January 1, 2017, and that even though your estimated annual income increased when you modified your application on September 7, 2017 you should remain enrolled in Medicaid for the remainder of your 12-month eligibility period.

Therefore, the September 8, 2017 eligibility determination stating that you were eligible for up to $19.00 per month in advance premium tax credits, and that you your children were eligible to enroll in Child Health Plus with a $30.00 monthly premium each, effective October 1, 2017 is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your and your children's coverage in your Medicaid Managed Care plan as of September 1, 2017 through the remainder of your 12-month continuous coverage period which began as of January 1, 2017, and to notify you accordingly.

Decision

The August 31, 2017 eligibility determination notice is RESCINDED.

The August 31, 2017 disenrollment notice is RESCINDED.

The September 8, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your and your children's coverage in your Medicaid Managed Care plan as of September 1, 2017 through the remainder of your 12-month continuous coverage period which began as of January 1, 2017, and to notify you accordingly.

Effective Date of this Decision: November 3, 2017

How this Decision Affects Your Eligibility

Your case is sent back to NYSOH to reinstate you and your children in your Medicaid Managed Care plan as of September 1, 2017.

NYOSH will notify you once this change has been completed.

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.

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).

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 August 31, 2017 eligibility determination notice is RESCINDED.

The August 31, 2017 disenrollment notice is RESCINDED.

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).

The September 8, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your and your children's coverage in your Medicaid Managed Care plan as of September 1, 2017 through the remainder of your 12-month continuous coverage period which began as of January 1, 2017, and to notify you accordingly.

Your case is sent back to NYSOH to reinstate you and your children in your Medicaid Managed Care plan as of September 1, 2017.

NYOSH will notify you once this change has been completed.

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)

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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).