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

Notice of Decision

Decision Date: October 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022792

[redacted]

Dear [redacted],

On October 10, 2017, you appeared by telephone at an expedited hearing on your appeal of NY State of Health's September 17, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: October 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022792

[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 no longer eligible for Medicaid and terminate your Medicaid Managed Care (MMC) coverage effective September 30, 2017?

Procedural History

On February 22, 2017, NYSOH issued an eligibility determination notice stating that you remained eligible for Medicaid, effective April 1, 2017.

On August 30, 2017, your NYSOH account was updated.

On August 31, 2017, NYSOH issued an eligibility determination notice stating that you were no longer eligible for Medicaid, effective August 1, 2017, but your Medicaid coverage would continue until March 31, 2018, because certain individuals who qualify for Medicaid get coverage for twelve continuous months.

On September 14, 2017, the August 31, 2017, notices were returned to NYSOH and stamped, "RETURN MAIL" (*see* Documents [redacted]; [redacted]; uploaded [redacted]).

On September 15, 2017, your NYSOH account was systemically updated.

On September 17, 2017, NYSOH issued an eligibility determination notice stating, in relevant part, that you were no longer qualified for Medicaid, effective

September 16, 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 September 17, 2017, NYSOH issued a disenrollment notice stating that your MMC coverage would end on September 30, 2017.

On September 25, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as your coverage in your MMC plan was to end effective September 30, 2017.

On September 29, 2017, you faxed a letter to NYSOH requesting an expedited hearing and provided documentation to grant that request (*see* Document [redacted]; uploaded [redacted]). Your request for an expedited hearing was granted.

On October 10, 2017, you had an expedited 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 February 22, 2017, NYSOH issued a notice stating that you were eligible for Medicaid, effective as of April 1, 2017 (*see* Document [redacted]).

2) According to your NYSOH account, you were enrolled in a MMC, through Metro Plus, from January 1, 2016, through September 30, 2017.

3) On August 31, 2017, NYSOH issued eligibility determination and enrollment notices to the mailing address "[redacted]" (*see* Documents [redacted]).

4) The August 31, 2017, notices were returned to NYSOH as undeliverable on September 14, 2017 (*see* Documents [redacted]; [redacted]; uploaded [redacted]).

5) According to your NYSOH account, your address was:

   (a) [redacted] from December 2, 2014 through August 30, 2017;
   (b) [redacted] from August 30, 2017 through September 22, 2017;

(c) [redacted] from September 22, 2017 through present.

6) According to your NYSOH account, on August 30, 2017, your address was updated by a NYSOH representative to: [redacted].

7) You testified that you moved from [redacted] to [redacted] on August 21, 2017.

8) On September 26, 2017, you submitted a letter from the United States Postal Service. The letter confirmed that your request for a "PERMANENT Change-of-Address Order" had been received. Your mail would be forwarded from your old address, [redacted], to your new address, [redacted], as of August 25, 2017 (*see* Document [redacted]; 9/28/2017).

9) You testified you first learned about the disenrollment of your MMC coverage when you received the September 17, 2017 disenrollment notice.

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 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 federal poverty level (FPL) for the applicable family size (42 CFR §§ 435.119(b), 435.911(b)(1), 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, 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)).

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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were ineligible for Medicaid and ended your MMC plan effective September 30, 2017.

You were determined eligible for Medicaid effective April 1, 2017, and were enrolled in a MMC plan through Metro Plus.

The record reflects that, on August 30, 2017, your address was updated by a NYSOH representative to [redacted]. Based on that update, the August 31, 2017 notices were issued to that address. However, those notices were returned to NYSOH as undeliverable on September 14, 2017(*see* Documents [redacted]). Since the notices were returned to NYSOH, your Medicaid coverage was discontinued effective September 30, 2017.

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.

You testified that you moved from [redacted] to [redacted] on August 21, 2017. Further, you submitted a letter from the United States Postal Service confirming that your mail would be forwarded from your old address, [redacted], to your new address, [redacted], as of August 25, 2017 (see Document [redacted]). 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.

When your MMC coverage was discontinued on September 30, 2017, the twelve-month period of Medicaid eligibility that began on April 1, 2017, had not expired. Further, the record does not contain any evidence that your eligibility should have been discontinued before the end of your twelve-months of eligibility for any other reason.

Therefore, the September 17, 2017 eligibility determination and disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid coverage in your MMC plan as of October 1, 2017, and to notify you accordingly.

Decision

The September 17, 2017 eligibility determination is RESCINDED.

The September 17, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid coverage in your MMC plan as of October 1, 2017, and to notify you accordingly.

Effective Date of this Decision: October 11, 2017

How this Decision Affects Your Eligibility

NYSOH incorrectly ended your Medicaid coverage in your MMC plan effective September 30, 2017.

Your case has been returned to NYSOH to effectuate your Medicaid coverage in your MMC plan as of October 1, 2017. NYSOH will notify you once this has been done.

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 September 17, 2017 eligibility determination is RESCINDED.

The September 17, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid coverage in your MMC plan as of October 1, 2017, and to notify you accordingly.

NYSOH incorrectly ended your Medicaid coverage in your MMC plan effective September 30, 2017.

Your case has been returned to NYSOH to effectuate your Medicaid coverage in your MMC plan as of October 1, 2017. NYSOH will notify you once this has been done.

Legal Authority

We are sending you this notice 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)

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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