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: AP000000022815

[redacted]

Dear [redacted],

On October 6, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 16, 2017 determination notice and disenrollment notice, and the September 27, 2017 plan enrollment 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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DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: October 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022815

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health properly determine that you were no longer eligible for health insurance through NY State of Health and disenroll from Medicaid and your Medicaid Managed Care plan, effective August 31, 2017?

Procedural History

On September 17, 2016, NY State of Health (NYSOH) issued an eligibility determination notice stating you were eligible for Medicaid, effective September 1, 2016. You then enrolled in a Medicaid Managed Care plan with a November 1, 2016 start date.

On July 2, 2017, NYSOH issued a notice of renewal stating you had been re-enrolled in your current health plan for another year, and you did not have to do anything more. The notice stated you were determined eligible for Medicaid, effective September 1, 2017, and that your Medicaid Managed Care plan would start September 1, 2017.

This notice was returned as undeliverable to NYSOH on August 07, 2017 (*see* Document [redacted]). The notice was issued to your previous address in [redacted]

On August 16, 2017, NYSOH issued a notice stating your eligibility had been redetermined on August 15, 2017 and that you were not eligible for health insurance through NYSOH, effective August 16, 2017. This was because notices sent to you by U.S. mail to the address provided in your account were returned to NYSOH as undeliverable. This notice was returned as undeliverable to NYSOH on August 24, 2017 (*see* Document [redacted]). The notice was issued to your previous address in [redacted].

On August 16, 2017, a disenrollment notice was issued stating your enrollment in your Medicaid Managed Care plan would end August 31, 2017. The notice stated this was because you are no longer eligible to enroll in health insurance through NYSOH. This notice was returned as undeliverable to NYSOH on August 24, 2017 (*see* Document [redacted]). The notice was issued to your previous address in [redacted]

On September 26, 2017, NYSOH received your updated application for financial assistance with your health insurance.

That day a preliminary eligibility determination was prepared based on your last application finding you eligible for the Essential Plan for $20.00 per month, effective November 1, 2017. You enrolled in a plan that day.

On September 26, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your enrollment in the Essential Plan insofar as it did not begin September 1, 2017.

On September 27, 2017, NYSOH issued a notice stating you updated your mailing address in your account.

Also on September 27, 2017, NYSOH issued a notice of enrollment, based on your plan selection on September 26, 2017, stating that you were enrolled in an Essential Plan, and that your plan would start November 1, 2017.

On October 1, 2017, NYSOH issued an eligibility determination notice stating you were eligible to enroll in the Essential Plan with a $20.00 per month premium, effective November 1, 2017.

On October 2, 2017, you requested an expedited appeal hearing and provided supporting documentation for your request in [redacted].

On October 3, 2017, your request for an expedited appeal hearing was approved.
On October 6, 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 you are seeking insurance for yourself.

2) You testified you have lived in New York State throughout 2017.

3) You testified you have not had coverage outside of NYSOH for 2017.

4) You testified you currently reside at [redacted], [redacted].

5) You testified you moved to your current address in another county on [redacted] 2017.

6) You testified your previous address was [redacted], [redacted].

7) You testified your previous address was at an apartment complex, where people would take each other's mail or mail was not properly delivered.

8) You submitted an application to NYSOH for financial assistance on September 26, 2017. This was the first time NYSOH received your updated address information.

9) You testified you first realized you had been disenrolled from your health coverage when you went to the doctor and were told that the insurance was not working [redacted] around [redacted].

10) You testified you believed your coverage had been renewed in August 2017, and that there was nothing more you needed to do.

11) The July 2, 2017 renewal notice was sent back to NYSOH as undeliverable on August 7, 2017. The notice had your prior address listed on the first page.

12) The August 16, 2017 notices from NYSOH explaining the reasoning for your disenrollment were sent back to NYSOH as undeliverable on August 24, 2017. These notices had your prior address listed on the first page.

13) You testified, and the record reflects, that you were found eligible for and selected and enrolled in an Essential Plan on September 26, 2017, with a November 1, 2017 start date.

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 through NYSOH can be provided 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); N.Y. Soc. Serv. Law § 366(1)(b)).

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)).

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 no longer eligible for health insurance through NYSOH and were disenrolled from Medicaid and your Medicaid Managed Care plan, effective August 31, 2017.

You were found eligible for Medicaid, effective September 1, 2016, and were subsequently enrolled into Medicaid Managed Care plan that was effective as of November 1, 2016.

Nearing the end of your twelve-month coverage period, NYSOH issued a notice of renewal for 2017 on July 2, 2017. The notice stated you had been re-enrolled in your current health plan for another year, and you did not have to do anything more. The notice stated you were determined eligible for Medicaid, effective September 1, 2017, and that your Medicaid Managed Care plan would start September 1, 2017. This notice was returned as undeliverable to NYSOH on August 07, 2017 and had been issued to your previous address of [redacted].

Two additional notices were returned to NYSOH with your previous known address on August 24, 2017. These notices were dated August 16, 2017, and had stated your eligibility was redetermined on August 15, 2017. The result of the redetermination was that you were not eligible for health insurance through NYSOH, and were going to be disenrolled as of August 31, 2017, because notices sent to you by U.S. mail to the address provided in your account were returned to NYSOH as undeliverable.

It is unclear from the record why the three notices were returned in August 2017, but based on your testimony it is plausible that these notices were taken by someone else in your former apartment complex and returned to NYSOH. The record does show that, on September 26, 2017, within 30 days of moving in to your current residence on [redacted], your application for financial assistance was updated with your new address.

On September 26, 2017, you were found eligible for the Essential Plan and enrolled in a plan that day with a November 1, 2017 start date.

Generally, an individual remains eligible for Medicaid for twelve continuous months unless the person becomes otherwise ineligible. If a person lacks state residence or is unable to prove state residence during those twelve months they become ineligible for Medicaid and continuous coverage.

The record reflects your continuous coverage period was set to end August 31, 2017, and you had been automatically renewed for a September 1, 2017 start date in your Medicaid Managed Care plan. That renewal did not take place as a result of three of your notices being returned as undeliverable.

You credibly testified that you have remained a New York State resident for all of 2017. The record supports you moved between counties from Richmond County in August 2017 to Bronx County on [redacted].

As there is sufficient evidence in the record to conclude you have continuously retained New York State residency during the relevant time in question, you were improperly disenrolled from Medicaid and your Medicaid Managed Care plan as of August 31, 2017 for failure to meet residency requirements. There are no other

facts present in the record that would support you being ineligible for Medicaid as of [redacted].

Therefore, the August 16, 2017 eligibility determination and disenrollment notices are RESCINDED because they improperly disenrolled you from Medicaid coverage set to begin September 1, 2017.

Accordingly, your case is RETURNED to NYSOH to reinstate you into your Medicaid Managed Care plan from September 1, 2017 and continuing for 12 months, barring any disqualifying events occurring before then.

It follows that the September 27, 2017 notice of enrollment and October 1, 2017 eligibility determination notice stating respectively that you are enrolled in and eligible for the Essential Plan, effective November 1, 2017, are rendered MOOT by this decision.

Decision

The August 16, 2017 eligibility determination and disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to reinstate you into your Medicaid Managed Care plan from September 1, 2017 and continuing for 12 months, barring any disqualifying events occurring before then. NYSOH will notify you once your reinstatement has been effectuated.

The September 27, 2017 notice of enrollment and October 1, 2017 eligibility determination notice stating respectively that you are enrolled in and eligible for the Essential Plan, effective November 1, 2017, are rendered MOOT by this decision.

Effective Date of this Decision: October 11, 2017

How this Decision Affects Your Eligibility

You should have remained enrolled in your Medicaid Managed Care plan from September 1, 2017 and continuing for 12 months, provided no disqualifying events take place in the future.

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

Since you are being reinstated into your Medicaid Managed Care plan from September 1, 2017 onward, your eligibility for and enrollment in the Essential Plan as of November 1, 2017, is no longer at issue.

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:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The August 16, 2017 eligibility determination and disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to reinstate you into your Medicaid Managed Care plan from September 1, 2017 and continuing for 12 months, barring any disqualifying events occurring before then. NYSOH will notify you once your reinstatement has been effectuated.

The September 27, 2017 notice of enrollment and October 1, 2017 eligibility determination notice stating respectively that you are enrolled in and eligible for the Essential Plan, effective November 1, 2017, are rendered MOOT by this decision.

You should have remained enrolled in your Medicaid Managed Care plan from September 1, 2017 and continuing for 12 months, provided no disqualifying events take place in the future.

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

Since you are being reinstated into your Medicaid Managed Care plan from September 1, 2017 onward, your eligibility for and enrollment in the Essential Plan as of November 1, 2017, is no longer at issue.

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.

□□□□□ (Bengali)

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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 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)

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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.

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