



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

Notice of Decision

Decision Date: January 02, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000023651

[REDACTED]

[REDACTED]

On December 18, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 18, 2017 disenrollment 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
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Decision

Decision Date: January 02, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000023651

[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 your enrollment in a Medicaid Managed Care (MMC) plan terminated effective October 31, 2017?

Procedural History

On November 27, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective November 1, 2016. The notice further stated that you were not eligible to enroll in an MMC plan because you had other full benefit health insurance or Medicare.

On March 15, 2017, you were enrolled into an MMC plan.

On March 16, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in an MMC plan, beginning April 1, 2017.

On October 17, 2017, NYSOH redetermined your eligibility.

On October 18, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective November 1, 2017. The notice also stated that NYSOH's records showed that you had other health insurance or Medicare, and could therefore not enroll in an MMC plan.

Also on October 18, 2017, NYSOH issued a disenrollment notice, stating that your enrollment in your MMC plan was ending, effective October 31, 2017, because you were no longer eligible to enroll in an MMC plan.

On October 24, 2017, you spoke with NYSOH's Account Review Unit and appealed the fact that you had been disenrolled from your MMC coverage as of November 1, 2017.

On October 31, 2017, NYSOH uploaded documentation to your NYSOH account that you had mailed to them.

On November 3, 2017, NYSOH redetermined your eligibility.

On November 4, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective November 1, 2017, and that you should select a health plan for enrollment.

Also on November 4, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in an MMC plan, beginning December 1, 2017.

On December 18, 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, and your account confirms, that you were determined eligible for Medicaid effective November 1, 2016.
- 2) You testified that you previously had health insurance coverage through your mother, and that this coverage ended as of April 1, 2017.
- 3) Your NYSOH account reflects that you were enrolled into an MMC plan as of April 1, 2017, and you confirmed this in your testimony.
- 4) The "Notes" tab in your NYSOH account reflects that, on February 27, 2017, a NYSOH agent entered a note stating, "Outreached to the consumer and informed he is currently eligible and enrolled in Regular MA until 3/31/2017 when his ESI {Employer-Sponsored Insurance} will end through parents [sic] plan ...Account will need to be updated once the TPHI {Third-Party Health Insurance} is ended in eMedNY so plan selection is available."

- 5) The “Notes” tab also reflects that, on March 15, 2017, a NYSOH agent entered the following note, “Spoke to [REDACTED] and enrolled [REDACTED] in MMC Emblem to start 4/1/2017.”
- 6) Your NYSOH account confirms that an MMC plan was selected for enrollment on your behalf on March 15, 2017.
- 7) You testified that you received the October 18, 2017 notice stating that you were being disenrolled from your NYSOH plan, and that the notice did not provide you with enough time to correct the issue so that there would be no gap in your MMC coverage.
- 8) Your NYSOH account reflects that, on October 30, 2017, NYSOH received a letter from you containing a copy of a letter from EmblemHealth dated April 17, 2017 stating that your coverage on your mother’s health plan ended effective April 1, 2017 [REDACTED]
- 9) Your NYSOH account reflects that, after you provided this documentation, NYSOH updated your account, and you were re-enrolled into your MMC plan as of December 1, 2017.
- 10) You testified that you do not have any bills that were not covered during the month of November 2017 when you did not have MMC coverage.

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 that individual was eligible at 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)).

MMC 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 18 NYCRR § 360-10.3(h); Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13 ADM-03(III)(F)).

Continuous Coverage

Most applicants determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage offered through MMC, even if they lose Medicaid eligibility because of any changes or updates they make to their Marketplace 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 any subsequent Medicaid eligibility determination based on modified adjusted gross income (see 42 CFR § 435.916; NY Social Services Law (NY SSL) § 366(4)(c)).

Third Party Health Insurance

A person who has primary medical or health care coverage available from or under a third-party insurance provider is not permitted to enroll into an MMC plan (NY SSL § 364-j(3)(e)(xx); Medicaid Managed Care Model Contract (Appendix H-6), effective 3/1/2014 – 2/28/2019). However, they will remain eligible for fee-for-service Medicaid with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, or failing to provide a valid Social Security number (NY SSL § 366(4)(c)).

Legal Analysis

The issue under review is whether NYSOH properly disenrolled you from your MMC plan, as of November 1, 2017.

You were originally found eligible for Medicaid as of November 1, 2016. At that time, you were not enrolled into an MMC plan because you had other health insurance coverage through your mother. You testified, and your NYSOH account confirms, that this coverage ended as of March 31, 2017. You were subsequently enrolled into an MMC plan, beginning April 1, 2017, as confirmed in the March 16, 2017 enrollment confirmation notice.

Generally, when an individual is eligible for Medicaid through NYSOH they are required to enroll in an MMC plan. Applicants determined eligible will be enrolled or remain in their Medicaid plan for a twelve-month period, with limited exceptions, including entering prison or another facility that provides medical care, moving out of state, or failing to provide a valid Social Security number.

On October 17, 2017, NYSOH's system appears to have detected that you had TPHI, and on October 18, 2017, NYSOH issued a notice disenrolling you from your MMC plan, effective October 31, 2017, because you allegedly had other full benefit health insurance.

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).

When NYSOH determines that a person has active coverage in a health insurance plan outside of NYSOH, that person is not eligible to enroll or remain enrolled in a MMC plan. However, you mailed documentation to NYSOH, which was received on October 30, 2017, that confirmed your coverage under your mother's health insurance ended on March 31, 2017. After you submitted this documentation, you were permitted to re-enroll in an MMC plan. However, your coverage did not go into effect until December 1, 2017, as confirmed in the November 4, 2017 enrollment confirmation notice.

Notes in NYSOH's system made on February 27, 2017 indicate that NYSOH was aware that you had TPHI that ended as of March 31, 2017 and, indeed, NYSOH allowed you to enroll in an MMC plan beginning April 1, 2017. Therefore, when NYSOH cancelled your MMC plan coverage at the end of October due to your allegedly having TPHI, the information relied upon by NYSOH in making the determination to terminate your coverage under your MMC plan was incorrect and out of date.

For this reason, the October 18, 2017 disenrollment notice is **RESCINDED**.

Your case is **RETURNED** to NYSOH to reinstate you in your MMC plan for the month of November 2017.

Decision

The October 18, 2017 disenrollment notice is **RESCINDED**.

Your case is **RETURNED** to NYSOH to reinstate you in your MMC plan for the month of November 2017.

Effective Date of this Decision: January 02, 2018

How this Decision Affects Your Eligibility

NYSOH improperly disenrolled you from your MMC plan.

Your case is being sent back to reinstate your MMC plan coverage for the month of November 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:

- 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 October 18, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you in your MMC plan for the month of November 2017.

NYSOH improperly disenrolled you from your MMC plan.

Your case is being sent back to reinstate your MMC plan coverage for the month of November 2017.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:



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 مجاناً.

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।

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).

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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&btumi ama wo obi a okyerE kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 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.