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

Notice of Decision

Decision Date: December 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023677

[redacted]

Dear [redacted]

On December 19, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 18, 2017 eligibility determination notice and April 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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DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: December 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023677

[redacted]

Issues

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

> Was your appeal of NY State of Health's April 18, 2017 eligibility determination notice and April 18, 2017 disenrollment notice timely?
>
> Did NY State of Health properly determine that you, your spouse, and your children were no longer eligible for health insurance through NY State of Health and disenrolled from Medicaid and your Medicaid Managed Care plans, effective April 30, 2017?

Procedural History

On February 25, 2017, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you, your spouse, and your children were no longer eligible for health insurance through NYSOH, effective February 25, 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 mailed to [redacted].

Also on February 25, 2017, NYSOH issued a disenrollment notice stating that your, your spouse's, and your children's enrollment in your Medicaid Managed Care plans would end on February 28, 2017. This was because you, your spouse, and your children were no longer eligible to enroll in health insurance through NYSOH. This notice was mailed to [redacted].

On March 13, 2017, the February 25, 2017 eligibility determination notice and February 25, 2017 disenrollment notice were returned to NYSOH by the United States Postal Service as undeliverable as there was “no such number”.

On March 15, 2017, you contacted NYSOH and updated your mailing address to [redacted]

Also on March 15, 2017, you submitted an application to NYSOH for financial assistance for your household.

On March 16, 2017, NYSOH issued a notice of eligibility determination stating that you, your spouse, and your children were eligible for Medicaid, effective March 1, 2017.

Also on March 16, 2017, NYSOH issued a notice of enrollment confirmation stating that you, your spouse, and your children were enrolled in your Medicaid Managed Care plans with a plan enrollment start date of April 1, 2017.

On April 17, 2017, the February 25, 2017 eligibility determination notice and the February 25, 2017 disenrollment notice which had been returned to NYSOH as undeliverable on March 13, 2017, were uploaded to your NYSOH account.

On April 18, 2017, NYSOH issued a notice of eligibility determination stating that you, your spouse, and your children were no longer eligible for health insurance through NYSOH, effective April 18, 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.

Also on April 18, 2017, NYSOH issued a disenrollment notice stating that your, your spouse’s, and your children’s enrollment in your Medicaid Managed Care plans would end on April 30, 2017. This was because you, your spouse, and your children were no longer eligible to enroll in health insurance through NYSOH.

On April 28, 2017, you updated your household’s application for financial assistance.

On April 29, 2017, NYSOH issued a notice of eligibility determination stating that you and your spouse were eligible to enroll in the Essential Plan, effective June 1, 2017, and that your children were eligible for Medicaid, effective May 1, 2017.

Also on April 29, 2017, NYSOH issued a notice of enrollment confirmation stating that you and your spouse were enrolled in an Essential Plan with a plan enrollment start date of June 1, 2017, and that your children were enrolled in their Medicaid Managed Care plans with a plan enrollment start date of June 1, 2017.

On October 24, 2017, you contacted NYSOH's Account Review Unit and requested an appeal insofar as you, your spouse, and your children had been disenrolled from your Medicaid and Medicaid Managed Care plans as of April 30, 2017.

On December 19, 2017, you had a hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, Mandarin Interpreter [redacted] translated. 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 your and your family reside at [redacted] You further testified that your family has lived at this address for three to four years.

2) You testified that you have been a New York resident for sixteen or seventeen years.

3) You testified that neither you, your spouse, nor your children were incarcerated in 2017.

4) You testified that neither you, your spouse, nor your children had health insurance outside of NYSOH in 2017.

5) The record reflects that on March 15, 2017 you updated your family's address from [redacted] to [redacted]

6) You testified that you did receive the April 18, 2017 eligibility determination notice and the April 18, 2017 disenrollment notice advising you that your family was to be disenrolled from your coverage as of April 30, 2017.

7) You further testified that you contacted NYSOH as soon as you received the disenrollment notice.

8) Your NYSOH account reflects that you contacted NYSOH on April 28, 2017 to reenroll your household in coverage. In the application that you submitted on April 28, 2017, you indicated that your household income had increased. This resulted in you and your spouse being found eligible for the Essential Plan.

9) You testified that in late April 2017 or early May 2017 you began speaking with the NYSOH Account Review Unit and requesting that your household be reenrolled in coverage as of May 1, 2017. You went on to testify that

you continued to follow-up with NYSOH until formally filing your appeal on October 24, 2017.

10) The record reflects that on May 1, 2017 you spoke with NYSOH's Account Review Unit asserting that your household had been improperly disenrolled from coverage as a result of returned mail. As a result, incident [redacted] was created. Notes within this incident reflect that you contacted NYSOH to follow-up on the status of your request that your household be reinstated into their coverage as of May 1, 2017, on May 13, 2017, May 16, 2017, May 31, 2017, June 13, 2017, June 15, 2017, June 28, 2017, July 21, 2017, August 15, 2017, and September 6, 2017.

11) On October 18, 2017, you contacted NYSOH to follow-up on incident [redacted], as a result incident [redacted] was created. A note within incident [redacted] indicates that as of October 19, 2017 there was no resolution of the initial incident ([redacted]).

12) On October 24, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal of your household's disenrollment from coverage as of April 30, 2017, seeking reenrollment as of May 1, 2017.

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

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR §155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

However, where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe as determined by NYSOH that failure to timely submit the

appeal was due to exceptional circumstances and should not preclude the appeal (45 CFR §155.520(d)(2)(i)(D)).

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)).

Medicaid for Children

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the federal poverty level (FPL) for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

In the case of an individual who expects to file a tax return and does not expect to be claimed by another taxpayer, the household consists of the taxpayer and all persons whom such individual expects to claim as a tax dependent (42 CFR § 435.603(f)(1).

In an analysis of Medicaid eligibility, the determination is based on the FPL “for the applicable budget period used to determine an individual's eligibility” (42 CFR § 435.4). On the date of your application, that was the 2017 FPL, which is $16,240.00 for a two-person household (82 Fed. Reg. 8831).

Medicaid Continuous Coverage

Most individuals 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 first issue is whether your appeal of NYSOH’s April 18, 2017 eligibility determination notice and April 18, 2017 disenrollment notice was timely.

On April 18, 2017, NYSOH issued a notice of eligibility determination stating that you, your spouse, and your children were no longer eligible to enroll in health insurance through NYSOH, effective April 18, 2017. Also on April 18, 2017, NYSOH issued a disenrollment notice stating that your, your spouse’s, and your children’s enrollment in your Medicaid Managed Care plans would end as of April 30, 2017.

The record reflects that you first contacted NYSOH to file a formal appeal regarding the April 18, 2017 eligibility determination notice and April 18, 2017 disenrollment notice on October 24, 2017.

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of your, your spouse’s, and your children’s ineligibility for Medicaid and disenrollment from your Medicaid Managed Care plans, an appeal should have been filed by June 17, 2017.

Although your appeal was untimely on its face, you contacted the NYSOH Account Review Unit on May 1, 2017 regarding your request that your household be reinstated into coverage as of May 1, 2017. This contact was within the 60-day time frame to appeal. As a result of this contact, incident [redacted] was created.

The record reflects that NYSOH never resolved [redacted]. Furthermore, you followed-up with NYSOH regarding this incident on May 13, 2017, May 16, 2017, May 31, 2017, June 13, 2017, June 15, 2017, June 28, 2017, July 21, 2017, August 15, 2017, and September 6, 2017, and October 18, 2017, ultimately resulting in your filing of a formal appeal request on October 24, 2017.

As you contacted NYSOH on May 1, 2017 to request that your household be reinstated into coverage as of May 1, 2017, which was within 60-days of the April 18, 2017 eligibility determination notice and April 18, 2017 disenrollment notice, you continued to follow-up with NYSOH regarding your request, and NYSOH never issued a resolution of the incident you filed on May 1, 2017, your appeal was timely and will be addressed.

The second issue is whether NYSOH properly determined that you, your spouse, and your children were no longer eligible for health insurance through NYSOH and disenrolled from Medicaid and your Medicaid Managed Care plans, effective April 30, 2017.

You, your spouse, and your children were found eligible for Medicaid effective March 1, 2017 and were subsequently enrolled into Medicaid Managed Care plans that were effective as of April 1, 2017.

On March 13, 2017, notices that were sent to you via regular mail to [redacted] were returned to NYSOH as undeliverable and on April 17, 2017, these returned notices were uploaded to your NYSOH account.

As a result of the notices being returned to NYSOH, on April 18, 2017 an eligibility determination was issued stating that you, your spouse, and your children were not eligible for health insurance through NYSOH as notices sent to you by U.S. mail to the mailing address provided in your account were returned to NYSOH as undeliverable. You, your spouse, and your children were subsequently disenrolled from your Medicaid and Medicaid Managed Care plans as of April 30, 2017.

Generally, an individual remains eligible for Medicaid for twelve continuous months, even if the household income rises above 138% of the relevant Federal poverty level, 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 that on March 15, 2017, you updated the address in your account to [redacted]. This is the same residence that was listed on the February 25, 2017 notices, only the address is written in a different format. You testified that this is your correct address. You also testified that this has been your address for the last three to four years.

As there is sufficient evidence in the record to conclude that you, your spouse, and your children have continuously retained New York State residency during the relevant time period, you, your spouse, and your children were improperly disenrolled from Medicaid and your Medicaid Managed Care plans as of April 30, 2017 for failure to meet residency requirements. There are no other facts

present in the record that would support you, your spouse, and your children being disenrolled from Medicaid and your Medicaid Managed Care plans.

Although your estimated annual income increased when you submitted your application on April 28, 2017, as you, your spouse, and your children were improperly found ineligible for and disenrolled from Medicaid and your Medicaid Managed Care plans, you, your spouse, and your children should have remained enrolled in Medicaid for the remainder of your 12-month eligibility period.

Therefore, the April 18, 2017 eligibility determination notice and the April 18, 2017 disenrollment notice are RESCINDED.

Accordingly, your case is RETURNED to NYSOH to reinstate you, your spouse, and your children into Medicaid and your Medicaid Managed Care plans, effective May 1, 2017 and to continue your, your spouse's, and your children's Medicaid barring subsequent changes in your, your spouse's, and your children's eligibility until February 28, 2018.

Decision

The April 18, 2017 eligibility determination is RESCINDED.

The April 18, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you, your spouse, and your children into Medicaid and your Medicaid Managed Care plans, effective May 1, 2017 and to continue your, your spouse's, and your children's Medicaid barring subsequent changes in your, your spouse's, and your children's eligibility until February 28, 2018.

Effective Date of this Decision: December 26, 2017

How this Decision Affects Your Eligibility

You, your spouse, and your children should have remained eligible for Medicaid Continuous Coverage until February 18, 2018 and enrolled in your Medicaid Managed Care plans.

Your case is being sent back to NYSOH to reinstate you, your spouse, and your children into Medicaid and your Medicaid Managed Care plans as of May 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:

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

  NY State of Health Appeals
  P.O. Box 11729

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).

Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The April 18, 2017 eligibility determination is RESCINDED.

The April 18, 2017 disenrollment notice is RESCINDED.

You, your spouse, and your children should have remained eligible for Medicaid Continuous Coverage until February 18, 2018 and enrolled in your Medicaid Managed Care plans.

Your case is RETURNED to NYSOH to reinstate you, your spouse, and your children into Medicaid and your Medicaid Managed Care plans, effective May 1, 2017 and to continue your, your spouse's, and your children's Medicaid barring subsequent changes in your, your spouse's, and your children's eligibility until February 28, 2018.

Your case is being sent back to NYSOH to reinstate you, your spouse, and your children into Medicaid and your Medicaid Managed Care plans as of May 1, 2017.

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)

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).

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).