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

Notice of Decision

Decision Date: February 02, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023961

[redacted]

[redacted],

On January 4, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 13, 2017 discontinuance notice and October 13, 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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Decision

Decision Date: February 02, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023961

[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 your Medicaid Managed Care plan ended effective October 31, 2017?

Procedural History

On September 21, 2017, you updated your NYSOH account.

On September 22, 2017, NYSOH issued an enrollment confirmation notice stating that you remained enrolled in a Medicaid Managed Care plan, effective October 1, 2015.

On October 10, 2017, the September 22, 2017 enrollment confirmation notice was returned to NYSOH by the US Postal Service.

On October 12, 2017, NYSOH redetermined your eligibility.

On October 13, 2017, NYSOH issued a notice of discontinuance stating that you were no longer eligible to receive health insurance through NYSOH, effective October 12, 2017, because a notice regarding your eligibility and coverage sent to you by NYSOH was 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 NYOSH.

Also on October 13, 2017, NYSOH issued a plan disenrollment notice confirming that your Medicaid Managed Care plan would end on October 31, 2017.

On October 23, 2017, NYSOH received your updated application for financial assistance with health insurance.

On October 24, 2017, NYSOH issued an eligibility determination stating that you were eligible for Medicaid, effective November 1, 2017.

Also on October 24, 2017, NYSOH issued a plan enrollment notice, based on your October 23, 2017 plan selection, confirming that you were enrolled in a Medicaid Managed Care plan, effective December 1, 2017.

On November 2, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination, insofar, as your Medicaid Managed Care plan started on December 1, 2017 and not November 1, 2017.

On January 4, 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 that you are only appealing your eligibility.

2) You testified, and the record reflects, that you were enrolled in a Medicaid Managed Care plan, effective October 1, 2015.

3) The record indicates that you were subsequently disenrolled from your Medicaid Managed Care plan, effective October 31, 2017.

4) According to your NYSOH account, a September 22, 2017 enrollment confirmation notice addressed to you was returned as undeliverable on October 10, 2017.

5) No other NYSOH notices were returned as undeliverable except for the September 22, 2017 enrollment confirmation notice.

6) The notice sent to you on September 22, 2017 was addressed to: [redacted]

7) You testified that this address was correct [redacted]

8) You testified and NYSOH records reflect that you have lived at that address since September 1, 2017.

9) You testified that you are appealing your eligibility because you incurred medical bills in November 2017 which were not covered by your Medicaid fee-for-service 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 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 issue under review is whether NYSOH properly determined that your enrollment in your Medicaid Managed Care plan ended effective October 31, 2017.

You became eligible for Medicaid and subsequently enrolled into a Medicaid Managed Care plan, effective October 1, 2015.

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, on September 22, 2017, NYSOH issued an enrollment confirmation notice that was returned to NYSOH as undeliverable on October 10, 2017.

As a result, you were subsequently disenrolled from your Medicaid Managed Care plan 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 October 13, 2017, NYSOH issued a discontinuance notice and a plan disenrollment notice, stating that you were no longer eligible to enroll in Medicaid and that your Medicaid Managed Care plan would end, effective October 31, 2017.

However, a review of the record reflects that this was the only notice returned as undeliverable, despite several other notices being sent to the same address. You testified, and the record reflects, that your address is: [redacted]. You testified, and the record reflects, that you have lived at that address since [redacted] 2017.

Based on the credible evidence of the record, since the September 22, 2017 enrollment confirmation notice was the only notice returned as undeliverable to NYSOH despite other notices being sent to the same mailing address, it is reasonable to conclude that this notice was returned as undeliverable through no fault of your own, and was the result of an error of the United State Postal Service. As a result, it is reasonable to conclude that your disenrollment from your Medicaid Managed Care plan was in error.

Therefore, the October 13, 2017 discontinuance notice and October 13, 2017 plan disenrollment notice must be RESCINDED.

Your case is RETURNED to NYSOH to reinstate your coverage in your Medicaid Managed Care plan for the month of November 2017, and to notify you accordingly.

Decision

The October 13, 2017 discontinuance notice is RESCINDED.

The October 13, 2017 plan disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to ensure you are enrolled in your Medicaid Managed Care plan for the month of November 2017.

Effective Date of this Decision: February 02, 2018

How this Decision Affects Your Eligibility

Your case is sent back to NYSOH to reinstate you in your Medicaid Managed Care plan for the month of November 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.

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 October 13, 2017 discontinuance notice is RESCINDED.

The October 13, 2017 plan disenrollment notice is RESCINDED.

Your case is sent back to NYSOH to reinstate you in your Medicaid Managed Care plan for the month of November 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)

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 तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई 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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