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

# Notice of Decision

Decision Date: February 12, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000024662

On February 6, 2018, 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 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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**Decision**

Decision Date: February 12, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000024662

## Issue

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

> Did New York State of Health (NYSOH) properly end your Medicaid Managed Care (MMC) plan coverage as of October 31, 2017?

## Procedural History

On October 9, 2016, NYSOH issued an eligibility determination notice stating that you were still qualified to get health coverage under Medicaid and enrolled in an MMC plan, effective December 1, 2016.

On September 21, 2017, NYSOH issued a renewal notice stating that it was time to renew your health insurance for the upcoming coverage year. The notice stated that, based on information from federal and state sources, NYSOH was unable to determine whether you qualified for financial help paying for your health coverage. The notice instructed you to return to your account between October 16, 2017, and November 15, 2017, to see what you qualified for on December 1, 2017.

On October 17, 2017, your account was updated.

On October 18, 2017, NYSOH issued three notices:

(1) An eligibility determination notice stating that you were eligible to enroll in the Essential Plan with a $20.00 per month, effective December 1, 2017;

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(2) A plan enrollment notice confirming that, as of October 17, 2017, you were enrolled in an Essential Plan with an enrollment start date of December 1, 2017;

(3) A disenrollment notice stating that your MMC plan coverage would end as of October 31, 2017.

On November 21, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as your MMC plan ended as of October 31, 2017.

On February 6, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken and the record was fully developed during the hearing. The record was closed at the end of the proceeding.

## Findings of Fact

A review of the record supports the following findings of fact:

1) According to your NYSOH account, you were determined eligible for Medicaid and enrolled in an MMC plan, effective December 1, 2016.

2) On September 21, 2017, NYSOH issued a notice directing you to update your account by November 15, 2017, or risk losing your financial assistance (

3) According to your NYSOH account, on October 17, 2017, your account was updated, and your annual household income was changed to $18,200.00.

4) According to your NYSOH account and testimony, your Medicaid coverage ended as of October 31, 2017.

5) According to your NYSOH account, on October 17, 2017, you were enrolled in an Essential Plan with an enrollment start date of December 1, 2017.

6) You testified that you incurred medical expenses in the month of November 2017 and want Medicaid to cover those expenses.

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

## Applicable Law and Regulations

Medicaid Eligibility

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

Reimbursement for Out-of-Pocket Expenses

Generally, Medicaid payments are made to providers which furnished the services (18 NYCRR § 360-7.5(a)(1)). However, Medicaid recipients or their representatives may be reimbursed when, through no fault of their own:

> (a) an erroneous Medicaid eligibility determination is reversed (whether the reversal is due to the state or local agency discovering its own error or is the result of a fair hearing decision or court order), or the state or local agency fails to determine Medicaid eligibility within the applicable time periods; and
>
> (b) an erroneous eligibility determination or the delay in determining eligibility caused the recipient or the recipient's representative to pay for medically necessary services which otherwise would have been paid for by the Medicaid program.

(18 NYCRR §360-7.5(a)(3)(i)).

## Legal Analysis

The issue under review is whether NYSOH properly ended your MMC plan effective October 31, 2017.

You were determined eligible for Medicaid and enrolled in an MMC plan effective December 1, 2016.

Generally, once individuals are determined eligible for Medicaid, they are guaranteed 12 months of Medicaid coverage, even if the adult loses Medicaid eligibility because of any changes or updates they make to their NYSOH account. This twelve-month period is based on the effective date of the Medicaid eligibility determination.

On September 21, 2017, NYSOH issued you a notice directing you to update your account by November 15, 2017, or you may lose your financial assistance (*see* Document ). Based on that notice, on October 17, 2017, you updated your account and your annual household income was changed to $18,200.00. You were determined eligible to enroll in an Essential Plan with a $20.00 monthly premium, effective December 1, 2017.

Once a person is eligible for Medicaid, that eligibility continues for 12 months, even if the household income rises above 138% of the FPL. When your Medicaid coverage terminated on October 31, 2017, the twelve-month period of Medicaid eligibility that was effective on December 1, 2016, had not yet expired and was not due to expire until November 30, 2017.

Therefore, the October 18, 2017 disenrollment notice stating that your MMC coverage would end October 31, 2017 is MODIFIED to state your MMC coverage would end November 30, 2017.

Your case is RETURNED to NYSOH to reinstate your Medicaid coverage from November 1, 2017 through November 30, 2017, and to notify you accordingly.

## Decision

The October 18, 2017, disenrollment notice stating that your MMC coverage would end October 31, 2017 is MODIFIED to state your MMC coverage would end November 30, 2017.

Your case is RETURNED to NYSOH to reinstate your Medicaid coverage from November 1, 2017 through November 30, 2017, and to notify you accordingly.

**Effective Date of this Decision:** February 12, 2018

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## How this Decision Affects Your Eligibility

Your Medicaid coverage will be reinstated from November 1, 2017 through November 30, 2017. NYSOH will inform you once it has been reinstated so you and/or your provider(s) can process your medical claims through your MMC plan.

## 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):

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

  NY State of Health Appeals<br>
  P.O. Box 11729<br>
  Albany, NY 12211
- By fax: 1-855-900-5557

## Summary

The October 18, 2017, disenrollment notice stating that your MMC coverage would end October 31, 2017 is MODIFIED to state your MMC coverage would end November 30, 2017.

Your case is RETURNED to NYSOH to reinstate your Medicaid coverage from November 1, 2017 through November 30, 2017, and to notify you accordingly.

Your Medicaid coverage will be reinstated from November 1, 2017 through November 30, 2017. NYSOH will inform you once it has been reinstated so you and/or your provider(s) can process your medical claims through your MMC plan..

## Legal Authority

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## A Copy of this Decision Has Been Provided To:

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 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.

## (Urdu)اردو

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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