



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

Notice of Decision

Decision Date: February 28, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025236

[REDACTED]

[REDACTED],

On February 5, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's September 8, 2017 discontinuance and plan disenrollment notices.

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 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 28, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025236



Issue

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

Did NY State of Health properly determine that your eligibility for and enrollment in your Medicaid Managed Care plan terminated effective September 30, 2017?

Procedural History

On March 6, 2017, NY State of Health (NYSOH) issued a notice stating that it was time to renew your coverage through NYSOH. This notice stated that you were being transferred from your local Department of Social Services (LDSS) and that your coverage would be ending as of May 31, 2017. This notice further directed you to log on to your NYSOH account between April 16, 2017 and May 15, 2017, to complete the renewal process for anyone who needs health coverage in your household.

On May 8, 2017, an updated application for financial assistance was submitted on your behalf.

On May 9, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective June 1, 2017.

On June 13, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective July 1, 2017.

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On July 27, 2017, NYSOH issued an eligibility determination notice stating that you remained eligible for Medicaid, effective July 1, 2017. This notice was returned to NYSOH as undeliverable on August 9, 2017, and uploaded to your NYSOH account on August 17, 2017.

Also on July 27, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective July 1, 2017. This notice was returned to NYSOH as undeliverable on August 9, 2017, and was uploaded to your NYSOH account on August 17, 2017.

On August 17, 2017, NYSOH reissued the July 27, 2017 eligibility determination and plan enrollment notices. These notices were returned as undeliverable on September 5, 2017, and uploaded to your NYSOH account on September 9, 2017.

On September 8, 2017, NYSOH issued a discontinuance notice stating that you were no longer eligible to enroll in health insurance through NYSOH, effective September 8, 2017, because NYSOH sent information to you through the United States Postal Service (USPS) and the information had been returned to NYSOH as undeliverable.

Also on September 8, 2017, NYSOH issued a plan disenrollment notice stating that your enrollment in your Medicaid Managed Care plan terminated as of September 30, 2017.

On October 30, 2017, NYSOH received your updated application for financial assistance with health insurance.

On October 31, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan with a \$20.00 monthly premium for a limited time, effective December 1, 2017. This notice further directed you to submit income documentation by January 28, 2018, to confirm your eligibility.

Also on October 31, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in an Essential Plan with a \$20.00 monthly premium, effective December 1, 2017.

Also on December 4, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your Essential Plan coverage as it did not start as of October 1, 2017.

On February 5, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed the end of the hearing.

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Findings of Fact

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

- 1) According to your NYSOH account, you were transferred from your LDSS in May 2017, and that you were found eligible for Medicaid through NYSOH, effective June 1, 2017.
- 2) According to your NYSOH account, you were found no longer eligible for health insurance coverage through NYSOH, effective September 8, 2017.
- 3) According to your NYSOH account, you were disenrolled from your Medicaid Managed Care plan, effective September 30, 2017.
- 4) According to your NYSOH account, you were disenrolled from coverage because NYSOH had sent information to you through USPS and these mailings were returned as undeliverable to NYSOH.
- 5) According to your NYSOH account, prior to October 31, 2017 all the notices in your account were being sent to the following address:

[REDACTED]

- 6) You testified that this address is incorrect. You testified that you were released from prison and you received help from your [REDACTED] when you first signed up for health insurance after being released.
- 7) You testified that your [REDACTED] last name was [REDACTED] and that he worked out of Rochester, NY.
- 8) You testified that your current address is:

[REDACTED]

- 9) You testified that you did not give NYSOH the Rochester address, nor have you ever lived in Rochester. You testified that you have had your current address for about three years, prior to and after [REDACTED].
- 10) You testified that you did not receive any notices via regular mail from NYSOH prior to the notices issued on October 31, 2017.

- 11) You testified that you discovered that you did not have insurance when you had an appointment in October 2017, and you were informed that your insurance had lapsed.
- 12) According to your NYSOH account, NYSOH received your updated application for financial assistance with health insurance on October 30, 2017. This application indicated that your mailing address was [REDACTED].
- 13) According to your NYSOH account, you were found eligible for and enrolled in an Essential Plan, effective December 1, 2017.
- 14) You testified that you are seeking to have your health insurance coverage start as of October 1, 2017, because you have unpaid medical bills from that month.

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)).

Medicaid Continuous Coverage:

Most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, unless the adult loses Medicaid eligibility because of

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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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your enrollment in your Medicaid Managed Care plan terminated effective September 30, 2017.

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 July 27, 2017, NYSOH issued an eligibility determination notice and a plan enrollment notice that were returned as undeliverable on August 9, 2017. These notices were uploaded to your account on August 17, 2017. After receiving these notices, NYSOH reissued the July 27, 2017 eligibility determination and plan enrollment notices to the same address. However, these notices were also returned as undeliverable on September 5, 2017. These returned notices were uploaded to your account on September 9, 2017.

As a result, you were 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 an Medicaid Managed Care plan. As such, on September 8, 2017, NYSOH issued a discontinuance notice and a plan disenrollment notice stating that you were no longer eligible to enroll in a health insurance through NYSOH, effective September 8, 2017, and your Medicaid Managed Care plan coverage would end effective September 30, 2017.

You testified that, after you were released from [REDACTED], you received assistance with your application for financial assistance from your [REDACTED]. You testified that your [REDACTED] last name was [REDACTED] and that his office was in Rochester, NY. You further testified that you were receiving health insurance through your LDSS prior to being transferred to NYSOH. The record indicates that you were transferred from your LDSS office to NYSOH on March 6, 2017. The NYSOH account that was created for you had, [REDACTED] listed as your mailing address.

You testified that you did not give either LDSS or NYSOH the Rochester address, but that it is possible that your [REDACTED] did when you were receiving his assistance. You testified that you have never lived at the Rochester address. You further testified that you have had the same address for about three years; prior to and after [REDACTED], which is [REDACTED]
[REDACTED]

Based on the credible evidence of the record, it is reasonable to conclude that the notices that were returned as undeliverable was through no fault of your own, and quite possibly the result of an error made by your [REDACTED], your LDSS, or NYSOH. Further, even though the mailing address listed in your account was incorrect, based on your testimony and the information listed in your NYSOH account, you have not moved out of New York State since March 2017. As a result, it is reasonable to conclude that your disenrollment from your Medicaid Managed Care plan was in error.

Therefore, the September 8, 2017 discontinuance and plan disenrollment notices must be RESCINDED.

Your case is RETURNED to NYSOH to reinstate you in your Medicaid Managed Care plan, effective October 1, 2017, and to notify you accordingly.

Generally, once individuals are determined eligible for Medicaid, they are guaranteed 12 months of Medicaid coverage, even if the applicant 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.

The record indicates that you were found eligible for Medicaid, effective June 1, 2017. As a result, even though your annual expected income increased when you modified your application on October 30, 2017, you should have remained enrolled in Medicaid for the remainder of your 12-month eligibility period; which would be until May 31, 2018.

As a result, your enrollment in your Medicaid Managed Care plan should continue until May 31, 2018, or through the end of your twelve-month period, unless a disqualifying event occurs.

Decision

The September 8, 2017 discontinuance notice is RESCINDED.

The September 8, 2017 plan disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you in your Medicaid Managed Care plan, effective October 1, 2017 through the end of your twelve-month eligibility period, unless a disqualifying event occurs, and to notify you accordingly.

Effective Date of this Decision: February 28, 2018

How this Decision Affects Your Eligibility

Your case is being sent back to NYSOH to reinstate your eligibility for Medicaid and enrollment in your Medicaid Managed Care plan as of October 1, 2017, and will continue until May 31, 2018, barring a valid reason to end your eligibility and/or coverage. NYSOH will notify you once this 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 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).

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
P.O. Box 11729
Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The September 8, 2017 discontinuance notice is RESCINDED.

The September 8, 2017 plan disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you in your Medicaid Managed Care plan, effective October 1, 2017 through the end of your twelve-month eligibility period, unless a disqualifying event occurs, and to notify you accordingly.

Your case is being sent back to NYSOH to reinstate your eligibility for Medicaid and enrollment in your Medicaid Managed Care plan as of October 1, 2017, and until May 31, 2018, barring a valid reason to end your eligibility and/or coverage. NYSOH will notify you once this 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:



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।

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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 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. y&b&tumi ama wo obi a okyer& 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.

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