



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

Notice of Decision

Decision Date: March 27, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025254

[REDACTED]

Dear [REDACTED],

On February 26, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 22, 2017 and December 28, 2017 disenrollment notices, and December 29, 2017 plan enrollment 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: March 27, 2018

NY State of Health Account ID [REDACTED]
Appeal Identification Number: AP000000025254

[REDACTED]

Issues

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

Did NY State of Health properly determine that you were no longer eligible to remain enrolled in your Medicaid Managed Care plan, effective November 30, 2017 and again as of December 31, 2017?

Did NY State of Health properly determine that your Medicaid Managed Care plan enrollment was effective February 1, 2018?

Procedural History

On October 19, 2017, NY State of Health (NYSOH) issued a notice of change in mailing address. The notice stated NYSOH received information from the U.S. Postal Service that your address had changed. The notice was issued to [REDACTED]

On October 19, 2017, NYSOH issued a notice stating the income information in your October 18, 2017 application did not match what NYSOH received from state and federal data sources. The notice directed you to provide proof of your household income by November 2, 2017.

On October 20, 2017, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective October 1, 2017.

On October 25, 2017, NYSOH issued a notice of change in mailing address. The notice stated NYSOH received information from the U.S. Postal Service that your address has changed.

On October 25, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan with an effective start date of December 1, 2017.

On November 22, 2017, NYSOH issued a notice of change in mailing address. The notice stated NYSOH received information from the U.S. Postal Service that your address has changed. The notice was issued to [REDACTED]
[REDACTED]

On November 22, 2017, NYSOH issued a notice stating you were no longer eligible to enroll in health insurance through NYSOH, effective November 22, 2017. The notice stated this was because you were not a resident of New York State. The notice was issued to [REDACTED]
[REDACTED].

On November 22, 2017, NYSOH issued a disenrollment notice terminating your enrollment in your Medicaid Managed Care plan, effective December 1, 2017. The notice stated this was because you were no longer eligible to enroll in insurance through NYSOH. The notice was issued to [REDACTED]
[REDACTED].

On November 28, 2017, NYSOH issued an eligibility determination notice, based on your updated application on November 27, 2017, stating you were eligible for Medicaid, effective November 1, 2017. The notice was issued to [REDACTED]
[REDACTED].

On November 28, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective January 1, 2018. The notice was issued to [REDACTED]

On November 28, 2017, NYSOH issued a notice of change in mailing address. The notice stated NYSOH receive information from the U.S. Postal Service that your address has changed. The notice was issued to [REDACTED]
[REDACTED].

On November 30, 2017, NYSOH issued a notice stating your contact preference had changed and was updated to receive notices by email.

On December 4, 2017, you contacted NYSOH's Account Review Unit and appealed the start date of your Medicaid Managed Care plan, requesting it be changed from January 1, 2018, to December 1, 2017.

On December 28, 2017, NYSOH issued a notice entitled resending returned mail. The notice stated you were receiving the letters because NYSOH sent you information by U.S. Mail to the mailing address in your account, but the mailing was returned to NYSOH as undeliverable. The notice had been issued to [REDACTED]

On December 28, 2017, NYSOH issued a notice stating you were no longer eligible to enroll in health insurance through NYSOH, effective December 28, 2017. The notice stated this was because NYSOH sent you information, including notices about your eligibility by U.S. mail to the mailing address in your account, but those mailings were returned as undeliverable.

On December 28, 2017, NYSOH issued a disenrollment notice stating your coverage with your Medicaid Managed Care plan was ending as of January 1, 2018. The notice stated this was because you were no longer eligible to enroll in insurance through NYSOH.

On December 29, 2017, NYSOH issued a notice of change in mailing address. The notice stated you updated your mailing address in your account. The notice was issued to [REDACTED].

On December 29, 2017, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective December 1, 2017.

On December 29, 2017, NYSOH issued a plan enrollment notice stating your Medicaid Managed Care plan was effective February 1, 2018.

On December 29, 2017, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid from July 1, 2017 through September 30, 2017.

On February 13, 2018, a Hearing Officer from NYSOH's Appeals Unit contacted you for your scheduled hearing. An adjournment of your hearing was granted per your request for a new date and time.

On February 26, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Through sworn testimony, you waived formal written notice for the hearing to proceed at this date and time. 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 you are requesting a backdate of your Medicaid Managed Care plan to December 1, 2017.

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- 2) You testified you have been a New York State resident throughout 2017.
- 3) You testified you currently reside at [REDACTED].
- 4) Your NYSOH account shows that your address was updated to [REDACTED] on November 22, 2017. Notices were then issued to this address stating you were no longer eligible for Medicaid because you were no longer a New York State resident.
- 5) You testified you were not sure who initiated the change in your mailing address to [REDACTED]. You are not sure if it was the post office.
- 6) You testified you were not aware of anyone else in your household who would have made changes to your address.
- 7) You were disenrolled from your Medicaid Managed Care plan for the months of December 2017 and January 2018. The first disenrollment was because NYSOH determined you were no longer a New York State resident, the second disenrollment was because NYSOH received return mail notices from [REDACTED] address.
- 8) You testified you contacted NYSOH on November 27, 2017, and explained you did not update your address to [REDACTED] address and that you still were living in New York at [REDACTED].
- 9) You enrolled yourself back into a Medicaid Managed Care plan on December 28, 2017 for a February 1, 2018 start date.

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

Applicable Law and Regulations

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)).

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)).

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)).

Requirement for Individuals to Report Changes

NYSOH must require an applicant to report any change which may affect eligibility, such as citizenship status, incarceration, residency, household size, and income within 30 days of such change (45 CFR §155.330(b), 45 CFR §155.305, 42 CFR §435.403, 42 CFR §435.406, 42 CFR §425.603).

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)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were no longer eligible to remain enrolled in your Medicaid Managed Care plan, effective November 30, 2017 and again as of December 31, 2017.

You were originally determined eligible for Medicaid, effective October 1, 2017. You then enrolled yourself in a Medicaid Managed Care plan, effective December 1, 2017.

Generally, an individual remains eligible for Medicaid for twelve continuous months unless the person becomes otherwise ineligible. If a person lacks state residence or is unable to prove state residence during those twelve months, then they become ineligible for Medicaid and continuous coverage.

On November 22, 2017, NYSOH issued a notice stating you were no longer eligible to enroll in health insurance through NYSOH, effective November 22, 2017. A notice issued on this date explained NYSOH received information from the U.S. Postal Service that your address had changed. The notice was issued to [REDACTED]. The result of the change in address was that you were determined to no longer be a New York State resident and, therefore, were no longer eligible to remain enrolled in coverage through NYSOH.

You were then disenrolled from your Medicaid Managed Care plan as of November 30, 2017.

You testified that you have remained a New York State resident for all of 2017. You further testified you were not sure who initiated the change in your mailing address to [REDACTED], and you were not aware of anyone else in your household who would have made changes to your address. The record shows this change may have originated from information NYSOH received from the U.S. Post Office, as explained in the November 22, 2017 notice.

You then updated your address with NYSOH and changed it back to your New York address on November 27, 2017. However, notices continued to be delivered and returned as undeliverable to [REDACTED] address. You were subsequently disenrolled from your Medicaid Managed Care plan effective January 1, 2017 as a result of the return mail notices.

NYSOH must require an applicant to report any change which may affect eligibility, such as citizenship status, incarceration, residency, household size, and income within 30 days of such change. Since you credibly testified you have remained a New York State resident for all of 2017, and you updated your application with NYSOH within 30 days to confirm your current and correct

address, the November 22, 2017 and December 28, 2017 disenrollment notices were issued improperly and are RESCINDED.

The second issue under review is whether NYSOH properly determined that your enrollment in your Medicaid Managed Care plan was effective February 1, 2018.

The record supports you contacted NYSOH on December 28, 2017 and enrolled into a Medicaid Managed Care plan.

Ordinarily, the date on which a Medicaid Managed Care plan can take effect depends on the day a person selects the plan for enrollment. A plan that is selected from the first day to and including the fifteenth day of a month will go into effect on the first day of the following month. A plan that is selected on or after the sixteenth day of the month will go into effect on the first day of the second following month.

However, as discussed above, your previous enrollment in your Medicaid Managed Care plan was incorrectly ended and resulted in your loss of insurance coverage for the months of December 2017 and January 2018.

Therefore, the December 29, 2017 plan enrollment notice stating that your enrollment in your Medicaid Managed Care plan would be effective February 1, 2018, is MODIFIED to indicate a start date of December 1, 2017.

Your case is RETURNED to NYSOH to enroll you in your Medicaid Managed Care plan for the months of December 2017 and January 2018, and notify you once this has been accomplished.

Decision

The November 22, 2017 and December 28, 2017 disenrollment notices were issued improperly and are RESCINDED.

The December 29, 2017 plan enrollment notice stating that your enrollment in your Medicaid Managed Care plan would be effective February 1, 2018, is MODIFIED to indicate a start date of December 1, 2017.

Your case is RETURNED to NYSOH to enroll you in your Medicaid Managed Care plan for the months of December 2017 and January 2018, and notify you once this has been accomplished.

Effective Date of this Decision: March 27, 2018

How this Decision Affects Your Eligibility

Your case is being sent back to NYSOH to change your enrollment in your Medicaid Managed Care plan to be effective December 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):

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).

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 November 22, 2017 and December 28, 2017 disenrollment notices were issued improperly and are **RESCINDED**.

The December 29, 2017 plan enrollment notice stating that your enrollment in your Medicaid Managed Care plan would be effective February 1, 2018, is **MODIFIED** to indicate a start date of December 1, 2017.

Your case is **RETURNED** to NYSOH to enroll you in your Medicaid Managed Care plan for the months of December 2017 and January 2018, and notify you once this has been accomplished.

Your case is being sent back to NYSOH to change your enrollment in your Medicaid Managed Care plan to be effective December 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:



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।

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. 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.

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).