



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

## Notice of Decision

Decision Date: February 22, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000025315

[REDACTED]

On February 8, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 15, 2017 discontinuance notice and November 15, 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 22, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000025315

[REDACTED]

## Issue

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

Did NY State of Health properly determine that you, your spouse, and your oldest child's enrollment in your Medicaid Managed Care coverage ended effective November 30, 2017?

## Procedural History

On November 3, 2017, NYOSH issued an eligibility determination stating that you, your spouse, and your oldest child were eligible for Medicaid, effective November 1, 2017.

Also on November 3, 2017, NYSOH issued a plan enrollment notice, confirming that you remained enrolled in a Medicaid Managed Care plan since April 1, 2016, your spouse since February 1, 2017, and your oldest child since October 1, 2016.

On November 15, 2017, NYSOH issued a notice of discontinuance stating that you, your spouse and your oldest child were no longer eligible to receive health insurance through NYSOH, effective December 1, 2017, because notices regarding your, your spouse and your oldest child's eligibility and coverage sent to you by NYSOH were 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.

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Also on November 15, 2017, NYSOH issued a plan disenrollment notice stating that you, your spouse, and your oldest child's Medicaid Managed Care plan would end on November 30, 2017.

On November 21, 2017, NYSOH received your updated application for financial assistance with health insurance.

On November 22, 2017, NYSOH issued an eligibility determination stating that you, your spouse, and your oldest child were eligible for Medicaid, effective December 1, 2017.

Also on November 22, 2017, NYSOH issued a plan enrollment notice, based on your November 21, 2017 plan selection, confirming that you, your spouse, and your oldest child were enrolled in a Medicaid Managed Care plan, effective January 1, 2018.

On December 4, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination, insofar, as you, your spouse, and your oldest child's Medicaid Managed Care plan started on January 1, 2018 and not December 1, 2017.

On February 8, 2018, 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 were enrolled in a Medicaid Managed Care plan since April 1, 2016; your spouse since February 1, 2017; and your oldest child since October 1, 2016.
- 2) You, your spouse, and your oldest child were subsequently disenrolled from your Medicaid Managed Care plans, all effective November 30, 2017.
- 3) According to your NYSOH account, as of the time of the issuance of this decision, there are no visible notices from NYSOH addressed to you that were returned as undeliverable to NYSOH.
- 4) You testified that your address is [REDACTED]

- 5) You testified that you have lived at this address for the past [REDACTED] years.
- 6) You testified that you, your spouse and your oldest child have always been New York State residents.
- 7) You testified that you are seeking to have your Medicaid Managed Care plans reinstated for the month of December 2017 because you have a medical bill for \$130.00 from December 2017.

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 you, your spouse and your oldest child's enrollment in your Medicaid Managed Care plans ended effective November 30, 2017.

You, your spouse, and your oldest child were determined eligible for Medicaid and subsequently enrolled in Medicaid Managed Care plans: you were enrolled on April 1, 2016, your spouse was enrolled on February 1, 2017 and your oldest child was enrolled on October 1, 2016.

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.

On November 15, 2017, you, your spouse and your oldest child were disenrolled from your Medicaid Managed Care plans because NYOSH purportedly received mail addressed to you that was undeliverable; therefore, the system assumed that you, your spouse and your oldest child no longer met the state residency requirement for enrollment in a Medicaid Managed Care plan. As such, on November 15, 2017, NYSOH issued a discontinuance notice and a plan disenrollment notice, stating that you, your spouse and oldest your oldest child were no longer eligible to enroll in Medicaid and you, your spouse and your oldest child's coverage in your Medicaid Managed Care plans would end, effective November 30, 2017.

However, you testified that your address is [REDACTED] and that you have lived at this address for the past [REDACTED] years.

Although there is a note in your NYSOH account indicating that mail has been returned, at the time of the writing of this decision, there is no returned mail viewable in your NYSOH account. Based on the lack of evidence in the record and your testimony that you have lived at the same address for the past [REDACTED] years, the Appeals Unit finds that you, your spouse, and your oldest child's disenrollment from your Medicaid Managed Care coverage was in error.

Therefore, the November 15, 2017 discontinuance notice and November 15, 2017 plan disenrollment notice must be RESCINDED.

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).

Your case is sent back to NYSOH to reinstate you, your spouse and your oldest child in your Medicaid Managed Care plan for the month of December 2017 and to notify you accordingly.

## **Decision**

The November 15, 2017 discontinuance notice is RESCINDED.

The November 15, 2017 plan disenrollment notice is RESCINDED.

Your case is sent back to NYSOH to reinstate you, your spouse and your oldest child in your Medicaid Managed Care plan for the month of December 2017.

**Effective Date of this Decision:** February 22, 2018

## **How this Decision Affects Your Eligibility**

Your case is sent back to NYSOH to reinstate you, your spouse and your oldest child in your Medicaid Managed Care plan for the month of December 2017.

NYOSH will notify you once the changes have 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:

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).

- 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 November 15, 2017 discontinuance notice is RESCINDED.

The November 15, 2017 plan disenrollment notice is RESCINDED.

Your case is sent back to NYSOH to reinstate you, your spouse and your oldest child in your Medicaid Managed Care plan for the month of December 2017.

NYOSH will notify you once the changes have been completed.

### **Legal Authority**

We are issuing this determination in accordance with 45 CFR § 155.545.

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**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. ye&btumi ama wo obi a okyerε 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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