



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

Notice of Decision

Decision Date: April 12, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000027655

[REDACTED]

On March 28, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 20, 2017 discontinuance notice and December 20, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: April 12, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000027655

[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 oldest child's enrollment in his Medicaid Managed Care plan ended effective December 31, 2017?

Procedural History

On January 18, 2017, NYOSH issued an eligibility determination stating that your oldest child was eligible for Medicaid, effective February 1, 2017.

Also on January 18, 2017, NYSOH issued a plan enrollment notice, confirming that your oldest child remained enrolled in a Medicaid Managed Care plan since May 1, 2016.

On December 3, 2017, NYSOH issued a renewal notice stating that your oldest child qualified for Medicaid, effective February 1, 2018. That notice stated that your oldest child was re-enrolled into the same insurance product that he had before.

On December 20, 2017, NYSOH issued a notice of discontinuance stating that your oldest child was no longer eligible to receive health insurance through NYSOH, effective December 20, 2017, because a notice regarding your oldest child's 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.

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Also on December 20, 2017, NYSOH issued a plan disenrollment notice stating that your oldest child's Medicaid Managed Care plan would end on December 31, 2017.

On December 20, 2017, NYSOH received your updated application for financial assistance with health insurance and you selected a Child Health Plus plan for your oldest child.

On December 21, 2017, NYSOH issued an eligibility determination stating that your oldest child was eligible for Child Health Plus, effective February 1, 2018.

Also on December 21, 2017, NYSOH issued a plan enrollment notice, based on your December 20, 2017 plan selection, confirming that your oldest child was enrolled in a Child Health Plus plan, effective February 1, 2018.

On January 23, 2018, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination, insofar, as your oldest child did not have Medicaid Managed Care plan coverage during January 2018.

On March 28, 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) Your oldest child was enrolled in a Medicaid Managed Care plan since May 1, 2016.
- 2) Your oldest child was subsequently disenrolled from his Medicaid Managed Care plan, effective December 31, 2017.
- 3) According to your NYSOH account, a renewal notice dated December 2, 2017 from NYSOH, addressed to you, was 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 seven years.
- 6) You testified that you have received mail from NYSOH prior to the above referenced renewal notice being returned as undeliverable.

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- 7) You testified that you have received mail from NYSOH after the above referenced notice was returned as undeliverable.
- 8) You testified that you, your spouse and your children have always been New York State residents.
- 9) You testified that you are seeking to have your oldest child's Medicaid Managed Care plan reinstated for the month of January 2018 because he has medical bills from January 2018.

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 oldest child's enrollment in a Medicaid Managed Care plan ended effective December 31, 2017.

Your oldest child was determined eligible for Medicaid and subsequently enrolled in a Medicaid Managed Care plan effective May 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.

Effective December 20, 2017, your oldest child was disenrolled from his Medicaid Managed Care plan because NYOSH purportedly received mail addressed to you that was undeliverable; therefore, the system assumed that your oldest child no longer met the state residency requirement for enrollment in a Medicaid Managed Care plan.

As such, on December 20, 2017, NYSOH issued a discontinuance notice and a plan disenrollment notice, stating that your oldest child was no longer eligible to enroll in Medicaid and your oldest child's coverage in a Medicaid Managed Care plan would end, effective December 31, 2017.

However, you testified that your address is [REDACTED] and that you have lived at this address for the past seven years. In addition, you testified that you, your spouse and your children have always been New York State residents.

Based on your testimony that you have lived at the same address for the past seven years; the Appeals Unit finds that your oldest child's disenrollment from his Medicaid Managed Care coverage was in error.

Therefore, the December 20, 2017 discontinuance notice and December 20, 2017 plan disenrollment notice must be RESCINDED.

Your case is sent back to NYSOH to reinstate your oldest child in his Medicaid Managed Care plan for the month of January 2018.

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).

Decision

The December 20, 2017 discontinuance notice is RESCINDED.

The December 20, 2017 disenrollment notice is RESCINDED.

Your case is sent back to NYSOH to reinstate your oldest child in his Medicaid Managed Care plan for the month of January 2018.

Effective Date of this Decision: April 12, 2018

How this Decision Affects Your Eligibility

Your case is sent back to NYSOH to reinstate your oldest child in his Medicaid Managed Care plan for the month of January 2018.

NYOSH will notify you once the 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

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).

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

Summary

The December 20, 2017 discontinuance notice is RESCINDED.

The December 20, 2017 disenrollment notice is RESCINDED.

Your case is sent back to NYSOH to reinstate your oldest child in his Medicaid Managed Care plan for the month of January 2018.

NYOSH will notify you once the 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:



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&etumi 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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