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

Notice of Decision

Decision Date: May 15, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000030037

[redacted]

Dear [redacted]

On May 8, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's March 9, 2018 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: May 15, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000030037

[redacted]

Issue

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

> Did the NY State of Health properly determine that you were not eligible to remain enrolled in your Medicaid Managed Care plan through NY State of Health as of April 1, 2018?

Procedural History

On March 5, 2018, NY State of Health (NYSOH) received your updated application for financial assistance with health insurance.

On March 6, 2018, NYSOH issued an eligibility determination notice stating that you were conditionally eligible for Medicaid, effective March 1, 2018. This notice further directed you to submit proof of your citizenship status by June 3, 2018.

On March 7, 2018, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective April 1, 2018.

On March 9, 2018, NYSOH issued a discontinuance notice stating that you were no longer eligible for health insurance through NYSOH, effective April 1, 2018, because state data sources showed that you had Medicaid coverage through the New York City Human Resources Administration (HRA).

Also on March 9, 2018, NYSOH issued a disenrollment notice stating that your enrollment in your Medicaid Managed Care plan terminated as of April 1, 2018.

On March 12, 2018, NYSOH received your updated application for financial assistance. That day, a preliminary eligibility determination was prepared stating that you were not eligible for health insurance through NYSOH.

Also on March 12, 2018, you spoke to the NYSOH's Account Review Unit and requested an appeal of the preliminary eligibility determination insofar as you were ineligible for Medicaid through NYSOH.

On March 13, 2018, NYSOH issued an eligibility determination notice based on the information contained in the March 12, 2018 application, stating that you were not eligible for health insurance coverage through NYSOH. The notice further stated that you were not eligible for Medicaid because state data sources showed that you had Medicaid coverage through your local HRA and that individuals who have Medicaid coverage through their Local Department of Social Services are not qualified to enroll in health insurance through NYSOH.

On May 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 testified that you do not expect to file taxes for the 2018 tax year.

2) You are seeking health insurance for yourself.

3) You testfied, and your NYSOH account indicates, that your annual expected household income is $0.00.

4) You testfied that you did not have any income in the month of March 2018.

5) Your NYSOH account indicates that, on March 5, 2018, you were found eligible for and enrolled in a Medicaid Managed Care plan through NYSOH, effective April 1, 2018.

6) Your NYSOH account indicates that your Medicaid Managed Care plan coverage through NYSOH did not start because NYSOH received information from state data sources that you were enrolled into Medicaid coverage through your local HRA.

7) You testified that you were told by your local HRA that you never had Medicaid coverage through them.

8) Your NYSOH account indicates that you did have coverage through your local HRA, but on March 9, 2018, your Medicaid coverage through your local HRA was made inactive and your Medicaid coverage terminated as of March 31, 2018.

9) You testfied that you are a permanent resident of the United States, but that you lost your Permanent Resident Card and are in the process of applying for a new one.

10) You testfied that you are seeking Medicaid coverage through NYSOH through this appeal because you are unable to obtain your medication without insurance.

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

Applicable Law and Regulations

Medicaid

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)).

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if that individual was eligible at 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* 18 NYCRR § 360-10.3(h), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were not eligible to receive Medicaid through NYSOH.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size.

Your NYSOH account indicates that, on March 5, 2018, you were found eligible for and enrolled in a Medicaid Managed Care plan, effective April 1, 2018. However, on March 9, 2018, NYSOH issued a discontinuance notice and a plan disenrollment notice indicating that you were no longer eligible for and enrolled in your Medicaid Managed Care plan through NYSOH, as of April 1, 2018, because data sources showed that you were enrolled into Medicaid coverage through your local HRA.

Individuals who are otherwise eligible for and enrolled in Medicaid coverage outside of NYSOH are not eligible for Medicaid coverage through NYSOH.

However, your NYSOH account indicates that, on March 9, 2018, your Medicaid coverage through your local HRA was inactivated and your Medicaid coverage through your local HRA terminated as of March 31, 2018. As a result, the data sources that NYSOH relied upon when finding you ineligible to remain enrolled in your Medicaid Managed Care plan were incorrect and you were incorrectly disenrolled from your Medicaid Managed Care plan as of April 1, 2018.

Therefore, the March 9, 2018 discontinuance and plan disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to reenroll you in your Medicaid Managed Care plan as of April 1, 2018, and to notify you accordingly.

Decision

The March 9, 2018 discontinuance notice is RESCINDED.

The March 9, 2018 plan disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reenroll you in your Medicaid Managed Care plan as of April 1, 2018, and to notify you accordingly.

Effective Date of this Decision: May 15, 2018

How this Decision Affects Your Eligibility

Your Medicaid coverage through your local HRA ended effective April 1, 2018.

You should not have been disenrolled from your Medicaid Managed Care plan as of April 1, 2018.

Your case is being sent back to NYSOH to reenroll you in your Medicaid Managed Care plan as of April 1, 2018. 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):

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 March 9, 2018 discontinuance notice is RESCINDED.

The March 9, 2018 plan disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reenroll you in your Medicaid Managed Care plan as of April 1, 2018, and to notify you accordingly.

Your Medicaid coverage through your local HRA ended effective April 1, 2018.

You should not have been disenrolled from your Medicaid Managed Car plan as of April 1, 2018.

Your case is being sent back to NYSOH to reenroll you in your Medicaid Managed Care plan as of April 1, 2018. NYSOH will notify you once this has been completed.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545(a).

A Copy of this Decision Has Been Provided To:

[redacted]

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।

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 महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क 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.

اردو (Urdu)

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.

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).