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

Notice of Decision

Decision Date: May 8, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000032495

[redacted]

Dear [redacted],

On May 7, 2018, you appeared by telephone at an expedited hearing on your appeal of NY State of Health's April 28, 2018 discontinuance and disenrollment notices and the May 5, 2018 eligibility determination 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: May 8, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000032495

[redacted]

Issue

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

> Did NYSOH properly determined your Medicaid coverage ended no earlier than May 31, 2018?

Procedural History

On March 15, 2018, NYSOH issued a notice stating you were eligible for Medicaid, effective March 1, 2018.

Also on March 15, 2018, NYSOH issued an enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective April 1, 2018.

On April 27, 2018, an updated application was submitted on your behalf changing your mailing address to [redacted]. That day, a preliminary eligibility determination was prepared finding you ineligible for health insurance through NYSOH.

Also on April 27, 2018, you spoke to NYSOH's Account Review Unit and appealed the end date of your Medicaid coverage insofar as it did not end earlier than May 31, 2018.

On April 28, 2018, NYSOH issued a notice stating you no longer qualified for health coverage through NYSOH, because you were not a resident of New York State.

Also on April 28, 2018, NYSOH issued a disenrollment notice stating your Medicaid Managed Care plan coverage would end on May 31, 2018, because you were no longer eligible to enroll in health insurance through NYSOH.

Additionally, on April 28, 2018, NYSOH issued a notice confirming the mailing address on your account had been changed.

On May 7, 2018, you had an expedited telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed thereafter.

Findings of Fact

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

1) Your initial application for health coverage through NYSOH was submitted on March 14, 2018.

2) You were determined eligible for fee-for-service Medicaid coverage, effective March 1, 2018.

3) A Medicaid Managed Care plan was selected on your behalf on March 14, 2018 and coverage through that plan became effective April 1, 2018.

4) On April 27, 2018, your account was updated and your mailing address was changed to [redacted].

5) An updated application was submitted on your behalf the same day, April 27, 2018. NYSOH determined you were ineligible for health insurance, because, based on the information in your application, you were not a resident of New York State.

6) The April 28, 2018 discontinuance notice did not specify a date in which your ineligibility for health coverage was effective.

7) You were disenrolled from your Medicaid Managed Care plan, effective May 31, 2018.

8) You appealed insofar as your Medicaid coverage did not end on April 30, 2018.

9) You testified that you moved to [redacted].

10) You testified that you have applied for health coverage through [redacted] marketplace.

11) You testified that you have been directed by the [redacted] marketplace that you must submit documentation of the termination of your New York coverage before you can get health coverage in [redacted]

12) You testified that you are currently undergoing [redacted] and that you have any appointment scheduled for [redacted].

13) On May 1, 2018, NYSOH received a letter from [redacted] dated April 30, 2018, requesting an expedited appeal, requesting immediate disenrollment from your Medicaid coverage, and confirming that you had moved to [redacted]

14) On May 5, 2018, NYSOH issued an eligibility determination notice, based on a May 4, 2018 systematic eligibility redetermination, stating you were eligible for Medicaid, effective June 1, 2018.

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

Applicable Law and Regulations

Medicaid – Continuous Coverage

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)).

Termination of Medicaid - Notification of discontinuance

(a) When a social services district determines that a recipient is no longer eligible for Medicaid, Medicaid will be terminated. The effective date of discontinuance

will be the date the recipient becomes ineligible, or a later date if necessary to provide the recipient with timely notice of the discontinuance, as required by section 358-3.3 of this Title. Except as limited by the provisions of this subdivision, the effective date of discontinuance may be any day during the month.

(b) The social services district must send a notice of discontinuance on a State-prescribed form to a Medicaid recipient if it determines that the recipient has become ineligible for Medicaid. The notice of discontinuance must be adequate, as defined in section 358-2.2 of this Title.

Timely Notice Requirement

According to 18 NYCRR § 360-3.3 (a)(1), Medicaid recipients generally have a right to timely and adequate notice when a social services agency proposes to discontinue, suspend, reduce, and/ or restrict benefits.

18 NYCRR § 360-3.3(d) provides the following exceptions to the timely notice requirements.

(1) A Medicaid recipient has the right to adequate notice sent no later than the effective date of the proposed action when:

(ii) the social services agency has received a clear written statement signed by you which includes information that requires the social services agency to discontinue or reduce your public assistance or medical assistance and you have indicated in such statement that you understand that such action will be taken as a result of supplying such information; or

(iii) the social services agency has received a clear written statement from you indicating that you no longer wish to receive public assistance or medical assistance; or

(vi) you have been accepted for public assistance or medical assistance in another local social services district, state, territory or commonwealth, and that acceptance has been verified by the social services district previously providing you with such assistance.

Legal Analysis

The issue under review is whether NYSOH properly determined your Medicaid coverage ended no earlier than May 31, 2018.

According to your account, you were determined eligible for Medicaid, effective March 1, 2018 and you enrolled in a Medicaid Managed Care plan, effective April

1, 2018. On April 27, 2018, your account was updated and your mailing address was changed to [redacted]. An updated application was submitted on your behalf the same day. Subsequently, NYSOH determined you were ineligible for health insurance, because, based on the information in your application, you were not a resident of New York State.

Although, the April 28, 2018 discontinuance notice did not specify the date in which your ineligibility for health coverage was effective, the disenrollment notice issued the same day stated your Medicaid Managed Care plan coverage would end on May 31, 2018. You appealed insofar as your Medicaid coverage did not end on April 30, 2018.

You testified that you moved to [redacted] on [redacted]. Your testimony is corroborated by your NYSOH account wherein your mailing address was updated on April 27, 2018 to a [redacted] address. Your testimony is further corroborated by the April 30, 2018 letter from [redacted] confirming that you had moved to [redacted] Based on this evidence, it is concluded that the record supports a finding that you ceased to be a New York State resident on April 28, 2018.

Generally, once a person is determined eligible for Medicaid, that eligibility continues for 12 months, with limited exceptions. This concept is called continuous coverage. One such exception to the continuous coverage rule is "lack of state residence." As discussed above, the evidence established that you ceased to be a New York State resident on April 28, 2018; as a result, you were no longer eligible for Medicaid.

According to the above cited regulations, the effective date of the discontinuance of Medicaid benefits will be the date the recipient becomes ineligible, or a later date if necessary to provide the recipient with timely notice of the discontinuance, as required. However, one exception to the timely notice requirement is when the recipient submits a clear signed written statement including information that requires the social services agency to discontinue or reduce Medicaid benefits and the statement indicates that the recipient understands that such action will be taken because of supplying such information.

It is concluded that the April 30, 2018 letter submitted from [redacted] constitutes such a statement that alleviates NYSOH from providing you with timely written notice of the discontinuation of your Medicaid benefits. That statement indicated you were no longer a New York State resident, thus, requiring NYSOH to determine you were ineligible for Medicaid benefits. Furthermore, the letter requested that your Medicaid coverage be terminated immediately and, therefore, confirms your understanding that your coverage would be terminated because you admitted you were no longer a New York State resident. In accordance with the regulations, based on the April 30, 2018

statement from [redacted], NYSOH was not required to provide you with timely notice of the discontinuation of your Medicaid benefits.

Since the record establishes that you were no longer eligible for Medicaid because of the end of your New York State residency on [redacted], and according to the regulations, NYSOH was not required to provide you with timely notice of the discontinuation of your benefits, as discussed above, your Medicaid coverage should have ended on the date in which you became ineligible, April 28, 2018.

Therefore, both the April 28, 2018 discontinuance and disenrollment notices are MODIFIED to reflect that your fee for service Medicaid and your Medicaid Managed Care plan coverage ended on April 30, 2018.

It is noted that, according to your account, NYSOH issued a notice on May 5, 2018, based on a May 4, 2018 systematic eligibility redetermination, stating you were eligible for Medicaid, effective June 1, 2018. Based on the evidence establishing that you have not been a New York State resident since [redacted], the May 5, 2018 eligibility determination notice is not supported by the record and is RESCINDED.

Decision

The April 28, 2018 discontinuance and disenrollment notices are MODIFIED to reflect that your fee for service Medicaid and your Medicaid Managed Care plan coverage ended on April 30, 2018.

The May 5, 2018 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to correct your enrollment in accordance with this decision and to issue updated discontinuance and disenrollment notices specifying that your Medicaid coverage ended on April 30, 2018.

Effective Date of this Decision: May 8, 2018

How this Decision Affects Your Eligibility

Your fee-for-service Medicaid and your Medicaid Managed Care plan coverage should have ended on April 30, 2018.

Your case is being sent back to NYSOH to correct your enrollment in accordance with this decision.

You will receive updated discontinuance and disenrollment notices from NYSOH specifying that your Medicaid coverage ended on April 30, 2018.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as a portion of your case was decided, the 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):

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 April 28, 2018 discontinuance and disenrollment notices are MODIFIED to reflect that your fee for service Medicaid and your Medicaid Managed Care plan coverage ended on April 30, 2018.

The May 5, 2018 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to correct your enrollment in accordance with this decision and to issue updated discontinuance and disenrollment notices specifying that your Medicaid coverage ended on April 30, 2018.

Your fee-for-service Medicaid and your Medicaid Managed Care plan coverage should have ended on April 30, 2018.

You will receive updated discontinuance and disenrollment notices from NYSOH specifying that your Medicaid coverage ended on April 30, 2018.

Legal Authority

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

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।

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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 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.

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