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

Notice of Decision

Decision Date: January 12, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: APM28892644

[redacted]

[redacted]

On January 8, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's September 22, 2017 eligibility determination notice and September 22, 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: January 12, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: APM28892644

[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 you were no longer eligible for Medicaid and disenrolled from your Medicaid Managed Care plan, effective October 1, 2017?

Procedural History

On August 20, 2017, you updated your application for financial assistance.

On August 21, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH had received from state and federal data sources and that additional information was needed to confirm the information in your application. This notice directed you to submit proof of your household income by September 4, 2017 in order for your eligibility for financial assistance to be determined. This notice was sent to [redacted].

On August 21, 2017, you uploaded income documentation to your NYSOH account.

Also on August 21, 2017, NYSOH reviewed the income documentation you submitted and determined that this was insufficient to resolve the inconsistency in your account.

On August 22, 2017, NYSOH issued a notice stating that the income documentation you submitted did not confirm the information in your application and that additional income documentation was due by September 4, 2017. This notice was sent to [redacted]

On August 28, 2017, a navigator updated your application for financial assistance. In addition to update your income, the navigator updated your residential address to [redacted].

Also, on August 28, 2017, you uploaded income documentation to your NYSOH account.

On August 29, 2017, NYSOH issued a notice of change in mailing address, informing you that the mailing address in your account had been updated. This notice was sent to [redacted]

Also on August 29, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH had received from state and federal data sources and that additional information was needed to confirm the information in your application. This notice directed you to submit proof of your household income by September 12, 2017 in order for your eligibility for financial assistance to be determined. This notice was sent to 100 [redacted] This notice was returned to NYSOH on September 20, 2017 by the United State Postal Service (USPS) as the address was insufficient.

Additionally, on August 29, 2017, NYSOH reviewed the income documentation you submitted and determined that this was insufficient to resolve the inconsistency in your account.

On August 30, 2017, NYSOH issued a notice stating that the income documentation you submitted did not confirm the information in your application and that additional income documentation was due by September 27, 2017. This notice was sent to [redacted] This notice was returned to NYSOH on September 27, 2017 by the USPS as the address was insufficient.

On September 11, 2017, you uploaded income documentation to your NYSOH account.

On September 12, 2017, NYSOH verified the income documentation and submitted an application on your behalf.

On September 13, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective September 1, 2017. This notice was sent to [redacted] This notice

was returned to NYSOH on September 27, 2017 by the USPS as it was not deliverable as addressed.

On September 14, 2017, NYSOH issued a notice of enrollment confirmation, based on your plan selection on September 13, 2017, stating that you were enrolled in a Medicaid Managed Care plan with a plan enrollment start date of October 1, 2017. This notice was sent to [redacted] This notice was returned to NYSOH on October 4, 2017 by the USPS as the address was insufficient.

On September 22, 2017, NYSOH issued a notice of eligibility redetermination stating that you were not qualified to enroll through NYSOH as notices sent to you by U.S mail to the mailing address provided in your account were returned to NYSOH as undeliverable. This notice was sent to [redacted] This notice was returned to NYSOH on October 10, 2017 by the USPS as the address was insufficient.

Also on September 22, 2017, NYSOH issued a disenrollment notice stating that your enrollment in your Medicaid Managed Care plan would end effective October 1, 2017. This was because you were no longer eligible to enroll in health insurance through NYSOH. This notice was sent to [redacted] This notice was returned to NYSOH on October 10, 2017 by the USPS as the address was insufficient.

On October 13, 2017, you updated your application for financial assistance. Specifically, you updated your address.

On October 16, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH had received from state and federal data sources and that additional information was needed to confirm the information in your application. This notice directed you to submit proof of your household income by October 28, 2017 in order for your eligibility for financial assistance to be determined.

On October 17, 2017, you uploaded income documentation to your NYSOH account.

On October 18, 2017, NYSOH verified the income documentation you submitted, updated your application based on this documentation, and submitted an application on your behalf.

On October 19, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan, effective December 1, 2017.

On October 20, 2017, NYSOH issued a notice of enrollment confirmation, based on your plan selection on October 19, 2017, stating that you were enrolled in an Essential Plan with a plan enrollment start date of December 1, 2017.

On October 24, 2017, you spoke with NYSOH's Account Review Unit and appealed insofar as you were found ineligible for Medicaid and disenrolled from your Medicaid Managed Care plan.

On October 25, 2017, you updated your application for financial assistance.

On October 26, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH had received from state and federal data sources and that additional information was needed to confirm the information in your application. This notice directed you to submit proof of your household income by November 9, 2017 in order for your eligibility for financial assistance to be determined.

On November 6, 2017, you uploaded income documentation to your NYSOH account.

On November 7, 2017, NYSOH verified the income documentation and submitted an application on your behalf.

On November 8, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective October 1, 2017.

On November 10, 2017, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in a Medicaid Managed Care plan with a plan enrollment start date of December 1, 2017.

On January 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 your address is [redacted], [redacted] You testified that you lived at this address from 2010 until 2015. You then moved back to this address on July 1, 2017 or July 6, 2017 and have lived at this address since that time.

2) None of the notices sent to you at [redacted], [redacted] have been returned as undeliverable.

3) You testified that in 2017 you were not incarcerated at any time.

4) You testified that you did have coverage outside of NYSOH for part of 2017, however, this had ended when you applied for coverage through NYSOH in August 2017.

5) You testified that you realized there was an issue with your coverage in early October 2017, when you did not get a card for your Medicaid Managed Care plan. This prompted you to sign-on to your NYSOH account at which time you saw the notices stating that you were no longer eligible for or enrolled in Medicaid. You testified that you contacted NYSOH as soon as you realized there was an issue with your coverage.

6) The record reflects that you first contacted NYSOH following your disenrollment, on October 13, 2017.

7) Your NYSOH account reflects that on August 28, 2017, a navigator input your residential address as [redacted]. However, your mailing address remained as [redacted].

8) On October 13, 2017, you updated your residential address to [redacted]

9) You testified that you are seeking reinstatement into your Medicaid Managed Care plan, effective October 1, 2017, as you believe that your coverage should not have been cancelled.

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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were no longer eligible for Medicaid, effective September 22, 2017, and disenrolled from your Medicaid Managed Care plan, effective October 1, 2017.

A navigator updated your application for financial assistance on August 28, 2017. As a result, on August 29, 2017, NYSOH issued a notice advising you that additional documentation was needed in order to determine your eligibility for financial assistance. This notice was sent to you at [redacted]

You were found eligible for Medicaid in the September 13, 2017 eligibility determination notice, effective September 1, 2017. You subsequently enrolled in a Medicaid Managed Care plan with a plan enrollment start date of October 1, 2017.

On September 20, 2017, the August 29, 2017 notice was returned to NYSOH because the address was insufficient.

On September 22, 2017, NYSOH issued a notice of eligibility redetermination stating that you were not qualified to enroll through NYSOH as notices sent to you by U.S mail to the mailing address provided in your account were returned to NYSOH as undeliverable, and disenrolled you from Medicaid and your Medicaid Managed Care plan as of October 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 they become ineligible for Medicaid and continuous coverage.

You testified that you have lived in New York State since 2007 and that you have continuously resided at [redacted], since July 1, 2017 or July 6, 2017.

The record reflects that on August 28, 2017, a navigator updated your residential address. Your NYSOH account reflects that when the navigator updated your address, they failed to include your entire apartment number. This resulted in mail being returned to NYSOH as undeliverable.

No notices sent to you at [redacted] have been returned. This is also the address that has remained on your account as your mailing address since being found eligible for Medicaid.

As there is sufficient evidence in the record to conclude that you have continuously retained New York State residency during the relevant time period, you were improperly disenrolled from Medicaid and your Medicaid Managed Care plan as of October 1, 2017 for failure to meet residency requirements. There are no other facts present in the record that would support you being disenrolled from Medicaid and your Medicaid Managed Care plan.

Therefore, the September 22, 2017 eligibility determination notice and the September 22, 2017 disenrollment notice are RESCINDED.

Accordingly, your case is RETURNED to NYSOH to reinstate you into Medicaid and your Medicaid Managed Care plan, effective October 1, 2017.

Decision

The September 22, 2017 eligibility determination notice is RESCINDED.

The September 22, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you into Medicaid and your Medicaid Managed Care plan, effective October 1, 2017.

Effective Date of this Decision: January 12, 2018

How this Decision Affects Your Eligibility

Your Medicaid coverage should not have been terminated as of October 1, 2017.

Your enrollment in your Medicaid Managed Care plan should not have been terminated as of October 1, 2017.

Your case is being sent back to NYSOH to reenroll you into Medicaid and your Medicaid Managed Care plan as of October 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 September 22, 2017 eligibility determination notice is RESCINDED.

The September 22, 2017 disenrollment notice is RESCINDED.

Your Medicaid coverage should not have been terminated as of October 1, 2017.

Your enrollment in your Medicaid Managed Care plan should not have been terminated as of October 1, 2017.

Your case is being sent back to NYSOH to reenroll you into Medicaid and your Medicaid Managed Care plan as of October 1, 2017.

Your case is RETURNED to NYSOH to reinstate you into Medicaid and your Medicaid Managed Care plan, effective October 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:

[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.

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).