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

Notice of Decision

Decision Date: March 29, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026831

[redacted]

Dear [redacted]

On March 15, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 17, 2017 discontinuance and 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 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).

This page intentionally left blank.

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).

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

Decision

Decision Date: March 29, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026831

[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 not eligible for Medicaid effective January 1, 2018?

Procedural History

On January 11, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective January 1, 2017. You were also enrolled into an Medicaid Managed Care (MMC) plan, beginning February 1, 2017.

On October 24, 2017, NYSOH issued a notice that it was time to renew your health insurance for 2018. That notice stated that, based on information from federal and state sources, NYSOH could not determine whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by December 15, 2017, or your coverage, and any financial assistance you were currently receiving, could end.

No updates were made to your account by December 15, 2017.

On December 17, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid, Child Health Plus, or to receive tax credits or cost-sharing reductions to help pay for the cost of insurance. You also could not enroll in a qualified health plan at full cost. This was because you had not

responded to the renewal notice and had not completed your renewal within the required time frame. This eligibility was effective January 1, 2018.

Also on December 17, 2017, NYSOH issued a disenrollment notice, stating that your enrollment in your MMC plan was ending, effective December 31, 2017. This was because you were no longer eligible to remain enrolled in your MMC plan.

On January 5, 2018, NYSOH received your updated application for health insurance.

Also on January 5, 2018, you spoke to NYSOH's Account Review Unit and appealed the December 17, 2017 discontinuance and disenrollment notices, insofar as you were no longer eligible for Medicaid coverage and for enrollment in your MMC plan. You also requested Aid to Continue, pending the outcome of your appeal.

On January 6, 2018, NYSOH issued a notice stating that your January 5, 2018 application had been reviewed, but that the income information in the application did not match the information NYSOH received from state and federal data sources. The notice stated that you needed to provide documentation of your income by January 20, 2018.

On January 11, 2018, you updated your NYSOH application again.

On January 12, 2018, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to $372.00 per month in advance payments of the premium tax credit, and eligible for cost-sharing reductions, for a limited time, effective February 1, 2018. The notice directed you to provide documentation of your income by April 11, 2018 to confirm your eligibility.

On January 24, 2018, NYSOH issued a notice of eligibility determination, stating that you were eligible for Medicaid for a limited time, effective January 1, 2018. This was because your request for Aid to Continue, pending the outcome of the appeal, was granted by NYSOH.

Also on January 24, 2018, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in an MMC plan, beginning January 1, 2018. This was also because your request for Aid to Continue was granted, pending the outcome of your appeal.

On March 15, 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 support the following findings of fact:

1) Your NYSOH account reflects that you were originally found eligible for Medicaid, effective January 1, 2017.

2) On October 24, 2017, NYSOH sent you a renewal notice stating that you needed to update your application for the 2018 coverage year, and that any failure to do so could result in the termination of your coverage, as well as any financial assistance you were receiving.

3) You testified, and your NYSOH account confirms, that you receive notices from NYSOH in the regular mail.

4) You testified that you did not receive the October 24, 2017 notice informing you that you needed to update your application.

5) No mail sent to you by NYSOH has been returned to NYSOH as undeliverable.

6) During the hearing, you confirmed that your mailing address was [redacted] in October 2017, and this is the address on the October 24, 2017 renewal notice.

7) You testified that you moved to your current address in January 2018.

8) You testified that you did not know your insurance coverage had ended until you went to the doctor [redacted] and were told that your coverage was not active.

9) You testified that you called NYSOH and were told that you did not respond to a notice they sent you to recertify your coverage.

10) You testified that updated your application that day, and your NYSOH account confirms that your application was updated on January 11, 2018.

11) You testified that you are appealing because you did not receive the notice informing you that you needed to renew your coverage, and because you used your medical coverage in the month of January 2018 (Aid to Continue).

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

Applicable Law and Regulations

Medicaid Renewal

In general, NYSOH must review Medicaid eligibility once every 12 months or "whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility" (42 CFR § 435.916(a)(1), (d)). NYSOH must make its "redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency" (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates provided by the individual (45 CFR § 155.335(h)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were not eligible for Medicaid, effective January 1, 2018.

Generally, NYSOH must redetermine a qualified individual's eligibility for Medicaid once every 12 months without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency. NYSOH's October 24, 2017 renewal notice stated that there was not enough information to determine whether you were eligible to continue your financial assistance for health insurance, and that you needed to supply additional information by December 15, 2017, or your financial assistance might end. The notice directed you to update your application between November 16, 2017 and December 15, 2017.

After a 30-day period specified in the notice, NYSOH must redetermine an applicant's eligibility, based on the information available, and with consideration given to any updates made by the applicant.

Since you did not provide any updated information to NYSOH before the December 15, 2017 deadline, NYSOH properly terminated your Medicaid and MMC plan coverage, effective January 1, 2018, for failure to complete your renewal within the required timeframe. Though you testified that you did not receive the October 24, 2017 renewal notice, you confirmed that your mailing address in October 2017 was the address listed on the renewal notice, and no

mail sent to you by NYSOH has been returned to NYSOH as undeliverable. Therefore, you are considered to have been on notice that you needed to renew your NYSOH application.

For this reason, the December 17, 2017 discontinuance and disenrollment notices are AFFIRMED.

Decision

The December 17, 2017 discontinuance notice is AFFIRMED.

The December 17, 2017 disenrollment notice is AFFIRMED.

Effective Date of this Decision: March 29, 2018

How this Decision Affects Your Eligibility

Your Medicaid and MMC plan enrollment properly ended as of December 31, 2017 because you did not respond to the renewal notice and did not complete your renewal within the required timeframe.

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):

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 December 17, 2017 discontinuance notice is AFFIRMED.

The December 17, 2017 disenrollment notice is AFFIRMED.

Your Medicaid and MMC plan enrollment properly ended as of December 31, 2017 because you did not respond to the renewal notice and did not complete your renewal within the required timeframe.

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।

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).