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

Notice of Decision

Decision Date: April 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000012758

[redacted]

Dear [redacted],

On April 5, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 17, 2016 disenrollment and October 18, 2016, eligibility determination 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).

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

Decision

Decision Date: April 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000012758

[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 terminated your Medicaid Managed Care (MMC) coverage effective October 31, 2016?

Procedural History

On November 14, 2015, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective as of November 1, 2015.

On December 4, 2015, NYSOH issued an enrollment notice confirming that as of November 27, 2016, you were enrolled in a MMC plan with an enrollment start date of January 1, 2016.

On September 3, 2016, NYSOH issued a renewal notice regarding your financial assistance for the upcoming policy year. The notice stated that, based on federal and state data sources, a decision about where or not you qualified for financial assistance could not be made and you needed to update the information on your NYSOH by October 15, 2016, or the financial assistance you were currently getting may end.

No updates were made to your NYSOH account before October 15, 2016.

On October 17, 2016, NYSOH issued a disenrollment notice stating that your coverage in your MMC plan would end effective October 31, 2016.

On October 18, 2016, NYSOH issued an eligibility redetermination notice stating you did not qualify for any financial assistance and could not purchase a qualified health plan at full cost, effective November 1, 2016. The notice stated that you no longer qualified to enroll through NYSOH because you did not respond to the renewal notice and did not complete your renewal within the required timeframe.

On October 24, 2016, you spoke to NYSOH's Account Review Unit and requested an appeal insofar as the termination of your Medicaid coverage effective October 31, 2016.

On November 5, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid for a limited time because you had been granted Aid to Continue until a decision is made on your appeal, effective November 1, 2016.

Also on November 5, 2016, NYSOH issued an enrollment notice confirming that as of November 4, 2016, you were enrolled in a MMC plan with an enrollment start date of November 1, 2016.

On April 5, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was closed at the end of the proceeding.

Findings of Fact

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

1) According to your NYSOH account, you were determined eligible for Medicaid effective as of November 1, 2015.

2) According to your NYSOH account and testimony, you receive notices from NYSOH via regular mail.

3) You testified that you did not receive a renewal notice from NYSOH directing you to update your account to ensure that your coverage would not be interrupted.

4) You testified that the mailing address listed in your account is correct, and you have had the same mailing address for over twenty years.

5) You testified that you received an application from NYSOH via U.S. mail in October 2016, and you mailed and faxed the application to NYSOH in the same month.

6) On January 24, 2017, NYSOH uploaded an Evidence Packet, in anticipation of your telephone hearing, to your NYSOH account

([redacted]). According to the Appeal Summary, "Appellant has not completed renewal; attempts to contact appellant to assist with renewal have been unsuccessful" ([redacted]).

7) You testified that you expect to file your 2017 federal income tax return with the tax status of single, and currently do not have any dependents.

8) You testified that you expect to become a parent on [redacted].

9) You testified you are currently employed at [redacted].

10) You testified that you work approximately thirty-six hours per week at $15.00 per hour.

11) According to your NYSOH account, you reside in [redacted], New York.

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 twelve 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 no longer eligible for Medicaid and terminated your MMC coverage effective October 31, 2016.

You were originally found eligible for Medicaid effective November 1, 2015 and were enrolled in a MMC plan effective January 1, 2016.

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 September 3, 2016 renewal notice stated that there was not enough information to determine whether you were eligible to continue your financial assistance, and that you needed to update your account by October 15, 2016, or your financial assistance might end.

Because there was no timely response to this notice, your Medicaid coverage ended and your MMC plan terminated effective October 31, 2016, which was the last day of the 12-month eligibility period that began on November 1, 2015.

You testified that you did not receive any notice from NYSOH telling you that you needed to update the information in your NYSOH account. You testified, and your NYSOH account confirms, that you elected to receive notifications by regular mail. However, there is no evidence in the record that any of the notices that were sent to your mailing address were returned as undeliverable.

Furthermore, you testified that you received a renewal application from NYSOH in the mail, and you promptly completed and returned the application to NYSOH. However, there is no record in your account that supports that a written application was received by NYSOH.

Therefore, the record reflects that NYSOH properly notified you of your annual renewal and that information in your NYSOH account needed to be updated in order to ensure your enrollment in your health plan and eligibility for financial assistance would continue.

Since income information could not be ascertained from federal and state data sources, and you did not update your NYSOH account with such information within the required timeframe, you were redetermined ineligible for any financial assistance, effective November 1, 2016.

Therefore, the October 17, 2016 disenrollment and October 18, 2016 eligibility redetermination notices are AFFIRMED.

The record reflects that a completed renewal for financial assistance has not been received by NYSOH. During the hearing, you testified that you expect to file a 2017 federal income tax return with the tax status of single, and currently do not have any tax dependents. Furthermore, you testified that you are currently employed at [redacted] and have an expected yearly income of (36 hours per

week (X) $15.00 per hour (X) 52 weeks) $28,080.00. Lastly, you currently reside in [redacted], New York.

Therefore, your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a one-person household, living in [redacted], with an expected 2017 household income $28,080.00.

Decision

The October 17, 2016 disenrollment and October 18, 2016 eligibility redetermination notices are AFFIRMED.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a one-person household, living in [redacted], with an expected 2017 household income $28,080.00.

Effective Date of this Decision: April 11, 2017

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

Your Medicaid coverage properly ended as of October 31, 2016.

Your case has been returned to NYSOH to recalculate your financial eligibility and will notify you of the results.

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 October 17, 2016 disenrollment and October 18, 2016 eligibility redetermination notices are AFFIRMED.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a one-person household, living in [redacted], with an expected 2017 household income $28,080.00.

This decision does not change your eligibility.

Your Medicaid coverage properly ended as of October 31, 2016.

Your case has been returned to NYSOH to recalculate your financial eligibility and will notify you of the results.

Legal Authority

We are issuing this determination in accordance with 45 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).

A Copy of this Decision Has Been Provided To:

[redacted]

Getting Help in a Language Other than English

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 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.

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