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

Notice of Decision

Decision Date: May 10, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013835

[redacted]

Dear [redacted],

On April 26, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 23, 2016 disenrollment notice, and NYSOH's failure to issue timely 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 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 Date: May 10, 2017

NY State of Health Account ID: [redacted]
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Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did New York State of Health (NYSOH) properly terminate your Medicaid Managed Care (MMC) plan effective November 30, 2016?
>
> Did NYSOH fail to provide a timely determination of your Medicaid eligibility?

Procedural History

On January 9, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid effective as of January 1, 2016.

On January 20, 2016, NYSOH issued an enrollment notice confirming that as of January 19, 2016, you were enrolled in a MMC plan with an enrollment notice of March 1, 2016.

On October 10, 2016, NYSOH issued a notice stating that it was time to renew your health insurance for the next coverage year. That notice stated that NYSOH did not have enough information from state and federal data sources to determine whether you qualified for financial help paying for your coverage. The notice directed you to update the information in your account by November 15, 2016 or the financial assistance you were receiving may end.

On November 17, 2016, NYSOH issued an eligibility determination notice stating that you were not eligible for financial assistance or to enroll in health coverage through NYSOH because you did not complete your renewal within the required timeframe.

On November 21, 2016, you updated your account and submitted an application for financial assistance through NYSOH.

On November 23, 2016, NYSOH issued a notice stating that the income information in your application does not match what NYSOH received from state and federal data sources. Furthermore, you needed to submit additional proof of income by December 6, 2016, to confirm your eligibility.

Also on November 23, 2016, issued a disenrollment notice stating that your MMC plan coverage would end on November 30, 2016.

On December 6, 2016, your NYSOH was updated, and you spoke with NYSOH's Account Review Unit. You requested an appeal insofar as the discontinuance of your Medicaid coverage.

On December 7, 2016, NYSOH issued a notice stating that the income information in your application does not match what NYSOH received from state and federal data sources. Furthermore, you needed to submit additional proof of income by December 21, 2016, to confirm your eligibility.

On December 13, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid for a limited time. You have been granted Aid to Continue until a decision has been made on your appeal.

Also on December 13, 2016, NYSOH issued an enrollment notice confirming that you were enrolled in a MMC plan with a plan enrollment start date of December 1, 2016.

Lastly, on December 13, 2016, additional income documentation was uploaded to your NYSOH account [redacted].

On April 26, 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, you were determined eligible for Medicaid, effective January 1, 2016.

2) According to your NYSOH account, you enrolled in a MMC plan on January 19, 2016, with an enrollment start date of March 1, 2016.

3) You testified that you faxed the necessary income documentation to NYSOH in November 2016. However, when you contacted NYSOH, the representatives stated that they did not receive the documentation.

4) According to your NYSOH account, your MMC plan was discontinued effective November 30, 2016.

5) According to your NYSOH account and testimony, you are applying for health insurance for yourself.

6) According to your NYSOH account and testimony, you expect to file a 2017 federal income tax return, with the tax status of Head of Household (with qualifying individual), and expect to claim three dependents on that return.

7) On November 21, 2016, and December 6, 2016, you attested to an annual household income of $14,513.20.

8) On December 13, 2016, you uploaded earnings statements from your employer, [redacted] You were issued gross pay of:

    (a) $210.42 on 11/18/2016;
    (b) $137.36 on 11/25/2016;
    (c) $245.49 on 12/02/2016;
    (d) $350.70 on 12/09/2016

    [redacted]

9) According to your NYSOH account, the income documentation that was uploaded to your account on December 13, 2016 has not been verified.

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

Applicable Law and Regulations

Medicaid Eligibility

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)).

In an analysis of Medicaid eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR § 435.4). On the date of your application, that was the 2017 FPL, which is $24,600.00 for a four-person household (82 Fed. Reg. 8831).

Medicaid Continuous Coverage:

Most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, unless the adult loses Medicaid eligibility because of citizenship status, lack of state residence, or failure to provide a valid social security number, before the end of a twelve-month period. This twelve-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 (*see* 42 CFR § 435.916(a); N.Y. Soc. Serv. Law § 366(4)(c)).

Verification Process

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income (45 CFR §155.320(c)(1)(i), 42 CFR § 435.945).

If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR §155.315(f) 42 CFR § 435.952).

Timely Notice of Medicaid Eligibility

When an individual applies for insurance through NYSOH, NYSOH must determine that person's eligibility promptly and without undue delay (45 CFR § 155.310(e)(1); 42 CFR § 435.1200(b)(3)(iii)).

To assess whether an eligibility determination was untimely, NYSOH must base the time period from the date of application to the date NYSOH notifies the applicant of its decision (45 CFR § 155.310(e)(2)). However, if the applicant submits an incomplete application or there is not sufficient information for NYSOH to make an eligibility determination, then NYSOH must notify that applicant that more information is needed to complete the application (45 CFR § 155.310(k)(1)).

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the application (42 CFR § 435.912).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your MMC plan was terminated effective November 30, 2016.

On January 9, 2016, NYSOH issued a notice stating that you were eligible for Medicaid effective January 1, 2016, and on January 20, 2016, enrolled in a MMC plan, with an enrollment state date of March 1, 2016.

Generally, once adults are determined eligible for Medicaid, they are guaranteed 12 months of Medicaid coverage, even if the adult loses Medicaid eligibility because of any changes or updates they make to their NYSOH account. This twelve-month period is based on the start date of the original Medicaid eligibility determination.

When your MMC plan was terminated on November 30, 2016, the twelve-month period of Medicaid eligibility that began on January 1, 2016, had not expired, and no event had occurred to end that eligibility. Per the credible evidence of record, your MMC coverage should not have been discontinued effective November 30, 2016.

Therefore, the November 23, 2016, disenrollment notice is RESCINDED.

Your case is RETURNED to reinstate your MMC coverage from December 1, 2016 through December 31, 2016.

The second issue is whether NYSOH's provided you with timely determination of your Medicaid eligibility.

For all individuals, whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income.

If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence.

You updated your NYSOH account on December 6, 2016. The income amount that was entered this application did not match federal and state data sources. As a result, NYSOH asked that you submit additional documentation to confirm your income.

On December 13, 2016, you uploaded a copy of your earnings statements. Therefore, your application was considered complete as of that date, for purposes of issuing an eligibility determination.

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the completed application. To assess whether an eligibility determination was untimely, NYSOH must base the time period from the date of the completed application to the date NYSOH notifies the applicant of its decision.

As of the date of your hearing, the income documentation has not been verified and an eligibility determination has not been issued. Therefore, NYSOH has failed to issue a timely eligibility determination notice.

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.

You testified that you expect to file your 2017 federal income tax return, with the tax status of Head of Household (with qualifying individual), and expect to claim three dependents on that return. Therefore, you are in a household of four.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is an annual household income of $33,948.00 for a four-person household.

On December 13, 2016, you submitted your earnings statements from your employer to demonstrate your household income. Based on that income documentation, your projected household income is ($210.42 (+) $137.36 (+) $245.49 (+) $350.70 = $943.97 (X) 13) $12,271.61.

Since your projected household income of $12,271.61 does not exceed the maximum allowable income amount of $33,948.00, you did qualify for Medicaid based on the documentation you provided as of December 13, 2016.

Your case is RETURNED to facilitate your enrollment in a MMC plan effective January 1, 2017.

Decision

The November 23, 2016, disenrollment notice is RESCINDED.

Your case is RETURNED to reinstate your MMC coverage from December 1, 2016 through December 31, 2016.

NYSOH has failed to issue a timely eligibility determination notice.

Your case is RETURNED to facilitate your enrollment in a MMC plan effective January 1, 2017.

Effective Date of this Decision: May 10, 2017

How this Decision Affects Your Eligibility

Your MMC plan will be reinstated from December 1, 2016 through December 31, 2016.

Your case has been returned to NYSOH to facilitate your enrollment in a MMC plan effective January 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):

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 November 23, 2016, disenrollment notice is RESCINDED.

Your MMC plan will be reinstated from December 1, 2016 through December 31, 2016.

NYSOH has failed to issue a timely eligibility determination notice.

Your case has been returned to NYSOH to facilitate your enrollment in a MMC plan effective January 1, 2017.

Legal Authority

We are sending you this notice 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.

□□□□□ (Bengali)

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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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)

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).

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).