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

Notice of Decision

Decision Date: May 8, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013892

[redacted]

Dear [redacted],

On April 12, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 17, 2016 eligibility redetermination notice and November 23, 2016 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: May 8, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013892

[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 for the months of December 2016 and January 2017?

Procedural History

On July 17, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective July 1, 2016.

Also, on July 17, 2016, NYSOH issued a notice of enrollment confirmation stating that you remained enrolled in a Medicaid Managed Care plan, effective January 1, 2016.

On October 6, 2016, NYSOH issued an enrollment confirmation notice stating that you would remain enrolled in your Medicaid Managed Care plan, effective January 1, 2016.

On October 10, 2016, NYSOH issued a notice which redetermined your eligibility, finding that you remained eligible for Medicaid, effective October 1, 2016.

On November 16, 2016, NYSOH redetermined your eligibility.

On November 17, 2016, NYSOH issued an eligibility redetermination notice stating that you did not qualify for Medicaid, Child Health Plus, Essential Plan, premium tax credits, cost sharing reductions or to purchase a qualified health

plan at full cost, effective December 1, 2016, because you did not respond to the renewal notice.

On November 23, 2016, NYSOH issued a disenrollment notice stating that your coverage in your Medicaid Managed Care plan was ending effective November 30, 2016.

On December 8, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of your eligibility for Medicaid insofar as you were seeking reinstatement in your Medicaid Managed Care plan for the months of December 2016 and January 2017.

On February 25, 2017, NYSOH issued an eligibility determination stating that you were eligible for Medicaid, effective February 1, 2017.

On March 7, 2017, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in a Medicaid Managed Care plan, effective April 1, 2017.

On April 12, 2017, 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 you did not receive a renewal notice from NYSOH in 2016. You testified that you were confused when you received the November 2016 notice stating that you did not respond to a renewal notice.

2) According to the July 17, 2016 eligibility redetermination notice, you remained eligible for Medicaid, effective July 1, 2016. This notice did not contain any requests for income documentation.

3) NYSOH records show that no notices were sent to you requesting income information or any documentation from January 2016 through November 2016.

4) On November 17, 2016, NYSOH issued a notice stating that you did not qualify for Medicaid because you had not responded to a renewal notice and that your coverage would be ending effective December 1, 2016.

5) On December 6, 2016, you uploaded a letter to NYSOH stating that you did not receive a renewal notice, only notices stating that you were no longer eligible for Medicaid coverage [redacted].

6) NYSOH records reflect that the last renewal notice you received was on October 25, 2015. This renewal notice did not request that you update your application or provide any information or documentation.

7) You testified that you are not appealing your Medicaid Fee-for-Service coverage for the months of February and March 2017.

8) You testified that you are seeking to have your Medicaid Managed Care plan coverage reinstated for the months of December 2016 and January 2017.

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 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 federal poverty level (FPL) for the applicable family size (42 CFR §§ 435.119(b), 435.911(b)(1), 435.603(d)(4); NY Social Services Law § 366(1)(b)).

Generally, 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)).

Legal Analysis

The issue is whether NYSOH properly determined that you were no longer eligible for Medicaid or your Medicaid Managed Care plan for the months of December 2016 and January 2017.

NYSOH records reflect that you were enrolled in a Medicaid Managed Care plan effective January 1, 2016.

On November 17, 2016, NYSOH issued a notice stating that you did not qualify for Medicaid or to purchase a qualified health plan at full cost because you did not respond to a renewal notice, effective December 1, 2016. On November 23, 2016, NYSOH issued a disenrollment notice stating that your coverage in your Medicaid Managed Care plan was ending effective November 30, 2016.

You credibly testified that you did not receive a renewal notice in 2016 from NYSOH and that you were confused when you received the November 2016 notice stating that you did not respond to a renewal notice.

On December 6, 2016, you uploaded a letter to NYSOH stating that you did not receive a renewal notice, only notices stating that you were no longer eligible for Medicaid coverage.

NYSOH records reflect that the last renewal notice you received was on October 25, 2015. This renewal notice did not request that you update your application or provide any information or documentation.

NYSOH records do not reflect that any notices issued during January 2016 through November 2016 requested income information or any documentation from you.

Moreover, apart from the lack of any request for further documentation and the lack of any renewal notice, NYSOH again found you eligible for Medicaid effective October 1, 2016.

Based on your testimony and NYSOH records, there is no evidence of a renewal notice being issued to you requesting information and as such, the November 17, 2016 eligibility determination stating that you did not respond to a renewal notice from NYSOH was incorrect. Therefore, it was improper for NYSOH to discontinue your coverage.

Therefore, the November 17, 2016 eligibility redetermination notice is MODIFIED to reflect that your eligibility for and enrollment in Medicaid and your Medicaid Managed Care plan was effective during the months of December 2016 and January 2017 and the November 23, 2016 disenrollment notice is RESCINDED.

Additionally, under New York State law, once a person is eligible for Medicaid, that eligibility continues for 12 months. This provision is called “continuous coverage.” In addition, with limited exceptions, such as incarceration, lack of state residency, no valid Social Security number, or having third party health insurance, an individual remains eligible for Medicaid throughout this 12 months of continuous coverage.

NYSOH records confirm that you were eligible for Medicaid, effective July 1, 2016, and again effective October 1, 2016. Even though NYSOH determined that you were not eligible for your Medicaid Managed Care plan effective November 30, 2016, you should have remained enrolled in Medicaid for the remainder of your 12-month eligibility period. There is no evidence that you experienced one of the limiting exceptions that would disqualify you from remaining enrolled in your Medicaid Managed care plan until then.

However, you testified that you are not appealing your Medicaid Fee-for-Service coverage for the months of February 2017 and March 2017 and that you are asking that your Medicaid Managed Care plan coverage reinstated for the months of December 2016 and January 2017. Therefore, your case is RETURNED to NYSOH to reinstate your coverage in your Medicaid Managed Care plan for the months of December 2016 and January 2017, and to notify you accordingly.

Decision

The November 17, 2016 eligibility redetermination notice is MODIFIED to reflect that your eligibility for and enrollment in Medicaid and your Medicaid Managed Care plan was effective during the months of December 2016 and January 2017.

The November 23, 2016 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid Managed Care plan for the months of December 2016 and January 2017 and to notify you accordingly.

Effective Date of this Decision: May 8, 2017

How this Decision Affects Your Eligibility

Your case is RETURNED to NYSOH to reinstate your Medicaid Managed Care plan for the months of December 2016 and January 2017 and to notify you accordingly.

NYSOH incorrectly determined that you were ineligible for your Medicaid Managed Care plan for the months of December 2016 and January 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

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).

- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The November 17, 2016 eligibility redetermination notice is MODIFIED to reflect that your eligibility for and enrollment in Medicaid and your Medicaid Managed Care plan was effective during the months of December 2016 and January 2017.

The November 23, 2016 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid Managed Care plan for the months of December 2016 and January 2017 and to notify you accordingly.

NYSOH incorrectly determined that you were ineligible for your Medicaid Managed Care plan for the months of December 2016 and January 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:

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.

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