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

Notice of Decision

Decision Date: April 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014042

[redacted]

Dear [redacted],

On April 10, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 13, 2016 eligibility determination and November 5, 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).

This page intentionally left blank.

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

Decision

Decision Date: April 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014042

[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, but would continue to receive Medicaid coverage until November 30, 2016?

Procedural History

On December 31, 2015, NYSOH issued a notice of eligibility determination stating that you remained eligible for Medicaid because your household income of $49,900.00 was at or below the allowable income limit. This eligibility was effective as of January 1, 2016.

On January 14, 2016, NYSOH issued an enrollment notice confirming your enrollment Affinity Health Plan, Inc. (Affinity) as your Medicaid Managed Care (MMC) plan as of January 13, 2016. The notice stated that your MMC plan coverage with Affinity would begin effective February 1, 2016.

On August 13, 2016, NYSOH issued an enrollment notice and disenrollment notice reflecting that you had elected to switch your MMC plan coverage from Affinity to Empire Blue Cross Blue Shield (Empire) as of August 12, 2016. The enrollment notice reflected that you Empire MMC plan coverage would begin effective September 1, 2016. Your MMC plan coverage with Affinity concluded effective August 31, 2016.

On September 12, 2016, NYSOH received your updated application for health insurance; specifically, the income information was updated.

On September 13, 2016, NYSOH issued a notice of eligibility determination stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until November 30, 2016 because certain individuals determined eligible for Medicaid remain eligible for benefits for 12 continuous months from the date that they were determined eligible. This eligibility was effective as of September 1, 2016.

On November 5, 2016, NYSOH issued a disenrollment notice stating that your MMC plan coverage with Empire would end effective November 30, 2016.

On December 15, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as your enrollment in Medicaid had been terminated effective November 30, 2016. You were seeking for such coverage to be reinstated during the month of December 2016.

You were subsequently found eligible for coverage under the Essential Plan effective January 1, 2017.

On April 10, 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) Your account reflects that you were initially enrolled in Medicaid effective January 1, 2016.

2) You subsequently enrolled in an MMC with Affinity for coverage beginning on February 1, 2016. This coverage concluded on August 31, 2016.

3) You enrolled in an Empire MMC on August 12, 2016, with such coverage beginning September 1, 2016.

4) Your account reflects that after updating your application on September 12, 2016, you were found not eligible for Medicaid; however, your Medicaid coverage would continue until November 30, 2016.

5) You were subsequently found eligible for coverage under the Essential Plan effective January 1, 2017.

6) You testified that you were seeking a reinstatement of your MMC plan coverage with Empire as you were not provided with a full twelve continuous months of coverage from the date you were first found eligible for Medicaid.

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, but would continue to receive Medicaid coverage until November 30, 2016.

The record reflects that your first became eligible for Medicaid coverage beginning January 1, 2016 because of your December 30, 2015 application. This eligibility determination is not under review since it was not the subject of the appeal.

You revised your application on September 12, 2016 to reflect a change in income, which resulted in a finding that you were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until November 30, 2016.

Under New York State law, once a person is eligible for Medicaid, that eligibility continues for 12 months, even if the household income rises above 138% of the FPL. This provision is called “continuous coverage.”

Credible evidence confirms that you were eligible for Medicaid effective January 1, 2016, and that even though your estimated annual income changed when you modified your application on September 12, 2016, you remain enrolled in Medicaid for the remainder of your 12-month eligibility period.

Since your credible evidence of record reflects that your Medicaid coverage began effective January 1, 2016, you Medicaid coverage should not have concluded until December 31, 2016.

Therefore, the September 13, 2016 eligibility determination is MODIFIED to state that your Medicaid coverage would continue until December 31, 2016.

Furthermore, the November 5, 2016 disenrollment notice is also MODIFIED to state that your Empire MMC plan coverage would end effective December 31, 2016.

Your case is RETURNED to NYSOH to effectuate the changes to your eligibility and coverage as referenced above.

Decision

The September 13, 2016 eligibility determination is MODIFIED to state that your Medicaid coverage would continue until December 31, 2016.

The November 5, 2016 disenrollment notice is also MODIFIED to state that your Empire MMC plan coverage would end effective December 31, 2016.

Your case is RETURNED to NYSOH to effectuate the changes to your eligibility and coverage as referenced above.

Effective Date of this Decision: April 13, 2017

How this Decision Affects Your Eligibility

Your MMC plan coverage with Empire is reinstated for the month of December 2016.

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 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).

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 September 13, 2016 eligibility determination is MODIFIED to state that your Medicaid coverage would continue until December 31, 2016.

The November 5, 2016 disenrollment notice is also MODIFIED to state that your Empire MMC plan coverage would end effective December 31, 2016.

Your case is RETURNED to NYSOH to effectuate the changes to your eligibility and coverage as referenced above.

Your MMC plan coverage with Empire is reinstated for the month of December 2016.

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.

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 निःशुल्क 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).