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

Notice of Decision

Decision Date: April 14, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014504

Dear [redacted]

On March 30, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 25, 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 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: April 14, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000014504

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 and your child were disenrolled from your Medicaid Managed Care plans, effective December 31, 2016?

Procedural History

On February 2, 2016, NYSOH redetermined your and your child's eligibility for financial assistance with health insurance.

On February 3, 2016, NYSOH issued a notice of eligibility determination notice stating that you and your child were eligible for Medicaid. This eligibility was effective as of March 1, 2016.

On February 10, 2016, NYSOH issued an enrollment confirmation notice, confirming your selection of a Medicaid Managed Care plan, with an enrollment start date of March 1, 2016.

On October 14, 2016, NYSOH issued a notice that it was time to renew your and your child's health insurance for the upcoming coverage year. That notice stated that based on information from federal and state sources, NYSOH could not make a decision about whether you or your child would qualify for financial help paying for your health coverage. You were directed to update your account by December 15, 2016 or you and your child might lose the financial assistance you were currently receiving.

On November 16, 2016, you updated your application for financial assistance.

On November 17, 2016, NYSOH issued a notice stating additional information was required to confirm eligibility for members of your household. You were asked to submit documentation confirming your household's income by December 1, 2016.

On November 25, 2016, NYSOH issued a disenrollment notice stating that your and your child's coverage with your Medicaid Managed Care plans would end December 31, 2016, because you and your child were no longer eligible to enroll in health insurance through NYSOH.

On November 30, 2016, you updated your application for financial assistance.

Also on November 30, 2016, you uploaded a letter stating that your income is $0.00, that your employment ended on January 20, 2016 and that you did not qualify for unemployment benefits.

On December 1, 2016, NYSOH issued a notice stating additional information was required to confirm eligibility for members of your household. You were asked to submit documentation confirming your household's income by December 1, 2016.

On December 13, 2016, the system ran an application on your behalf.

On December 14, 2016, NYSOH issued an eligibility determination notice stating that you and your child were eligible for a full cost qualified health plan, effective January 1, 2017.

On December 20, 2016, you updated your application for financial assistance and the system ran an application on your behalf.

On December 21, 2016, NYSOH issued an eligibility determination notice stating that you and your child were eligible for Medicaid effective January 1, 2017, and directed you to pick a plan.

On December 29, 2016, NYSOH issued an enrollment confirmation notice stating that you and your child were enrolled in a Medicaid Managed Care plan effective February 1, 2017.

On January 2, 2017, you spoke to NYSOH's Account Review Unit and appealed the November 25, 2016 disenrollment notice, insofar as you and your child were not enrolled in a Medicaid Managed Care plan for the month of January 2017.

On March 30, 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 and your child were determined eligible for Medicaid, effective March 1, 2016.

2) There is no indication in the record that you or your child were incarcerated, permanently moved, or obtained health insurance outside of NYSOH in 2016 or 2017.

3) You testified that your current income is $0.00, and that you have not worked since January 19, 2016.

4) You testified that you are seeking enrollment in a Medicaid Managed Care plan for yourself and your child for the month of January 2017.

5) You testified that you have outstanding medical bills.

6) You testified and your application states that you reside in [redacted]

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

Applicable Law and Regulations

<u>Medicaid</u>

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)).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size

(42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

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 2016 FPL, which is $16,020.00 for a two-person household (81 Federal Register 4036).

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 under review is whether NYSOH properly disenrolled you and your child from your Medicaid Managed Care plans, effective December 31, 2016.

On February 3, 2016, NYSOH issued an eligibility determination notice stating that you and your child were eligible for Medicaid, effective March 1, 2016. That determination has not been appealed and is not under review.

On October 14, 2016, NYSOH issued a renewal notice requesting that you update your NYSOH account by December 15, 2016 in order for your and your child's eligibility to be determined.

You updated your account on November 16, 2016. As a result, on November 17, 2016, NYSOH issued an eligibility determination notice stating additional information was required to confirm eligibility for members of your household. On November 25, 2016, NYSOH issued a disenrollment notice stating that your and your child's coverage with your Medicaid Managed Care plans would end December 31, 2016, because you and your child were no longer eligible to enroll in health insurance through NYSOH.

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

The record reflects that there were no events that would have been a basis for your or your child’s Medicaid coverage to have been terminated prior to the end of the 12 months of coverage, such as a permanent move or incarceration.

Since you and your child were determined eligible for Medicaid effective March 1, 2016, you remained eligible for Medicaid for 12 continuous months, regardless of any changes in your household income. As a result, you and your child were improperly disenrolled from Medicaid and your Medicaid Managed Care plans, effective December 31, 2016.

Since NYSOH determined you and your child were eligible for Medicaid as of March 1, 2016, and therefore eligible for continuous coverage, the November 25, 2016 disenrollment notice is RESCINDED.

You testified that you are looking for coverage for yourself and your child for the month of January 2017 only. Therefore, your case is RETURNED to NYSOH to reinstate you and your child into your Medicaid Managed Care plans for the month of January 2017.

Decision

The November 25, 2016 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your and your child’s Medicaid Managed Care plans for the month of January 2017.

Effective Date of this Decision: April 14, 2017

How this Decision Affects Your Eligibility

Your case is being sent back to NYSOH to reinstate you and your child in your Medicaid Managed Care plans for the month of January 2017.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services. 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 25, 2016 disenrollment notice is RESCINDED.

Your case is being sent back to NYSOH to reinstate you and your child in your Medicaid Managed Care plans for the month of 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 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.

(Urdu)اردو

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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