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

Notice of Decision

Decision Date: June 9, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015771

[redacted]

Dear [redacted]

On June 1, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 14, 2017 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
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Decision

Decision Date: June 9, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015771

[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 eligible for an advance premium tax credit and cost-sharing reductions, effective March 1, 2017?

Procedural History

On December 29, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid because your original eligibility was determined by an eligibility specialist at NYSOH. This eligibility was effective January 1, 2017. You were subsequently enrolled in a Medicaid Managed Care (MMC) with such coverage having begun effective January 1, 2017.

On February 13, 2017, NYSOH received an update to your application for health insurance. In response to this application, NYSOH prepared a preliminary eligibility determination stating that you were temporarily eligible to enroll in a qualified health plan (QHP) and receive an advance premium tax credit (APTC), or up to $150.00 per month and, if you selected a silver-level plan, eligible for cost-sharing reductions (CSR). You were also found no longer eligible for Medicaid. This eligibility determination was effective March 1, 2017.

Also on February 13, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you were seeking for your Medicaid coverage to be reinstated.

On February 14, 2017, NYSOH issued an eligibility determination notice based on the information contained in the February 13, 2017 application. The notice stated that you were found eligible to receive an APTC of up to $150.00 per month, eligible for CSR, provided you enrolled in a silver-level plan, and ineligible for Medicaid. This eligibility determination was effective March 1, 2017.

Also on February 14, 2017, NYSOH issued a disenrollment notice confirming that your MMC plan coverage would be terminated effective February 28, 2017.

On June 1, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. At your request, a [redacted] interpreter (ID # [redacted]) also attended the hearing. 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 were seeking an appeal with respect to your eligibility only.

2) You were found eligible for Medicaid, without condition, effective January 1, 2017.

3) Your child was born on [redacted].

4) On February 13, 2017, NYSOH received an update to your application, which reflected a decrease in income, but also the additional of your newborn child. Because of this application update, you were found eligible for APTC and CSR, but also ineligible for Medicaid, effective March 1, 2017.

5) Your Medicaid coverage was terminated effective February 28, 2017.

6) You testified that you were seeking a reinstatement of your Medicaid coverage for the full twelve-month period to which you are entitled.

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

Applicable Law and Regulations

<u>Medicaid Continuous Coverage</u>

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 determined that you were eligible for an APTC and CSR, effective March 1, 2017.

The record reflects that you were found eligible for Medicaid, without condition, effective January 1, 2017. This determination is reflected in an eligibility determination notice issued on December 29, 2016. This eligibility determination is not under appeal.

On February 13, 2017, NYSOH received an update to your application, which reflected a decrease in income, but also contained the addition of your newborn child. Because of this application update, you were found eligible for APTC and CSR, but also ineligible for Medicaid, effective March 1, 2017.

Your Medicaid coverage, including your MMC plan coverage, was terminated effective February 28, 2017.

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, 2017, and that even though you revised your household size and annual household income on February 13, 2017, you should not have been found eligible for either APTC or CSR. Further, you should have remained enrolled in Medicaid for the remainder of your twelve-month eligibility period.

Therefore, the February 14, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to reinstate your MMC plan coverage as of March 1, 2017, and to continue such coverage until the expiration of your twelve-month eligibility period on December 31, 2017.

Decision

The February 14, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to reinstate your MMC plan coverage as of March 1, 2017, and to continue such coverage until the expiration of your twelve-month eligibility period on December 31, 2017.

Effective Date of this Decision: June 9, 2017

How this Decision Affects Your Eligibility

Your Medicaid coverage, which began on January 1, 2017, continues until December 31, 2017, barring subsequent changes in your eligibility.

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 February 14, 2017 eligibility determination notice is RESCINDED.

Your Medicaid coverage, which began on January 1, 2017, continues until December 31, 2017, barring subsequent changes in your eligibility.

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)

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).

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।

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)

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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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