



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

Notice of Decision

Decision Date: July 27, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000017508

[REDACTED]

Dear [REDACTED],

On July 18, 2017, your authorized representative, [REDACTED], appeared by telephone at a hearing on your appeal of NY State of Health's March 17, 2017 disenrollment notice and March 30, 2017 eligibility determination and plan enrollment 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 at the top of this notice.

Legal Authority

We are sending you this notice in accordance with federal regulation 45 CFR § 155.545(b).

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: July 27, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000017508



Issues

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

Did NY State of Health (NYSOH) properly terminate your Medicaid coverage as of March 31, 2017,?

Did NYSOH properly determine that you were eligible to enroll in an Essential Plan?

Did NYSOH properly determine that you were ineligible for Medicaid?

Did NYSOH properly enroll you in an Essential Plan with an enrollment start date of May 1, 2017?

Procedural History

On April 12, 2016, NYSOH issued an eligibility determination stating that you were eligible for Medicaid effective as of April 1, 2016.

On April 15, 2016, NYSOH issued an enrollment notice confirming that as of April 14, 2016, you were enrolled in a Medicaid Managed Care (MMC) plan with an enrollment start date of May 1, 2016.

On February 3, 2017, NYSOH issued a notice that it was time to renew your health insurance. That notice stated that, based on information from federal and state sources, NYSOH could not make a decision about whether you would

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qualify for financial help paying for your health coverage, and that you needed to update your account by March 15, 2017 or you might lose the financial assistance you were currently receiving.

No updates were made to your account by March 15, 2017.

On March 17, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for financial assistance or to enroll in health insurance at full cost because you had not completed your renewal within the required time frame. You were no longer eligible for health insurance, effective April 1, 2017.

On March 17, 2017, NYSOH issued a disenrollment notice stating that your MMC coverage would end March 31, 2017.

On March 29, 2017, your NYSOH account was updated.

On March 30, 2017, NYSOH issued two notices:

- (1) An eligibility determination notice stating that you were eligible to enroll in the Essential Plan, effective May 1, 2017;
- (2) An enrollment notice confirming that, as of your March 29, 2017 plan selection, you were enrolled in an Essential Plan with an enrollment start date of May 1, 2017.

On March 30, 2017, an appeal was requested relative to your eligibility for Medicaid coverage being discontinued.

On April 6, 2017, NYSOH issued a notice stating that you are eligible Medicaid through NYSOH for a limited time because you had been granted Aid to Continue until a decision is made on your appeal.

On July 18, 2017, your authorized representative, [REDACTED], had a telephone hearing with a Hearing Officer from NYSOH Appeals Unit. The record was developed during the hearing and 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 account, you are applying for health insurance for yourself.

- 2) According to your NYSOH account, you expect to file a 2017 federal income tax return with the tax status of single, and do not expect to claim any dependents on that return.
- 3) According to your NYSOH account, you do not expect to claim any deductions on your 2017 federal income tax return.
- 4) According to your NYSOH account, you are issued \$1,441.00 monthly in Social Security Disability Insurance (SSDI) benefits.
- 5) According to your NYSOH account, you were found eligible for Medicaid coverage effective April 1, 2016.
- 6) According to your NYSOH account, you receive notices from NYSOH via regular mail.
- 7) According to your NYSOH account, your mailing address was listed as [REDACTED], from April 4, 2016 through March 29, 2017.
- 8) Your authorized representative testified that [REDACTED] obtained the renewal notice at your residence. However, [REDACTED] did not recall when [REDACTED] obtained the notice.
- 9) Your authorized representative testified that [REDACTED] was told by the health insurance company's nurse care manager that your Medicaid coverage was about to expire.
- 10) Your authorized representative testified that [REDACTED] attempted to renew your health insurance coverage; however, the NYSOH representatives stated that [REDACTED] was not authorized to do so.
- 11) Your authorized representative testified that [REDACTED] did not recall when [REDACTED] first attempted to renew your health insurance coverage through NYSOH.
- 12) According to your NYSOH account, your account was first updated on March 29, 2017.
- 13) According to your NYSOH account, you were enrolled in an Essential Plan on March 29, 2017 with May 1, 2017 enrollment start date.
- 14) Your authorized representative testified that you are seeking to be 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 Renewal

In general, NYSOH must review Medicaid eligibility once every 12 months or “whenever it receives information about a change in a beneficiary’s circumstances that may affect eligibility” (42 CFR § 435.916(a)(1), (d)). NYSOH must make its “redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual’s account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency” (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates that may have been provided by the individual (45 CFR § 155.335(h)).

Essential Plan - Eligibility

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (see 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). On the date of your application, that was the 2016 FPL, which is \$11,800.00 for a one-person household (81 Fed. Reg. 4036).

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

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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 \$12,060.00 for a one -person household (82 Fed. Reg. 8831).

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).

Essential Plan - Effective Date

For individuals seeking enrollment in an Essential Plan, New York State has elected to follow the same rules that NYSOH uses in determining effective dates for individuals seeking enrollment in qualified health plans (NY Social Services Law § 369-gg(4)(c); New York’s Basic Health Plan Blueprint, p. 16, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/basic-health-program.html>).

The effective date of coverage by an Essential Plan is determined by the date on which an applicant selects a plan for enrollment. For individuals who are eligible for enrollment, NYSOH must generally ensure that coverage is effective the first day of the following month for selections received by NYSOH from the first to the fifteenth of any month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(i); see also 42 CFR § 600.320). For selections received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(ii)).

Legal Analysis

The first issue under review is whether NYSOH properly terminated your Medicaid coverage March 31, 2017.

You were originally found eligible for Medicaid effective April 1, 2016.

Generally, NYSOH must redetermine a qualified individual's eligibility for Medicaid once every 12 months without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency. NYSOH's February 3, 2017, renewal notice stated that there was not enough information to determine whether you were eligible to continue your financial assistance for health

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insurance, and that you needed to supply additional information by March 15, 2017, or your financial assistance might end.

NYSOH properly notified you of your annual renewal and that information in your NYSOH account needed to be updated in order to ensure your enrollment in your health plan and eligibility for financial assistance would continue.

Your authorized representative testified that [REDACTED] obtained the renewal notice at your residence, but was unable to recall when [REDACTED] obtained the notice. Further, [REDACTED] testified that [REDACTED] attempted to renew your health insurance coverage, but was informed by NYSOH that [REDACTED] was not authorized to renew your coverage. However, your authorized representative does not recall when [REDACTED] first attempted to renew your health insurance coverage.

The available record reflects that your NYSOH account was not updated until March 29, 2017. Because there was no timely response to this notice, your Medicaid coverage was terminated March 31, 2017.

The March 17, 2017, disenrollment notice is AFFIRMED.

The second issue under review is whether NYSOH properly determined you eligible for the Essential Plan

The record reflects that you expect to file your 2017 federal income tax return, with the tax status of single, and do not expect to claim any dependents on that tax return. Therefore, you are in a one-person household.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$11,880.00 for a one-person household.

According to your NYSOH account, you receive \$1,441.00 monthly in SSDI benefits. Therefore, your 2017 projected household income is \$17,292.00.

An annual income of \$17,292.00 is 143.38% of the 2017 FPL for a one-person household. Therefore, NYSOH properly determined you to be eligible for the Essential Plan.

The third issue under review is whether NYSOH failed to determine you eligible for Medicaid.

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

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family size. On the date of your application, the relevant FPL was \$12,060.00 for a one-person household.

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 \$1,387.00 per month for a one-person household.

The record reflects that you are issued \$1,441.00 in SSDI benefits on a monthly basis. Therefore, your monthly income exceeds the maximum allowable monthly income amount of \$1,387.00 and did not qualify for Medicaid.

The March 30, 2017, eligibility determination notice properly determined you eligible for the Essential Plan and not eligible for Medicaid. Therefore, it is correct and AFFIRMED.

The fourth issue is whether your Essential Plan properly had an enrollment start date of May 1, 2017.

On March 29, 2017, your NYSOH account was updated, and you were enrolled in an Essential Plan.

The date on which an Essential Plan can take effect depends on the day a person selects the plan for enrollment. A plan that is selected from the first day to and including the fifteenth day of a month will go into effect on the first day of the following month. A plan that is selected on or after the sixteenth day of the month will go into effect on the first day of the second following month.

Since you were enrolled in an Essential Plan on March 29, 2017, it properly took effect on the first day of the second month following March 29, 2017; that is, on May 1, 2017.

Therefore, the March 30, 2017 plan enrollment notice is AFFIRMED.

Decision

The March 17, 2017 disenrollment notice is AFFIRMED.

The March 30, 2017 eligibility determination notice is AFFIRMED.

The March 30, 2017 plan enrollment notice is AFFIRMED.

Effective Date of this Decision: July 27, 2017

How this Decision Affects Your Eligibility

NYSOH properly terminated your Medicaid coverage effective March 31, 2017.

You were properly determined eligible for and remain eligible to enroll in the Essential Plan.

You remain ineligible for Medicaid through NYSOH.

NYSOH properly determined that the enrollment start date of your Essential Plan was May 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

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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 March 17, 2017 disenrollment notice is AFFIRMED.

The March 30, 2017 eligibility determination notice is AFFIRMED.

The March 30, 2017 plan enrollment notice is AFFIRMED.

NYSOH properly terminated your Medicaid coverage effective March 31, 2017.

You were properly determined eligible for and remain eligible to enroll in the Essential Plan.

You remain ineligible for Medicaid through NYSOH.

NYSOH properly determined that the enrollment start date of your Essential Plan was May 1, 2017.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545(a).

A Copy of this Decision Has Been Provided To:



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 1-855-355-5777번으로 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 مجاناً.

বাংলা (Bengali)

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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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. y&b&tumi ama wo obi a okyerE 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 کرم 1-855-355-5777 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.

שׂוֹדִישׁ (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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