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

Notice of Decision

Decision Date: September 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018800

[redacted]

[redacted]

On August 16, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 8, 2017 disenrollment notice and April 27, 2017 eligibility determination 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.

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).

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

Decision

Decision Date: September 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018800

[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 and disenrolled from your Medicaid Managed Care plan, effective April 30, 2017?

Procedural History

On August 26, 2016, NYSOH received your application for financial assistance with health insurance.

On August 27, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid because your household income of $32,684.48 was at or below the allowable income limit. This eligibility was effective as of August 1, 2016.

Also on August 27, 2016, NYSOH issued an enrollment confirmation notice stating that you were enrolled in a Medicaid Managed Care plan, effective October 1, 2016

On April 6, 2017, NYSOH received your application for financial assistance with health insurance. That day, you also submitted income documentation.

On April 7, 2017, NYSOH issued a notice stating that the income information in your application does not match what NYSOH received from state and federal

data sources. You were directed to submit proof of household income for yourself and two children by April 21, 2017, and for your spouse by July 5, 2017.

Also on April 7, 2017, NYSOH issued a disenrollment notice, stating that your coverage through a Medicaid Managed Care plan would end on April 30, 2017.

On April 13, 2017, NYSOH determined that the documentation you submitted was insufficient and directed you to produce additional documentation by April 21, 2017. That same day, you submitted additional documentation.

On April 19, 2017, NYSOH determined that the documentation you submitted was insufficient and directed you to provide additional documentation by May 6, 2017.

On April 24, 2017, you submitted an updated application for financial assistance with health insurance as well as additional income documentation.

On April 26, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan for a limited time, effective June 1, 2017.

Also on April 26, 2017, NYSOH issued an enrollment confirmation notice, stating that you were enrolled in the Essential Plan, effective June 1, 2017.

Also on April 26, 2017, NYSOH validated your income documentation and an application for financial assistance with health insurance was run on your behalf.

On April 27, 2017, NYSOH issued an eligibility determination notice, stating that you were eligible for the Essential Plan, effective June 1, 2017.

Also on April 27, 2017, NYSOH issued an enrollment confirmation notice, stating that you were enrolled in the Essential Plan, effective June 1, 2017.

On May 8, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility insofar as you did not have coverage in May 2017.

On August 16, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open up to August 31, 2017 to allow you time to submit income documentation.

On August 31, 2017, NYSOH received the requested documentation and it was entered into the record as appellant's "Exhibit #1." The record was closed at end of business that day.

Findings of Fact

A review of the record supports the following findings of fact:

1) You were determined eligible for Medicaid, effective August 1, 2016.

2) There is no indication in the record that you were incarcerated, or obtained health insurance outside of NYSOH since you were determined eligible for Medicaid.

3) You testified that you were seeking to correct a birthday in your account and request a new card on April 6, 2017. You testified that you did not intend to submit a new application for financial assistance.

4) You submitted income documentation on April 6, 2017, April 13, 2017, and April 24, 2017. You were determined fully eligible for the Essential Plan, effective June 1, 2017.

5) You testified that you are seeking coverage for May 2017 for yourself because you have outstanding bills for medical treatment rendered that month.

6) On August 31, 2017, you submitted your spouse's paystubs dated May 12, 2017, May 19, 2017, May 26, 2017, June 2, 2017, and June 9, 2017. The record does not contain all of your spouse's paystubs from May 2017.

7) 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

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)).

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 2017 FPL, which is $12,060.00 for a one-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 determined that you were no longer eligible for Medicaid and disenrolled from your Medicaid Managed Care plan, effective April 30, 2017.

On August 27, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective August 1, 2016. That determination has not been appealed and is not under review.

On April 6, 2017, you updated your application for financial assistance. On April 7, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal data sources. Also on April 7, 2017, NYSOH issued a disenrollment notice, stating that your coverage through a Medicaid Managed Care plan would end on April 30, 2017.

You credibly testified that you contacted NYSOH on April 6, 2017 to request a new card and correct a birthday on your account. You did not intend to submit an updated application for financial assistance. As a result of that call, a new

application was run and you were disenrolled from your Medicaid Managed Care plan, with direction to submit income documentation for your household.

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 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 were determined eligible for Medicaid based on the application submitted on August 26, 2016, effective August 1, 2016, you remained eligible for Medicaid for 12 continuous months, regardless of any increases in your household income. As a result, you were improperly disenrolled from Medicaid and your Medicaid Managed Care plan, effective April 30, 2017.

Since NYSOH determined you were eligible for Medicaid as of August 1, 2016, and therefore eligible for continuous coverage, the April 8, 2017 disenrollment notice is RESCINDED.

Since you should have remained eligible for Medicaid until July 31, 2017, the April 27, 2017 eligibility determination notice stating that you were eligible for the Essential Plan is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you into your Medicaid Managed Care plan as of May 1, 2017 and to continue your coverage until the end of your 12-month continuous coverage period, that is until July 31, 2017.

Decision

The April 8, 2017 disenrollment notice is RESCINDED.

The April 27, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you into your Medicaid Managed Care plan as of May 1, 2017 and to continue your coverage until the end of your 12-month continuous coverage period, that is until July 31, 2017.

Effective Date of this Decision: September 21, 2017

How this Decision Affects Your Eligibility

Your case is being sent back to NYSOH to reinstate you in your Medicaid Managed Care plan as of 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 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 April 8, 2017 disenrollment notice is RESCINDED.

The April 27, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you into your Medicaid Managed Care plan as of May 1, 2017 and to continue your coverage until the end of your 12-month continuous coverage period, that is until July 31, 2017.

Your case is being sent back to NYSOH to reinstate you in your Medicaid Managed Care plan as of May 1, 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.

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).