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

Notice of Decision

Decision Date: September 22, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018914

[redacted]

[redacted],

On August 22, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 18, 2017 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).

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Decision

Decision Date: September 22, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018914

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Issues

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

> Was your appeal of NY State of Health's (NYSOH) February 18, 2017 disenrollment notice timely?
>
> Did NYSOH properly determine that your eligibility for and enrollment in Medicaid and your Medicaid Managed Care plan ended February 28, 2017?

Procedural History

On March 14, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid because your household income of $42,900.00 was at or below the allowable income limit. This eligibility was effective as of March 1, 2016. You subsequently enrolled into a Medicaid Managed Care plan.

On November 29, 2016, NYSOH received your updated application for health insurance; specifically, the size of your household was updated.

On November 30, 2016, NYSOH issued a notice of eligibility determination stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until February 28, 2017 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 November 1, 2016.

On January 5, 2017, NYSOH issued a renewal notice, stating that NYSOH did not have enough information from state and federal data sources, and directed you to update your account between January 16, 2017 and February 15, 2017.

On January 10, 2017, an application for financial assistance with health insurance was run on your behalf.

On January 11, 2017, NYSOH issued a notice of eligibility determination stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until March 31, 2017 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 January 1, 2017.

On February 3, 2017, NYSOH issued a renewal notice, stating that NYSOH did not have enough information from state and federal data sources, and directed you to update your account between February 15, 2017 and March 15, 2017.

On February 17, 2017, NYSOH received your updated application for financial assistance with health insurance.

On February 18, 2017, NYSOH issued an eligibility determination notice, stating that you were eligible to receive up to $210.00 in advance payment of the premium tax credit and eligible for cost-sharing reductions if you enrolled in a silver-level qualified health plan, effective April 1, 2017.

Also on February 18, 2017, NYSOH issued an enrollment confirmation notice, directing you to pick a plan.

Also on February 18, 2017, NYSOH issued a disenrollment notice, stating that your coverage with a Medicaid Managed Care plan would end effective February 28, 2017.

On April 20, 2017, NYSOH received your updated application for financial assistance with health insurance.

On April 21, 2017, NYSOH issued an eligibility determination notice, stating that you were eligible for the Essential Plan, effective June 1, 2017.

Also on April 21, 2017, NYSOH issued an enrollment confirmation notice, stating that you were enrolled in the Essential Plan, effective June 1, 2017.

On May 11, 2017, you contacted NYSOH’s Account Review Unit and requested an appeal of that eligibility determination insofar as your enrollment in Medicaid ended February 28, 2017 and not March 31, 2017.

On August 21, 2017, you were scheduled to have a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. You requested an adjournment and the Hearing Officer agreed to adjourn your hearing to August 22, 2017.

On August 22, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit, with the assistance of your authorized representative [redacted]. 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 are seeking Medicaid coverage for March 2017 because you have outstanding bills for medical services rendered that month.

2) You expect to file your 2017 federal income tax return as head of household, and claim two dependents.

3) The record reflects that your Medicaid coverage ended as of February 28, 2017.

4) You first contacted NYSOH regarding your March 2017 Medicaid coverage on April 19, 2017, as evidenced by [redacted]. The complaint states that you called on April 19, 2017 seeking to have your Medicaid Managed Care plan reinstated with an end date of March 31, 2017.

5) The record reflects that you were first determined eligible for Medicaid effective March 1, 2016.

6) According to the April 20, 2017 application, you attested to an expected household income of $38,740.00.

7) The record reflects that NYSOH issued two renewal notices: one dated January 5, 2017 requesting that you update your account by February 15, 2017 and one dated February 3, 2017 requesting that you update your account by March 15, 2017.

8) You testified that you received the January 11, 2017 eligibility determination notice stating that your Medicaid coverage would continue until March 31, 2017 and you relied on this notice.

9) You testified that you received both renewal notices issued by NYSOH.

10) You testified that you relied on the February 3, 2017 renewal notice that advised you to update your account between February 15, 2017 and March 15, 2017 in order to continue your eligibility.

11) You testified that you contacted NYSOH to update your account on February 17, 2017.

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

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR §155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

However, where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe as determined by NYSOH that failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal (45 CFR §155.520(d)(2)(i)(D)).

Medicaid

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)).

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 $11,880 for a one-person household (81 Fed. Reg. 4036).

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).

Medicaid Continuous Coverage

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)).

Medicaid Renewal

In general, NYSOH must review Medicaid eligibility once every twelve 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 provided by the individual (45 CFR §155.335(h)).

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

Medicaid Managed Care (MMC) plan enrollments received on or before the fifteenth day of the month are effective the first day of the following month. Enrollments received after the fifteenth day of the month are effective the first day of the second following month (Medicaid Managed Care Model Contract (Appendix H(6)(b)(ii) & (iii), effective 3/1/2014 – 2/28/2019, N.Y. Soc. Serv. Law §364-j(1)(c); 18 NYCRR § 360-10.3(h)).

Legal Analysis

The first issue is whether your appeal of NYSOH's February 18, 2017 disenrollment notice was timely.

The record reflects that you first contacted NYSOH to file a formal appeal regarding your Medicaid coverage for March 2017 on May 11, 2017.

Individual applicants and enrollees must request a hearing within sixty (60) days of the due date of their notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of the disenrollment from your Medicaid, an appeal should have been filed by April 19, 2017. The record reflects that you filed your appeal on May 11, 2017, which is beyond the 60-day deadline.

Although the appeal was untimely on its face, the record reflects that you contacted NYSOH and filed a complaint on April 19, 2017, which was within the 60-day deadline. As you filed a complaint within the 60-day deadline, and the subject of the complaint is the same as the appeal, the appeal is considered timely and will be addressed.

The second issue is whether NYSOH properly determined that your eligibility for and enrollment in Medicaid and your Medicaid Managed Care plan ended February 28, 2017.

You were originally found eligible for Medicaid effective March 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.

Since you were found eligible for Medicaid effective March 1, 2016 your eligibility would therefore continue for 12 continuous months, or until February 28, 2017.

NYSOH's January 5, 2017 renewal notice stated that there was not enough information to determine whether you were eligible to continue your financial assistance for health insurance, and that you needed to supply additional information between January 15, 2017 and February 15, 2017, or your financial assistance might end. You testified that you received this notice.

On January 10, 2017, your NYSOH account was updated, which was prior to the dates listed in the renewal notice. However, based on this update NYSOH issued an eligibility determination notice stating that your Medicaid coverage would continue until March 31, 2017 because certain individuals determined eligible for Medicaid remain eligible for benefits for 12 continuous months from the date that they were determined eligible.

On February 3, 2017, another renewal notice was issued by NYSOH telling you that you needed to update the information in your NYSOH account between February 16, 2017 and March 15, 2017.

You testified that you received the January 11, 2017 eligibility determination notice stating that your Medicaid coverage would continue until March 31, 2017 and the February 3, 2017 renewal notice that advised you to update your account between February 16, 2017 and March 15, 2017 in order to continue your eligibility. You testified that you relied on both of these notices.

On February 17, 2017, your NYSOH account was updated which was within the timeframe indicated in the February 3, 2017 renewal notice. As a result of this update, you were found newly eligible for tax credits and cost-sharing reductions as of April 1, 2017. However, because the system had identified your 12 month Medicaid eligibility which began on March 1, 2016 as ending at the end of February 2017, you were disenrolled from your Medicaid Managed Care plan as of February 28, 2017.

Since NYSOH issued two notices indicating that your Medicaid coverage would continue until March 31, 2017, and you relied on the statements in those notices, NYSOH should have not have disenrolled you from your Medicaid Managed Care plan prior to March 31, 2017.

Therefore, the February 18, 2017 disenrollment notice is MODIFIED to state that your eligibility for Medicaid and enrollment in a Medicaid Managed Care plan ends on March 31, 2017. Your case is RETURNED to NYSOH to reinstate your Medicaid Managed Care plan for the month of March 2017.

Decision

The February 18, 2017 disenrollment notice is MODIFIED to state that your eligibility for Medicaid and enrollment in a Medicaid Managed Care plan ends on March 31, 2017.

Your case is RETURNED to NYSOH to reinstated your Medicaid Managed Care plan for the month of March 2017.

Effective Date of this Decision: September 22, 2017

How this Decision Affects Your Eligibility

Your eligibility for Medicaid should have ended as of March 31, 2017.

Your enrollment in your Medicaid Managed Care plan should have ended March 31, 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
- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The February 18, 2017 disenrollment notice is MODIFIED to state that your eligibility for Medicaid and enrollment in a Medicaid Managed Care plan ends on March 31, 2017.

Your case is RETURNED to NYSOH to reinstated your Medicaid Managed Care plan for March 2017.

Your eligibility for Medicaid should have ended as of March 31, 2017.

Your enrollment in your Medicaid Managed Care plan should have ended March 31, 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:

[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 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).

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