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

Notice of Decision

Decision Date: November 22, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019873

[redacted]

Dear [redacted],

On September 18, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 26, 2017 eligibility determination notice and NYSOH's issuance of an eligibility determination.

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 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: November 22, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019873

[redacted]

Issues

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

> Did New York State of Health (NYSOH) properly determine you to be ineligible for health insurance and end your Medicaid coverage effective as of May 31, 2017?
>
> Did NY State of Health (NYSOH) fail to provide you with a timely eligibility determination for the reimbursement of your Medicare premiums?

Procedural History

On April 18, 2017, NYSOH issued an eligibility determination notice stating, in relevant part, that you were eligible for Medicaid as of February 1, 2017.

Also on April 18, 2017, NYSOH issued a plan enrollment notice stating, in relevant part, that the type of Medicaid coverage you were eligible for did not require or allow you to enroll in a Medicaid Managed Care (MMC) plan.

On April 25, 2017, your NYSOH account was updated.

On April 26, 2017, NYSOH issued an eligibility determination notice stating that effective June 1, 2017, you were no longer eligible for health insurance through NYSOH. The notice stated that you were not eligible for Medicaid because the household income you provided was over the allowable income limit for that program. Further, the notice stated that, based on federal and state data

sources, you were already enrolled in or eligible for a public insurance program such as Medicare.

On April 26, 2017, and April 27, 2017, your NYSOH account was updated.

On April 27, 2017 and April 28, 2017, NYSOH issued an eligibility determination notice stating that you did not qualify for health insurance through NYSOH. The notice stated that you were not eligible for Medicaid because the household income you provided was over the allowable income limit for that program. Further, the notice stated that, based on federal and state data sources, you were already enrolled in or eligible for a public insurance program such as Medicare.

On June 20, 2017, your NYSOH account was updated.

Also on June 20, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as you did not qualify for health insurance through NYSOH.

On June 21, 2017, NYSOH issued an eligibility determination notice stating that you did not qualify for health insurance through NYSOH. The notice stated that you were not eligible for Medicaid because the household income you provided was over the allowable income limit for that program. Further, the notice stated that, based on federal and state data sources, you were already enrolled in or eligible for a public insurance program such as Medicare.

On September 18, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was left open until September 25, 2017, to allow to submit documentation of your spouse and child's June 2017 income.

On September 25, 2017, you faxed a one-page letter to NYSOH Appeals Unit. You stated that you were waiting on the documentation requested and mail or fax it, once it was received [redacted]

On September 26, 2017, NYSOH Appeals Unit issued to you a notice stating that the record would remain open until October 9, 2017, for you to submit the requested documentation [redacted]

No additional documentation was submitted to NYSOH Appeal Unit. Therefore, the record is complete and closed.

Findings of Fact

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

1) You testified that you were appealing that your Medicaid coverage had been discontinued.

2) According to your NYSOH account, you were determined eligible for Medicaid, effective February 1, 2017.

3) According to your NYSOH account, you were enrolled in Medicare as of June 1, 2016.

4) On April 13, 2017, you submitted a benefit statement, dated February 28, 2017, from the Social Security Administration (SSA). It confirms that beginning December 2016, your monthly benefit was $696.80 and monthly deduction for Medicare medical insurance premium was $123.00 (*see* [redacted]

5) You testified that you want Medicaid to pay from your Medicare insurance premiums.

6) On April 20, 2017, you contacted NYSOH to request assistance with your Medicare premiums [redacted]

7) You testified that you have not received any notice from NYSOH stating whether you are eligible for reimbursement of your Medicare premiums.

8) On April 25, 2017, your household income was changed to $29,778.32.

9) According to your NYSOH account, your Medicaid coverage ended as of May 31, 2017.

10) The Appeal Summary in the Evidence Packet that was created in anticipation of your hearing states in relevant part that:

> The appellant['s] spouse…was also determined not eligible for financial assistance due to having Duplicate Coverage with the Marketplace [redacted]

11) According to NYSOH, your spouse is enrolled in Essential Plan coverage on Account Work Area [redacted].

12) According to NYSOH accounts [redacted], you and your spouse are married and expect to be filing a joint federal income tax return.

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

Applicable Law and Regulations

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 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)).

Medicaid Continuous Coverage:

Most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, unless the adult loses Medicaid eligibility because of citizenship status, lack of state residence, or failure to provide a valid social security number, before the end of a twelve-month period. This twelve-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 (*see* 42 CFR § 435.916(a); N.Y. Soc. Serv. Law § 366(4)(c)).

Medicaid Premium Reimbursement

When a Medicaid eligible individual has third party health insurance in force, the Medicaid program may determine to pay part all cost of the premiums when payment of the premium is determined to be cost-effective. By paying the premium, the Medicaid program may cost avoid claims that would otherwise be covered by Medicaid (*see* NYS Social Services Law § 367-a(1)(b), 18 NYCRR § 360-7.5(g), GIS 15 MA/04).

Payment of Medicare part B premiums will be made by Medicaid if a Medicaid recipient is a qualified Medicare beneficiary, pursuant to 18 NYCRR § 360-7.7(g). Payment of the part B premium begins in the month following the month in which the qualified Medicare beneficiary applies for Medicaid payment of the premiums (18 NYCRR § 360-7.8(b)(5)).

Timely Notice of Medicaid Eligibility

When an individual applies for insurance through NYSOH, NYSOH must determine that person's eligibility promptly and without undue delay (45 CFR § 155.310(e)(1); 42 CFR § 435.1200(b)(3)(iii)).

To assess whether an eligibility determination was untimely, NYSOH must base the time-period from the date of application to the date NYSOH notifies the applicant of its decision (45 CFR § 155.310(e)(2)). However, if the applicant submits an incomplete application or there is not sufficient information for NYSOH to make an eligibility determination, then NYSOH must notify that applicant that more information is needed to complete the application (45 CFR § 155.310(k)(1)).

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the application (42 CFR § 435.912).

Legal Analysis

The first issue under review is whether NYSOH properly ended your Medicaid coverage effective May 31, 2017.

On April 18, 2017, NYSOH issued an eligibility determination notice stating, in relevant part, that you were eligible for Medicaid as of February 1, 2017.

Generally, once individuals are determined eligible for Medicaid, they are guaranteed 12 months of Medicaid coverage, even if the adult loses Medicaid eligibility because of any changes or updates they make to their NYSOH account. This twelve-month period is based on the effective date of the Medicaid eligibility determination and is known as "continuous coverage.".

On April 25, 2017, your NYSOH account was updated and your household income was changed to $29,778.32. Based on that update, on April 26, 2017, NYSOH issued an eligibility determination notice stating that you were no longer eligible for Medicaid because the household income you provided was over the allowable income limit.

Once a person is eligible for Medicaid, that eligibility continues for 12 months, even if the household income rises above 138% of the FPL. When your Medicaid coverage terminated on May 31, 2017, the twelve-month period of Medicaid eligibility that was effective on February 1, 2017, had not expired.

Therefore, the April 26, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid coverage as of June 1, 2017, and for the remainder of your twelve months of eligibility.

The second issue under review is whether NYSOH failed to provide you with a timely determination of your eligibility for reimbursement of your Medicare premiums.

Payment of Medicare part B premiums will be made by Medicaid if a Medicaid recipient is a qualified Medicare beneficiary. Payment of the part B premium begins in the month following the month in which the qualified Medicare beneficiary applies for Medicaid payment of the premiums

NYSOH must provide adult applicants notice of their eligibility determination within 45 days from the date of the application.

The record reflects that on April 20, 2017, you contacted NYSOH to request assistance with your Medicare premiums; however, you testified that you have not received any notice from NYSOH stating whether you are eligible for reimbursement of your Medicare premiums. Therefore, it is concluded that NYSOH did fail to issue you a timely eligibility determination.

Therefore, your case is RETURNED to NYSOH to determine your eligibility for reimbursement of your Medicare premiums as of April 20, 2017.

The record reflects that on June 20, 2017, your spouse was determined ineligible for financial assistance because they already were enrolled in coverage through NYSOH. Further, your spouse is enrolled in Essential Plan coverage on Account Work Area [redacted]. Each account, [redacted], indicates that you and your spouse are married and expect to be file a joint federal income tax return.

Your case is RETURNED to NYSOH to ascertain why you and your spouse are enrolled in health insurance on two separate accounts. If no reason is determined, NYSOH shall inactivate one account and enroll you and your spouse in health insurance coverage on the same account.

Decision

The April 26, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid coverage as of June 1, 2017, and for the remainder of your twelve months of eligibility.

NYSOH failed to issue you a timely determination of your eligibility for reimbursement of your Medicare premiums.

Your case is RETURNED to NYSOH to determine your eligibility for reimbursement of your Medicare premiums as of April 20, 2017.

Your case is RETURNED to NYSOH to ascertain why you and your spouse are enrolled in health insurance on two separate accounts. If no reason is determined, NYSOH shall inactivate one account and enroll you and your spouse in health insurance coverage on the same account.

Effective Date of this Decision: November 22, 2017

How this Decision Affects Your Eligibility

NYSOH improperly ended your Medicaid coverage as of May 31, 2017.

Your case has been returned to NYSOH to reinstate your Medicaid coverage as of June 1, 2017, and the remainder of your twelve months of eligibility.

NYSOH failed to issue you a timely determination of your eligibility for reimbursement of your Medicare premiums.

Your case is returned to NYSOH to determine your eligibility for reimbursement of your Medicare premiums as of April 20, 2017. NYSOH will notify you of its determination.

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 April 26, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid coverage as of June 1, 2017, and for the remainder of your twelve months of eligibility.

NYSOH failed to issue you a timely determination of your eligibility for reimbursement of your Medicare premiums.
Your case is RETURNED to NYSOH to determine your eligibility for reimbursement of your Medicare premiums as of April 20, 2017.

Your case is RETURNED to NYSOH to ascertain why you and your spouse are enrolled in health insurance on two separate accounts. If no reason is

determined, NYSOH shall inactivate one account and enroll you and your spouse in health insurance coverage on the same account.
NYSOH improperly ended your Medicaid coverage as of May 31, 2017.

Your case has been returned to NYSOH to reinstate your Medicaid coverage as of June 1, 2017, and the remainder of your twelve months of eligibility.

NYSOH failed to issue you a timely determination of your eligibility for reimbursement of your Medicare premiums.

Your case is returned to NYSOH to determine your eligibility for reimbursement of your Medicare premiums as of April 20, 2017. NYSOH will notify you of its determination.

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)

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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)

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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