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

Notice of Decision

Decision Date: October 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020327

[redacted]

Dear [redacted],

On September 26, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 26, 2017 eligibility determination and plan disenrollment 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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Decision

Decision Date: October 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020327

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health properly determined that your enrollment in your Medicaid Managed Care plan ended as of April 30, 2017, and that you were eligible for a full price qualified health plan, effective June 1, 2017?

Procedural History

On December 3, 2016, NY State of Health (NYSOH) issued an eligibility determination notice stating that it was time for you to renew your NYSOH coverage. This notice stated that if the information in your application was still accurate, that NYSOH had reenrolled you into your Medicaid Managed Care plan, effective February 1, 2017. This notice further directed you to update your NYSOH account between December 16, 2016 and January 15, 2017 if any household information had changed which may affect your eligibility; including a change in income.

On December 17, 2016, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective November 1, 2015.

On February 27, 2017, NYSOH received your updated application for financial assistance with health insurance; which included an updated expected annual income.

On February 28, 2017, NYSOH issued a notice of eligibility determination based on the February 27, 2017 application, stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until January 31, 2018 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 February 1, 2017. This notice also directed you to submit proof of income to confirm your eligibility by March 14, 2017.

Also on February 28, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective November 1, 2015.

No income documentation was received by March 14, 2017.

On April 10, 2017, NYSOH issued an eligibility determination stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until January 31, 2018 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 April 1, 2017.

Also on April 10, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective November 1, 2015.

On April 26, 2017, NYSOH issued an eligibility determination stating that you were newly eligible to purchase a qualified health plan at full cost through NYSOH. This eligible was effective June 1, 2017. This notice further stated that this was because you had failed to submit income documentation by the due date.

Also on April 26, 2017, NYSOH issued a plan disenrollment notice stating that your enrollment in your Medicaid Managed Care plan terminated, effective May 1, 2017.

On May 11, 2017, NYSOH received your updated application for financial assistance with health insurance.

On May 12, 2017, NYSOH issued a notice stating that you may be eligible for health insurance but more information was needed to make a determination. This was because the income information you provided did not match what NYSOH had obtained from state and federal data sources and NYSOH was unable to make a determination until you submitted additional income documentation. You had until May 26, 2017 to submit income documentation for your household.

On May 16, 2017, NYSOH received your application for financial assistance with health insurance.

On May 17, 2017, NYSOH issued a notice stating that you may be eligible for health insurance but more information was needed to make a determination. This was because the income information you provided did not match what NYSOH had obtained from state and federal data sources and NYSOH was unable to make a determination until you submitted additional income documentation. You had until May 31, 2017 to submit income documentation for your household.

On May 25, 2017, you uploaded one document to your NYSOH account.

On June 21, 2017, NYSOH received your updated application for financial assistance with health insurance, and you uploaded one document to your NYSOH account.

On June 22, 2017, NYSOH issued an eligibility determination stating that you were eligible for Medicaid, effective June 1, 2017.

On June 27, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective August 1, 2017.

On July 8, 2017, you contacted NYSOH's Accounts Review Unit and requested an appeal of that eligibility determination insofar as your eligibility and enrollment in your Medicaid Managed Care plan had been terminated for the month of May 2017.

On September 26, 2017, you had a telephone hearing with a Hearing Officer from the NYSOH's Appeals Unit. The record was developed during the hearing and the record was closed at the end of the hearing.

Findings of Fact

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

1) The record indicates that on December 3, 2016, NYSOH issued a renewal notice stating that, based on state and federal data sources you were eligible for Medicaid, effective February 1, 2017.

2) The December 3, 2016 renewal notice indicated that if anything had changed in that would affect your eligibility, to update your NYSOH account between December 16, 2016 and January 15, 2017; which included if your income had changed.

3) The record indicates, and you testified, that on February 27, 2017 you contacted NYSOH to update your mailing address.

4) The record indicates that, on February 27, 2017, an updated application for financial assistance was submitted on your behalf; which included a change in income.

5) The record indicates that your expected annual income increased from $1,900.00 listed in your February 10, 2016 application, to $12,480.00 listed in your February 27, 2017 application.

6) You testified that you would like to be reenrolled into Medicaid for the month of May 2017 because you have unpaid medical bills from that month.

7) You testified that you were under the impression that you would have Medicaid coverage until the end of the year.

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 two-person household (82 Fed. Reg. 8831).

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 your enrollment in your Medicaid Managed Care plan ended as of April 30, 2017, and that you were eligible for a full price qualified health plan, effective June 1, 2017.

On December 3, 2016, NYSOH issued an eligibility determination notice stating that it was time for you to renew your NYSOH coverage. This notice stated that if the information in your application was still accurate, that NYSOH had reenrolled you into your Medicaid Managed Care plan, effective February 1, 2017. This notice also directed you to update your NYSOH account between December 16, 2016 and January 15, 2017 if any information had changed which may affect your eligibility; including a change in income.

The record indicates, that on February 27, 2017, NYSOH received your updated application for financial assistance with health insurance; which included an updated expected annual income.

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

On February 28, 2017, NYSOH issued a notice of eligibility determination based on the February 27, 2017 application, stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until January 31, 2018 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 February 1, 2017. This notice also directed you to submit proof of income to confirm your eligibility by March 14, 2017.

The record indicates that no income documentation was received by March 14, 2017, and NYSOH reran your eligibility on April 25, 2017. On April 26, 2017, NYSOH issued an eligibility determination stating that you were newly eligible to purchase a qualified health plan at full cost through NYSOH. This eligible was effective June 1, 2017. This notice further stated that this was because you had failed to submit income documentation by the due date.

Credible evidence confirms that you were found eligible for Medicaid, effective February 1, 2017, and that even though your estimated annual income increased when you modified your application on February 28, 2017, you should have remained in Medicaid for the remainder of the 12-month eligibility period; which is until January 31, 2018. As such, NYSOH erred in disenrolling you from your Medicaid Managed Care plan, effective April 30, 2017.

Therefore, the April 26, 2017 eligibility determination and plan disenrollment notices are RESINCDED.

Your case is RETURNED to NYSOH to reinstate your coverage in your Medicaid Managed Care plan with Healthfirst as of May 1, 2017.

Decision

The April 26, 2017 eligibility determination is RESCINDED.

The April 26, 2017 plan disenrollment is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your coverage in your Medicaid Managed Care plan with Healthfirst as of May 1, 2017.

Effective Date of this Decision: October 13, 2017

How this Decision Affects Your Eligibility

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

Your case is being sent back to NYSOH to reinstate your coverage in your Medicaid Managed Care plan with Healthfirst 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
- By mail at:

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

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 fax: 1-855-900-5557

Summary

The April 26, 2017 eligibility determination notice is RESCINDED.

The April 26, 2017 plan disenrollment notice is RESCINDED.

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

Your case is being sent back to NYSOH to reinstate your coverage in your Medicaid Managed Care plan with Healthfirst 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).