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

Notice of Decision

Decision Date: October 2, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020345

[redacted]

Dear [redacted]

On September 27, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 30, 2017 disenrollment and July 6, 2017 eligibility determination 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 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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Decision

Decision Date: October 2, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000020345

[redacted]

Issue

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

> Did New York State of Health (NYSOH) properly end your Medicaid eligibility and Medicaid Managed Care (MMC) plan, effective July 31, 2017?

Procedural History

On February 3, 2017, NYSOH issued a renewal notice stating that, based on federal and state data sources, you qualified for Medicaid effective April 1, 2017. The notice stated that you were enrolled in a Medicaid Managed Care (MMC) plan with an enrollment start date of April 1, 2017.

On February 17, 2017, NYSOH issued a plan enrollment notice confirming that you were enrolled in an MMC plan with an enrollment start date of April 1, 2017.

On June 18, 2017, NYSOH issued a notice that it was time to renew your health insurance for the upcoming coverage year. That notice stated that based on information from federal and state sources, NYSOH could not make a decision about whether you would qualify for financial help paying for your health coverage. The notice instructed you to update your account by July 15, 201,7 or you might lose the financial assistance you were receiving.

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

On June 30, 2017, NYSOH issued a disenrollment notice stating that your MMC coverage would end July 31, 2017.

Also on June 30, 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. The notice directed you to provide proof of your household income by July 14, 2017, to confirm your eligibility.

On July 3, 2017, additional documentation was uploaded to your account (*see* Documents [redacted]), and were validated on July 5, 2017.

On July 5, 2017, your NYSOH account was updated by NYSOH.

On July 6, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for a tax credit up to $229.00 per month and cost-sharing reductions, effective August 1, 2017. The notice stated that you were ineligible for Medicaid because your household income was over the allowable income limit.

On July 7, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as your Medicaid coverage was to be terminated August 1, 2017.

On July 13, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid for a limited time. You had been granted Aid to Continue until a decision is made on your appeal, effective August 1, 2017.

Also on July 13, 2017, NYSOH issued a plan enrollment notice confirming that as of July 12, 2017, you were enrolled in a MMC plan with an enrollment start date of August 1, 2017.

On September 27, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's 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 and testimony, you are seeking to get financial assistance through Medicaid and your MMC plan reinstated.

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

3) According to your NYSOH account, you were enrolled in a MMC plan with an enrollment start date of April 1, 2017.

4) On June 18, 2017, NYSOH issued you a notice directing you to update your account by July 15, 2017, or lose your financial assistance (*see* Document [redacted]).

5) On July 3, 2017, you submitted four earnings statements to NYSOH (*see* Documents [redacted]).

6) According to your NYSOH account, based on the earnings statements submitted on July 3, 2017, your annual household income was calculated to be $27,112.80.

7) According to your account, your Medicaid FFS coverage and MMC plan ended July 31, 2017.

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)).

Legal Analysis

The issue under review is whether NYSOH properly ended your Medicaid eligibility and coverage in your MMC plan, effective July 31, 2017.

On February 3, 2017, NYSOH issued a notice stating that, based on federal and state data sources, you qualified for Medicaid and were enrolled in a MMC plan effective April 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.

On June 18, 2017, NYSOH issued you a notice directing you to update your account by July 15, 2017, or lose your financial assistance (*see* Document [redacted]). Based on that notice, you updated your account and submitted four earnings statements to NYSOH (*see* Documents [redacted]).

The record reflects that on July 5, 2017, your account was updated by NYSOH and your annual household income was calculated to be $27,112.80. Your eligibility was redetermined based on that income amount and you were found eligible for a tax credit up to $229.00 per month and cost-sharing reductions. You were also determined ineligible for Medicaid because your household income was over the allowable income threshold.

However, 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 July 31, 2017, the twelve-month period of Medicaid eligibility that was effective on April 1, 2017, had not expired.

Therefore, the June 30, 2017 disenrollment notice stating that coverage in your MMC plan would end July 31, 2017 is RESCINDED.

The July 6, 2017, eligibility determination notice stating in relevant part that you were ineligible for Medicaid is also RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid eligibility and MMC plan enrollment from August 1, 2017 through the end of your twelve-month eligibility period, unless a disqualifying event occurs.

Decision

The June 30, 2017 disenrollment notice stating that your MMC coverage would end July 31, 2017 is RESCINDED.

The July 6, 2017, eligibility determination notice stating in relevant part that you were ineligible for Medicaid is also RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid eligibility and MMC plan from August 1, 2017 through the end of your twelve-month eligibility period, unless a disqualifying event occurs.

Effective Date of this Decision: October 2, 2017

How this Decision Affects Your Eligibility

Your case is being sent back to NYSOH to reinstate your eligibility for Medicaid and enrollment in your MMC plan as of August 1, 2017, and will continue until March 31, 2018, barring a valid reason to end your coverage. NYSOH will notify you once this has been done.

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 June 30, 2017 disenrollment notice stating that your MMC coverage would end July 31, 2017 is RESCINDED.

The July 6, 2017, eligibility determination notice stating in relevant part that you were ineligible for Medicaid is also RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid eligibility and MMC plan from August 1, 2017 through the end of your twelve-month eligibility period, unless a disqualifying event occurs.

Your case is being sent back to NYSOH to reinstate your eligibility for Medicaid and enrollment in your MMC plan as of August 1, 2017, and will continue until March 31, 2018, barring a valid reason to end your coverage. NYSOH will notify you once this has been done.

Legal Authority

We are sending you this notice in accordance with 45 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).

A Copy of this Decision Has Been Provided To:

[redacted]

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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.

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).

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।

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.

(Urdu)اردو

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.

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(Yiddish) אידיש

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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