



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

Notice of Decision

Decision Date: October 20, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000020511

[REDACTED]

Dear [REDACTED]

On September 27, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's May 24, 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: October 20, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000020511

[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 were disenrolled from your Medicaid Managed Care (MMC) plan coverage, effective June 30, 2017?

Procedural History

On January 10, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid because your household income of \$15,671.00 was at or below the allowable income limit. This eligibility was effective as of January 1, 2017.

On January 11, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in an MMC plan, beginning February 1, 2017.

On May 23, 2017, NYSOH redetermined your eligibility for financial assistance.

On May 24, 2017, NYSOH issued a notice stating that the income information in your May 23, 2017 "application" did not match what NYSOH received from state and federal data sources. The notice directed you to submit documentation of your income by June 7, 2017.

That same day, NYSOH issue a notice stating that the income documentation received by NYSOH did not confirm the information in your application. The notice directed you to submit documentation of your income by June 22, 2017.

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Also on May 24, 2017, NYSOH issued a disenrollment notice, stating that your enrollment in your MMC plan was ending as of June 30, 2017 because you were no longer eligible to enroll in that plan.

On July 3, 2017, NYSOH redetermined your eligibility.

On July 4, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to purchase a qualified health plan through NYSOH at full cost, effective August 1, 2017. The notice stated that you were not eligible for Medicaid, the Essential Plan, or tax credits because NYSOH did not receive income documentation needed to verify the income listed in your application.

On July 14, 2017, you updated your NYSOH application. That day, NYSOH prepared a preliminary eligibility determination stating that you were eligible to enroll in the Essential Plan with a \$20.00 monthly premium, effective August 1, 2017. You also selected an Essential Plan for enrollment.

Also on July 14, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal, insofar as you had no coverage in the month of July 2017.

On July 15, 2017, NYSOH issue a notice of eligibility determination, stating that you were eligible to enroll in the Essential Plan with a \$20.00 monthly premium, effective August 1, 2017.

Also on July 15, 2017, NYSOH issue a notice of enrollment confirmation, confirming your enrollment in an Essential Plan beginning 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 held open through October 12, 2017 to allow you time to submit additional documentation.

On October 4, 2017, you sent a 16-page fax to the Appeals Unit. The record is now closed.

Findings of Fact

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

- 1) You were found eligible for Medicaid, effective January 1, 2017, and that eligibility determination is not under appeal.
- 2) Your eligibility was based on income documentation that you submitted on November 25, 2016 and December 16, 2016. These documents

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were reviewed and verified by NYSOH on January 9, 2017, and your eligibility was determined that day.

- 3) According to the January 10, 2017 eligibility determination, your Medicaid eligibility was neither conditional nor limited, and NYSOH did not ask for any additional information or documentation in that notice.
- 4) On May 23, 2017, a NYSOH agent re-reviewed the income documentation you submitted in November and December 2016, and entered notes in your NYSOH account indicating that this income documentation was now invalid. The agent also redetermined your eligibility.
- 5) On May 24, 2017, NYSOH issued a notice stating that you needed to supply additional documentation to confirm your eligibility. NYSOH also issued a notice that day stating that your enrollment in your MMC plan was ending as of June 30, 2017.
- 6) You testified that you received three notices sent on May 24, 2017, and that they were very confusing, as two had different deadlines for the submission of income documentation, and one said that your coverage was ending.
- 7) You testified that you contacted NYSOH and were told that you needed to submit three months of earnings and expenses (as you are self-employed) by June 22, 2017.
- 8) You testified that you faxed this documentation to NYSOH on June 21, 2017.
- 9) Your NYSOH account does not contain any indication that NYSOH received documentation from you during June or July 2017.
- 10) You testified that you were out of state visiting [REDACTED] in July 2017, and you sustained an injury on [REDACTED]. You testified that you called NYSOH that day to find out whether your coverage would work in another state and were informed that your coverage had ended June 30, 2017.
- 11) You testified that you told NYSOH that you did not understand why your coverage had ended when you faxed income documentation to them, and that they informed you that it takes at least ten business days to acknowledge a fax and review any paperwork.

- 12) Your NYSOH account reflects that your NYSOH application was updated on July 14, 2017, and you were found eligible for the Essential Plan, effective August 1, 2017.
- 13) You testified that you are looking to either be re-enrolled in your Medicaid and MMC plan for July, or have your Essential Plan coverage backdated to July 1, 2017, as you have outstanding medical bills from July.
- 14) After the hearing, you faxed a sixteen-page document to NYSOH, consisting of: a fax cover sheet; a fax transmission report dated June 21, 2017, showing a fax sent to [REDACTED] with a result of "sent"; pages of income and expenses for the months of March, April, and May 2017; and copies of the May 24, 2017 notices that you were sent. This packet of documents is collectively marked and entered in the record as "Appellant's Exhibit One."

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)).

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

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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 that you were disenrolled from your MMC plan, as of June 30, 2017.

You were found fully eligible for Medicaid, with no limitations or conditions, in a notice dated January 10, 2017. This eligibility was effective January 1, 2017, and is not under appeal. You were subsequently enrolled into an MMC plan, beginning February 1, 2017.

Under New York State law, once a person is eligible for Medicaid, that eligibility continues for 12 months, even if the household income rises above 138% of the FPL. This provision is called “continuous coverage.” This also means that an individual enrolled in an MMC plan generally remains enrolled in that plan until the 12 months of continuous coverage is complete, unless they obtain third party health insurance or Medicare, or leave NY State.

There is no indication in the record that your eligibility for Medicaid should have ended for any non-financial reasons. Moreover, NYSOH's decision to re-review the income documentation that you submitted in November and December 2016, which had already been verified in January 2017, was seemingly random and unwarranted. There is no indication in the record that you reported any changes or made any updates to your account that should have triggered any actions by NYSOH. Nevertheless, for reasons that remain unclear, NYSOH invalidated your already-verified income documentation, and redetermined your eligibility.

NYSOH's decision to redetermine your eligibility led to your disenrollment from your MMC plan. Additionally, NYSOH's failure to upload or verify the income documentation you sent on June 21, 2017, as confirmed by the fax transmission report in “Appellant's Exhibit One,” led to their erroneous determination that you were not eligible for any financial assistance. Since you had already been removed from your Medicaid coverage, when you updated your application on July 14, 2017, you were found newly eligible for the Essential Plan, instead of being given your 12 months of continuous Medicaid coverage.

Therefore, since you should have remained eligible for Medicaid, NYSOH's May 24, 2017 disenrollment notice is **RESCINDED**.

Your case is **RETURNED** to NYSOH to reinstate you in your Medicaid and MMC plan coverage for the month of July 2017.

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With regard to your coverage as of August 1, 2017: you should have remained enrolled in Medicaid and your MMC plan through December 31, 2017, as that would be the end of your 12 months of continuous coverage. However, because of NYSOH's actions, you eventually were enrolled into the Essential Plan instead, and have been paying for and utilizing this coverage. Placing you into your Medicaid and MMC plan coverage as of August 1, 2017 could have negative consequences for you if you have utilized providers who only accept the Essential Plan, and not your MMC plan.

For this reason, you may choose to:

1. Re-enroll in your Medicaid and MMC coverage for the entire 12 months of 2017; OR
2. Keep your Essential Plan coverage for the months that have passed (August, September and October), and re-enroll in your Medicaid and MMC plan coverage for November and December 2017; OR
3. Keep your Essential Plan coverage for the period of August 1, 2017 through December 31, 2017.

Your case is RETURNED to NYSOH, and NYSOH is directed to immediately contact you to assist you in choosing one of these options.

Decision

The May 24, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid and MMC coverage for the month of July 2017.

Your case is RETURNED to NYSOH to assist you in enrolling in from August 1, 2017 through December 31, 2017, after you have selected one of the following options:

1. Re-enroll in Medicaid and your MMC plan for all of 2017; OR
2. Keep your Essential Plan coverage for August, September, and October, and re-enroll in your Medicaid and MMC coverage for November and December; OR
3. Keep your Essential Plan coverage for the period of August 1, 2017 through December 31, 2017.

Effective Date of this Decision: October 20, 2017

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How this Decision Affects Your Eligibility

Your Medicaid coverage, which began on January 1, 2017, should have continued until December 31, 2017, barring subsequent changes to your eligibility.

Your case is being sent back to NYSOH to reinstate you in your Medicaid and MMC plan coverage for the month of July 2017.

Your case is also being sent back to NYSOH, and NYSOH will contact you immediately, so that you can choose whether you want to:

1. Re-enroll in your Medicaid and MMC plan for all of 2017, keeping in mind that your Essential Plan coverage may have paid for bills that your MMC plan will not; or
2. Keep your Essential Plan coverage for August, September, and October, and re-enroll in your Medicaid and MMC coverage for November and December 2017; or
3. Keep your Essential Plan coverage for the period of August 1, 2017 through December 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

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).

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 May 24, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid and MMC coverage for the month of July 2017.

Your case is RETURNED to NYSOH to assist you in enrolling in from August 1, 2017 through December 31, 2017, after you have selected one of the following options:

4. Re-enroll in Medicaid and your MMC plan for all of 2017; OR
5. Keep your Essential Plan coverage for August, September, and October, and re-enroll in your Medicaid and MMC coverage for November and December; OR
6. Keep your Essential Plan coverage for the period of August 1, 2017 through December 31, 2017.

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Your Medicaid coverage, which began on January 1, 2017, should have continued until December 31, 2017, barring subsequent changes to your eligibility.

Your case is being sent back to NYSOH to reinstate you in your Medicaid and MMC plan coverage for the month of July 2017.

Your case is also being sent back to NYSOH, and NYSOH will contact you immediately, so that you can choose whether you want to:

4. Re-enroll in your Medicaid and MMC plan for all of 2017, keeping in mind that your Essential Plan coverage may have paid for bills that your MMC plan will not; or
5. Keep your Essential Plan coverage for August, September, and October, and re-enroll in your Medicaid and MMC coverage for November and December 2017; or
6. Keep your Essential Plan coverage for the period of August 1, 2017 through December 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:



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 مجاناً.

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।

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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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye b&etumi ama wo obi a okyer& 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 کرم 1-855-355-5777 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).