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

Notice of Decision

Decision Date: November 9, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020845

[redacted]

[redacted]

On September 25, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 17, 2017 discontinuance and 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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DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: November 9, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020845

[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 your eligibility for and enrollment in your Medicaid Managed Care plan ended, August 1, 2017?

Procedural History

On March 3, 2017, NYSOH issued a notice that it was time to renew your health insurance for 2017. That notice stated that, you were re-enrolled in your current health plan for another year and you don't have to do anything more. The notice stated you were determined eligible for Medicaid effective May 1, 2017, and that your Medicaid Managed Care plan would start, May 1, 2017.

On June 18, 2017, NYSOH issued a notice that it was time to renew your health insurance for 2017. 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, and that you needed to update your account by July 15, 2017, or you might lose the financial assistance you were currently receiving.

No updated were received by NYSOH prior to the July 15, 2017 deadline.

On July 16, 2017, NYSOH redetermined your eligibility for financial assistance with your health insurance.

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On July 17, 2017, NYSOH issued a discontinuance notice stating that you are not eligible for Medicaid, Child Health Plus, or to receive tax credits or cost-sharing reductions to help pay for the cost of insurance. You also could not enroll in a qualified health plan at full cost. This was because you had not responded to the renewal notice and had not completed your renewal within the required time frame. Your eligibility ended August 1, 2017.

On July 17, 2017, a disenrollment notice was issued stating your coverage with your Medicaid Managed Care plan would end July 31, 2017. The notice stated this was because you were no longer eligible to enroll in health insurance through NYSOH.

On July 25, 2017, NYSOH received your updated application for health insurance. That day, a preliminary eligibility determination was prepared stating you were eligible to enroll in the Essential Plan, effective September 1, 2017.

Also on July 25, 2017, you spoke to NYSOH's Account Review Unit and appealed your disenrollment from your Medicaid Managed Care plan as you had previously been told you did not have to renew for 2017. You also appealed your new eligibility for the Essential Plan, requesting you be redetermined eligible for Medicaid.

On July 26, 2017, NYSOH issued a notice of eligibility determination stating you were eligible to enroll in the Essential Plan with a $20.00 per month premium, effective September 1, 2017. The notice further stated you were not eligible for Medicaid, because the household income you provided was over the allowable income limit for that program.

On August 2, 2017, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid for a limited time, effective August 1, 2017. The notice stated you had been granted Aid to Continue until a decision is made on your appeal.

On August 2, 2017, NYSOH issued an enrollment notice stating you were enrolled in a Medicaid Managed Care plan, effective August 1, 2017.

On September 25, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and kept open 15 days to provide proof of your household income for the month of July 2017. On October 3, 2017, NYSOH Appeals Unit received an 8-page document which has been incorporated into the record as Appellant's Exhibit 1. The record was then closed that day.

Findings of Fact

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

1) You are seeking insurance for yourself.

2) You testified you are seeking to be found eligible for Medicaid and remain enrolled in your Medicaid Managed Care plan effective August 1, 2017.

3) A renewal notice was issued by NYSOH on March 3, 2017 stating that you were eligible for Medicaid effective May 1, 2017.

4) On June 18, 2017, NYSOH issued another renewal notice requesting that you update your account by July 15, 2017.

5) You testified that you never received a renewal notice dated June 18, 2017, and that you believed you had already been renewed for coverage.

6) The record reflects that no updates were made to your NYSOH account by the deadline of July 15, 2017.

7) On July 25, 2017, you updated your NYSOH application and attested to a household income of $21,060.00.

8) The record supports you have not moved in 2017.

9) You testified you have not had any third-party health insurance other than your Medicaid Managed Care plan in 2017.

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 applications, that was the 2017 FPL, which is $12,060.00 for a one-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)).

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 issue presented for review is whether NYSOH properly determined that your eligibility for and enrollment in your Medicaid Managed Care plan ended, August 1, 2017.

On March 3, 2017, NYSOH issued a renewal notice stating you had been determined eligible for Medicaid for 2017 and that there was nothing further you had to do with your application. The notice further explained you would be enrolled in a Medicaid Managed Care plan, effective May 1, 2017.

NYSOH issued a second renewal notice on June 18, 2017, requesting that you update your account by July 15, 2017, as NYSOH could not make a determination on your eligibility for 2017. No updates were made by the notice's stated deadline of July 15, 2017. You were subsequently determined no longer eligible for Medicaid and disenrolled as of August 1, 2017.

On July 25, 2017, you submitted an updated application for financial assistance with an increased annual household income of $21,060.00. As a result of this application, you were found eligible for the Essential Plan.

However, 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."

Credible evidence confirms that you were eligible for Medicaid effective May 1, 2017, and that even though your estimated annual income increased when you updated your application on July 25, 2017, you should have remained enrolled in Medicaid for the remainder of your 12-month eligibility period. The record supports no triggering event occurred which would have made you no longer eligible for Medicaid continuous coverage.

Therefore, the July 17, 2017 discontinuance notice finding you no longer eligible for Medicaid because you had not responded to the renewal notice and had not completed your renewal within the required time frame and the July 17, 2017 disenrollment notice terminating your coverage in your Medicaid Managed Care plan, effective July 31, 2017 are RESCINDED.

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).

Your case is RETURNED to NYSOH to ensure your eligibility for Medicaid and your enrollment in your Medicaid Managed Care plan which began May 1, 2017, continues until April 30, 2018, barring subsequent changes in your eligibility.

Decision

The July 17, 2017 discontinuance notice is RESCINDED.

The July 17, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to ensure your eligibility for Medicaid and your enrollment in your Medicaid Managed Care plan which began May 1, 2017, continues until April 30, 2018, barring subsequent changes in your eligibility.

Effective Date of this Decision: November 9, 2017

How this Decision Affects Your Eligibility

Your Medicaid coverage and enrollment in your Medicaid Managed Care plan, which began on May 1, 2017, continues until April 30, 2018, barring subsequent changes in your eligibility.

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 July 17, 2017 discontinuance notice is RESCINDED.

The July 17, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to ensure your eligibility for Medicaid and your enrollment in your Medicaid Managed Care plan which began May 1, 2017, continues until April 30, 2018, barring subsequent changes in your eligibility.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

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A Copy of this Decision Has Been Provided To:

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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.

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 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.

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