



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

Notice of Decision

Decision Date: October 18, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000020951



Dear [REDACTED],

On October 12, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 7, 2017 disenrollment and July 7, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: October 18, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000020951



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 and your spouse's Medicaid coverage effective as of July 31, 2017?

Procedural History

On September 14, 2016, NYSOH issued an eligibility determination notice stating, in relevant part, that you and your spouse were no longer eligible for Medicaid, effective as of September 1, 2016. The notice directed you and your spouse to submit additional proof of Benefit Information for Third Party Health Insurance (TPHI) and current income by September 28, 2017, to confirm your eligibility.

Also on September 14, 2016, NYSOH issued a plan enrollment notice confirming that you and your spouse were enrolled in a Medicaid Managed Care (MMC) plan with an enrollment start date of September 1, 2016. The notice directed you and your spouse to submit additional proof of Benefit Information for TPHI and current income by September 28, 2017, to confirm your eligibility.

On September 16, 2016, you uploaded additional documentation to your account (see Documents [REDACTED]).

On September 27, 2016, your account was systemically updated.

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On September 28, 2016, NYSOH issued a plan enrollment notice confirming that, as of September 27, 2016, you and your spouse were enrolled in an MMC plan with an enrollment start date of September 1, 2016.

On October 7, 2016, NYSOH issued an eligibility determination notice stating, based on your household's eligibility being redetermined on September 27, 2016, you and your spouse remained eligible for Medicaid, effective September 1, 2016.

On July 2, 2017, NYSOH issued a renewal notice stating that it was time to renew your and your spouse's health insurance for the upcoming coverage year. The notice stated that, based on information from federal and state sources, NYSOH was unable to determine whether you and your spouse qualified for financial help paying for your health coverage. The notice instructed you to update your account between July 16, 2017, and August 15, 2017, to see what you both qualified for on September 1, 2017.

On July 6, 2017, your account was updated.

On July 7, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible for a tax credit up to \$327.00 per month, effective as of September 1, 2017. Further, the notice also that you and your spouse no longer qualified for Medicaid as of July 31, 2017.

Also on July 7, 2017, NYSOH issued a disenrollment notice stating that your and your spouse's MMC plan coverage would end on July 31, 2017.

On July 19, 2017, your account was updated.

On July 20, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible for a tax credit up to \$327.00 per month, effective as of September 1, 2017.

Also on July 21, 2017, NYSOH issued a plan enrollment notice confirming that as of July 20, 2017, you and your spouse were enrolled in a qualified health plan with an enrollment start date of September 1, 2017.

On July 28, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as your and your spouse's Medicaid coverage was discontinued, effective July 31, 2017.

On October 12, 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) You testified that you want Medicaid coverage reinstated for the month of August 2017 for you and your spouse.
- 2) On October 7, 2016, NYSOH issued an eligibility determination notice stating, that you and your spouse remained eligible for Medicaid, without any conditions, effective September 1, 2016 (see Document [REDACTED]).
- 3) On July 2, 2017, NYSOH issued a renewal notice directing you to update your account by August 15, 2017, or you and your spouse might lose your financial assistance (see Document [REDACTED]).
- 4) According to your NYSOH account, on July 6, 2017, your account was updated and your annual household income was changed to \$57,856.00.
- 5) You testified that, on July 6, 2017, the NYSOH representative informed you that had to wait until after July 15, 2017, to enroll in a QHP.
- 6) According to your NYSOH account and testimony, your and your spouse's Medicaid coverage ended July 31, 2017.
- 7) According to your NYSOH account, on July 20, 2017, you and your spouse were enrolled in a QHP with an enrollment start date of September 1, 2017.
- 8) According to your NYSOH account, your spouse was pregnant with a due date of September 9, 2017.
- 9) You testified that you and your spouse enrolled in a private health insurance plan, through Independent Health, for the month of August 2017. You paid \$1,103.94 for the August 2017 premium.
- 10) You testified that you and your spouse incurred medical expenses in the month of August 2017 and want Medicaid to cover those expenses.

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)).

Reimbursement for Out-of-Pocket Expenses

Generally, Medicaid payments are made to providers which furnished the services (18 NYCRR § 360-7.5(a)(1)). However, Medicaid recipients or their representatives may be reimbursed when, through no fault of their own:

(a) an erroneous Medicaid eligibility determination is reversed (whether the reversal is due to the state or local agency discovering its own error or is the result of a fair hearing decision or court order), or the state or local agency fails to determine Medicaid eligibility within the applicable time periods; and

(b) an erroneous eligibility determination or the delay in determining eligibility caused the recipient or the recipient's representative to pay for medically necessary services which otherwise would have been paid for by the Medicaid program.

18 NYCRR §360-7.5(a)(3)(i).

Legal Analysis

The issue under review is whether NYSOH properly ended your and your spouse's Medicaid coverage effective July 31, 2017.

On October 7, 2016, NYSOH issued an eligibility determination notice stating, that you and your spouse remained eligible for Medicaid, without any conditions, effective September 1, 2016 (see Document [REDACTED]).

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 July 2, 2017, NYSOH issued you a notice directing you to update your account by August 15, 2017, or you and your spouse may lose your financial assistance (see Document [REDACTED]). Based on that notice, on July 6, 2017, you updated your account and your annual household income was changed to \$57,856.00. You and your spouse were determined eligible for a tax credit up to \$327.00 per month, and determined ineligible for Medicaid because your household income was over the allowable income threshold, as of July 31, 2017.

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 September 1, 2016, was not due to expire until August 31, 2017.

Therefore, the July 7, 2017 eligibility determination notice stating, in relevant part, that you and your spouse were ineligible for Medicaid is **RESCINDED**.

Likewise, the July 7, 2017 disenrollment notice stating that your and your spouse's MMC coverage would end July 31, 2017 is **RESCINDED**.

Your case is **RETURNED** to NYSOH to reinstate your and your spouse's Medicaid coverage from August 1, 2017 through August 31, 2017, and to notify you accordingly.

You testified that because your and your spouse's Medicaid coverage ended prematurely: (1) You and your spouse were enrolled in a private health insurance plan, through Independent Health, and paid \$1,103.94 for the August 2017 premium; and, (2) You and your spouse incurred out-of-pocket medical expense in the month of August 2017.

Your case is REFERRED to New York State Department of Health, Office of Health Insurance Programs, Stakeholder Relations and Exchange Support to investigate the possibility of you qualifying to be reimbursed for the out-of-pocket expenses that resulted from the discontinuance of your and your spouse's Medicaid coverage for the month of August 2017.

Decision

The July 7, 2017 eligibility determination notice stating, in relevant part, that you and your spouse were ineligible for Medicaid is RESCINDED.

The July 7, 2017 disenrollment notice stating that your and your spouse's MMC coverage would end July 31, 2017 is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your and your spouse's Medicaid coverage from August 1, 2017 through August 31, 2017, and to notify you accordingly.

Your case is REFERRED to New York State Department of Health, Office of Health Insurance Programs, Stakeholder Relations and Exchange Support to investigate the possibility of you qualifying to be reimbursed for the out-of-pocket expenses that resulted from the discontinuance of your and your spouse's Medicaid coverage for the month of August 2017, and will notify you accordingly.

Effective Date of this Decision: October 18, 2017

How this Decision Affects Your Eligibility

Your and your spouse's Medicaid coverage will be reinstated from August 1, 2017 through August 31, 2017. NYSOH will notify once this has been done.

New York State Department of Health, Office of Health Insurance Programs, Stakeholder Relations and Exchange Support will investigate whether you qualify for reimbursements of any nature for expenses you incurred during August 2017. You will be notified directly of the outcome of its investigation.

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.

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).

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

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Summary

The July 7, 2017 eligibility determination notice stating, in relevant part, that you and your spouse were ineligible for Medicaid is **RESCINDED**.

The July 7, 2017 disenrollment notice stating that your and your spouse's MMC coverage would end July 31, 2017 is **RESCINDED**.

Your case is **RETURNED** to NYSOH to reinstate your and your spouse's Medicaid coverage from August 1, 2017 through August 31, 2017, and to notify you accordingly.

Your case is **REFERRED** to New York State Department of Health, Office of Health Insurance Programs, Stakeholder Relations and Exchange Support to investigate the possibility of you qualifying to be reimbursed for the out-of-pocket expenses that resulted from the discontinuance of your and your spouse's Medicaid coverage for the month of August 2017, and will notify you accordingly.

Your and your spouse's Medicaid coverage will be reinstated from August 1, 2017 through August 31, 2017. NYSOH will notify once this has been done.

New York State Department of Health, Office of Health Insurance Programs, Stakeholder Relations and Exchange Support will investigate whether you qualify for reimbursements of any nature for expenses you incurred during August 2017. You will be notified directly of the outcome of its investigation.

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।

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 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&btumi ama wo obi a okyerε 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.

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