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: AP000000021111

[redacted]

Dear [redacted]

On October 17, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 28, 2017 eligibility determination 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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Decision

Decision Date: October 20, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021111

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Issue

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

> Did NY State of Health (NYSOH) properly terminate your and your Child's Medicaid Managed Care plan as of July 31, 2017?

Procedural History

According to your NYSOH account, on August 24, 2016, you were found eligible for your child and was found conditionally eligible for Medicaid, effective September 1, 2016. You were enrolled in a Medicaid Managed Care plan effective October 1, 2016 and your child was subsequently enrolled in a Medicaid Managed Care plan effective February 1, 2017.

On June 28, 2017, NYSOH issued an eligibility determination notice that stated the income information in you and your child's application did not match what NYSOH received from state and federal data sources. You were directed to provide proof of income by July 12, 2017 to confirm your and your child's eligibility.

Also on June 28, 2017, NYSOH issued a disenrollment notice stating that you and your child's coverage in your Medicaid Managed Care plan would end effective July 31, 2017. This was because you and your child were no longer eligible for Medicaid.

On July 25, 2017, NYSOH issued an eligibility determination notice, based on a July 24, 2017 system update, stating that you were eligible to receive an advance

payment of the premium tax credit of up to $69.00 and your child was eligible for Child Health Plus with a monthly premium of $30.00, both effective September 1, 2017. The notice stated that you and your child were not eligible for Medicaid because your household income was over the allowable income limit for that program.

On August 2, 2017, a plan enrollment notice was issued confirming that you were enrolled in the bronze-level qualified health plan and your child was enrolled in a Child Health Plus plan, effective September 1, 2017.

Also on August 2, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of the eligibility determination insofar as it began your and your child's health coverage on September 1, 2017 and not August 1, 2017.

On October 17, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Your request to amend your appeal to have your and your child's Medicaid Managed Care plan reinstated for the month of August 2017 was granted and testimony was received. The record was developed during the hearing and closed at that end of the hearing.

Findings of Fact

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

1) According to your NYSOH account, you were determined eligible for Medicaid, effective as of September 1, 2016, and you were enrolled in a Medicaid Managed Care plan, effective October 1, 2017. In addition, your child was determined conditionally eligible for Medicaid, effective as of September 1, 2016 and he was enrolled in a Medicaid Managed Care effective February 1, 2017.

2) You testified that you are seeking health insurance for yourself and your child.

3) According to your NYSOH account, NYSOH did not issue a renewal notice. Instead, on June 27, 2017, NYSOH attempted to re-determine your and your child's eligibility through federal and data sources, but was unable to do so. As such, NYSOH issued a notice directing you to provide proof of income to confirm your and your child's eligibility by July 12, 2017 and simultaneously terminated your and your child's Medicaid Managed Care plan, effective July 31, 2017.

4) According to your NYSOH account, you and your child were not put in to Medicaid Fee-For-Service for the remained of the 12 month period; that is, for the month of August 2017.

5) You testified that you are seeking Medicaid coverage to cover the gap in coverage for the month of August 2017 because you incurred medical bills that month.

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 through NYSOH can be provided 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)).

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 terminated your and your child’s Medicaid Managed Care plans as of July 31, 2017.

According to your NYSOH account you and your child were determined Medicaid eligible for Medicaid, effective September 1, 2016. You and your child were

enrolled in a Medicaid Managed Care plan, effective October 1, 2016 and February 1, 2017, respectively, which is not in dispute.

On June 28, 2017, NYSOH issued a notice, based on a systematic update, that the income information in your application does not match what NYSOH received from state and federal data sources. As such, you and your child were terminated from your Medicaid Managed Care plans, effective July 31, 2017, and were not covered by Medicaid Fee-For-Service for the month of August 2017.

However, New York State has elected to re-determine Medicaid enrollees only every 12 months from the effective date of eligibility as long as enrollees are under age 65, are not enrolled in minimum essential coverage, and remain state residents. An individual enrolled in Medicaid shall have coverage continued until the end of the 12-month period, provided he or she does not lose eligibility by reason of citizenship status, lack of state residence, failure to provide a valid social security number, providing inaccurate information that would affect eligibility when requesting or renewing health coverage, or having third party health insurance. In fact, most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage even if their income increases above the Medicaid limit allowed for their household size.

In the present case, on June 28, 2017, NYSOH issued an eligibility determination notice stating that you needed to provide proof of your income to confirm your and your child's eligibility for health coverage for the upcoming year. However, it appears this notice was intended as a renewal notice for the upcoming policy year.

Although you and your child did had an increase in your household income during the 2016 - 2017 12-month period of Medicaid, this would not be considered a disqualifying event that would have ended your continuous Medicaid coverage. Further, there is no evidence in the record to demonstrated that any of the disqualifying events occurred to cause your and your child's coverage in Medicaid to end. Therefore, your and your child's enrollment in your Medicaid Care plans should not have been terminated prior to the end of your and your child's 12-months of Medicaid continuous coverage, which date is August 31, 2017.

Since you and your child were found eligible for and enrolled in Medicaid as of September 1, 2016, your coverage should have continued for 12 months until August 31, 2017, barring any of the disqualifying events.

Since the record is devoid of any such disqualifying events, it is concluded that NYSOH improperly and prematurely redetermined your eligibility on June 27, 2017. Therefore, the June 28, 2017 eligibility determination and disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to reinstate you and your child in your Medicaid Managed Care plan for the month of August 2017, and to notify you accordingly.

Decision

The June 28, 2017 eligibility determination and disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to REINSTATE you and your child in your Medicaid Managed Care plan for the month of August 2017, and to notify you accordingly.

This Decision does not affect any subsequent eligibility determinations made by NYSOH.

Effective Date of this Decision: October 20, 2017

How this Decision Affects Your Eligibility

You and your child were improperly terminated from your Medicaid Managed Care plan before the end of the 12-months of continuous coverage.

Your case is being sent back to reinstate you and your child in your Medicaid Managed Care plan for the month of August 2017. 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 28, 2017 eligibility determination and disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to REINSTATE you and your child in your Medicaid Managed Care plan for the month of August 2017, and to notify you accordingly.

This Decision does not affect any subsequent eligibility determinations made by NYSOH.

You and your child were improperly terminated from your Medicaid Managed Care plan before the end of the 12-months of continuous coverage.

Your case is being sent back to reinstate you and your child in your Medicaid Managed Care plan for the month of August 2017. NYSOH will notify you once this has been done.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

Getting Help in a Language Other than English

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).

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).