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

Notice of Decision

Decision Date: November 6, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021379

[redacted]

Dear [redacted],

On October 31, 2017 you appeared by telephone at a hearing on your appeal of NY State of Health's February 3, 2017 eligibility determination and February 3, 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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Decision

Decision Date: November 6, 2017

NY State of Health Account ID: [redacted]
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Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Was your appeal of NY State of Health's February 3, 2017 eligibility determination and February 3, 2017 disenrollment notice timely?
>
> Did NY State of Health properly determine that you were eligible for Medicaid effective January 1, 2017?
>
> Did NY State of Health properly determine that you were no longer eligible for Medicaid, effective February 28, 2017?

Procedural History

On October 22, 2015, NY State of Health (NYSOH) issued a renewal notice stating that you were eligible for Medicaid, effective January 1, 2016.

On January 1, 2016, NYSOH issued a notice of enrollment confirmation, based on your December 31, 2015 plan selection, stating that you were enrolled in a Medicaid Managed Care plan through Fidelis with a plan enrollment start date of February 1, 2016.

On October 17, 2016, NYSOH issued a notice that it was time to renew your health insurance. 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 December 15, 2016 or you might lose the financial assistance you were currently receiving.

No updates were received by December 15, 2016.

On December 19, 2016, NYSOH issued a notice of eligibility determination stating that you were not eligible for Medicaid, Child Health Plus, the Essential Plan, to receive premium tax credits or cost sharing reductions, or to purchase a qualified health plan, effective January 1, 2017. This was because you did not respond to the renewal notice and did not complete your renewal within the required timeframe.

On December 19, 2016, NYSOH issued a disenrollment notice stating that your enrollment with your Medicaid Managed Care plan through Fidelis was ending on December 31, 2016. This was because you were longer eligible to enroll in health insurance through NYSOH.

On December 30, 2016, you updated your application for financial assistance.

On December 31, 2016, NYSOH issued a notice stating that the income information in your application did not match what NYSOH had received from state and federal data sources and that additional information was needed to confirm the information in your application. This notice directed you to submit documentation of your income by January 14, 2017 in order for your eligibility to be determined.

On January 4, 2017, you faxed income documentation to NYSOH. On January 25, 2017, this income documentation was uploaded to your NYSOH account.

On January 25, 2017, you updated your application for financial assistance.

On January 26, 2017, NYSOH issued a notice of eligibility determination, based on your January 25, 2017 application, stating that you were eligible for Medicaid, effective January 1, 2017.

Also on January 26, 2017, NYSOH issued a notice of enrollment confirmation, based on your plan selection on January 25, 2017, stating that you were enrolled in a Medicaid Managed Care plan through Fidelis with a plan enrollment start date of January 1, 2017.

On February 2, 2017, NYSOH reviewed the income documentation you submitted, recalculated your household income based on the income documentation you submitted, updated your application to reflect this recalculated income, and submitted an application on your behalf.

On February 3, 2017, NYSOH issued a notice of eligibility determination, based on the February 2, 2017 application, stating that you were eligible for the Essential Plan, effective March 1, 2017, and that you no longer qualified for Medicaid, effective February 28, 2017.

Also on February 3, 2017, NYSOH issued a notice of enrollment stating that you were enrolled in a medical only Essential Plan through Fidelis, effective March 1, 2017. The notice further states that NYSOH enrolled you into this plan because it was similar to the coverage you previously had with this insurance company.

On June 12, 2017, you requested to change your enrollment.

On June 13, 2017, NYSOH issued a notice of disenrollment stating that your enrollment with your Essential Plan would end on June 30, 2017.

Also on June 13, 2017, NYSOH issued an enrollment notice stating that you were enrolled in an Essential Plan with dental and vision through United Healthcare with a plan enrollment start date of July 1, 2017.

On June 15, 2017, you contacted NYSOH's Account Review Unit and an incident ([redacted]) was created. The notes within this incident reflect that you were requesting to be enrolled into the plan you selected on January 25, 2017 and not the plan into which NYSOH had automatically enrolled you. The notes within this incident reflect that no resolution was reached by NYSOH on your request until August 9, 2017, at which time your request was denied.

On August 11, 2017, you contacted NYSOH's Account Review Unit and filed an appeal insofar as you were requesting to be enrolled into the plan you selected on January 25, 2017 and not the plan into which NYSOH had automatically enrolled you.

On October 31, 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 hearing.

Findings of Fact

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

1) According to the January 25, 2017 application, you attested to an expected annual household income of $31,200.00. This is based on wages of $600.00 per week you receive from your employer. In this application, you indicated that you expect to file your 2017 tax return as single and will claim three dependents on that tax return.

2) You testified that you selected a plan for enrollment on January 25, 2017. You further testified that you could not recall which plan you had been enrolled in, however, you told the NYSOH representative that you wanted to be enrolled in the same plan for 2017 that you had in 2016. You went on to state that the NYSOH representative told you that you were all set for 2017 coverage.

3) Your NYSOH account reflects that in 2016 you were enrolled in a Medicaid Managed Care plan through Fidelis.

4) On January 25, 2017, the NYSOH representative enrolled you in Medicaid Managed Care plan through Fidelis.

5) On January 4, 2017, you faxed income documentation to your NYSOH account, these documents were uploaded to your NYSOH account on January 25, 2017. You submitted four paystubs; the first is for pay date December 9, 2016 for a gross salary amount of $600.00 and a gross year to date amount of $22,200.00; the second is for pay date December 16, 2016 for a gross salary amount of $600.00 and a gross year to date amount of $22,800.00; the third is for pay date December 16, 2016 for a gross bonus amount of $350.00 and a gross year to date bonus amount of $350.00; the fourth is for pay date December 30, 2016 for a gross salary amount of $600.00 and shows a gross year to date amount of $24,000.00 and shows a gross year to date bonus amount of $350.00. You also submitted a letter indicating that you provide support for your children and that your children do not have any income.

6) On February 2, 2017, NYSOH recalculated your annual expected income to be $35,750 ($600.00 per week for four weeks plus $350.00, divided by four weeks for a weekly average of $687.50, multiplied by 52 weeks).

7) On February 3, 2017, NYSOH issued a notice of eligibility determination stating that you were no longer eligible for Medicaid effective March 1, 2017.

8) You testified that you receive your notices from NYSOH via regular mail.

9) You testified that you did not receive the February 3, 2017 eligibility determination.

10) You testified that in March or April 2017 you went to a dentist appointment. You were not advised at that time that you had no dental coverage. You went on to testify that it was not until June 2017 when

you received a bill from your dentist that you discovered that you had been disenrolled from the plan you selected on January 25, 2017.

11) You testified that on June 12, 2017 you contacted NYSOH to enroll in a plan with dental and vision coverage. You further testified that you also spoke to the Account Review Unit that day and requested to be reenrolled in the plan you selected on January 25, 2017.

12) You testified that you are seeking to have the plan you had beginning on January 1, 2017 for all of 2017.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR §155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

However, where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe as determined by NYSOH that failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal (45 CFR §155.520(d)(2)(i)(D)).

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 application, that was the 2016 FPL, which is $24,300.00 for a four-person household (81 Federal Register 4036).

Most applicants determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage offered through Medicaid Managed Care, even if the adult loses Medicaid eligibility because of any changes or updates they make to their Marketplace 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 any subsequent Medicaid eligibility determination based on modified adjusted gross income (*see* 42 CFR § 435.916; NY Social Services Law (NY SSL) § 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 first issue is whether your appeal of NYSOH's February 3, 2017 eligibility determination notice and February 3, 2017 disenrollment notice was timely.

The record reflects that you first contacted NYSOH to file a formal appeal regarding your ineligibility for and disenrollment from Medicaid and your Medicaid Managed Care plan on August 11, 2017.

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of your ineligibility for Medicaid, an appeal should have been filed by April 4, 2017. The record reflects that you first filed you appeal on August 11, 2017, which is beyond the 60-day deadline.

Although your appeal was untimely on its face, you credibly testified that you did not receive the February 3, 2017 eligibility determination notice. You further testified that you went to a dentist appointment in March 2017 or April 2017 and were not advised that you no longer had your Medicaid or Medicaid Managed Care plan coverage. You also testified that it was not until you received the bill for the dentist visit in June of 2017 that you became aware that your coverage in Medicaid and your Medicaid Managed Care plan had ended.

The record reflects that you contacted NYSOH to enroll in an Essential Plan with dental and vision coverage on June 12, 2017, shortly after learning that you no longer had Medicaid and your Medicaid Managed Care plan. You then filed your appeal within 60 days of the June 13, 2017 enrollment confirmation notice.

Furthermore, no notice of disenrollment was issued stating that your enrollment in your Medicaid Managed Care plan was ending as of February 28, 2017.

In light of the above facts, your failure to timely submit an appeal of the February 3, 2017 eligibility determination notice was due to exceptional circumstances and should preclude the appeal.

The second issue under review is whether NYSOH properly determined that you were eligible for Medicaid effective January 1, 2017.

According to the record, you expect to file your 2017 tax return as single and claim three children as dependents. Therefore, you are in a four-person household.

On your January 25, 2017 application, you attested to an expected household income of $31,200.00 consisting of $600.00 per week you receive in wages. You submitted paystubs which show that you were receiving a salary of $600.00 per week at that time.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 64 who meet the non-financial requirements and have a household MAGI that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $24,300.00 for a four-person household. Since $31,200.00 is 128.40% of the 2016 FPL, NYSOH properly found you to be eligible for Medicaid on an expected annual income basis, using the information provided in your application.

Since the January 26, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for Medicaid, it is correct and is AFFIRMED.

The third issue is whether NYSOH properly determined that you were no longer eligible for Medicaid, effective February 28, 2017.

On February 2, 2017, NYSOH recalculated your income based on the documentation you submitted and determined that your household income was now over the income limit for Medicaid.

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.”

The record reflects that there were no events that would have been a basis for your Medicaid coverage to have been terminated, such as a permanent move or incarceration. Since you were determined eligible for Medicaid based on the application submitted on January 25, 2017, effective January 1, 2017, you remain eligible for Medicaid for 12 continuous months, regardless of any increase in household income. As a result, you were improperly disenrolled from Medicaid and your Medicaid Managed Care plan, effective February 28, 2017.

Since NYSOH determined you were eligible for Medicaid as of January 1, 2017, and therefor eligible for continuous coverage, the February 3, 2017 eligibility determination is MODIFIED to provide you Medicaid coverage until the end of your 12-month continuous coverage period.

Your case is RETURNED to NYSOH to reinstate you into Medicaid and your Medicaid Managed Care plan as of March 1, 2017 and to continue your Medicaid barring subsequent changes in your eligibility until December 31, 2017.

Decision

The January 26, 2017 eligibility determination is AFFIRMED.

The February 3, 2017 eligibility determination is MODIFIED to provide you Medicaid coverage until the end of your 12-month continuous coverage period.

Your case is RETURNED to NYSOH to reinstate you into Medicaid and your Medicaid Managed Care plan as of March 1, 2017 and to continue your Medicaid barring subsequent changes in your eligibility until December 31, 2017.

Effective Date of this Decision: November 6, 2017

How this Decision Affects Your Eligibility

Your Medicaid coverage, which began on January 1, 2017, continues until December 31, 2017, barring subsequent changes in your eligibility.

Your case is being sent back to NYSOH to reinstate you into your Medicaid and your Medicaid Managed Care plan as of March 1, 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
  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):

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 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 January 26, 2017 eligibility determination is AFFIRMED.

The February 3, 2017 eligibility determination is MODIFIED to provide you Medicaid coverage until the end of your 12-month continuous coverage period.

Your Medicaid coverage, which began on January 1, 2017, continues until December 31, 2017, barring subsequent changes in your eligibility.

Your case is RETURNED to NYSOH to reinstate you into Medicaid and your Medicaid Managed Care plan as of March 1, 2017 and to continue your Medicaid barring subsequent changes in your eligibility until 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:

[redacted]

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)

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 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.

(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.

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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