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: AP000000021400

[redacted]

[redacted]

On October 20, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 17, 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: November 9, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021400

[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 not eligible for Medicaid as of August 1, 2017?

Procedural History

On June 18, 2017, NYSOH issued a notice that it was time to renew your health insurance for the upcoming coverage year. 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 between June 16, 2017 and July 15, 2017 or you might lose the financial assistance you were currently receiving.

No updates were received by July 15, 2017.

On July 17, 2017, NYSOH issued an eligibility determination notice stating that you were no longer eligible for health insurance through NYSOH, effective August 1, 2017. The notice stated that you were not eligible for Medicaid, Child Health Plus, or the Essential Plan, because you did not respond to the renewal notice in the required timeframe.

Also on July 17, 2017, NYSOH issued a disenrollment notice stating that your coverage in your Medicaid Managed Care plan would end effective July 31, 2017.

On July 22, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive an advance payment of the premium tax credit in an amount of up to $301.00 per month, effective September 1, 2017, based on a household income of $26,115.72.

On July 21, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you were no longer eligible for Medicaid.

On August 17, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive Medicaid for a limited time, effective August 1, 2017. The notice further stated that you had been granted Aid to Continue until a decision is made on your appeal.

Also on August 17, 2017, NYSOH issued a plan enrollment notice confirming that you were enrolled in a Medicaid Managed Care plan, effective August 1, 2017.

On October 6, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was held open to November 4, 2017 to allow you time to submit supporting documentation.

On November 3, 2017, you submitted proof of income and a student loan interest deduction. These documents were made part of the record as "Appellant's Exhibit A." The record closed that day.

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 and were enrolled in a Medicaid Managed Care plan, effective as of March 1, 2017.

2) According to your NYSOH account, you were terminated from your Medicaid coverage, effective July 31, 2017.

3) According to your NYSOH account and your testimony, you updated your NYSOH application for financial assistance on July 21, 2017 and you were found eligible to receive up to $301.00 in an advance payment of the premium tax credit, effective September 1, 2017.

4) The documentation you submitted shows that your expected 2017 modified adjusted gross annual income to increase from the amount you reported on your January 4, 2017 application.

5) You testified that you need your Medicaid coverage and Medicaid Managed Care Plan reinstated because you have a lot of expenses.

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 application, that was the 2017 FPL, which is $16,240.00 for a two-person household (81 Federal Register 4036).

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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were not eligible for Medicaid as of August 1, 2017.

According to your NYSOH account, you were determined Medicaid eligible and enrolled in a Medicaid Managed Care plan, effective March 1, 2017, which is not in dispute.

On June 18, 2017, NYSOH issued a notice that it was time to renew your health insurance for the upcoming coverage year. That notice stated that based on information from federal and state sources, NYSOH could not make a decision about whether your spouse would qualify for financial help paying for your health coverage, and that you needed to update your account between June 16, 2017 and July 15, 2017 or you might lose the financial assistance you were currently receiving.

Since no updates were received by July 15, 2017, on July 17, 2017, NYSOH issued a disenrollment notice stating that your enrollment in your Medicaid Managed Care Plan would terminate, effective July 31, 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 18, 2017, NYSOH issued a notice stating that it was time to renew your eligibility for health coverage for the upcoming year. However, that notice was issued well before the 12-month period of continuous coverage was to expire absent a disqualifying event occurring.

Although you did have an increase in your household income during the 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 so as to end your coverage in Medicaid. Therefore, your eligibility should not have been terminated prior to the end of your 12-months of Medicaid continuous coverage.

Since you were found eligible for and enrolled in Medicaid as of March 1, 2017, your coverage should have continued for 12 months; that is, until February 28, 2018, barring any of the disqualifying events occurring in the future.

Therefore, NYSOH improperly and prematurely re-determined your eligibility on July 16, 2017, such that the July 17, 2017 eligibility determination and disenrollment notices are RESCINDED.

As such, it follows that the July 22, 2017 eligibility determination notice is also RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid Managed Care plan for the months of August 2017 through February 28, 2018 barring subsequent changes in your eligibility occurring in the future, and to notify you accordingly.

Decision

The July 17, 2017 eligibility determination and disenrollment notices are RESCINDED.

The July 22, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid Managed Care plan for the months of August 2017 through February 28, 2018 barring subsequent changes in your eligibility occurring in the future, and to notify you accordingly.

Effective Date of this Decision: November 9, 2017

How this Decision Affects Your Eligibility

Your Medicaid coverage, which began on March 1, 2017, continues until February 28, 2018, barring subsequent changes in your eligibility.

Your case is being sent back to reinstate your Medicaid Managed Care plan for the months of August 2017 through February 28, 2018, barring subsequent changes in your eligibility. NYSOH will notify you once this has been completed.

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

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).

Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The July 17, 2017 eligibility determination and disenrollment notices are RESCINDED.

The July 22, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid Managed Care plan for the months of August 2017 through February 28, 2018 barring subsequent changes in your eligibility occurring in the future, and to notify you accordingly.

Your Medicaid coverage, which began on March 1, 2017, continues until February 28, 2018, barring subsequent changes in your eligibility.

Your case is being sent back to reinstate your Medicaid Managed Care plan for the months of August 2017 through February 28, 2018, barring subsequent changes in your eligibility. NYSOH will notify you once this has been completed.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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).

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 तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई 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.

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