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

Notice of Decision

Decision Date: November 10, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021538

[redacted]

[redacted]

On October 26, 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
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Albany, NY 12211

Decision

Decision Date: November 10, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021538

[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 no longer eligible for Medicaid, effective July 31, 2017?

Procedural History

On March 3, 2017, NYSOH issued a renewal and eligibility determination notice based on information about you from state and federal data sources obtained as of March 2, 2017. The notice stated that you now qualify for health care coverage under Medicaid, effective May 1, 2017.

On March 17, 2017, NYSOH issued an enrollment notice stating confirming your selection of a Medicaid Managed Care (MMC) plan as of March 16, 2017. The notice stated that your MMC plan coverage would also begin as of May 1, 2017.

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 determine 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 update to your NYSOH account was made by July 15, 2017.

On July 17, 2017, NYSOH issued an eligibility determination 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 July 31, 2017.

Also on July 17, 2017, NYSOH issued a disenrollment notice confirming that your MMC plan coverage would end effective July 31, 2017.

On August 13, 2017, NYSOH received an update to your application for health insurance.

On August 14, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for an advance premium tax credit (APTC) of up to $320.00 per month, effective September 1, 2017. The notice also stated that you were not qualified for Medicaid because your household income was over the allowable income limit of for that program.

On August 17, 2017, you contacted NYSOH's Account Review Unit and requested an appeal insofar as your Medicaid coverage had been terminated as of July 31, 2017.

On October 26, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and remained open as the Hearing Officer directed you to provide as additional evidence to corroborate your testimony: all earnings statements issued to you during the month of August 2017. The record was to be closed 15 days after the hearing date, or upon the receipt of the above referenced documents, whichever occurred earlier.

On November 1, 2017, you provided to the NYSOH Appeals Unit all of the above referenced documents through your NYSOH account.

Accordingly, the record was closed on November 1, 2017.

Findings of Fact

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

1) You were found eligible for Medicaid, without condition, effective May 1, 2017.

2) Your MMC plan coverage began effective May 1, 2017.

3) NYSOH issued you a renewal notice on June 18, 2017, requesting that you update the information in your NYSOH account by July 15, 2017, or you might lose your financial assistance you were receiving.

4) You testified that you were surprised at receiving an additional renewal notice so shortly after receiving one on March 3, 2017. You further testified that you were told by a NYSOH representative that your coverage would continue until at least April 30, 2018.

5) You were disenrolled from your MMC plan effective July 31, 2017.

6) The record reflects that you did not update your account prior to July 15, 2017.

7) You testified that you were seeking a reinstatement of your Medicaid coverage as of August 1, 2017 since the plans available to you through NYSOH are unaffordable to you.

8) On November 1, 2017, you provided to the NYSOH Appeals Unit two earnings statements issued to you by your employer, [redacted] reflecting that you received (1) $1,383.20 on August 11, 2017, and (2) $1,849.04 on August 25, 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).

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 no longer eligible for Medicaid effective July 31, 2017.

You were found eligible for Medicaid, and enrolled in an MMC plan, effective May 1, 2017. This eligibility determination is not under review.

The record reflects that on June 18, 2017, you were issued a renewal notice requesting an update to your account no later than July 15, 2017 so that your eligibility could be determined for the upcoming plan year.

You testified, and the record reflects, that at the time of your August 13, 2017 update to your application, your projected income from your employer during 2017 was $24,960.00. However, since there was no update to your account by the July 15, 2017 deadline reflected in the June 18, 2017 renewal notice, you were disenrolled from your Medicaid coverage, effective July 31, 2017.

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 credible evidence confirms that you were eligible for Medicaid effective May 1, 2017, and that even though you did not update your application until August 13, 2017, when your updated application reflected an estimated annual income increased to above the allowable Medicaid limit, you were entitled to remain enrolled in Medicaid for the remainder of your 12-month eligibility period, which ends as of April 30, 2018.

Therefore, the July 17, 2017 eligibility determination notice is RESCINDED.

The July 17, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your MMC plan coverage as of August 1, 2017.

Decision

The July 17, 2017 eligibility determination notice is RESCINDED.

The July 17, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your MMC plan coverage as of August 1, 2017.

Effective Date of this Decision: November 10, 2017

How this Decision Affects Your Eligibility

Your Medicaid coverage is reinstated as of August 1, 2017, and will continue until April 30, 2018, provided no qualifying events occur to terminate your enrollment in that program.

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 eligibility determination notice is RESCINDED.

The July 17, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your MMC plan coverage as of August 1, 2017.

Your Medicaid coverage is reinstated as of August 1, 2017, and will continue until April 30, 2018, provided no qualifying events occur to terminate your enrollment in that program.

Legal Authority

We are sending you this notice in accordance with 45 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).

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 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.

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).