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

Notice of Decision

Decision Date: November 8, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000021619

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On October 23, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 17, 2017 discontinuance 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
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: November 8, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021619

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 and your spouse were no longer eligible for Medicaid, and were disenrolled from your Medicaid Managed Care (MMC) plan, effective July 31, 2017?

Procedural History

On October 21, 2016, NYSOH issued a notice of eligibility determination stating that you and your spouse were eligible for Medicaid, effective January 1, 2017.

On November 18, 2016, NYSOH issued a notice of enrollment confirmation, confirming that you and your spouse were enrolled in an MMC plan, beginning January 1, 2017.

On June 18, 2017, NYSOH issued a notice stating that it was time to renew your application for financial assistance. The notice stated that, based on information available from state and federal data sources, NYSOH could not determine whether you and your spouse would be eligible for financial assistance going forward. The notice directed you to update the information in your NYSOH account by July 15, 2017, or the financial assistance you were receiving could end.

No updates were made to your NYSOH account by July 15, 2017.

On July 17, 2017, NYSOH issued a discontinuance notice stating that you and your spouse were no longer eligible to enroll in coverage through NYSOH, effective August 1, 2017. This was because you failed to respond to the renewal notice, and failed to complete your renewal within the required timeframe.

Also on July 17, 2017, NYSOH issued a disenrollment notice, stating that you and your spouse were being disenrolled from your MMC plan, effective July 31, 2017, because you were no longer eligible to enroll in coverage through NYSOH.

On August 18, 2017, you updated your NYSOH account. That same day NYSOH prepared a preliminary eligibility determination stating that you and your spouse were eligible to receive up to $723.00 per month in advance payments of the premium tax credit, and eligible for cost-sharing reductions if you enrolled in a silver level qualified health plan, effective October 1, 2017.

Also on August 18, 2017, you contacted NYSOH's Account Review Unit and requested an appeal, insofar as you and your spouse had been disenrolled from your Medicaid and MMC plan.

On August 19, 2017, NYSOH issued a notice of eligibility determination, stating that you and your spouse were eligible to receive up to $723.00 per month in advance payments of the premium tax credit, and eligible for cost-sharing reductions if you enrolled in a silver level qualified health plan, effective October 1, 2017. The notice also stated that you and your spouse were not eligible for Medicaid or the Essential Plan because your household income was over the allowable income limit for those programs.

On October 23, 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) You and your spouse were found eligible for Medicaid in an eligibility determination dated October 12, 2016, effective January 1, 2017. That eligibility determination is not under appeal.

2) On June 18, 2017, NYSOH issued a renewal notice stating that it was time to renew your application for health insurance.

3) You testified that you did not receive any notice from NYSOH informing you that you needed to update your application in order to renew your coverage.

4) You testified that you did not realize that you and your spouse had been disenrolled from your coverage until you went to a doctor's appointment in August 2017.

5) You testified that you called NYSOH to find out why you did not have coverage, and you were told that you did not renew your application.

6) You testified that you updated your application and were told by the NYSOH agent that you and your spouse were no longer eligible for your MMC plan.

7) Your NYSOH account reflects that you updated your application for health insurance on August 18, 2017.

8) You testified that you were told that you and your spouse were now eligible for a different kind of coverage where you would have to pay for your insurance.

9) You testified that you and your spouse cannot afford to pay premiums and deductibles.

10) You testified that you do not work and your spouse will probably earn less this year than he did last year because he [redacted]

11) You testified that you would like you and your spouse to continue to be eligible for Medicaid.

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)).

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)).

Medicaid Renewal

In general, NYSOH must review Medicaid eligibility once every twelve months or “whenever it receives information about a change in a beneficiary’s circumstances that may affect eligibility” (42 CFR § 435.916(a)(1), (d)). NYSOH must make its “redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency” (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates provided by the individual (45 CFR §155.335(h)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you and your spouse were no longer eligible for Medicaid and were disenrolled from your MMC plan, effective July 31, 2017.

You and your spouse were found eligible for Medicaid in an eligibility determination dated October 12, 2016, and that eligibility went into effect on January 1, 2017. This eligibility determination is not under appeal.

Under New York State law, once a person is eligible for Medicaid, that eligibility continues for 12 months, even if they lose Medicaid eligibility because of any changes or updates they make to their NYSOH account. This provision is called “continuous coverage.”

NYSOH must redetermine a qualified individual's eligibility for Medicaid once every 12 months without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency. NYSOH's June 18, 2017 renewal notice stated that there was not enough information to determine whether you were eligible to continue your financial assistance for health insurance, and that you needed to supply additional information by July 15, 2017, or your financial assistance might end.

However, since you and your spouse became eligible for Medicaid effective January 1, 2017, there was no reason to require you to renew your application by July 15, 2017. You and your spouse should have received 12 months of continuous coverage in your Medicaid and MMC plan, and should not have been required to update your account until the period between November 16, 2017 and December 15, 2017.

For this reason:

The June 18, 2017 renewal notice is RESCINDED.

The July 17, 2017 discontinuance notice is RESCINDED.

The July 17, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you and your spouse in your Medicaid and MMC plan coverage for the period of August 1, 2017 through December 31, 2017.

NYSOH is also directed to issue an updated renewal notice to reflect that you must renew your application for financial assistance for 2018 between November 16, 2017 and December 15, 2017.

Decision

The June 18, 2017 renewal notice is RESCINDED.

The July 17, 2017 discontinuance notice is RESCINDED.

The July 17, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you and your spouse in your Medicaid and MMC plan coverage for the period of August 1, 2017 through December 31, 2017.

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).

Your case is RETURNED to NYSOH to issue an updated renewal notice to reflect that you must renew your application for financial assistance for 2018 between November 16, 2017 and December 15, 2017.

Effective Date of this Decision: November 8, 2017

How this Decision Affects Your Eligibility

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

NYSOH should not have sent you a renewal notice in June 2017.

Your case is being sent back to NYSOH to reinstate you and your spouse in your Medicaid and MMC plan for the period of August 1, 2017 through December 31, 2017.

NYSOH will send you a renewal notice to remind you to update your application for the 2018 coverage year. You will need to renew your application between November 16 and December 15, 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):

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 18, 2017 renewal notice is RESCINDED.

The July 17, 2017 discontinuance notice is RESCINDED.

The July 17, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you and your spouse in your Medicaid and MMC plan coverage for the period of August 1, 2017 through December 31, 2017.

Your case is RETURNED to NYSOH to issue an updated renewal notice to reflect that you must renew your application for financial assistance for 2018 between November 16, 2017 and December 15, 2017.

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

NYSOH should not have sent you a renewal notice in June 2017.

Your case is being sent back to NYSOH to reinstate you and your spouse in your Medicaid and MMC plan for the period of August 1, 2017 through December 31, 2017.

NYSOH will send you a renewal notice to remind you to update your application for the 2018 coverage year. You will need to renew your application between November 16 and December 15, 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:

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)

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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।

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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