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

Notice of Decision

Decision Date: December 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022293

[redacted]

On November 22, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 30, 2017 eligibility determination 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: December 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022293

[redacted]

Issue

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

> Did NY State of Health (NYSOH) properly end your Medicaid eligibility and coverage in your Medicaid Managed Care plan, effective September 30, 2017?

Procedural History

On April 25, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid because your household income of $6,500.00 was at or below the allowable income limit. This eligibility was effective as of June 1, 2017.

On April 26, 2017, NYSOH issued a plan enrollment notice stating that you were enrolled in Medicaid Managed Care plan, effective June 1, 2017.

On August 29, 2017, NYSOH received your updated application for health insurance; specifically, the income information was updated.

On August 30, 2017, NYSOH issued an eligibility determination notice stating you were eligible to receive up to $296.00 in advance premium tax credit (APTC), and you were 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 were no longer eligible for Medicaid as of September 30, 2017, because your household income was over the allowable income limit for that program.

Also on August 30, 2017, NYSOH issued a disenrollment notice stating that your coverage in your Medicaid Managed Care plan would end effective September 30, 2017. This was because you were no longer eligible to enroll in a Medicaid Managed Care plan.

On September 11, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of the August 30, 2017 eligibility determination and disenrollment notices insofar as your eligibility for Medicaid and disenrolled you from your Medicaid Managed Care plan ended.

On September 14, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective October 1, 2017. This notice stating that you had been granted Aid to Continue until a decision could be made on your appeal.

Also on September 14, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective October 1, 2017.

On November 22, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open until December 7, 2017, to allow you to submit supporting documentation.

As of the close of business on December 7, 2017, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day and this decision is based on the record as developed at the time of the hearing.

Findings of Fact

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

1) According to your NYSOH account and your testimony, you expect to file your 2017 federal income tax return as single, and will claim no dependents.

2) You are seeking health insurance for yourself.

3) According to the April 24, 2017 application, you attested to an expected annual household income of $6,500.00 consisting of $15,000.00 in [redacted] employment you expected to earn less deductions of $3,000.00 for IRA contribution, $5,000.00 in business expenses and $500.00 in [redacted].

4) You testified that, at the time you submitted your April 24, 2017 application, $6,500.00 was an accurate reflection of your expected income for 2017 tax year.

5) You testified that you received a [redacted] employment payment of $20,000.00 in August 2017.

6) According to your NYOSH account and your testimony, on August 29, 2017 you updated your account with this new income information.

7) According to the August 29, 2017 updated application, you attested to an expected household income of $26,500.00.

8) According to your NYSOH account and your testimony, you live in [redacted]

9) You testified that you would like to continue to be eligible for Medicaid for twelve continuous months from June 1, 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)).

Medicaid Continuous Coverage:

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 ended your Medicaid eligibility and coverage in your Medicaid Managed Care plan, effective September 30, 2017.

You are in a one-person household for purposes of this analysis This is because, according to the record, you expect to file your 2017 tax return as single and claim no dependents.

On your April 24, 2017 application, you attested to an expected household income of $6,500.00 consisting of $15,000.00 in [redacted] employment you expected to earn less deductions of $3,000.00 for IRA contribution, $5,000.00 in business expenses and $500.00 in student loan interest.

NYSOH relied upon this information and, on April 25, 2017, issued an eligibility determination notice stating that you qualified for Medicaid, effective June 1, 2017. Also, on April 25, 2017, NYSOH issued a plan enrollment notice stating that you were enrolled in your Medicaid Managed Care plan effective June 1, 2017.

You testified and the record reflects that you updated your application on August 29, 2017 and increased your expected annual household income by $20,000.00, based on [redacted] employment payment your received. Based on this updated income, on August 30, 2017, NYSOH issued an eligibility determination stating that you were eligible for APTC of $296.00 per month and cost-sharing reductions if you enrolled in a silver-level qualified health plan, effective October 1, 2017. The notice stated you no longer qualified for Medicaid because your income of $26,500.00 was over the allowable income limit for that program. Also on August 30, 2017, NYSOH issued a disenrollment notice stating your Medicaid Managed Care plan ended of September 30, 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.” When your Medicaid coverage terminated on September 30, 2017, the 12-month period of Medicaid eligibility that was effective on June 1, 2017, had not expired.

Credible evidence confirms that you were eligible for Medicaid effective June 1, 2017, and that even though your estimated annual income increased when you modified your application on August 29, 2017, you should have remained in Medicaid for the remainder of the 12-month eligibility period; that is, until May 31, 2018. As such, NYSOH erred in terminating you from your Medicaid Managed Care plan as of September 30, 2017.

Therefore, NYSOH's August 30, 2017 eligibility determination notice that states you were eligible to receive up to $296.00 per month in APTC and eligible for cost-sharing reductions, effective October 1, 2017, is RESCINDED. Similarly the August 30, 2017 disenrollment notice stating that your Medicaid Managed Care plan would end on September 30, 2017, is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid eligibility and Medicaid Managed Care plan enrollment from October 1, 2017 through the end of your 12-month eligibility period, unless a disqualifying event occurs.

Decision

The August 30, 2017 eligibility determination notice that states you were eligible to receive up to $296.00 per month in APTC and eligible for cost-sharing reductions, effective October 1, 2017, is RESCINDED.

The August 30, 2017 disenrollment notice stating that your Medicaid Managed Care plan would end on September 30, 2017, is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid eligibility and Medicaid Managed Care plan enrollment from October 1, 2017 through the end of your 12-month eligibility period, unless a disqualifying event occurs.

Effective Date of this Decision: December 13, 2017

How this Decision Affects Your Eligibility

NYSOH erred in terminating your coverage in your Medicaid Managed Care plan as of September 30, 2017, before the 12 months of continuous coverage had ended; and in redetermining you eligible for APTC and cost-sharing reductions as of October 1, 2017.

Your Medicaid Managed Care coverage started June 1, 2017 and should have continued until May 31, 2018, barring subsequent changes in your eligibility.

Your case is RETURNED to NYSOH to reinstate your Medicaid eligibility and Medicaid Managed Care plan enrollment from October 1, 2017 through the end of your 12-month eligibility period, unless a disqualifying event occurs.

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:

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).

- 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 August 30, 2017 eligibility determination notice that states you were eligible to receive up to $296.00 per month in APTC and eligible for cost-sharing reductions, effective October 1, 2017, is RESCINDED.

The August 30, 2017 disenrollment notice stating that your Medicaid Managed Care plan would end on September 30, 2017, is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid eligibility and Medicaid Managed Care plan enrollment from October 1, 2017 through the end of your 12-month eligibility period, unless a disqualifying event occurs.

NYSOH erred in terminating your coverage in your Medicaid Managed Care plan as of September 30, 2017, before the 12 months of continuous coverage had ended; and in redetermining you eligible for APTC and cost-sharing reductions as of October 1, 2017.

Your Medicaid Managed Care coverage started June 1, 2017 and should have continued until May 31, 2018, barring subsequent changes in your eligibility.

Your case is RETURNED to NYSOH to reinstate your Medicaid eligibility and Medicaid Managed Care plan enrollment from October 1, 2017 through the end of your 12-month eligibility period, unless a disqualifying event occurs.

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]

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.

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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