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

Notice of Decision

Decision Date: January 17, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022629

[redacted]

[redacted]

On November 29, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 17, 2017 discontinuance and disenrollment notices, and August 23, 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 NY State of Health 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: January 17, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022629

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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 (NYSOH) July 17, 2017 discontinuance and disenrollment notices timely?
>
> Did NYSOH properly determine that you were eligible for the Essential Plan and not Medicaid, effective October 1, 2017?

Procedural History

On April 6, 2017, NYSOH issued a notice that it was time to renew your health insurance for the upcoming year. The notice stating that you were qualified for Medicaid and that you were re-enrolled in your current Medicaid Managed Care plan, and that no action was required. This coverage was effective June 1, 2017.

On April 17, 2017, NYSOH issued an enrollment confirmation notice, stating that you were enrolled in a Medicaid Managed Care plan, effective June 1, 2016.

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 by July 15, 2017 or you might lose the financial assistance you were currently receiving.

No updates were received by July 15, 2017 and NYSOH redetermined your eligibility for financial assistance with health insurance.

On July 17, 2017, NYSOH issued a discontinuance 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 financial assistance because you did not respond to the renewal notice.

Also on July 17, 2017, NYSOH issued a disenrollment notice stating that your enrollment in your Medicaid Managed Care plan was terminated, effective July 31, 2017.

On August 18, 2017, you submitted an application for financial assistance.

On August 19, 2017, NYSOH issued a notice stating that the information in your application did not match what NYSOH received from state and federal data sources. You were directed to provide proof of income documentation by September 2, 2017.

On August 18, 2017, you submitted income documentation.

On August 21, 2017, an application for financial assistance was run on your behalf.

On August 22, 2017, NYSOH issued an eligibility determination notice, stating that you were eligible for the Essential Plan for a limited time, effective October 1, 2017. You were directed to provide income documentation by November 19, 2017.

On August 22, 2017, an application was run on your behalf.

On August 23, 2017, NYSOH issued an eligibility determination notice, stating that you were eligible for the Essential Plan for a limited time, effective October 1, 2017. You were directed to confirm the immigration status as listed in your application.

Also on August 23, 2017, NYSOH issued an enrollment confirmation notice, stating that you were enrolled in the Essential Plan, effective October 1, 2017.

On September 20, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination, insofar as you did not have coverage in August 2017.

On November 29, 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 were determined eligible for Medicaid effective June 1, 2017.

2) You testified that you expect to file your 2017 taxes with a tax filing status of single. You will claim no dependents on that tax return.

3) You are seeking insurance for yourself for August 2017.

4) You testified that you were not aware that you had been disenrolled from your Medicaid Managed Care plan until August 2017, when you were advised by your doctor's office.

5) The application that was submitted on August 22, 2017 listed annual household income of $19,762.86, consisting of income you earn from your employment.

6) Your application states that you will not be taking any deductions on your 2017 tax return.

7) Your application states that you live in Essex County.

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

Most individuals 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)).

Under 42 CFR § 435.403 Medicaid must be provided to “eligible residents of the State” (42 CFR § 435.403(a)). A person shall not be eligible for Medicaid unless he or she is a resident of the state, or, while temporarily in the state, requires immediate medical care which is not otherwise available (N.Y. Soc. Serv. Law § 366(1)(d)(1)).

Legal Analysis

The first issue under review is whether your appeal of NYSOH’s July 17, 2017 discontinuance and disenrollment notices was timely.

The record reflects that you filed an appeal with NYSOH regarding your eligibility and coverage on September 20, 2017.

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

For an appeal to have been valid on the issue of disenrollment as stated in the July 17, 2017 notice, an appeal should have been filed by September 15, 2017.

Although your appeal was untimely on its face with regard to the July 17, 2017 notice, the record reflects that you were unaware of the disenrollment until you were at doctor's office in August 2017.

As you contacted NYSOH within sixty days of your knowledge of the disenrollment, your failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal.

The second issue under review is whether NYSOH properly determined that you were eligible for the Essential Plan and not Medicaid, effective October 1, 2017.

You were found fully eligible for Medicaid effective June 1, 2017, per the April 6, 2017 renewal notice. This notice is not under appeal.

According to your NYSOH account, 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 by July 15, 2017 or you might lose the financial assistance you were currently receiving. There was no update to your account by July 15, 2017.

As such, on July 17, 2017, NYSOH issued a discontinuance notice and a plan disenrollment notice, stating that you were no longer eligible to enroll in Medicaid and your Medicaid Managed Care plan would end, effective July 31, 2017.

However, there is no indication in the record as to why NYSOH issued a second renewal notice in 2017 based on federal and state data sources, requesting that you update your account.

Based on the credible evidence of the record, it is reasonable to conclude that the June 18, 2017 renewal notice was issued in error, and was the result of an error of NYSOH for failing to accurately update your account. As a result, your disenrollment from your Medicaid Managed Care plan for failure to respond to the June 18, 2017 renewal notice was also in error.

Therefore, the July 17, 2017 discontinuance and disenrollment notices are RESCINDED.

On August 22, 2017, an updated application for health insurance was submitted on your behalf. That application stated that your annual household income was $19,762.86. As a result of this application, you were found eligible for the Essential Plan, effective October 1, 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.”

Credible evidence confirms that you were eligible for Medicaid effective June 1, 2017, and that even though your estimated annual income increased in your subsequent August 22, 2017 application, you remain eligible for and enrolled in Medicaid for the remainder of your 12-month eligibility period, until May 31, 2018. Since you were erroneously disenrolled from your initial Medicaid coverage, the record supports no triggering event occurred which would have made you no longer eligible for Medicaid continuous coverage.

Therefore, the August 23, 2017 eligibility determination notice is RESCINDED.

Accordingly, your case is RETURNED to NYSOH to reinstate you into Medicaid and your Medicaid Managed Care plan, effective August 1, 2017 and to continue your Medicaid barring subsequent changes in eligibility until May 31, 2018.

Decision

The July 17, 2017 discontinuance and disenrollment notices are RESCINDED.

The August 23, 2017 eligibility determination notice is RESCINDED

Your case is RETURNED to NYSOH to reinstate you into Medicaid and your Medicaid Managed Care plan, effective August 1, 2017 and to continue your Medicaid barring subsequent changes eligibility until May 31, 2018.

Effective Date of this Decision: January 17, 2018

How this Decision Affects Your Eligibility

You should have remained eligible for Medicaid and a Medicaid Managed Care plan until May 31, 2018.

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

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

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 fax: 1-855-900-5557

Summary

The July 17, 2017 discontinuance and disenrollment notices are RESCINDED.

The August 23, 2017 eligibility determination notice is RESCINDED

Your case is RETURNED to NYSOH to reinstate you into Medicaid and your Medicaid Managed Care plan, effective August 1, 2017 and to continue your Medicaid barring subsequent changes eligibility until May 31, 2018.

You should have remained eligible for Medicaid and a Medicaid Managed Care plan until May 31, 2018.

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

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).

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.

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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