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

Notice of Decision

Decision Date: December 4, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022819

[redacted]

[redacted]

On November 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 17, 2017 eligibility redetermination 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.

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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).

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

Decision

Decision Date: December 4, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022819

[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 your eligibility for and enrollment in your Medicaid Managed Care plan ended August 1, 2017?

Procedural History

On May 5, 2016, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective June 1, 2016. You enrolled in a Medicaid Managed Care plan for a start date of July 1, 2016.

On April 6, 2017, NYSOH issued a renewal notice that it was time to renew your health insurance for 2017. That notice stated that you were redetermined eligible for Medicaid effective June 1, 2017, and were reenrolled into the same Medicaid Managed Care plan you previously were enrolled in for another year.

On June 18, 2017, NYSOH issued a renewal notice stating it was time to renew your health insurance for 2017. The notice stated a determination could not be made about your eligibility based on federal and state data sources. The notice requested you update the information in your account by July 15, 2017. If you missed this deadline, the financial assistance you were currently receiving could end.

No updates were received by NYSOH prior to the July 15, 2017 deadline.

On July 16, 2017, NYSOH redetermined your eligibility for financial assistance with your health insurance.

On July 17, 2017, NYSOH issued an eligibility redetermination 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 August 1, 2017.

On July 17, 2017, a disenrollment notice was issued stating your coverage with your Medicaid Managed Care plan would end, July 31, 2017. The notice stated this was because you were no longer eligible to enroll in health insurance through NYSOH.

On September 7, 2017, NYSOH received your updated application for financial assistance.

On September 8, 2017, a notice was issued based on your application stating the income information in your application does not match what NYSOH received from state and federal data sources, more information was required. The notice requested you provide proof of your income by September 22, 2017.

You provided income documentation in the form of copies of your paystubs on September 8, 13, 18, and 22, 2017.

On September 25, 2017, your income information was verified and a new application was submitted on your behalf. That day a preliminary eligibility determination was prepared stating you were eligible to enroll in the Essential Plan for $0.00 per month, effective November 1, 2017. You enrolled in a plan that day for a November 1, 2017 start date.

On September 26, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your new enrollment in the Essential Plan, requesting a backdate of your plan to October 1, 2017.

On October 1, 2017, an eligibility determination notice was issued based on the September 25, 2017 application stating you were eligible to enroll in the Essential Plan for $0.00 per month, effective November 1, 2017.

On November 28, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During your hearing you testified you are seeking a backdate of your coverage to August 1, 2017 when you were disenrolled from your Medicaid Managed Care plan. The record was developed during the hearing and closed at the end of the proceeding.

Findings of Fact

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

1) You are seeking insurance for yourself.

2) You testified you are seeking to be found eligible for a backdate of your Essential Plan to August 1, 2017.

3) On April 6, 2017, NYSOH issued a renewal notice that stated you were eligible for Medicaid effective June 1, 2017.

4) On June 18, 2017, NYSOH issued a second renewal notice requesting that you update your account by July 15, 2017.

5) You testified that you never received a renewal notice dated June 18, 2017, and that you believed you were already renewed for coverage for 2017.

6) No updates were made to your NYSOH account by the deadline of July 15, 2017.

7) The application submitted on September 25, 2017 shows you attested to a household income of for a single tax filer for 2017 of $16,718.00. You testified this was correct.

8) The testified you have not moved in 2017.

9) You testified you have not had any third-party health insurance in 2017.

10) You reside in [redacted]

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 $12,060.00 for a one-person household (82 Fed. Reg. 8831).

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 your eligibility for and enrollment in your Medicaid Managed Care plan ended, August 1, 2017.

You were previously found eligible for Medicaid effective June 1, 2016.

On April 6, 2017, NYSOH issued a renewal notice stating you had been determined eligible for Medicaid for another year and that there was nothing further you had to do with your application. The notice further explained you would be enrolled in the same Medicaid Managed Care plan, effective June 1, 2017.

The notice issued on April 6, 2017, was based on a one-person household with an annual household income of between $0 and $16,643.00.

NYSOH issued a second renewal notice on June 18, 2017, requesting that you update your account by July 15, 2017, as NYSOH could not make a determination on your eligibility for 2017. No updates were made by the notice's stated deadline of July 15, 2017. You were subsequently determined no longer eligible for Medicaid and disenrolled as of August 1, 2017.

However, 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 September 25, 2017 application, you remain eligible for and enrolled in Medicaid for the remainder of your 12-month eligibility period. The record supports no triggering event occurred which would have made you no longer eligible for Medicaid continuous coverage.

Therefore, the July 17, 2017 redetermination notice finding you no longer eligible for Medicaid because you had not responded to the renewal notice and had not completed your renewal within the required time frame and the July 17, 2017 disenrollment notice terminating your coverage in your Medicaid Managed Care plan, effective July 31, 2017 are RESCINDED.

Your case is RETURNED to NYSOH to ensure your eligibility for Medicaid and your enrollment in your Medicaid Managed Care plan which began June 1, 2017, continues until May 31, 2018, barring subsequent changes in your eligibility.

Decision

The July 17, 2017 redetermination notice is RESCINDED.

The July 17, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to ensure your eligibility for Medicaid and your enrollment in your Medicaid Managed Care plan which began June 1, 2017, continues until May 31, 2018, barring subsequent changes in your eligibility.

Effective Date of this Decision: December 4, 2017

How this Decision Affects Your Eligibility

Your Medicaid coverage and enrollment in your Medicaid Managed Care plan, which began on June 1, 2017, continues until May 31, 2017, barring subsequent changes in your eligibility.

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):

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).

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 redetermination notice is RESCINDED.

The July 17, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to ensure your eligibility for Medicaid and your enrollment in your Medicaid Managed Care plan which began June 1, 2017, continues until July 31, 2018, barring subsequent changes in your eligibility.

Legal Authority

We are issuing this determination 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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