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

Notice of Decision

Decision Date: December 18, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023239

[redacted]

Dear [redacted]

On December 4, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 8, 2017 and October 11, 2017 eligibility determinations.

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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DEPARTMENT OF HEALTH
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Decision

Decision Date: December 18, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023239

[redacted]

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) June 8, 2017 eligibility determination timely?
>
> Did NYSOH properly determine that you were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until August 31, 2018?

Procedural History

On June 8, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid because your household income of $15,000.00 was at or below the allowable income limit. This eligibility was effective as of June 1, 2017.

On June 14, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in a Healthfirst Medicaid Managed Care plan, beginning July 1, 2017.

On October 10, 2017, NYSOH received your updated application for health insurance; specifically, the income information was updated. That same day, NYSOH prepared a preliminary eligibility determination stating that you were no longer eligible for Medicaid, but that your Medicaid coverage would continue until August 31, 2018 because certain individuals determined eligible for Medicaid

remain eligible for benefits for twelve continuous months from the date they were determined eligible.

Also on October 10, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of the June 18, 2017 eligibility determination, as well as the October 10, 2017 preliminary eligibility determination, insofar as you did not want to be eligible for Medicaid.

On October 11, 2017, NYSOH issued a notice of eligibility determination stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until August 31, 2018 because certain individuals determined eligible for Medicaid remain eligible for benefits for twelve continuous months from the date that they were determined eligible. This eligibility was effective as of October 1, 2017.

On December 4, 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 expect to file your 2017 federal income tax return as single, and claim no dependents.

2) You testified that you called NYSOH on June 7, 2017 because Healthfirst told you that your mailing address was incorrect and that you needed to speak to NYSOH and change your address. You testified that, when you called NYSOH, the representative you spoke with updated your application.

3) Your NYSOH account does not reflect any changes in your address since you first created your account in February 2016.

4) According to the June 7, 2017 application, you attested to an expected annual household income of $15,000.00. You testified that this was never your income, and you did not know how it was entered into the system.

5) You then testified that you think you told the NYSOH agent you spoke with on June 7, 2017 that your income was between $15,000.00 and $20,000.00.

6) On June 8, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective June 1, 2017, based on the income information entered into your June 7, 2017 application.

7) No appeal of this eligibility determination was filed until October 10, 2017.

8) You testified that you never received the June 8, 2017 eligibility determination notice.

9) Your NYSOH account reflects that you receive notices from NYSOH by regular mail.

10) No notices sent to you at the mailing address in your account have been returned to NYSOH as undeliverable.

11) On June 27, 2017, NYSOH issued a notice stating that you were being placed back into your Essential Plan, effective July 1, 2017, because you had requested Aid to Continue, pending the outcome of an appeal that you filed in March 2017.

12) According to your NYSOH account, you did not attend the hearing for that appeal, which was scheduled for you on August 23, 2017, and your appeal in that matter was dismissed.

13) On October 1, 2017, you were placed back into Medicaid, effective September 1, 2017.

14) You testified that you found out that you were eligible for Medicaid when you called your health plan to make a payment for your October 2017 Essential Plan premium, and the person you spoke with at the plan said that you did not have coverage.

15) You testified that you called NYSOH and updated your application.

16) Your NYSOH account reflects that, on October 10, 2017, you updated your NYSOH account and changed your expected annual income to $20,000.00.

17) You testified that you want to be eligible for the Essential Plan because your doctors do not accept Medicaid.

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) a failure by the Exchange to provide timely notice of an eligibility determination; and (4) 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)).

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 Federal Register 8831).

Generally, most adults determined eligible for Medicaid are guaranteed twelve 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 twelve-month period. This twelve-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 first issue under review is whether your appeal of NYSOH's June 8, 2017 eligibility determination notice was timely.

You updated your NYSOH account on June 7, 2017 over the phone with a NYSOH representative. The income entered into your application on that day was $15,000.00, and, based on this, NYSOH determined that you were eligible for Medicaid. An eligibility determination notice was issued on June 8, 2017, stating that you were eligible for Medicaid, effective June 1, 2017.

An individual has the right to request an appeal of a NYSOH eligibility determination with which they do not agree, and must file that appeal within 60 days of the eligibility determination.

In order for an appeal of the June 8, 2017 eligibility determination to have been timely, it would have to have been filed by August 7, 2017. According to the credible evidence in the record, you did not contact NYSOH until October 10, 2017 to file a formal appeal, which is 124 days from the June 8, 2017 eligibility determination notice.

You testified during the hearing that you did not receive the June 8, 2017 eligibility determination notice, and that you did not realize that you had been found eligible for Medicaid until September 2017, when you tried to make a payment for your Essential Plan coverage and were told that you did not have any coverage. However, your NYSOH account indicates that you are enrolled to receive notices from NYSOH by regular mail. As none of the notices issued to you by NYSOH has been returned as undeliverable, it is concluded that you were properly sent and received the June 8, 2017 notice, and were therefore on notice of your Medicaid eligibility.

Therefore, there has been no timely appeal of the June 8, 2017 eligibility determination notice, and your appeal on the issue of your eligibility for Medicaid, as stated in that notice, is DISMISSED.

The second issue under review is whether NYSOH properly determined that you were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until August 31, 2018.

As discussed above, your appeal of the June 8, 2017 eligibility determination was untimely and, therefore, your underlying eligibility for Medicaid is not reviewed in this decision.

On October 10, 2017, you updated your NYSOH account and changed your income from $15,000.00 annually to $20,000.00 annually. This update increased your income above the annual household income limit for Medicaid.

However, under New York State law, once a person is eligible for Medicaid, that eligibility continues for twelve months, even if the household income rises above 138% of the FPL. This provision is called “continuous coverage.”

You were found eligible for Medicaid as of June 1, 2017, and that eligibility is not under review. Even though your estimated annual income increased when you modified your application on October 10, 2017, you remain enrolled in Medicaid for the remainder of your twelve-month eligibility period. However, since that eligibility period began on June 1, 2017, it should end on May 31, 2018. Therefore, the October 11, 2017 eligibility determination is MODIFIED to state that you will remain in your Medicaid coverage through May 31, 2018, barring an appropriate intervening event.

Decision

Your appeal of the June 8, 2017 eligibility determination is untimely and is therefore DISMISSED.

The October 11, 2017 eligibility determination notice is MODIFIED to state that you are no longer eligible for Medicaid, but that you will remain enrolled in your Medicaid coverage until May 31, 2018, barring an appropriate intervening event.

Effective Date of this Decision: December 18, 2017

How this Decision Affects Your Eligibility

Your Medicaid coverage, which began on June 1, 2017, continues until May 31, 2018, barring subsequent changes in your eligibility.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the 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 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).

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

Your appeal of the June 8, 2017 eligibility determination is untimely and is therefore DISMISSED.

The October 11, 2017 eligibility determination notice is MODIFIED to state that you are no longer eligible for Medicaid, but that you will remain enrolled in your Medicaid coverage until May 31, 2018, barring an appropriate intervening event..

Your Medicaid coverage, which began on June 1, 2017, continues until May 31, 2018, barring subsequent changes in your eligibility.

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)

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 नि:शुल्क 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).