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

Notice of Decision

Decision Date: February 27, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024326

[redacted]
[redacted]
[redacted]

[redacted],

On January 25, 2018, you appeared by telephone at a hearing on your appeal of your NY State of Health's October 17, 2017 eligibility determination 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
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Decision

Decision Date: February 27, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024326

[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 you, your spouse, and your children (family) were terminated from your Medicaid Managed Care Plan(s) as of October 31, 2017?

Procedural History

According to your NYSOH account, for the most recent Medicaid period, your family had coverage as follows: (1) Your two children were enrolled in a Medicaid Managed Care plan as of December 1, 2016; and, (2) You and your spouse had Medicaid Fee-For-Service as of December 1, 2016, and were enrolled in a Medicaid Managed Care plan as of January 1, 2017.

On September 3, 2017, NYSOH issued a notice that it was time to renew your family's health insurance for the upcoming policy year. That notice stated that, based on information from federal and state sources, NYSOH could not make a decision about whether your family would qualify for financial help paying for health coverage, and that you needed to update your account between September 16, 2017 and October 15, 2017, or your family might lose the financial assistance you were currently receiving.

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

On October 17, 2017, NYSOH issued an eligibility determination notice stating that your family was no longer eligible for health insurance through NYSOH,

effective November 1, 2017. This was because you failed to respond to the renewal notice within the required timeframe.

Also on October 17, 2017, a disenrollment notice was issued stating that your family would be terminated from your Medicaid Managed Care plan(s) as of October 31, 2017.

On November 14, 2017, you spoke to NYSOH's Account Review Unit and appealed your family's disenrollment from your Medicaid Managed Care plan(s), as of October 31, 2017.

On January 25, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. You request to amend your complaint to include an eligibility redetermination for retroactive Medicaid for your children for the month of November 2017 was granted and testimony was received.

The record was held open to February 9, 2018 to allow you time to submit supporting documents. On January 25, 2018, January 26, 2018 and February 5, 2018, you submitted four consecutive bi-weekly paystubs; a 2017 W-2 from your first employer, dated October 20, 2017 through December 1, 2017; one current weekly paystub from your second employer; and your profit and loss statements for the months of October 2017 and November 2017 [redacted]. No further documentation was received by NYSOH as of February 9, 2017 and the record closed that day.

Findings of Fact

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

1) According to the September 3, 2017 renewal notice, your family's eligibility for financial assistance was due to renew for the upcoming coverage year as of November 1, 2017.

2) According to your NYSOH account, your family was terminated from their Medicaid Managed Care plans, effective October 31, 2017, because you did not update the information in your account by the renewal deadline.

3) According to your NYSOH account and your testimony, you receive all your notices from NYSOH by regular mail.

4) You testified that you do not recall receiving any notices from NYSOH telling you that you needed to update the information in your NYSOH account to ensure that your family's coverage would not be interrupted.

5) No notices sent to you at the address listed on your NYSOH account have been returned as undeliverable.

6) According to your NYSOH account, on October 27, 2017, NYSOH received your family's updated application for health insurance.

7) At that time and according to your NYSOH account, your children were [redacted] and [redacted].

8) You testified that your family was not enrolled in health insurance through NYSOH as of December 1, 2017, because you no longer reside in New York State as of that date.

9) You testified that you are seeking to have your family reinstated in health insurance as of November 1, 2017 through November 30, 2017, because you out of pocket medical expenses for that month.

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 family's application, that was the 2017 FPL, which is $24,600.00 for a four-person household (82 Fed. Reg. 8831).

Generally, most adults and children 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 for Children

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the federal poverty level (FPL) for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

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 family’s application, that was the 2017 FPL, which is $24,600.00 for a four-person household (82 Fed. Reg. 8831).

A child under the age of nineteen who is determined eligible for medical assistance under Medicaid, remains eligible for such assistance until the last day of the twelfth month following the eligibility determination for such assistance (N.Y. Soc. Serv. Law § 366(4)(b)(3)(i)). This twelve-month period is f=referred to as “continuous coverage.”

Legal Analysis

The issue under review is whether NYSOH properly determined that your family was terminated from your Medicaid Managed Care Plan(s) as of October 31, 2017.

According to your NYSOH account, for the most recent Medicaid coverage period, your two children were enrolled in a Medicaid Managed Care plan as of December 1, 2016, and you and your spouse had Medicaid Fee-For-Service as of December 1, 2016, and were enrolled in a Medicaid Managed Care plan as of January 1, 2017. These facts are not in dispute.

On September 3, 2017, NYSOH issued a notice that it was time to renew your family's 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 your family would qualify for financial help paying for health coverage, and that you needed to update your account between September 16, 2017 and October 15, 2017 or your family might lose the financial assistance your family was currently receiving.

Since no updates were received by October 15, 2017, on October 17, 2017, NYSOH issued a disenrollment notice stating that your family's enrollment in their Medicaid Managed Care plans would terminate as of October 31, 2017.

You testified that you did not receive any notice from NYSOH telling you that you needed to update the information in your family's NYSOH account. You testified, and your NYSOH account confirms, that you elected to receive notifications by regular mail. However, there is no evidence in the record that any of the notices that were sent to your mailing address were returned as undeliverable.

Therefore, it is concluded that NYSOH properly notified you of your annual renewal and that information in your NYSOH account needed to be updated to ensure your family's enrollment in your health plan and eligibility for financial assistance would continue.

However, New York State has elected to re-determine Medicaid enrollees only once every 12 months from the effective date of eligibility if enrollees are under age 65, are not enrolled in minimum essential coverage, and remain state residents. An individual enrolled in Medicaid shall have coverage continued until the end of the 12-month period, provided he or she does not lose eligibility by reason of citizenship status, lack of state residence, failure to provide a valid social security number, providing inaccurate information that would affect eligibility when requesting or renewing health coverage, or having third party health insurance. In fact, most adults and children determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage even if their income increases above the Medicaid limit allowed for their household size.

In the present case, on September 3, 2017, NYSOH issued a notice stating that it was time to renew your family's eligibility for health coverage for the upcoming year, suggesting that 12 months of eligibility and coverage was to expire as of October 31, 2017, and eligibility was to end November 1, 2017.

However, since your two children were eligible for Medicaid as of December 1, 2016, their eligibility should have been redetermined on an annual basis as of December 1, 2017. Had NYSOH done this, their 12 months of Medicaid continuous coverage would not have ended before November 30, 2017, barring any disqualifying events.

Likewise, the record is devoid of any explanation as to why you and your spouse were included in the September 3, 2017 renewal notice. Since you and your spouse were found eligible for and enrolled in Medicaid also as of December 1, 2016, your and your spouse's coverage should have continued for 12 months; that is, until November 30, 2017, barring any of the disqualifying events.

The record is also lacking in any evidence of any disqualifying event that would interrupt your family's Medicaid continuous coverage. Although your household did have an increase in income during the 12-month period of Medicaid under review, this would not be considered a disqualifying event. Additionally, although you are no longer a New York State resident, you credibly testified that you did not move out of New York State until [redacted]. As such, this event would not disqualify your family from receiving continuous Medicaid coverage in the month of November 2017.

Since, there is no evidence in the record to demonstrate that any of the disqualifying events occurred to end your family's coverage in Medicaid before December 1, 2017, your family's eligibility should not have been terminated prior to that date. As such, it is concluded that NYSOH improperly and prematurely re-determined your family's eligibility on October 16, 2017. Therefore, the October 17, 2017 eligibility determination notice is incorrect and is MODIFIED to state that your family is no longer eligible for health insurance through NYSOH, effective December 1, 2017.

Likewise, the October 17, 2017 disenrollment notice is incorrect and must be MODIFIED to state that your family is terminated from your Medicaid Managed Care plan(s) as of November 30, 2017.

Your case is RETURNED to NYSOH to reinstate your family in your Medicaid Managed Care plan(s) for the month of November 2017, and to notify you accordingly.

Decision

The October 17, 2017 eligibility determination notice is MODIFIED to state that your family is no longer eligible for health insurance through NYSOH, effective December 1, 2017.

The October 17, 2017 disenrollment notice is MODIFIED to state that your family is terminated from your Medicaid Managed Care plan(s) as of November 30, 2017.

Your case is RETURNED to NYSOH to reinstate your family in your Medicaid Managed Care plan(s) for the month of November 2017, and to notify you accordingly.

Effective Date of this Decision: February 27, 2018

How this Decision Affects Your Eligibility

Your case is being sent back to NYSOH to reinstate your family in your Medicaid Managed Care plan for the month of November 2017. NYSOH will notify you once this is done.

This does not affect your family's current eligibility. Your family was no longer eligible for health insurance through NYSOH as of December 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

- By fax: 1-855-900-5557

Summary

The October 17, 2017 eligibility determination notice is MODIFIED to state that your family is no longer eligible for health insurance through NYSOH, effective December 1, 2017.

The October 17, 2017 disenrollment notice is MODIFIED to state that your family is terminated from your Medicaid Managed Care plan(s) as of November 30, 2017.

Your case is RETURNED to NYSOH to reinstate your family in your Medicaid Managed Care plan(s) for the month of November 2017, and to notify you accordingly.

Your case is being sent back to NYSOH to reinstate your family in your Medicaid Managed Care plan for the month of November 2017. NYSOH will notify you once this is done.

This does not affect your family's current eligibility. Your family was no longer eligible for health insurance through NYSOH as of December 1, 2017.

Legal Authority

We are issuing this determination 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)

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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).