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

Notice of Decision

Decision Date: January 11, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024365

[redacted]

On January 4, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's April 17, 2017 eligibility determination notice; October 29, 2017 eligibility determination notice; and your eligibility for the Medicaid Premium Assistance Program from May 1, 2017, through September 30, 2017.

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: January 11, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024365

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health (NYSOH) properly determine that you were no longer eligible for health insurance and properly end your Medicaid coverage as of April 30, 2017?
>
> Did NYSOH properly determine that you were eligible for Medicaid, effective as of October 1, 2017?
>
> Did NYSOH fail to determine you eligible for the Medicaid Premium Assistance Program from May 1, 2017, through September 30, 2017?

Procedural History

On June 1, 2016, NYSOH issued an eligibility determination notice stating, in relevant part, that you were eligible for Medicaid, effective as of May 1, 2016.

On June 4, 2016, NYSOH issued a plan enrollment notice confirming that as of June 1, 2016, the type of Medicaid coverage you were eligible for did not require/allow you to enroll in a health plan.

On March 3, 2017, NYSOH issued a notice stating, in relevant part, that it was time to renew your health insurance. 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 health coverage.

You were instructed to update your account between March 16, 2017, and April 15, 2017, or your eligibility for financial assistance might end.

On April 16, 2017, your NYSOH account was updated.

On April 17, 2017, NYSOH issued an eligibility determination notice stating that, effective May 1, 2017, you were no longer eligible for health insurance through NYSOH because you did not complete your renewal within the required timeframe.

On October 28, 2017, your NYSOH account was updated.

On October 29, 2017, NYSOH issued an eligibility determination notice stating, in relevant part, that you were eligible for Medicaid, effective October 1, 2017.

On November 15, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal relative to being eligible for Medicaid and the Medicaid Premium Assistance Program from May 1, 2017, through September 30, 2017.

On January 3, 2018, NYSDOH'S Third Party Liability Unit evidence packet was uploaded to your NYSOH account (*see* Document [redacted]). This thirteen-page packet has been made part of the record as "NYSDOH Exhibit 1."

Also on January 3, 2018, NYSOH issued a notice stating that Medicaid will reimburse you for your monthly Medicare Part B Premium, effective October 1, 2017 (see Document [redacted]; uploaded 1/04/2018).

On January 4, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken and the record was fully developed during the hearing. The record was closed at the end of the hearing.

Findings of Fact

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

1) According to your NYSOH account, you were determined eligible for Medicaid, effective May 1, 2016.

2) According to your NYSOH account and testimony, you receive notices from NYSOH by U.S. mail.

3) According to your NYSOH account, [redacted] was listed as your mailing address from March 15, 2016, through July 31, 2017.

4) According to your NYSOH account, the March 3, 2017 renewal notice was sent to [redacted].

5) You testified that you did not receive the March 3, 2017 renewal notice instructing you to renew your health insurance coverage between March 16, 2017, and April 15, 2017.

6) According to your NYSOH account, none of the notices issued by NYSOH have been returned as undeliverable.

7) According to your NYSOH account, your application was not updated by April 15, 2017.

8) You testified that you went for a medical test on or about [redacted] and were informed that your Medicaid coverage was no longer active.

9) According to your NYSOH account, on October 28, 2017, you updated your account and were determined eligible for Medicaid.

10) According to your NYSOH account, you have been enrolled in Medicare since April 1, 2014.

11) You were eligible for reimbursement of your Medicare Part B premiums from August 1, 2015, through April 30, 2017 (*see* [redacted]).

12) You were redetermined eligible to be reimbursed for your monthly Medicare Part B premiums, effective October 1, 2017 (*see* Document [redacted].

13) You testified that you are seeking to be reimbursed for your Medicare Part B premiums from May 1, 2017, through September 30, 2017.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Medicaid Renewal

In general, NYSOH must review Medicaid eligibility once every twelve months or "whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility" (42 CFR § 435.916(a)(1), (d)). NYSOH

must make its “redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency” (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates provided by the individual (45 CFR §155.335(h)).

Medicaid – Effective Date

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

Medicaid Premium Reimbursement

When a Medicaid eligible individual has third party health insurance in force, the Medicaid program may determine to pay part or all cost of the premiums when payment of the premium is determined to be cost-effective. By paying the premium, the Medicaid program may cost avoid claims that would otherwise be covered by Medicaid (*see* NYS Social Services Law § 367-a(1)(b), 18 NYCRR § 360-7.5(g)).

Payment of Medicare part B premiums will be made by Medicaid if a Medicaid recipient is a qualified Medicare beneficiary, pursuant to 18 NYCRR § 360-7.7(g). Payment of the part B premium begins in the month following the month in which the qualified Medicare beneficiary applies for Medicaid payment of the premiums (18 NYCRR § 360-7.8(b)(5)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were no longer eligible for health insurance and ended your Medicaid coverage as of April 30, 2017.

You were determined eligible for Medicaid, effective as of May 1, 2016.

NYSOH must redetermine a qualified individual's eligibility for Medicaid once every 12 months without requiring information from the individual if able to do so

based on reliable information contained in the individual's account or other more current information available to the agency.

On March 3, 2017, NYSOH issued a renewal notice stated that there was not enough information to determine whether you were eligible to continue your financial assistance and coverage, and that you needed to renew your application by April 15, 2017, or your financial assistance might end.

The record reflects that your NYSOH account was not updated by April 15, 2017, and your Medicaid coverage ended as of April 30, 2017.

You testified that you did not receive any notice from NYSOH informing you of the need to renew your coverage or that your Medicaid coverage had ended. You testified, and your NYSOH account confirms, that you elected to receive notifications by regular mail. There is no evidence in the record that any of the notices that were sent to your mailing address were returned as undeliverable.

Therefore, the record supports that NYSOH properly issued you an annual renewal notice and informed you that the information in your NYSOH account needed to be updated to ensure your coverage would continue.

NYSOH properly determined that you were no longer eligible for health insurance as of May 1, 2017, because you did not complete your renewal within the required timeframe. As such, the April 17, 2017 eligibility determination notice is AFFIRMED.

The second issue under review is whether NYSOH properly determined you eligible for Medicaid, effective as of October 1, 2017.

The record supports you found out on or around October 28, 2017, that your Medicaid coverage was no longer active. You contacted NYSOH on October 28, 2017, and updated your NYSOH application. Based on that update, you were determined eligible for Medicaid.

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month. Since you were determined eligible for Medicaid on October 28, 2017, your Medicaid coverage properly was effectuated October 1, 2017.

Therefore, the October 29, 2017 eligibility determination notice is AFFIRMED.

The third issue under review is whether NYSOH failed to determine you eligible for the Medicaid Premium Assistance Program from May 1, 2017, through September 30, 2017.

When a Medicaid eligible individual has third party health insurance in force, the Medicaid program may determine to pay part or all cost of the premiums when payment of the premium is determined to be cost-effective. Medicaid may cover the cost of Medicare Part B premiums, if a Medicaid recipient is a qualified Medicare beneficiary.

Based on the analysis above, you were not enrolled in Medicaid coverage from May 1, 2017, through September 30, 2017. An individual may only seek reimbursement of health insurance premiums during the months they were enrolled in Medicaid. Therefore, NYSOH did not fail to determine you eligible for the Medicaid Premium Assistance Program from May 1, 2017, through September 30, 2017.

Decision

The April 17, 2017 eligibility determination notice is AFFIRMED.

The October 29, 2017 eligibility determination notice is AFFIRMED.

NYSOH did not fail to determine you eligible for the Medicaid Premium Assistance Program from May 1, 2017, through September 30, 2017.

Effective Date of this Decision: January 11, 2018

How this Decision Affects Your Eligibility

Your Medicaid coverage properly ended as of April 30, 2017.

You were properly redetermined eligible for Medicaid as of October 1, 2017.

You were not eligible to be reimbursed for your Medicare Part B premiums from May 1, 2017, through September 30, 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 April 17, 2017 eligibility determination notice is AFFIRMED.

The October 29, 2017 eligibility determination notice is AFFIRMED.

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).

Your Medicaid coverage properly ended as of April 30, 2017.

You were properly redetermined eligible for Medicaid as of October 1, 2017.

You were not eligible to be reimbursed for your Medicare Part B premiums from May 1, 2017, through September 30, 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)

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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