STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: February 21, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025749

[redacted]

[redacted]

On February 15, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's July 2, 2017 renewal and eligibility determination notice and November 17, 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
  PO 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(b).

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: February 21, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025749

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Issues

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

> Was your appeal of the NY State of Health's (NYSOH) eligibility determination notice issued on July 2, 2017 finding you and your spouse eligible for Medicaid timely?
>
> Did NYSOH properly determine that you and your spouse were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until August 31, 2018?

Procedural History

On July 3, 2016, NYSOH issued a renewal and eligibility determination notice stating that you and your spouse were eligible for the Essential Plan, effective September 1, 2016. You and your spouse enrolled in an Essential Plan for your coverage that same day.

On July 2, 2017, NYSOH issued a renewal notice based on information about you and your spouse obtained from state and federal sources obtained as of July 1, 2017, stating that you and your spouse were found eligible for Medicaid, and enrolled in an Medicaid Managed Care (MMC) plan, effective September 1, 2017.

On July 16, 2017, NYSOH issued an enrollment notice confirming that the Essential Plan coverage for you and your spouse was effective June 1, 2017.

On July 17, 2017, NYSOH issued a disenrollment notice confirming that you and your spouse's Essential Plan coverage would end, effective August 31, 2017.

On November 13, 2017, NYSOH received an update to your application for financial assistance with health insurance.

On November 14, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were no longer eligible for Medicaid; however, you and your spouse's Medicaid coverage would continue until August 31, 2018 because certain individuals who qualified for Medicaid get coverage for twelve continuous months from the date they were last determined eligible. This determination was effective November 1, 2017.

On November 16, 2017, NYSOH received an update to your application for financial assistance with health insurance.

On November 17, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were no longer eligible for Medicaid; however, you and your spouse's Medicaid coverage would continue until August 31, 2018 because certain individuals who qualified for Medicaid get coverage for twelve continuous months from the date they were last determined eligible. This determination was effective November 1, 2017.

On December 13, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you and your spouse were not found eligible for the Essential Plan.

On February 15, 2018, 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 support the following findings of fact:

1) You and your spouse were enrolled in an Essential Plan beginning at least as early as September 1, 2016, and remained enrolled in that plan until August 31, 2017.

2) You testified that you were appealing you and your spouse's eligibility only.

3) On July 1, 2017, NYSOH redetermined the eligibility of you and your spouse for financial assistance with health insurance.

4) You and your spouse were found eligible for Medicaid and enrolled in an MMC plan, with such coverage effective September 1, 2017. You testified that you received the July 2, 2017 renewal notice, but that you did not believe there was anything in this notice that cause your coverage under the Essential Plan to end if you did not respond.

5) On July 16, 2017, NYSOH issued an enrollment notice confirming that the Essential Plan coverage for you and your spouse was effective June 1, 2017.

6) On July 17, 2017, NYSOH issued a disenrollment notice confirming that the Essential Plan coverage for you and your spouse would end effective August 31, 2017.

7) You testified that you first realized there was an issue with your coverage was during November 2017 when you went to your dentist and were informed that your Essential Plan coverage had been terminated as of August 31, 2017.

8) You testified that your dentist and other physicians do not accept "straight Medicaid," or your MMC plan coverage.

9) Your NYSOH account reflects that you did not contact NYSOH to appeal you and your spouse's Medicaid eligibility until December 13, 2017.

10) You testified that you were seeking for you and your spouse's Essential Plan coverage to be reinstated as soon as possible due to [redacted] you and your spouse had received.

11) You testified that you expect to file your 2017 federal income tax return as "married filing jointly," and claim your son as your sole dependent.

12) According to the November 16, 2017 application, you attested to an expected annual household income of $29,864.00. You testified that, at the time you submitted your application, this income was an accurate reflection of your expected income for the 2017 and 2018 tax years.

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 NYSOH to provide timely notice of an eligibility determination; and (4) a denial of a request for a special enrollment period (45 CFR § 155.505, 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 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)).

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, citizenship status, 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 the NYSOH eligibility determination notice issued on July 2, 2017 finding you and your spouse eligible for Medicaid was timely.

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

Any appeal regarding the renewal notice issued by NYSOH on July 2, 2017, which you testified that you had received and reviewed, should have been filed by August 31, 2017 to be timely. You did not contact NYSOH until December 13, 2017 to file a formal appeal, which is well beyond 60 days from the date the enrollment notice was issued.

Therefore, there has been no timely appeal of the July 2, 2017 eligibility determination notice, and your appeal of the start date of your Essential Plan coverage reference within that enrollment notice is DISMISSED.

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

You testified that at the time of your November 16, 2017 application, you anticipated receiving $29,864.00 during both 2017 and 2018. This update to your income reflects an increase of your annual household income that was referenced in the July 2, 2017 eligibility determination notice, which is above the Medicaid limit.

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 and your spouse were eligible for Medicaid effective September 1, 2017, and that even though your estimated annual income increased when you modified your application on November 16, 2017, you and your spouse remain enrolled in Medicaid for the remainder of your 12-month eligibility period. Therefore, the November 17, 2017 eligibility determination is correct and is AFFIRMED.

Decision

Your appeal of the July 2, 2017 eligibility is untimely and is DISMISSED.

The November 17, 2017 eligibility determination is AFFIRMED.

Effective Date of this Decision: February 21, 2018

How this Decision Affects Your Eligibility

You and your spouse’s Medicaid coverage, which began on September 1, 2017, continues until August 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 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
  PO Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

Your appeal of the July 2, 2017 eligibility is untimely and is DISMISSED.

The November 17, 2017 eligibility determination is AFFIRMED.

You and your spouse's Medicaid coverage, which began on September 1, 2017, continues until August 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:

[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)

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.

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