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

Notice of Decision

Decision Date: May 2, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028327

[redacted]

[redacted]

Dear [redacted] and [redacted]

On April 27, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 3, 2018 eligibility determination notice and February 3, 2018 disenrollment 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
  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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Decision

Decision Date: May 2, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028327

[redacted]

[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 were disenrolled from Medicaid and your Medicaid Managed Care plan, effective February 28, 2018?

Procedural History

On April 25, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective June 1, 2017. This was because your household income was at or below the allowable income limit for Medicaid.

On April 27, 2017, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in a Medicaid Managed Care plan with a plan enrollment start date of June 1, 2017.

On February 2, 2018, you updated your application for financial assistance. Specifically, you updated your annual expected income. That day, NYSOH prepared a preliminary eligibility determination with regard to that application stating that you were eligible for up to $473.00 per month in advance payments

of the premium tax credit and eligible for cost-sharing reductions if you enrolled in a silver level qualified health plan, effective March 1, 2018.

Also on February 2, 2018, you spoke to NYSOH's Account Review Unit and appealed this determination insofar as you were not eligible for 12 months of continuous Medicaid until May 31, 2018.

On February 3, 2018, NYSOH issued a notice of eligibility determination stating that you were eligible for up to $473.00 per month in advance payments of the premium tax credit and eligible for cost-sharing reductions if you enrolled in a silver level qualified health plan, effective March 1, 2018. This notice also stated that you no longer qualified for Medicaid through NYSOH as of February 28, 2018. This was because the income listed in your application was above the allowable income limit for Medicaid.

Also on February 3, 2018, NYSOH issued a disenrollment notice stating that your coverage in your Medicaid Managed Care plan would end on February 28, 2018. This was because you were no longer eligible for Medicaid.

On February 23, 2018, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid for a limited time, effective March 1, 2018. This was because you had been granted Aid to Continue until a decision was made on your appeal.

Also on February 23, 2018, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in a Medicaid Managed Care Plan with a plan enrollment start date of March 1, 2018.

On April 27, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, [redacted] [redacted] appeared as your Authorized Representative and assisted you with your testimony. 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) Your Authorized Representative testified that you previously had Medicaid through your Local Department of Social Services, which ended on May 31, 2017.

2) You were determined eligible for Medicaid through NYSOH effective June 1, 2017.

3) You testified that you filed your 2017 tax return with a tax filing status of single and you did not claim any dependents on that return.

4) The application that was submitted on April 24, 2017 listed annual expected income of $11,344.80 consisting of income you received from [redacted]. You testified that, at that time, this income was correct.

5) On February 2, 2018, you updated your application for financial assistance.

6) The application was submitted on February 2, 2018 listed annual expected income of $24,890.76 consisting of $11,480.76 in [redacted] payments, $210.00 in ordinary dividends, and $13,200.00 in [redacted]. You testified that this is correct.

7) You testified that you expect to file your 2018 tax return with a tax filing status of single and you will not claim any dependents on that tax return.

8) You testified that you did not claim any deductions on your 2017 tax return and you do not anticipate claiming any deductions on your 2018 tax return.

9) Your application states, and you confirmed, that you reside in Tompkins County.

10) You testified that you have not been incarcerated [redacted].

11) Your account indicates that you have not moved since first applying for coverage through NYSOH.

12) Your Authorized Representative testified that you are seeking to have continuous Medicaid coverage for twelve months from your initial Medicaid eligibility determination, and that you are not asserting that you remain eligible for Medicaid based on your income.

13) Your Authorized Representative testified that you are concerned about coverage for June 1, 2018 and want to have time to select a qualified health plan for your on-going coverage after your twelve months of Medicaid continuous coverage end.

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)).

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 you were disenrolled from Medicaid and your Medicaid Managed Care plan, effective February 28, 2018.

On April 24, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective June 1, 2017. That determination has not been appealed and is not under review.

On February 2, 2018, you updated your application for financial assistance. As a result of this update, NYSOH found that you were eligible for up to $473.00 per month in advance payments of the premium tax credit and eligible for cost-sharing reductions if you enrolled in a silver level qualified health plan, effective March 1, 2018. You were found ineligible for Medicaid coverage, effective

February 28, 2018, because your income was over the allowable income limit for that program.

However, under New York State law, once a person is found eligible for Medicaid, that eligibility generally continues for 12 months, even if the household income rises above 138% of the FPL. This provision is called “continuous coverage”.

The record reflects that there were no events that would have been a basis for your Medicaid coverage to have been terminated, such as a permanent move or incarceration. Since you were determined eligible for Medicaid in the April 24, 2017 eligibility determination notice, effective June 1, 2017, you remain eligible for Medicaid for 12 continuous months, regardless of any increases in your household income. As a result, you were improperly disenrolled from Medicaid and your Medicaid Managed Care plan, effective February 28, 2018.

Since NYSOH determined that you were eligible for Medicaid as of June 1, 2017, and therefore eligible for continuous coverage, the February 3, 2018 eligibility determination notice is MODIFIED to provide you Medicaid coverage until the end of your 12-month continuous coverage period.

The February 3, 2018 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you into your Medicaid and your Medicaid Managed Care plan as of March 1, 2018 and to continue your Medicaid barring subsequent changes in your eligibility until May 31, 2018, and to assist you in updating your application and selecting a plan for enrollment as of June 1, 2018.

Decision

The February 3, 2018 eligibility determination notice is MODIFIED to provide you Medicaid coverage until the end of your 12-month continuous coverage period.

The February 3, 2018 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you into your Medicaid and your Medicaid Managed Care plan as of March 1, 2018 and to continue your Medicaid barring subsequent changes in your eligibility until May 31, 2018, and to assist you in updating your application and selecting a plan for enrollment as of June 1, 2018.

Effective Date of this Decision: May 2, 2018

How this Decision Affects Your Eligibility

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

Your case is being sent back to NYSOH to reinstate you into your Medicaid and Medicaid Managed Care plan as of March 1, 2018 and to assist you in updating your application and selecting a plan for enrollment as of June 1, 2018.

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 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

The February 3, 2018 eligibility determination notice is MODIFIED to provide you Medicaid coverage until the end of your 12-month continuous coverage period.

The February 3, 2018 disenrollment notice is RESCINDED.

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

Your case is RETURNED to NYSOH to reinstate you into your Medicaid and your Medicaid Managed Care plan as of March 1, 2018 and to continue your Medicaid barring subsequent changes in your eligibility until May 31, 2018, and to assist you in updating your application and selecting a plan for enrollment as of June 1, 2018.

Your case is being sent back to NYSOH to reinstate you into your Medicaid and Medicaid Managed Care plan as of March 1, 2018 and to assist you in updating your application and selecting a plan for enrollment as of June 1, 2018.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

[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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