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

Notice of Decision

Decision Date: April 30, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000028356

[redacted]

[redacted]

On April 24, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 3, 2018 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
  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: April 30, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000028356

[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 remained eligible for Medicaid effective as of January 1, 2018?

Procedural History

On October 28, 2017, NYSOH issued a notice stating that it was time to renew your health insurance. That notice stated that, based on information from federal and state sources, you qualified for Medicaid effective January 1, 2018. The notice instructed you to update your account between November 16, 2017 and December 15, 2017 to reflect any changes in your life that would affect your health insurance coverage or financial assistance.

On November 29, 2017, NYSOH issued a plan enrollment notice confirming that as of November 28, 2017, you were enrolled in a Medicaid Managed Care (MMC) plan with an enrollment start date of January 1, 2018.

On January 16, 2018, your NYSOH account was updated.

On January 17, 2018, NYSOH issued an eligibility determination notice stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until December 31, 2018, because you qualified for Medicaid for twelve continuous months. The eligibility was effective as of January 1, 2018.

On February 2, 2018, your NYSOH account was updated.

On February 2, 2018, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as you were determined eligible for Medicaid continuous coverage.

On February 3, 2018, NYSOH issued an eligibility determination notice stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until December 31, 2018, because you qualified for Medicaid for twelve continuous months. The eligibility was effective as of February 1, 2018.

On April 24, 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 and testimony, you are applying for health insurance for yourself.

2) According to your NYSOH account and testimony, you receive notices from NYSOH by the United States Postal Service.

3) You testified that you received the October 28, 2017 renewal notice from NYSOH.

4) You testified that your username through NYSOH is '[redacted]

5) According to your NYSOH account, on November 28, 2017, you accessed your account and selected an MMC plan.

6) According to your NYSOH account, no updates were made to your account before December 15, 2017.

7) According to your NYSOH account, on January 16, 2018 and February 2, 2018, you updated your account to reflect that your expected yearly income was $41,200.04.

8) You testified that you have [redacted], and the doctors that have been treating you 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

Annual Eligibility Redetermination

Generally, NYSOH must conduct annual eligibility redeterminations for qualified individuals who are seeking financial assistance through insurance affordability programs for the upcoming year, such as tax credits and cost-sharing reductions, Medicaid, or Child Health Plus. In such cases, NYSOH is required to request that the qualified individual provide updated income and family size information for use in an eligibility redetermination for the upcoming year (*see* 45 CFR § 155.335(a) and (b)).

NYSOH must send an annual renewal notice that contains the information by which NYSOH will use to redetermine a qualified individual's projected eligibility for that year (45 CFR § 155.335(c)(3)). If a qualified individual does not respond to the notice after a 30-day period, NYSOH must redetermine that individual's eligibility using the information and projected eligibility provided in the annual renewal notice (45 CFR § 155.335(g), (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 Continuous Coverage - Adults

Most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, unless the adult loses Medicaid eligibility because of citizenship status, lack of state residence, or failure to provide a valid social security number, before the end of 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 (*see* 42 CFR § 435.916(a); N.Y. Soc. Serv. Law § 366(4)(c)).

In the following situations, individuals are not entitled to receive continuous coverage:

- Unable to locate;
- Death;
- Consumer requests to have his/her Medicaid closed;
- Failure to provide or cooperate in obtaining a Social Security Number, if otherwise required;

- Failure to provide documentation of citizenship after the reasonable opportunity period;
- Moved out of State;
- Coverage established under MAGI in error;
- Undocumented pregnant women (only get 60 days post-partum);
- Failure to comply with absent parent (IV-D) requirements; and
- Individuals receiving treatment in a setting where Medicaid eligibility is not available

(*see* 42 CFR § 435.916(a); N.Y. Soc. Serv. Law § 366(4)(c); GIS 15 MA/22).

Legal Analysis

The issue under review is whether NYSOH properly determined that you remained eligible for Medicaid effective as of January 1, 2018.

NYSOH must annually redetermine a qualified individual's eligibility for health insurance and financial assistance to help pay for that health insurance. NYSOH must issue a renewal notice that contains the individual's projected eligibility. If an individual does not respond to this notice, NYSOH must issue an eligibility determination for the upcoming coverage year based on the information contained in the renewal notice.

On October 28, 2017, NYSOH issued a notice stating that it was time to renew your health insurance. The notice stated that, based on information from federal and state sources, you qualified for Medicaid effective January 1, 2018. The notice instructed you to update your account between November 16, 2017 and December 15, 2017, to reflect any changes in your life that would affect your health insurance coverage or financial assistance.

The record reflects that you received the October 28, 2017 renewal notice, and on November 28, 2017, you accessed your account and enrolled in a MMC plan. Further, the record supports that you did not update the information in your account by December 15, 2017. Since your account was not updated, your eligibility was based on the information contained in the renewal notice. Therefore, you were determined eligible for Medicaid as of January 1, 2018.

The record reflects that on January 16, 2018 and February 2, 2018, your account was updated to reflect that your expected 2018 expected yearly income was $41,200.04.

Once a person is eligible for Medicaid, that eligibility continues for 12 months, even if the household income subsequently exceeds the income threshold. When you updated your account on January 16, 2018 and February 2, 2018, the twelve-month period of Medicaid eligibility had not expired.

Therefore, the February 3, 2018 eligibility determination notice is AFFIRMED.

Decision

The February 3, 2018 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: April 30, 2018

How this Decision Affects Your Eligibility

You remain eligible for Medicaid continuous coverage through December 31, 2018, barring any of the disqualifying events stated above.

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 February 3, 2018 eligibility determination notice is AFFIRMED.

You remain eligible for Medicaid continuous coverage through December 31, 2018, barring any of the disqualifying events stated above.

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।

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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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