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

Notice of Decision

Decision Date: January 14, 2016

NY State of Health Number: [redacted]
Appeal Identification Number: AP000000004212

[redacted]

Dear [redacted],

On September 4, 2015 you appeared by telephone at a hearing on your appeal of NY State of Health Marketplace's July 28, 2015 eligibility redetermination.

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 at the top of this notice.

Legal Authority

We are sending you this notice in accordance with Code of Federal Regulation 45 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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Issues

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

> Did the Marketplace properly determine that as of July 28, 2015, you were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until March 31, 2016?
>
> Did the Marketplace properly determine that you could not disenroll from your current Medicaid Managed Care plan to a Fee for Service Medicaid provider effective September 1, 2015?

Procedural History

On February 12, 2015, the Marketplace issued a renewal notice which found you eligible for Medicaid because your income was between $0 and $16,105.00. This finding was based upon Federal and State data sources. The notice explained that you were automatically enrolled through Fidelis Care effective April 1, 2015.

On July 28, 2015, your account was modified to reflect an attested income of $19,500.00 annually for 2015.

On July 29, 2015, an eligibility redetermination notice was issued stating that you were no longer eligible for Medicaid because your household income of $19,500.00 was above the allowable income limit. The notice further explained that despite you no longer being eligible for Medicaid you would continue to

receive coverage until March 31, 2016. This eligibility was effective as of July 1, 2015.

On that same day you received an enrollment confirmation notice stating you were automatically enrolled in Fidelis Care, New York State Catholic Health a Medicaid Managed Care plan.

On August 6, 2015, you spoke to the Marketplace's Account Review Unit and appealed the enrollment confirmation notice insofar as it determined you continuously eligible for Medicaid Managed care, which you believe your current specialist you are seeing for treatment of a life threatening condition does not accept.

On August 24, 2015, you requested an expedited hearing based upon an urgent medical need. The request was granted on September 1, 2015 based upon medical evidence in the form of a letter from your physician uploaded on August 26, 2015 (Documentation [redacted]).

On September 3, 2015, a Notice of Telephone Hearing was issued for a hearing scheduled for September 4, 2015 at 9:00 am.

On September 4, 2015, you had a telephone hearing with a Hearing Officer from the Marketplace'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 supports the following findings of fact:

1) You expect to file your 2015 federal income tax return as single, and will claim no dependents.

2) You testified that you are self-employed and that your current income for 2015 was being reviewed currently.

3) You testified that you currently reside in New York County.

4) You testified you never received the February 12, 2015 notice finding you eligible for Medicaid effective April 1, 2015. The record reflects that the mailing was returned on Feb. 19, 2015 from [redacted], [redacted].

5) According to the July 28, 2015 application, you attested to an expected household income of $19,500.00. You testified during the hearing that

at the time you submitted your application, this income was an accurate reflection of your expected income for the 2015 tax year.

6) You testified that you would like to be disenrolled from you Medicaid Managed care plan as your current specialist who you began seeing on August 17, 2015 for continuing treatment and consultation for breast cancer surgery does not accept Medicaid Managed care, but does accept Medicaid fee for service insurance coverage.

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 through the Marketplace can be provided 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); N.Y. Soc. Serv. Law § 366(1)(b)).

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 application, that was the 2015 FPL, which is $11,770.00 for a one-person household (80 Fed. Reg. 3236, 3237).

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 Marketplace 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 (N.Y. Soc. Serv. Law § 366(4)(c)).

Lock-in Periods for Managed Care Plans:

Medicaid enrollees who are enrolled in a Medicaid managed care (MMC) plan have 90 days from their initial enrollment date to change plans. If an enrollee

does not change plans within 90 days, the enrollee is “locked-in” to the plan, and cannot change plans for the following nine months, unless they show good cause to do so (18 NYCRR § 360-10.3(f)), (18 NYCRR § 360-10.6).

Medicaid enrollees may change or disenroll from an MMC during the lock-in period if:

- The MMC failed to provide accessible and appropriate care, services or supplies;
- The MMC fails to adhere to the standards prescribed by the Commissioner of Health and the failure negatively impacts the enrollee;
- Enrollment in the MMC was not consensual;
- The enrollee, the MMC and the social services district agree that changing plans would be in the best interest of the enrollee;
- The enrollee’s medical condition requires multiple services at the same time that the MMC has elected not to cover, and a physician determines that receiving the services separately would subject the enrollee to unnecessary risk; or
- There exists any other good cause

(18 NYCRR § 360-10.6).

<u>Exempted Individuals for Participation in Medicaid Managed Care Plans:</u>

Generally, with regard to enrollment in a Medicaid Managed Care plan (MMC), Medicaid recipients, except for those who are eligible for an exemption or an exclusion, must enroll in an MMC. Exempt populations are not required to enroll in an MMCO in a social services district where enrollment is mandatory; however, they may elect to voluntarily enroll. (18 NYCRR § 360-10.4(a)(c)). Mandatory enrollment in an MMC is required in New York County.

In order to fit an exemption as provided by NYSDOH requirements The NY State of Health or the local department of Social Services is responsible for determining the Exemption and Exclusion status of individuals determined to be eligible for Medicaid. Exemptions are provided for individuals who are in a category of persons specified by New York State’s Operational Protocol for the Partnership Plan that that are not required to participate in the MMC Program (Medicaid Managed Care Model Contract (Appendix H) H-3 (xi), March 1, 2014).

Individuals who may be exempted from Managed Care Plans include:

- Individuals with chronic medical conditions who have been under active treatment for at least 6 months with a sub-specialist who is not a network provider for any Medicaid Managed Care Operator. Exemption limited to six months.

- Individuals designated as participating in Office of People with Developmental Disabilities (OPWDD) - sponsored programs.

- Individuals already scheduled for a major surgical procedure (within 30 days of scheduled enrollment) with a provider who is not a participant in the network of any Medicaid MCO. Exemption limited to six months.

- Individuals with a developmental or physical disability receiving services through a Medicaid home- and community-based services waiver.

- Native Americans.

- Individuals with a "county of fiscal responsibility code of 98" (OPWDD in Medicaid Information System/MMIS) in counties where program features are approved by the state and operational at the local district level to permit these individuals to voluntarily enroll.

(Partnership Plan Medicaid Section 1115 Demonstration, Table 7 pg. 12, December 31, 2014).

Legal Analysis

The first issue under review is whether the Marketplace properly determined that as of July 28, 2015, you were no longer eligible for Medicaid effective July 1, 2015 but that you would continue to receive coverage until March 31, 2016.

You are in a one person household. According to the record, you expect to file your 2015 tax return as single and claim no children as dependents.

On your July 28, 2015 application, you attested to an expected household income of $19,500.00. You credibly testified that the income you provided of $19,500.00 in the July 28, 2015 application was an accurate reflection at that time of your expected 2015 household income.

Medicaid can be provided through the Marketplace to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for

the applicable family size. On the date of your application, the relevant FPL was $11,770.00 for a one-person household. Since $19,500.00 is 167.10% of the 2015 FPL, the Marketplace properly found you to be no longer eligible for Medicaid on an expected annual income basis, using the information provided in your application.

Under New York State law, once a person is 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 on July 28, 2015 you changed the income amount in your application and your expected income subsequently increased. However, since you were correctly determined eligible for Medicaid effective April 1, 2015, you remain eligible for Medicaid for 12 continuous months regardless of any increases in your household income.

Since the Marketplace properly determined you eligible for Medicaid as of April 1, 2015, and therefore eligible for continuous coverage until March 31, 2016, the July 28, 2015 eligibility determination notice is AFFIRMED.

The second issue is whether the Marketplace properly determined that you could not disenroll from your current Medicaid Managed Care (MMC) plan in order to enroll in a Fee for Service Medicaid plan effective September 1, 2015?

The “lock-in” period is only applicable to individuals looking to disenroll or change between MMC plans, and is not applicable to those seeking to change to a Medicaid fee for service plan.

Individuals may be exempt from participating in an MMC plan if they fall into one of a series of defined categories as provided by state regulation. Exemptions include those with a “chronic medical condition” who have been under active treatment for at least 6 months with a sub-specialist who is not a network provider for any Medicaid Managed Care Operator.

Since you have been in active treatment for less than 6 months for your condition you would not fit into this category of exempt persons.

Another category includes individuals already scheduled for a major surgical procedure (within 30 days of scheduled enrollment) with a provider who is not a participant in the network of any Medicaid MCO.

The record reflects that you are currently seeking treatment with a specialist which began on August 17, 2015. Because your enrollment in your Fidelis Care MMC plan was effective April 1, 2015, you were not at that time scheduled for a major surgical procedure within 30 days of enrollment.

Therefore the Marketplace's decision that you could not change your Medicaid Managed Care plan in order to enroll in a fee for service provider effective September 1, 2015 is AFFIRMED.

Decision

The July 28, 2015 eligibility determination is AFFIRMED.

The Marketplace's decision that you could not change your Medicaid Managed Care plan to FFS Medicaid in order to enroll in a fee for service provider effective September 1, 2015 is AFFIRMED.

This decision has no effect on any eligibility determination, enrollment or changes to your Marketplace account made by the Marketplace after July 28, 2015.

Effective Date of this Decision: January 14, 2016

How this Decision Affects Your Eligibility

This decision does not affect your eligibility. It Affirms the July 28, 2015, determination, but has no effect on any Marketplace determination after that date.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 after the date 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 U.S. Department of Health and Human Services. This must be done within 30 days of the date of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

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:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:

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- Sending a Fax to 1-855-900-5557

Summary

The July 28, 2015 eligibility determination is AFFIRMED.

The Marketplace's decision that you could not change your Medicaid Managed Care plan in order to enroll in a fee for service provider effective September 1, 2015 is AFFIRMED.

This decision has no effect on any Marketplace determination made subsequent to July 28, 2015.

Legal Authority

We are sending you this notice in accordance with Code of Federal Regulation 45 CFR § 155.545(a).

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).