



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

Notice of Decision

Decision Date: April 29, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000006023

[REDACTED]

Dear [REDACTED],

On April 27, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health’s January 6, 2016 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 and NY State of Health 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 29, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000006023

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Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

Did NY State of Health properly determine that you were no longer eligible for Medicaid, as of December 31, 2015?

Procedural History

On May 17, 2015, NY State of Health (NYSOH) issued a notice of eligibility redetermination that stated you were eligible for Medicaid, effective May 1, 2015.

On May 18, 2015, NYSOH issued an enrollment notice confirming that you had health insurance coverage with Medicaid Fee-For-Service as of May 1, 2015, and needed to select a Medicaid Managed Care (MMC) plan soon or one would be chosen for you.

On May 27, 2015, NYSOH issued another enrollment notice confirming that you had health coverage with Medicaid Fee-For-Service as of May 1, 2015 and were enrolled in New York State Catholic Health Plan, Inc., an MMC plan, effective July 1, 2015.

On October 26, 2015, NYSOH issued a renewal notice that instructed you to update your NYSOH account by December 15, 2015, so your eligibility for financial assistance could be redetermined.

Your NYSOH account was not updated by December 15, 2015.

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On December 22, 2015, NYSOH issued a notice of eligibility redetermination that stated, effective December 31, 2015, you were no longer eligible for financial assistance and could not enroll in a qualified health plan through NYSOH because you did not respond to the renewal notice and update your NYSOH account within the required timeframe.

On December 23, 2015, NYSOH issued a disenrollment notice informing you that your coverage in your MMC plan would end December 31, 2015.

On January 6, 2016, you updated your application. NYSOH preliminarily redetermined your eligibility and found you eligible for the Essential Plan, effective February 1, 2016.

Also on January 6, 2016, you spoke with a representative from NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you were no longer eligible for Medicaid and were disenrolled from your MMC plan as of December 31, 2015.

That same day, you requested that your aid through your MMC plan continue during the appeal process, which NYSOH granted on January 20, 2016. You were placed back in your MMC plan, effective January 1, 2016 through June 30, 2016.

On April 27, 2016, 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 supports the following findings of fact:

- 1) You testified that you and your spouse expect to file your 2016 taxes with a tax filing status of married filing jointly. You will claim no dependents on that tax return.
- 2) You are seeking insurance for only yourself.
- 3) You were determined eligible for Medicaid on May 17, 2015 beginning May 1, 2015 through December 31, 2015.
- 4) Your NYSOH account reflects that your monthly income is \$1,950.00, which equals \$23,400.00 annually, and that your spouse has no income.

- 5) You testified that your income is correct, but that your spouse receives Social Security Disability benefits of \$276.00 per month and has since May 2015, which equals \$3,312.00 annually.
- 6) Your application states that you will not be taking any deductions on your 2016 tax return.
- 7) Your application states that you live in Westchester County, New York at all times, were not incarcerated or placed in a facility that provided medical care, had provided a valid Social Security number, and did not have third party health insurance.

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 NYSOH 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)).

Most adults determined eligible for Medicaid are guaranteed twelve 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 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 (N.Y. Soc. Serv. 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 (N.Y. Soc. Serv. Law § 366(4)(c)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were no longer eligible for Medicaid, effective December 31, 2015.

The record reflects that you were determined eligible for Medicaid as of May 1, 2015 through December 31, 2015.

However, under New York State law, once a person is eligible for Medicaid, that eligibility continues for twelve months according to the “continuous coverage” provision.

Since the credible evidence of record confirms that you were eligible for Medicaid as of May 1, 2015, did not enter prison or another facility that provides medical care, remained a state resident, had provided a valid social security number, and did not have or gain third party health insurance, you should have remained enrolled in Medicaid for the remainder of your twelve month eligibility period, that is, through April 30, 2016.

Therefore, the October 24, 2015 renewal notice was issued in error and is RESCINDED.

The December 22, 2015 notice of eligibility redetermination was issued in error and is RESCINDED.

The December 23, 2015 disenrollment notice was issued in error and is RESCINDED.

The January 7, 2016 notices of eligibility and enrollment were issued in error and are RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance using a two-person household and a monthly income of \$2,226.00 (\$1,950.00 + \$276.00) and/or an annual household income of \$26,712.00 (\$23,400.00 + \$3312.00), for an individual living in Westchester County and to notify you accordingly.

Decision

The October 24, 2015 renewal notice was issued in error and is RESCINDED.

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Effective Date of this Decision: April 29, 2016

How this Decision Affects Your Eligibility

NYSOH will redetermine your eligibility for financial assistance based on the updated income information for your household received at the hearing and will notify you of its redetermination.

NYSOH will assist you in enrolling in an appropriate health plan so as to avoid a gap in coverage.

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 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 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.

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Summary

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A Copy of this Decision Has Been Provided To:

