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

Notice of Decision

Decision Date: July 12, 2016

NY State of Health Account ID:
Appeal Identification Number: AP000000006984

Dear

On June 29, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's February 11, 2016 eligibility determination.

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 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: July 12, 2016

NY State of Health Account ID:
Appeal Identification Number: AP000000006984

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 not eligible for Medicaid as of your February 10, 2016 application?

Procedural History

On June 30, 2015, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible for Medicaid. This eligibility was effective as of June 1, 2015.

On July 21, 2015, NYSOH received your updated application for health insurance; specifically the income information was updated.

On July 22, 2015, NYSOH issued a notice of eligibility determination stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until October 31, 2015 because certain individuals determined eligible for Medicaid remain eligible for benefits for twelve continuous months from the date that they were determined eligible. This eligibility was effective as of July 1, 2015.

On September 14, 2015, NYSOH issued a renewal notice stating that you now qualified for advance payments of the premium tax credit (APTC) of up to $91.26 per month, and that you were not eligible for Medicaid. Your new eligibility was effective November 1, 2015.

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On October 17, 2015, NYSOH issued a disenrollment notice notifying you that your fee-for-service Medicaid coverage was ending as of October 31, 2015.

On February 10, 2016, you updated your NYSOH account. That day, NYSOH issued a preliminary eligibility determination stating that you were eligible for APTC of up to $22.00 per month, based on an annual income of $43,056.00, effective March 1, 2016.

Also on February 10, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination insofar as you were not found eligible to have your Medicaid coverage continued.

On February 11, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for APTC of up to $22.00 per month, effective March 1, 2016. The notice also stated that you were not eligible for Medicaid because your household income of $43,056.00 is over the allowable income limit of $16,243.00.

On June 29, 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 were incarcerated in a NYS Correctional Facility until June 8, 2015.

2) NYSOH found you eligible for Medicaid as of June 1, 2015. That determination is not under appeal.

3) You testified that you have not been re-incarcerated at any point since your release.

4) You testified that you have lived at the same address in NY State continuously since your release.

5) You testified that you were not aware that your Medicaid coverage had ended until you received a call in January 2016 from a provider who stated that none of your claims had been covered by Medicaid since sometime in October 2015.

6) You testified that you began working sometime in June 2015 after your release.

7) The record reflects that you reported an annual income of $47,840.00 when you updated your application in July 2015, and an income of $43,056.00 in your application of February 10, 2016.

8) You testified that you are paid on an hour basis. You testified that your hourly rate is $25.00, and that you work forty or more hours per week.

9) You testified that you were told that your Medicaid would continue for one year from the date it started after your release from prison.

10) You testified that you received your Medicaid benefit card sometime in July or August of 2015.

11) You testified that you understand that your income is probably too high to have Medicaid going forward, but that you would like it to be reinstated for the one year period you believe you were eligible for.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

<u>Medicaid for Adults between the Ages of 19 and 65</u>

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 coverage with limited exceptions, including lack of state residence or failing to provide a valid social security number.(N.Y. Soc. Serv. Law § 366(4)(c)).

Legal Analysis

The only issue under review is whether NYSOH properly determined that you were not eligible for Medicaid as of your February 10, 2016 application.

You were found eligible for fee-for-service Medicaid in an eligibility determination notice dated June 30, 2015, with your Medicaid coverage starting on Jun 1, 2015. That eligibility determination is not under appeal.

Under New York State law, once a person is eligible for Medicaid, that eligibility continues for twelve months, even if the household income rises above 138% of the FPL. This provision is called "continuous coverage."

You testified that you have been a continuous resident of NY State since June 2015, and your account contains a valid social security number. Therefore, despite the fact that you reported income amounts that brought you above the Medicaid income limit in both July 2015 and February 2016, you should have had continuous fee-for-service Medicaid coverage through the end of May 2016.

Therefore, the February 10, 2016 eligibility determination is MODIFIED to state that you are no longer eligible for Medicaid coverage, but that your fee-for-service Medicaid coverage will continue until May 31, 2016 because you remain eligible for Medicaid for twelve continuous months from the date your Medicaid eligibility began.

Your case is RETURNED to NYSOH to re-enroll you in fee-for-service Medicaid for the period of November 1, 2015 through May 31, 2016.

With regard to your eligibility for Medicaid from June 1, 2016 going forward, there is no application on file for this time period, so the Appeals Unit cannot review your eligibility. If you wish to see what, if any, financial assistance you would be eligible for through NYSOH going forward, you must contact NYSOH and update your application.

Decision

The February 11, 2016 eligibility determination is MODIFIED to state that you are no longer eligible for Medicaid coverage, but that your fee-for-service Medicaid coverage will continue until May 31, 2016 because you remain eligible for Medicaid for twelve continuous months from when your coverage began.

Your case is RETURNED to NYSOH to re-enroll you in your fee-for-service Medicaid coverage for the period of November 1, 2015 through May 31, 2016.

There is no application or determination on file regarding your eligibility for the period beginning June 1, 2016, therefore the Appeals Unit cannot issue a decision regarding your eligibility for coverage after May 31, 2016.

Effective Date of this Decision: July 12, 2016

How this Decision Affects Your Eligibility

Your fee-for-service Medicaid coverage, which began on June 1, 2015, should have continued until May 31, 2016.

Your case is being sent back to NYSOH to re-enroll you in your fee-for-service Medicaid coverage for the period of November 1, 2015 through May 31, 2016.

If you wish to find out whether you are eligible for any financial assistance going forward, you must update your NYSOH application.

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 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 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:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:

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  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The February 11, 2016 eligibility determination is MODIFIED to state that you are no longer eligible for Medicaid coverage, but that your fee-for-service Medicaid coverage will continue until May 31, 2016 because you remain eligible for Medicaid for twelve continuous months from when your coverage began.

Your case is RETURNED to NYSOH to re-enroll you in your fee-for-service Medicaid coverage for the period of November 1, 2015 through May 31, 2016.

There is no application or determination on file regarding your eligibility for the period beginning June 1, 2016, therefore the Appeals Unit cannot issue a decision regarding your eligibility for coverage after May 31, 2016.

Your fee-for-service Medicaid coverage, which began on June 1, 2015, should have continued until May 31, 2016.

Your case is being sent back to NYSOH to re-enroll you in your fee-for-service Medicaid coverage for the period of November 1, 2015 through May 31, 2016.

If you wish to find out whether you are eligible for any financial assistance going forward, you must update your NYSOH application.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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