



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

Notice of Decision

Decision Date: December 8, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000009792

[REDACTED]

Dear [REDACTED],

On November 14, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's March 2, 2016 eligibility determination notice, April 19, 2016 eligibility determination notice and the April 20, 2016 notice of disenrollment.

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: December 8, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000009792

[REDACTED]

Issues

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

Did NY State of Health (NYSOH) properly determine you were eligible for Medicaid effective March 1, 2016?

Did NYSOH properly dis-enroll you from your Medicaid Managed Care (MMC) plan effective May 31, 2016?

Procedural History

On March 1, 2016 you updated your NYSOH application to indicate an expected yearly income of \$0.00.

On March 2, 2016, NYSOH issued an eligibility redetermination notice based on the application received on March 1, 2016 stating that you were eligible for Medicaid, effective March 1, 2016.

Also on March 2, 2016, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in a MMC plan effective April 1, 2016.

On April 18, 2016 income information in your NYSOH account was updated to indicate an expected household income of \$124,799.99.

On April 19, 2016, NYSOH issued an eligibility redetermination notice based on the updated information received on April 18, 2016 stating that you were no longer eligible for Medicaid, however, your coverage would continue until February 28, 2017.

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On April 20, 2016, NYSOH issued an eligibility redetermination notice based on updated information received stating that you were newly eligible to purchase a QHP through NYSOH at full cost, effective June 1, 2016.

Finally, on April 20, 2016, NYSOH issued a notice of disenrollment stating that your MMC plan was terminated effective May 31, 2016 because you were no longer eligible to remain enrolled in the plan.

On May 20, 2016 you spoke to NYSOH's Account Review Unit and appealed your disenrollment from your MMC plan.

On November 14, 2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was held open for you to submit documentation establishing your income for the month of March 2016. No such documentation was received and the record was closed at the end of business on November 29, 2016.

Findings of Fact

A review of the record supports the following findings of fact:

- 1) You testified that you had a waitressing job that ended February 1, 2016 and that you were unemployed for the month of February 2016 and the first week of March 2016. You testified that you began working at your current job the second week of March 2016 wherein your expected gross annual income is between \$100,000.00 and \$120,000.00.
- 2) You testified that you called into NYSOH on March 1, 2016 to report that you were between jobs. As a result, an updated application was submitted on your behalf listing your anticipated household income for the upcoming year as \$0. You testified that this amount was incorrect.
- 3) You testified that you knew you were beginning a new job in mid-March when you called NYSOH on March 1, 2016 to update your information.
- 4) The record reflects that you were found eligible for Medicaid on the basis of the March 1, 2016 application.
- 5) The record reflects that you called into NYSOH on April 18, 2016 to update your information. As a result, an application was submitted on your behalf listing an anticipated gross annual income of \$124,799.99.

- 6) On April 19, 2016, the record reflects that a “non-financial” application was submitted on your behalf and thereafter your MMC enrollment was deleted.
- 7) You testified that you are seeking continuous coverage under your MMC because you were advised by a representative of NYSOH that you were entitled to it

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

Applicable Law and Regulations

Medicaid

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 FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services 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 2016 FPL, which is \$11,880.00 for a one-person household (80 Fed. Reg. 3236, 3237).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

Continuous Coverage

Most applicants determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage offered through Medicaid Managed Care, even if the adult loses 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 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; N.Y. Soc. Serv. Law § 366(4)(c)).

Applicants determined eligible will be enrolled or remain in their Medicaid plan with limited exceptions, including entering prison or another facility that provides medical care, moving out of state, or failing to provide a valid social security number (N.Y. Soc. Serv. Law § 366(4)(c)).

Legal Analysis

The first issue is whether NYSOH properly determined you were eligible for Medicaid effective March 1, 2016.

You testified that you called into NYSOH on March 1, 2016 to report that you were between jobs. As a result, an updated application was submitted on your behalf listing your anticipated household income for the upcoming year as \$0.00.

Thereafter, NYSOH issued an eligibility redetermination based on the March 1, 2016 updated application stating that you were eligible for Medicaid, effective March 1, 2016. Subsequently, you enrolled in a MMC plan, effective April 1, 2016.

Medicaid can be provided through NYSOH 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. Your March 1, 2016 application listed your anticipated gross annual income as \$0. As a result, you were found eligible for Medicaid. However, you testified that the income amount of \$0 listed in your March 1, 2016 application was incorrect.

You testified that you knew you were starting a new job mid-March at the time you called NYSOH to update your information on March 1, 2016. Further, you were employed for the month of January 2016 and as such would have had some form of income from that employment. As the annual household income of \$0.00 contained in the March 1, 2016 application is inaccurate based on your sworn testimony, it is not supported by the record, and it cannot be the basis of an eligibility determination.

Therefore, the March 2, 2016 eligibility redetermination stating that you were eligible for Medicaid is **RESCINDED**.

The second issue is whether NYSOH properly dis-enrolled you from your MMC plan effective May 31, 2016.

The record reflects that you called into NYSOH on April 18, 2016 to update your information. As a result, an application was submitted on your behalf listing an anticipated gross annual income of \$124,799.99.

On April 19, 2016, a “non-financial” application was submitted on your behalf and thereafter your MMC enrollment was deleted. As a result, on April 20, 2016, NYSOH issued a notice of disenrollment stating that your MMC plan was terminated effective May 31, 2016 because you were no longer eligible to remain enrolled in the plan.

Applicants determined eligible for Medicaid are generally guaranteed twelve months of Medicaid coverage, even if they lose Medicaid eligibility because of any changes or updates they make to their NYSOH account. 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.

However, as discussed above your original Medicaid eligibility was based on an inaccurate application. As you were never properly determined eligible for Medicaid you do not receive the benefit of the continuous coverage rule.

Therefore, the April 19, 2016 eligibility redetermination stating that you were no longer eligible for Medicaid, however, your coverage would continue until February 28, 2017 is RESCINDED.

Additionally, the April 20, 2016 notice of disenrollment stating that your MMC plan was terminated effective May 31, 2016 because you were no longer eligible to remain enrolled in the plan is AFFIRMED.

Decision

The March 2, 2016 eligibility redetermination stating that you were eligible for Medicaid is RESCINDED.

The April 19, 2016 eligibility redetermination stating that you were no longer eligible for Medicaid, however, your coverage would continue until February 28, 2017 is RESCINDED.

The April 20, 2016 notice of disenrollment stating that your MMC plan was terminated effective May 31, 2016 is AFFIRMED.

Effective Date of this Decision: December 8, 2016

How this Decision Affects Your Eligibility

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).

Your Medicaid Managed Care plan ended effective May 31, 2016.

You are ineligible for Medicaid.

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

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The March 2, 2016 eligibility redetermination stating that you were eligible for Medicaid is RESCINDED.

The April 19, 2016 eligibility redetermination stating that you were no longer eligible for Medicaid, however, your coverage would continue until February 28, 2017 is RESCINDED.

The April 20, 2016 notice of disenrollment stating that your MMC plan was terminated effective May 31, 2016 is AFFIRMED.

Your Medicaid Managed Care plan ended effective May 31, 2016.

You are ineligible for Medicaid.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

