



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

Notice of Decision

Decision Date: March 20, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000013051

[REDACTED]

Dear [REDACTED],

On February 21, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 18, 2016 eligibility determination notice and September 30, 2016 disenrollment 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
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Decision

Decision Date: March 20, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000013051

[REDACTED]

Issues

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

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

Did NY State of Health properly disenroll you from Medicaid and your Medicaid Managed Care plan, effective September 30, 2016?

Procedural History

On February 18, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible for Medicaid because your household income of \$11,870.00 was at or below the allowable income limit. This eligibility was effective as of March 1, 2016.

On February 19, 2016, NYSOH issued a notice of enrollment confirming your enrollment in your Medicaid Managed Care plan with a plan enrollment start date of April 1, 2016.

On September 2, 2016, NYSOH received your updated application for health insurance.

On September 3, 2016, NYSOH issued a notice stating that additional information was required in order for NYSOH to make a determination with regard to your eligibility. This notice requested that you submit income documentation by September 17, 2016.

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Also on September 3, 2016, NYSOH issued a disenrollment notice stating that your coverage in your Medicaid Managed Care plan would end, effective September 30, 2016.

On October 4, 2016, you uploaded income documentation to your NYSOH account.

Also on October 4, 2016, NYSOH received your updated application for health insurance.

On October 5, 2016, NYSOH issued a notice stating that the income information in your application did not match what NYSOH had received from state and federal data sources, and that additional information was needed in order to confirm the information in your application. This notice also requested that you submit income documentation by November 3, 2016.

On October 10, 2016, you uploaded additional income documentation to your NYSOH account.

On October 14, 2016, NYSOH reviewed the submitted income documentation and determined that it was insufficient to resolve the inconsistency in your account, as the income documentation was with regard to earnings in 2015.

On October 15, 2016, NYSOH issued a notice advising that the income documentation you submitted did not confirm the information in your application, and requested that you submit additional proof of income by November 3, 2016.

On October 18, 2016, you uploaded additional income documentation to your NYSOH account.

On October 27, 2016, NYSOH reviewed the submitted income documentation and determined that it was insufficient to resolve the inconsistency in your account, as it was not specified that the income reported was your gross income.

On October 28, 2016, NYSOH issued a notice advising that the income documentation you submitted did not confirm the information in your application, and requested that you submit additional proof of income by November 18, 2016.

Also on October 28, 2016, you uploaded additional income documentation to your NYSOH account.

On November 1, 2016, NYSOH reviewed the income you submitted on October 28, 2016 and found this information sufficient to determine your annual income. NYSOH recalculated your 2016 annual income to be \$20,800.00 based on the income documentation you submitted. NYSOH updated your application to

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reflect an expected annual income for 2016 of \$20,800.00 and submitted an application on your behalf.

On November 2, 2016, NYSOH issued a notice of eligibility determination based on the November 1, 2016 application, stating that you were eligible for the Essential Plan, effective December 1, 2016. You were not eligible for Medicaid because your income was over the allowable income limit for that program.

On November 3, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you were not found eligible for Medicaid.

On November 4, 2016, NYSOH issued a notice of enrollment confirming your plan selection on November 3, 2016, stating that your enrollment in your Essential Plan was effective as of December 1, 2016.

On February 21, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open for 22 days to allow you time to submit supporting documentation, specifically your 2016 W-2. No documentation was received within the allotted time. The record is now closed.

Findings of Fact

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

- 1) You expect to file your 2016 federal tax return as single and claim no dependents on that return.
- 2) You testified that you also expect to file your 2017 federal tax return as single and claim no dependents on that return.
- 3) According to the September 2, 2016 and October 4, 2016 applications, you attested to an expected annual household income of \$11,870.00. You testified that you are not sure if this was correct, and that your 2016 W-2 would be the most accurate representation of your 2016 earnings.
- 4) You testified that you have worked for the same employer throughout 2016 and continue to work for the same employer, and that this was your only source of income.
- 5) You testified that you are paid on a weekly basis. You further testified that you are paid based on an hourly rate, but your hours vary.

- 6) You testified that you are not sure what your September 2016, October 2016, and November 2016 gross earnings were.
- 7) You testified that you do not plan on taking any deductions on your 2016 tax return or your 2017 tax return.
- 8) You have not submitted your 2016 W-2.
- 9) You testified that you reside in █████ County, and have lived at the same address for the last two to three years.
- 10) You testified that you were not incarcerated in 2016.
- 11) You testified that you did not obtain health insurance outside of NYSOH in 2016.
- 12) You testified that you were not in a residential care facility in 2016.
- 13) You testified that you are seeking to have your Medicaid reinstated as of October 1, 2016.

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 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 federal poverty level (FPL) for the applicable family size (42 CFR §§ 435.119(b), 435.911(b)(1), 435.603(d)(4); NY Social Services Law § 366(1)(b)).

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).

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 (81 Federal Register 4036).

Generally, 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 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 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 (NY Social Services 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 (NY Social Services Law § 366(4)(c)).

Legal Analysis

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

You are in a one-person household. According to the record, you expect to file your 2016 tax return as single and claim no dependents.

On the February 17, 2016 application, NYSOH determined your expected household income to be \$11,870.00.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 64 who meet the non-financial requirements and have a household 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 \$11,880.00 for a one-person household. Since \$11,870.00 is 99.92% of the 2016 FPL, NYSOH properly found you to be eligible for Medicaid on an expected annual income basis.

Since the February 18, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible for Medicaid, it is correct and is **AFFIRMED**.

The second issue is whether NYSOH properly disenrolled you from Medicaid and your Medicaid Managed Care plan, effective September 30, 2016.

On September 2, 2016 you updated your application for health insurance. As a result of that application, on September 3, 2016, NYSOH issued a notice

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requesting income documentation in order to determine your eligibility for financial assistance. Also on September 3, 2016, NYSOH issued a disenrollment notice, stating that your enrollment in your Medicaid Managed Care plan would end as of September 30, 2016.

Under New York State law, once a person is eligible for Medicaid, that eligibility 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 there were no events that would have been a basis for your Medicaid coverage to have been terminated, such as a permanent move, incarceration, or obtaining health insurance outside of NYSOH. Since you were determined eligible for Medicaid based on the application submitted on February 17, 2016, effective March 1, 2016, you remained eligible for Medicaid for 12 continuous months, regardless of any changes in your household income. As a result, you were improperly disenrolled from Medicaid and your Medicaid Managed Care plan, effective September 30, 2016.

Since NYSOH determined you were eligible for Medicaid as of March 1, 2016, and therefore eligible for continuous coverage, the September 3, 2016 disenrollment notice is MODIFIED to state that your enrollment in your Medicaid Managed Care plan is terminated effective February 28, 2017 to provide you coverage until the end of your 12-month continuous coverage period.

Your case is RETURNED to NYSOH to reinstate you into Medicaid as of March 1, 2016 and into your Medicaid Managed Care plan as of October 1, 2016 and to determine your eligibility for financial assistance as of March 1, 2017.

Decision

The February 18, 2016 notice of eligibility determination is AFFIRMED.

The September 3, 2016 disenrollment notice is MODIFIED to state that your enrollment in your Medicaid Managed Care plan is terminated effective February 28, 2017 to provide you coverage until the end of your 12-month continuous coverage period.

Your case is RETURNED to NYSOH to reinstate you into Medicaid and your Medicaid Managed Care plan as of October 1, 2016.

Your case is RETURNED to NYSOH to determine your eligibility for financial assistance as of March 1, 2017.

Effective Date of this Decision: March 20, 2017

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How this Decision Affects Your Eligibility

Your Medicaid coverage, which began on March 1, 2016, continued until February 28, 2016.

Your case is being sent back to reinstate you in your Medicaid and Medicaid Managed Care plan from October 1, 2016 through February 28, 2017.

Your case is also being sent back to NYSOH in order for your eligibility as of March 1, 2017 to be determined.

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:

NY State of Health Appeals

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- By fax: 1-855-900-5557

Summary

The February 18, 2016 notice of eligibility determination is AFFIRMED.

The September 3, 2016 disenrollment notice is MODIFIED to state that your enrollment in your Medicaid Managed Care plan is terminated effective February 28, 2017 to provide you coverage until the end of your 12-month continuous coverage period.

Your Medicaid coverage, which began on March 1, 2016, continued until February 28, 2016.

Your case is RETURNED to NYSOH to reinstate you into Medicaid and your Medicaid Managed Care plan as of October 1, 2016.

Your case is being sent back to reinstate you in your Medicaid and Medicaid Managed Care plan from October 1, 2016 through February 28, 2017.

Your case is RETURNED to NYSOH to determine your eligibility for financial assistance as of March 1, 2017.

Your case is also being sent back to NYSOH in order for your eligibility as of March 1, 2017 to be determined.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

