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

Notice of Decision

Decision Date: April 3, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014194

[redacted]

Dear [redacted],

On March 15, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 29, 2016 eligibility determination notice, November 9, 2016 disenrollment and eligibility determination notices, and December 5, 2016 and December 6, 2016 eligibility determination notices.

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).

This page intentionally left blank.

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

Decision

Decision Date: April 3, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014194

[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 that you were eligible for Medicaid effective November 1, 2016?
>
> Did NYSOH properly determine you from your Medicaid Managed Care plan, effective November 30, 2016?

Procedural History

On October 28, 2016, NYSOH received your updated application for health insurance.

On October 29, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid because your household income of $12,000.00 was at or below the allowable income limit. This eligibility was effective as of November 1, 2016.

Also on October 29, 2016, NYSOH issued a notice of enrollment confirmation, stating that you were enrolled in a Medicaid Managed Care (MMC) plan with a start date of November 1, 2016.

On November 8, 2016, NYSOH received your updated application for health insurance.

On November 9, 2016, NYSOH issued a notice of eligibility determination stating that you were conditionally eligible for Medicaid, and you were asked to submit documentation confirming your household's income by November 23, 2016. This eligibility was effective as of December 1, 2016. This determination was also based on a household income of $12,000.00.

Also on November 9, 2016, NYSOH issued a disenrollment notice stating that your enrollment in your MMC plan would end effective November 30, 2016 because you were no longer eligible to remain enrolled in your current health insurance coverage.

On November 16, 2016, a paystub was faxed to your NYSOH account, and was uploaded on December 1, 2016.

On December 4, 2016, the system ran an application.

On December 5, 2016, 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, 2017 because certain individuals determined eligible for Medicaid remain eligible for benefits for twelve continuous months from the date that they were determined eligible.

On December 6, 2016, NYSOH issued a notice of eligibility determination stating that you were conditionally eligible for Medicaid effective January 1, 2017. You were asked to submit documentation confirming your household's income by December 20, 2016. This determination was also based on a household income of $12,000.00.

On December 13, 2016, a letter from your employer was uploaded to your online Marketplace account, as well as a letter indicating that your spouse has no income.

On December 18, 2016, NYSOH issued a notice of eligibility determination stating that you remained eligible for Medicaid, effective December 1, 2016, and that you needed to pick a plan. The notice also stated that your spouse was eligible for Medicaid effective December 1, 2016. This determination was also based on a household income of $12,000.00.

On December 21, 2016, NYSOH issued a notice of enrollment confirmation stating that you and your spouse were enrolled in an MMC plan with a start date of February 1, 2017.

On December 20, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you were not enrolled in an MMC plan in December 2016 and January 2017.

On March 2, 2017, you were scheduled for a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. You requested that day that the hearing be adjourned to a later date.

On March 15, 2017, you had an adjourned 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 expect to file your 2017 federal income tax return as married filing jointly, and claim one dependent.

2) According to the October 28, 2016 application, you attested to an expected annual household income of $12,000.00. The application also states and your testimony confirms that at the time, you were pregnant and expecting one child with a due date of [redacted].

3) You faxed a paystub on November 16, 2016 which shows gross earnings of $1,000.00 for the month of September 2016.

4) You uploaded a letter from your employer on December 13, 2016 stating that your monthly gross salary is $1,000.00 and that you work twelve months a year.

5) You testified that you have not had insurance outside of NYSOH Marketplace since October 2016.

6) You testified that you have not been incarcerated since October 2016.

7) You testified that you have been a NYS resident since October 2016.

8) You testified that you do not remember why your account was updated on November 8, 2016.

9) The record reflects that you reside in [redacted] County.

10) The record reflects that you were without MMC coverage in December 2016 and January 2017.

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 $20,160.00 for a three-person household (81 Federal Register 4036).

Medicaid-Pregnant Women

For purposes of Medicaid eligibility, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

Medicaid is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the FPL for the applicable family size (see 42 CFR § 435.116(c); New York State Department of Health 13 OHIP/ADM-03). Once eligible, a pregnant woman will remain eligible until the end of the month in which the sixtieth day following the end of the pregnancy occurs, regardless of any change in household income, even if such change would render her ineligible for financial assistance (NY Social Services Law § 366(4)(b)(1)).

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 twelve 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 under review is whether NYSOH properly determined that you were eligible for Medicaid effective November 1, 2016.

When calculating family size for Medicaid purposes, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman but also the number of children she expects to deliver. According to the record and your testimony at the time of your October 28, 2016 application, you expected to file your 2016 tax return as married filing jointly. Since you were pregnant and expecting one child at the time of your application, your eligibility was determined for a three-person household.

On your October 28, 2016 application, you attested to an expected household income of $12,000.00. You credibly testified and provided documentation that $12,000.00 is an accurate reflection of your expected household income.

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, or to pregnant women who have a household MAGI that is at or below 223% of the FPL for the applicable family size. On October 28, 2016, the relevant FPL was $20,160.00 for a three-person household. Since $12,000.00 is 59.52% of the 2016 FPL, NYSOH properly found you to be eligible for Medicaid on an expected annual income basis, using the information provided in your application.

Since the October 29, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible for Medicaid effective November 1, 2016, it is correct and is AFFIRMED.

The second issue is whether NYSOH properly disenrolled you from your MMC plan, effective November 30, 2016.

After being found eligible for Medicaid, you enrolled in an MMC plan. On October 29, 2016, NYSOH issued a notice confirming your enrollment in a MMC plan with a start date of November 1, 2016.

On November 8, 2016, NYSOH received your updated application for health insurance. You testified that you do not remember why you made this application.

Following the November 8, 2016 application, NYSOH issued a disenrollment notice dated November 9, 2016 stating that your enrollment in your MMC plan would end effective November 31, 2016 because you were no longer eligible to enroll.

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 the applicable percentage 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.

Credible evidence confirms that you were eligible for Medicaid effective November 1, 2016, and that your application information remained the same for the applications on November 8, 2016 and December 4, 2016. Accordingly, your eligibility should not have been terminated prior to the end of your twelve months of Medicaid continuous coverage.

Therefore, the November 9, 2016 eligibility determination and disenrollment notices terminating your enrollment in an MMC plan, and the December 5, 2016 and December 6, 2016 notices of eligibility determinations are incorrect and are RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid coverage and MMC enrollment for the months of December 2016 and January 2017.

Decision

The October 29, 2016 eligibility determination is AFFIRMED.

The November 9, 2016 eligibility determination is RESCINDED.

The November 9, 2016 disenrollment notice is RESCINDED.

The December 5, 2016 eligibility determination is RESCINDED.

The November 6, 2016 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your MMC enrollment for the months of December 2016 and January 2017.

Effective Date of this Decision: April 3, 2017

How this Decision Affects Your Eligibility

Your Medicaid coverage and MMC enrollment, which began on November 1, 2016, continues until October 31, 2017, barring subsequent changes in your eligibility.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to the Federal Marketplace 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 Federal Marketplace. 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 have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:

Health Insurance Marketplace
Attn: Appeals
465 Industrial Blvd.
London, KY 40750-0061

- By fax: 1-877-369-0129

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
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The October 29, 2016 eligibility determination is AFFIRMED.

The November 9, 2016 eligibility determination is RESCINDED.

The November 9, 2016 disenrollment notice is RESCINDED.

The December 5, 2016 eligibility determination is RESCINDED.

The November 6, 2016 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your MMC enrollment for the months of December 2016 and January 2017.

Your Medicaid coverage and MMC enrollment, which began on November 1, 2016, continues until October 31, 2017, barring subsequent changes in 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).

Legal Authority

We are sending you this notice in accordance with 45 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).

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).

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

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).

Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई निःशुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

اردو (Urdu)

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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).