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

Notice of Decision

Decision Date: February 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015120

[redacted]

Dear [redacted],

On February 24, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 29, 2016 and December 19, 2016 eligibility determination notice and December 19, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: February 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015120

[redacted]

Issue

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

> Did NY State of Health (NYSOH) properly determine that you were no longer eligible for Medicaid effective December 31, 2016?

Procedural History

On January 30, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid because your household income of $2,100.00 was at or below the allowable income limit. This eligibility was effective as of March 1, 2016.

Also on January 30, 2016, NYSOH issued an enrollment notice confirming your selection of a Medicaid Managed Care (MMC) plan as of January 29, 2016. The notice stated that your MMC plan coverage would begin effective March 1, 2016.

On October 19, 2016, NYSOH issued a notice that it was time to renew your health insurance for 2017. That notice stated that, based on information from federal and state sources, NYSOH could not make a decision about whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by December 15, 2016 or you might lose the financial assistance you were currently receiving.

On October 28, 2016, NYSOH received your updated application for health insurance; specifically, the income information was updated.

On October 29, 2016, NYSOH issued a notice of eligibility redetermination notice stating that you were no longer eligible for Medicaid; however, your Medicaid coverage would continue until December 31, 2016 because certain individuals determined eligible for Medicaid remain eligible for benefits for 12 continuous months from the date that they were determined eligible. This eligibility was effective as of October 1, 2016. You were also requested to provide proof of your income by November 12, 2016.

On November 25, 2016, NYSOH received two earnings statements issued to you by [redacted] on October 14, 2016 and November 10, 2016.

On December 19, 2016, NYSOH issued an eligibility redetermination notice stating you were no longer eligible for health insurance through NYSOH since you did not provide proof of your income as requested above.

Also on December 19, 2016, NYSOH issued a disenrollment notice stating that your MMC plan coverage would end effective December 31, 2016.

On January 21, 2017, you were found eligible for and enrolled in a qualified health plan (QHP) through NYSOH with an advance premium tax credit of up to $269.00 per month, effective March 1, 2017.

On January 24, 2017, you contacted NYSOH's Account Review Unit and requested an appeal insofar as your MMC plan ended on December 31, 2016, rather than February 28, 2017.

On February 3, 2017, NYSOH received (1) a letter from you, dated January 24, 2017, stating the nature of your appeal, and (2) four earnings statements issued to you by [redacted] between December 22, 2016 and January 20, 2017.

On February 8, 2017, NYSOH received a letter issued by [redacted], [redacted] of [redacted], dated January 25, 2017, detailing your diagnosis and need for an expedited appeal.

On February 17, 2017, NYSOH approved your request for an expedited appeal.

On February 24, 2017, 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 found eligible for Medicaid, without condition, effective March 1, 2016.

2) Your MMC plan coverage began effective March 1, 2016.

3) You expect to file your 2016 federal income tax return as single, and claim no dependents.

4) You testified that you began a new job with [redacted] during late 2016.

5) NYSOH issued you a renewal notice on October 19, 2016, requesting that you update the information in your NYSOH account by NYSOH, or you might lose your financial assistance you were receiving.

6) According to the October 28, 2016 application, you attested to an expected annual household income of $10,400.00. You testified that, at the time you submitted your application, this income was an accurate reflection of your expected income for the 2016 tax year. You further testified that this was comprised partially of income from [redacted] and your unemployment benefits received earlier during 2016.

7) You were disenrolled from your MMC plan effective December 31, 2016.

8) You testified that you were seeking for your MMC plan coverage to be reinstated between January 1, 2017 and February 28, 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).

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 issue under review is whether NYSOH properly determined that you were no longer eligible for Medicaid effective December 31, 2016.

You were found eligible for Medicaid, and enrolled in an MMC plan, effective March 1, 2016. This eligibility determination is not under review.

The record reflects that on October 19, 2016, you were issued a renewal notice requesting an update to your account no later than December 15, 2016 so that your eligibility could be determined for the 2017 plan year.

You testified, and the record reflects, that at the time of your October 28, 2016 update to your application, you experienced an increase in your income from $2,100.00 to $10,400.00. You updated your application on October 28, 2016 to include the income you will be receiving from [redacted]. This update increased your annual household income to $10,400.00, which is still below the Medicaid limit, though NYSOH requested that you provide additional income documentation to confirm your eligibility.

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 credible evidence confirms that you were eligible for Medicaid effective March 1, 2016, and that even though your estimated annual income increased when you modified your application on October 28, 2016, you were entitled to remain enrolled in Medicaid for the remainder of your 12-month eligibility period, which ended effective February 18, 2017.

Therefore, the October 29, 2016 eligibility determination notice is RESCINDED.

The December 19, 2016 eligibility determination notice is RESCINDED.

The December 19, 2016 disenrollment notice is MODIFIED to state that MMC plan coverage would continue until February 28, 2017.

Your case is RETURNED to NYSOH to effectuate the above revisions to your account, and to reinstate your MMC plan coverage for the period between January 1, 2017 and February 28, 2017.

Decision

The October 29, 2016 eligibility determination notice is RESCINDED.

The December 19, 2016 eligibility determination notice is RESCINDED.

The December 19, 2016 disenrollment notice is MODIFIED to state that MMC plan coverage would continue until February 28, 2017.

Your case is RETURNED to NYSOH to effectuate the above revisions to your account, and to reinstate your MMC plan coverage for the period between January 1, 2017 and February 28, 2017.

Effective Date of this Decision: February 28, 2017

How this Decision Affects Your Eligibility

Your Medicaid coverage, which began on March 1, 2016, continues until February 28, 2017.

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 October 29, 2016 eligibility determination notice is RESCINDED.

The December 19, 2016 eligibility determination notice is RESCINDED.

The December 19, 2016 disenrollment notice is MODIFIED to state that MMC plan coverage would continue until February 28, 2017.

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Your Medicaid coverage, which began on March 1, 2016, continues until February 28, 2017.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

[redacted]

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