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

Notice of Decision

Decision Date: July 6, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016101

[redacted]

Dear [redacted],

On June 5, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 16, 2016 and January 14, 2017 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).

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

Decision

Decision Date: July 6, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016101

[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, your spouse, and your children were eligible for Medicaid effective November 1, 2016?
>
> Did NY State of Health properly determine that you, your spouse, and your children were disenrolled from Medicaid, effective January 31, 2017?

Procedural History

On November 1, 2016, you updated your household's application for financial assistance with health insurance.

On November 2, 2016, NY State of Health (NYSOH) issued a notice advising that the income information in your application did not match what NYSOH received from state and federal data sources and that documentation of your household's income was due by November 4, 2016 in order for your household's eligibility to be determined.

On November 1, 2016 and November 7, 2016, income documentation was uploaded to your NYSOH account.

On November 15, 2016, NYSOH reviewed the income documentation you submitted and redetermined your household's annual expected income. NYSOH submitted an application on your behalf that day which included the recalculated annual expected income.

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On November 16, 2016, NYSOH issued a notice of eligibility determination, based on the November 15, 2016 application, stating that you, your spouse, and your children were eligible for Medicaid because your household income of $20,640.00 was at or below the allowable income limit. This eligibility was effective as of November 1, 2016.

On November 17, 2016, NYSOH issued a notice of enrollment confirmation stating that you, your spouse, and your children were enrolled into a Medicaid Managed Care plan through United Healthcare, effective January 1, 2017.

On January 10, 2017, you requested that you, your spouse, and your children be disenrolled from your Medicaid Managed Care plan.

On January 12, 2017, NYSOH issued a disenrollment notice stating that your, your spouse's, and your children's enrollment in your Medicaid Managed Care plan through United Healthcare would end on January 31, 2017.

On January 13, 2017, your NYSOH account was updated to remove your spouse and your children from the application, to indicate that you were not applying for health insurance, and to update your application from a financial assistance application to a non-financial application.

That day, NYSOH issued a preliminary eligibility determination stating that you were not applying for health coverage through NYSOH.

Thereafter, on January 13, 2017, NYSOH received your updated application for health insurance which again included your spouse and your children, and indicated that your entire household was applying for financial assistance with health insurance, additionally the income information was updated.

On January 14, 2017, NYSOH issued a notice of eligibility determination stating that you and your spouse were eligible to purchase a qualified health plan at full cost through NYSOH and that your children were eligible to purchase a Child Health Plus plan at full cost through NYSOH, effective February 1, 2017. This notice also stated that you, your spouse, and your children were not eligible for Medicaid.

On February 22, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you, your spouse, and your children were not found eligible for 12 months of continuous Medicaid.

On June 5, 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.

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Findings of Fact

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

1) You and your spouse expect to file your 2017 federal tax return as married filing jointly, and will claim four dependents on that return.

2) On November 1, 2016, a copy of your Unemployment Insurance Monetary Benefit Determination from the NYS Department of Labor was uploaded to your NYSOH account. This shows that beginning October 17, 2016 you would begin receiving $430.00 per week in Unemployment Insurance Benefits, and that this could continue until October 22, 2017.

3) On November 7, 2016, a letter dated November 7, 2016 signed by yourself was uploaded to your NYSOH account. This letter indicates that neither your spouse nor any of your children have any income, and that prior to losing your job, you were the sole provider for your household.

4) On November 15, 2016, NYSOH reviewed the income documentation you submitted and recalculated your annual expected household income to be $20,640.00.

5) You testified that you began receiving Unemployment Insurance Benefits as of October 17, 2016, and that these continued for October 2016, November 2016, and December 2016. You testified that you were receiving $430.00 per week and that this was your household's only source of income during that time.

6) You testified that you began a new job in January 2017, and your income has since changed.

7) According to the January 13, 2017 application, you attested to an increased expected household income of $132,000.00.

8) You testified that you had tried to disenroll yourself, your spouse, and your children from your Medicaid Managed Care plan through United Healthcare, but you never requested that you, your spouse, or your children be disenrolled from Fee-For Service Medicaid, and that the request to disenroll from your Medicaid Managed Care plan was because you had access to employer sponsored health insurance.

9) Your NYSOH account reflects that on January 10, 2017 user [redacted]" accessed your account and you disenrolled yourself, your spouse, and

your children from your Medicaid Managed Care plan through United Healthcare.

10) Your NYSOH account reflects that on January 13, 2017 an NYSOH representative updated your account, removing your spouse and your children from your account, changing your application from a financial assistance application to a non-financial assistance application, and indicated that you were no longer seeking insurance through NYSOH.

11) During the hearing, you gave permission for the Hearing Officer to listen to phone calls between yourself and NYSOH.

12) The record reflects that on January 10, 2017, you placed a phone call to NYSOH. A review of the recording of that phone call reveals that you requested to disenroll yourself, your spouse, and your children from your Medicaid Managed Care plan, but that you requested to remain enrolled in your Fee-For Service Medicaid. While on the phone with the NYSOH representative, you accessed your NYSOH account on-line, and the NYSOH representative gave you instructions for disenrolling yourself, your spouse, and your children from your Medicaid Managed Care plan. No other changes were made to your account at that time.

13) The record reflects that on January 13, 2017 you placed a phone call to NYSOH. A review of the recording of that phone call reveals that you were calling to confirm your household's enrollment status. You advised the NYSOH representative that you wanted to make sure that your household had been disenrolled form your Medicaid Managed Care plan through United Healthcare, but still enrolled in Fee-For Service Medicaid. The NYSOH representative advised you that your application was still in progress, and that your application would need to be completed in order for her to see your household's current enrollment. The NYSOH representative offered to complete the application for you. The NYSOH representative was confused by your request and updated your application so as to result in your spouse and your children being removed from your account and you being marked as not applying for health insurance. The NYSOH representative also failed to confirm these changes with you prior to submitting them to the system. Following these changes, the NYSOH representative then added your spouse and your children to your NYSOH account and updated your household's application for financial assistance including your new income.

14) You testified that you are seeking for you, your spouse, and your children to be eligible for and enrolled in Fee-For Service Medicaid for a full 12 months.

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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 $32,580.00 for a six-person household (81 Federal Register 4036).

Medicaid for Children

A child who is under one year of age is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 223% of the federal poverty level (FPL) for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the federal poverty level (FPL) for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

A child aged 19 or 20, whose primary residence is with their parents, is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 155% of the federal poverty level (FPL) for the applicable family size (NY Social Services Law § 366)(b)(7);

New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

Medicaid Continuous Coverage

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, your spouse, and your children were eligible for Medicaid effective November 1, 2016.

According to the record, you expect to file your 2017 tax return as married filing jointly and claim four children as dependents. Therefore, you, your spouse, and your children are in a six-person household.

On November 15, 2016, NYSOH recalculated your household income to be $20,640.00 ($430.00 for 48 weeks) based on the income documentation you submitted, updated the income information in your application, and submitted a new application on your behalf.

You credibly testified that at the time of the November 15, 2016 application, your household’s only source of income was your Unemployment Insurance Benefits.

Therefore, the information relied upon by NYSOH in the November 16, 2016 eligibility determination, was an accurate reflection, at that time, of your expected household income for 2017.

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; to children between

the ages of 1 and 19 who meet the non-financial requirements and have a household MAGI that is at or below 154% of the FPL for the applicable family size; and for children under 1 year of age who meet the non-financial requirements and have a household MAGI that is at or below 223% of the FPL for the applicable family size . On the date of your household's application, the relevant FPL was $32,580.00 for a six-person household. Since $20,640.00 is 63.35% of the 2016 FPL, NYSOH properly found you, your spouse, and your children to be eligible for Medicaid on an expected annual income basis, using the information provided in your application.

Since the November 16, 2016 eligibility determination properly stated that, based on the information you provided, you, your spouse, and your children were eligible for Medicaid, it is correct and is AFFIRMED.

The second issue is whether NYSOH properly determined that you, your spouse, and your children were disenrolled from Medicaid, effective January 31, 2017.

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 at the time of the November 15, 2016 application, your household's only source of income was your Unemployment Insurance Benefits. You updated your application on January 13, 2017 to include the income you will be receiving from your new employment. This update increased your annual household income to $132,000.00, which is above the Medicaid limit.

However, prior to updating your household's application to include your new income, the NYSOH representative mistakenly removed your spouse and your children from your NYSOH account. The NYSOH representative also mistakenly updated your application to indicate that you were not applying for health insurance and marked your application as a non-financial rather than a financial assistance application.

These changes resulted in you, your spouse, and your children being terminated from Medicaid, effective January 31, 2017.

The record reflects that there were no events that would have been a basis for your, your spouse's, or your children's Medicaid coverage to have been terminated. Since you, your spouse, and your children were determined eligible for Medicaid based on the application submitted on November 15, 2016, effective November 1, 2016, you, your spouse, and your children remained eligible for Medicaid for 12 continuous months, regardless of any changes in your household income. As a result, you, your spouse, and your children were improperly disenrolled from Medicaid, effective January 31, 2017.

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).

Since NYSOH determined that you, your spouse, and your children were eligible for Medicaid as of November 1, 2016, and therefore eligible for continuous coverage, the January 14, 2017 eligibility determination is MODIFIED to provide you, your spouse, and your children Medicaid coverage until the end of your 12-month continuous coverage period.

Your case is RETURNED to NYSOH to reinstate you, your spouse, and your children into Medicaid as of February 1, 2017 and to continue your, your spouse's, and your children's Medicaid, barring subsequent changes in your household's eligibility, until October 31, 2017.

Decision

The November 16, 2016 eligibility determination notice is AFFIRMED.

The January 13, 2017 eligibility determination notice is MODIFIED to provide you, your spouse, and your children Medicaid coverage until the end of your 12-month continuous coverage period.

Your case is RETURNED to NYSOH to reinstate you, your spouse, and your children into Medicaid as of February 1, 2017 and to continue your, your spouse's, and your children's Medicaid, barring subsequent changes in your household's eligibility, until October 31, 2017.

Effective Date of this Decision: July 6, 2017

How this Decision Affects Your Eligibility

Your, your spouse's, and your children's Medicaid coverage, which began on November 1, 2016, continues until October 31, 2017, barring subsequent changes in your eligibility.

Your case is being sent back to NYSOH to reinstate you, your spouse, and your children into Medicaid as of February 1, 2017 and, barring subsequent changes in your household's eligibility, to continue your, your spouse's, and your children's Medicaid until October 31, 2017.

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

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- By fax: 1-855-900-5557

Summary

The November 16, 2016 eligibility determination notice is AFFIRMED.

The January 13, 2017 eligibility determination notice is MODIFIED to provide you, your spouse, and your children Medicaid coverage until the end of your 12-month continuous coverage period.

Your, your spouse's, and your children's Medicaid coverage, which began on November 1, 2016, continues until October 31, 2017, barring subsequent changes in your eligibility.

Your case is RETURNED to NYSOH to reinstate you, your spouse, and your children into Medicaid as of February 1, 2017 and to continue your, your spouse's, and your children's Medicaid, barring subsequent changes in your household's eligibility, until October 31, 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]

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.

□□□□□ (Bengali)

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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)

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).

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).