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

Notice of Decision

Decision Date: November 29, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022246

[redacted]

[redacted]

On November 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's May 17, 2017 disenrollment notice and September 9, 2017 eligibility determination 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 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: November 29, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022246

[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 your Medicaid Coverage ended June 30, 2017?
>
> Did NYSOH properly determine that you were not eligible for Medicaid for the months of July 2017 and August 2017?

Procedural History

On July 14, 2016, NYSOH issued a notice of eligibility determination stating you were eligible for Medicaid, effective August 1, 2016.

On July 15, 2016, NYSOH issued an enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective August 1, 2016.

On May 4, 2017, NYSOH issued a renewal notice stating it was time to renew your health insurance coverage with NYSOH. The notice stated you were now eligible for advance payments of the premium tax credit up to $250.17 per month, effective July 1, 2017. The notice requested you select a health plan between May 16, 2017 and June 15, 2017.

On May 17, 2017, NYSOH issued a disenrollment notice stating your coverage in your Medicaid Managed Care plan would end June 30, 2017. The notice stated this was because you were no longer eligible to enroll in your health plan.

On June 3, 2017, NYSOH issued an enrollment notice confirming your enrollment on June 2, 2017 in a bronze level qualified health plan, effective July 1, 2017.

On September 8, 2017, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for July and August 2017.

That day a preliminary eligibility determination was prepared stating you were eligible for Medicaid, effective September 1, 2017. You were further determined ineligible for Medicaid for the months of July and August 2017. You then enrolled in a Medicaid Managed Care plan that day for an October 1, 2017 start date.

On September 8, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as it denied retroactive Medicaid for the months of July and August 2017.

On September 9, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid. This eligibility was effective as of September 1, 2017. The notice stated you no longer qualified for advance premium tax credits as of August 31, 2017.

On September 9, 2017 NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid for July 2017 because the monthly household income of $3,800.00 is over the allowable monthly income limit of $1,387.00. The notice also stated you were not eligible for Medicaid for August 2017 because your monthly household income of $3,600.00 is over the allowable monthly income limit of $1,387.00.

On September 9, 2017, a disenrollment notice was issued stating you bronze level qualified health plan would end September 30, 2017. The notice stated this was because you were no longer eligible to enroll in your health plan.

On September 9, 2017, an enrollment confirmation notice was issued confirming your enrollment in a Medicaid Managed Care plan, effective October 1, 2017.

On November 7, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open up to November 22, 2017, to allow you to submit supporting documents.

On November 9, 2017, NYSOH received the requested documentation and it was incorporated into the record as Appellant's Exhibit #1, the record was closed that day.

Findings of Fact

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

1) You testified that you are seeking Medicaid from July to August 2017.

2) You testified that you expect to file your 2017 federal income tax return as single, and claim no dependents.

3) The renewal notice issued on May 4, 2017 states you were ineligible for Medicaid and that based on federal and state data sources your income was between $16,395.00 and $47,520.00.

4) You submitted an application for financial assistance on September 8, 2017. The application stated your annual household income for 2017 would be $10,200.01. You testified this amount was correct.

5) Your application submitted on September 8, 2017, states that for the month of August 2017 your income was $3,600.00. You testified that you believed that amount was correct.

6) You testified you earn an income from [redacted] which you receive $10,200.00 annually. You provided documentation in the form of a letter from your program confirming this.

7) You uploaded a copy of a paystub dated August 18, 2017 for a gross pay amount of $1,812.80.

8) You reside in [redacted]

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 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 2017 FPL, which is $ 12,060.00 for a one-person household (82 Fed. Reg. 8831).

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)).

Retroactive Medicaid

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of an initial application if the individual received medical services that would have been covered under Medicaid and the individual would have been eligible for Medicaid at the time he received the services if he had applied (42 USCA § 1396A(34); 42 CFR § 435.915(a)). The Department of Health may make eligibility effective for fee-for-service Medicaid on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

Legal Analysis

The first issue under review is whether NYSOH properly determined you were no longer eligible for Medicaid, effective June 30, 2017.

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.

You were determined eligible for Medicaid and enrolled in a Medicaid Managed Care plan effective August 1, 2016.

On May 4, 2017, NYSOH issued a renewal notice stating you were now eligible for advance payments of the premium tax credit up to $250.17 per month, effective July 1, 2017, as NYSOH had determined from federal and state data sources that your income was now over the Medicaid limit. You were subsequently disenrolled from your Medicaid Managed Care plan effective June 30, 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.”

Credible evidence confirms that you were eligible for Medicaid effective August 1, 2016, and that even though your estimated annual income increased when NYSOH checked federal and state data sources on May 3, 2017, you remain enrolled in Medicaid for the remainder of your 12-month eligibility period, until July 31, 2017. Since no other triggering events occurred based on the record other than the change to your estimated income, your eligibility should have continued. Therefore, the May 17, 2017, disenrollment notice was improper and is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you in your Medicaid Managed Care plan for the month of July 2017.

The second issue under review is whether NYSOH properly determined that you were not eligible for Medicaid for the months of July 2017 and August 2017.

As discussed above, you remained eligible for Medicaid through July 30, 2017, therefore only a discussion of your eligibility for retroactive Medicaid for the month of August 2017 is necessary.

You are in a one-person household; you file your taxes with a tax filing status of single and claim no dependents on your tax return for 2017.

You submitted an application for financial assistance on September 8, 2017 and requested help in paying for medical bills for July to August 2017. You were determined eligible for Medicaid effective September 1, 2017.

When an individual file, an initial application for Medicaid, his or her eligibility for retroactive Medicaid depends on the date of application. To this end, it does not matter whether or not that initial application resulted in Medicaid going forward. Instead, an individual, who has filed an initial application for Medicaid through NYSOH, has the right to be evaluated for Medicaid for the three months before the month of his or her application.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's initial application if the individual received medical services that would have been covered under Medicaid and if they would have been eligible for Medicaid in those three months had they applied.

You testified that you are seeking Medicaid from August 1, 2017 to August 30, 2017.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size. To be eligible for Medicaid in August, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,387.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during August 2017.

You uploaded a copy of a paystub dated August 18, 2017 for a gross pay amount of $1,812.80.

Therefore, the record indicates that in the month of August 2017, you had a monthly household income of at least $1,812.80.

Since your income of at least $1,812.80 was more than the $1,387.00 monthly Medicaid limit for August 2017, NYSOH properly determined that you were not eligible for Medicaid coverage during that month. Therefore, the September 9, 2017 eligibility determination stating that you were not eligible for Medicaid in the month of August, is correct and is AFFIRMED.

Decision

The May 17, 2017, disenrollment notice was improper and is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you in your Medicaid Managed Care plan for the month of July 2017.

The September 9, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: November 29, 2017

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).

You are eligible to remain enrolled in your Medicaid Managed Care plan until July 31, 2017.

You are not eligible for Medicaid in the month of August 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):

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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- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The May 17, 2017, disenrollment notice was improper and is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you in your Medicaid Managed Care plan for the month of July 2017.

The September 9, 2017 eligibility determination notice is AFFIRMED.

You are eligible to remain enrolled in your Medicaid Managed Care plan until July 31, 2017.

You are not eligible for Medicaid in the month of August 2017.

Legal Authority

We are issuing this determination 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.

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।

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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 तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई नि:शुल्क 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.

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