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

Notice of Decision

Decision Date: December 22, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022275

[redacted]

Dear [redacted]

On November 13, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 18, 2017 eligibility determination notice and the 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 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: December 22, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022275

[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 you were no longer eligible for Medicaid, effective September 1, 2017?

Procedural History

On January 10, 2017, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective January 1, 2017.

On January 19, 2017, NYSOH issued an enrollment notice confirming you were enrolled in a Medicaid Managed Care plan, effective February 1, 2017.

On August 17, 2017, NYSOH received an updated application for financial assistance with health insurance submitted on your behalf.

On August 18, 2017, NYSOH issued an eligibility determination notice stating you were newly eligible to purchase a full cost qualified health plan, effective September 1, 2017. The notice indicated that you were not eligible for Medicaid or the Essential Plan, because your income was over the allowable limits for those programs. The notice further stated that you were not eligible to receive advance payments of the premium tax credit (APTC), because you either would not file a federal tax return, you were married and filing your taxes separately from your spouse, or you received APTC in a prior year in which NYSOH could not tell if you filed a federal tax return.

Also on August 18, 2017, NYSOH issued a disenrollment notice stating your Medicaid Managed Care plan coverage would end on August 31, 2017, because you were no longer eligible for that plan.

On September 8, 2017, NYSOH received another updated application submitted on your behalf. That day a preliminary eligibility determination was prepared stating you were eligible to enroll in the Essential Plan with a $20.00 monthly premium.

Also on September 8, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as you were no longer eligible for Medicaid.

On September 9, 2017, NYSOH issued an eligibility determination stating you were eligible for the Essential Plan with a $20.00 monthly premium, effective October 1, 2017. The notice stated that you were not eligible for Medicaid, because the household income you provided was over the allowable limit for that program.

On September 14, 2017, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, for a limited time, effective September 1, 2017, until a decision was made on your appeal. You were subsequently reenrolled into your Medicaid Managed Care plan, effective September 1, 2017.

On November 13, 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 for you to submit updated income documentation. On November 16, 2017, documentation was uploaded to your NYSOH account and incorporated into the record as Appellant's Exhibit # 1. The record closed thereafter.

Findings of Fact

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

1) You were determined eligible for Medicaid, effective January 1, 2017. You enrolled into a Medicaid Managed Care plan, effective February 1, 2017.

2) You testified that you updated your application on August 17, 2017 to report that you began receiving Social Security benefit payments in June 2017.

3) That application listed your annual income as $26,356.00, including 12 monthly Social Security benefit payments.

4) Following the August 17, 2017 application, you were determined ineligible for Medicaid on the grounds you were over the allowable income limit for that program.

5) You were disenrolled from your Medicaid Managed Care plan, effective August 31, 2017.

6) You updated your application again on September 8, 2017, reducing your annual income to $ 19,103.63, including nine Social Security benefit payments.

7) NYSOH determined you eligible for the Essential Plan with a $20.00 monthly premium payment, effective October 1, 2017.

8) You appealed insofar as you were no longer eligible for Medicaid.

9) You were granted aid to continue in your Medicaid Managed Care plan pending the decision in your appeal. You were reenrolled into the plan, effective September 1, 2017.

10) You testified you are a seasonal worker at [redacted] and that your hours vary depending on the [redacted] schedule. You testified that you generally work from the end of March through the end of the [redacted] season. You testified that based on your final paystub for the 2017 season, you made $6,272.23 in gross income at this job.

11) You testified that you also collect unemployment insurance benefits for the weeks you do not work in the gross amount of $172.00.

12) You testified that you began receiving Social Security benefits in 2017 beginning in June in the amount of $1,062.00.

13) You were directed to submit documentation of your income and on November 16, 2017, the following documentation was posted to your NYSOH account:

    a. A letter from the Social Security Administration indicating that you would being receiving Social Security benefit payments in the amount of $1,062.00 beginning April 2017.

    b. A paystub from [redacted] for the period ending October 22, 2017 showing gross year to date income of $6,272.23.

    c. A monetary benefit determination from the State Department of Labor showing an unemployment insurance benefit award at a rate

of $172.00 for the benefit year ending December 3, 2017 with a handwritten note indicating “26 weeks.”

14) You testified, and your applications indicate, you will file your 2017 tax return with a tax filing status of single and you will claim no dependents.

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)).

Generally, most adults determined eligible for Medicaid are guaranteed twelve 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 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 (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 you were no longer eligible for Medicaid, effective September 1, 2017.

According to your account, you were determined eligible for Medicaid, effective January 1, 2017 and enrolled into a Medicaid Managed Care plan, effective February 1, 2017.

Pursuant to the above cited regulations, once a person is determined eligible for Medicaid, that eligibility continues for 12 months, with limited exceptions, even if the applicant's income increases above the allowable Medicaid limit within that period. This provision is called "continuous coverage."

Therefore, having been determined eligible for Medicaid effective June 1, 2017, barring the occurrence of certain events, your eligibility for Medicaid should not have ended prior to December 31, 2017.

Although you updated your application on August 17, 2017, increasing your attested household income amount, since you had already been determined eligible for Medicaid, you were eligible to continue your coverage for 12 months despite any subsequent income disqualification.

Because there is no evidence in your account that you entered prison or another facility that provides medical care, moved out of state, or failed to provide a valid Social Security number, it was improper for NYSOH to determine you were ineligible for Medicaid effective September 1, 2017.

Thus, the August 18, 2017 eligibility determination notice stating you were eligible for a full cost qualified health plan, effective September 1, 2017, and ineligible for Medicaid, is MODIFIED to reflect you were eligible for continuous Medicaid coverage until December 31, 2017.

The subsequent September 9, 2017 eligibility determination notice is similarly MODIFIED to reflect you were eligible for continuous Medicaid coverage until December 31, 2017.

Your case is RETURNED to NYSOH to reinstate you in your Medicaid Managed Care plan coverage, effective September 1, 2017.

It is noted that your Medicaid continuous coverage eligibility ends on December 31, 2017. You were directed to submit proof of your income for determination of your eligibility for health coverage in 2018. Based on the documentation submitted it is concluded that your year to date gross income earned from your employment in 2017 was $6,272.23, that you collected unemployment insurance benefits in the amount of $172.00 for 26 weeks, and you will collect Social Security benefits in the amount of $1,062.00 for all 12 months in 2018. Due to the variability of your earned income it is concluded that the best prediction for your 2018 earned income would be your actual earned income for 2017. Thus, based on the documentation submitted, your annual income for 2018 is $23,488.23.

Therefore, your case is RETURNED to NYSOH to determine your eligibility for health coverage for 2018 based on a household size of one and an annual income of $23,488.23, and to ensure that this eligibility and any subsequent enrollment becomes effective January 1, 2018.

Decision

The August 18, 2017 and September 9, 2017 eligibility determination notices are MODIFIED to reflect you were eligible for continuous Medicaid coverage until December 31, 2017.

Your case is RETURNED to NYSOH to reinstate you in your Medicaid Managed Care plan coverage, effective September 1, 2017.

Your case is also RETURNED to NYSOH to determine your eligibility for health coverage in 2018 based on a household size of one and an annual income of $23,488.23.

Effective Date of this Decision: December 22, 2017

How this Decision Affects Your Eligibility

Your Medicaid coverage should not have been terminated on September 1, 2017.

Your case is being sent back to NYSOH to reinstate you in your Medicaid coverage.

This is not a final determination of your eligibility for health coverage in 2018.

You will receive an eligibility determination notice from NYSOH regarding your eligibility for health insurance in 2018, based on the evidence submitted.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the

dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your appeal was decided, the 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 August 18, 2017 and September 9, 2017 eligibility determination notices are MODIFIED to reflect you were eligible for continuous Medicaid coverage until December 31, 2017.

Your case is RETURNED to NYSOH to reinstate you in your Medicaid Managed Care plan coverage, effective September 1, 2017.

Your case is also RETURNED to NYSOH to determine your eligibility for health coverage in 2018 based on a household size of one and an annual income of $23,488.23.

Your Medicaid coverage should not have been terminated on September 1, 2017.

Your case is being sent back to NYSOH to reinstate you in your Medicaid coverage.

This is not a final determination of your eligibility for health coverage in 2018.

You will receive an eligibility determination notice from NYSOH regarding your eligibility for health insurance in 2018, based on the evidence submitted.

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.

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 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.

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).