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

Notice of Decision

Decision Date: January 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022914

[redacted]

[redacted]

On December 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 12, 2017 eligibility determination notice and October 3, 2017 eligibility determination and disenrollment 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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Decision

Decision Date: January 10, 2018

NY State of Health Account ID: [redacted]
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[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 were no longer eligible for health insurance through NY State of Health and disenrolled from Medicaid and your Medicaid Managed Care plan, effective November 1, 2017?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid retroactively from August 1, 2017 through August 31, 2017?

Procedural History

On September 5, 2017, NY State of Health (NYSOH) issued an eligibility determination notice stating you were eligible to enroll in the Essential Plan at $20.00 per month for a limited time, effective October 1, 2017. The notice directed you to provide proof of your income by December 4, 2017, to confirm your eligibility.

On September 7, 2017, NYSOH issued a notice stating the income information in your application did not match what NYSOH received from state and federal data sources. The notice directed you to provide more information to confirm your household income by September 21, 2017.

On September 12, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid from August 1, 2017 through August 31,

2017, because your monthly household income of $1,632.58 that month was over the allowable monthly income limit of $1,387.00.

On September 14, 2017, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective September 1, 2017, because your household income of $0.00 was at or below the allowable income limit for that program.

On September 14, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid retroactively from July 1, 2017 through July 31, 2017, because your monthly household income of $0.00 was at or below the allowable monthly income limit of $1,387.00.

On September 19, 2017, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective September 1, 2017.

On September 21, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective November 1, 2017.

On September 28, 2017, you spoke to NYSOH's Account Review Unit and appealed the denial of Medicaid retroactively for the month of August 2017.

On October 3, 2017, NYSOH issued a notice stating you were no longer eligible to enroll in health insurance through NYSOH, effective October 3, 2017. The notice stated this was because NYSOH sent you information, including notices about your eligibility and coverage, by U.S. mail to the mailing address provided in your account and these notices were returned as undeliverable.

On October 3, 2017, NYSOH issued a disenrollment notice terminating your enrollment in your Medicaid Managed Care plan, effective November 1, 2017. The notice stated this was because you were no longer eligible to enroll in insurance through NYSOH.

On December 7, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During your hearing, you amended your appeal to include the October 3, 2017 determination and disenrollment notices. 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 testified you are seeking health insurance for yourself.

2) You testified you have lived in New York State throughout 2017.

3) You testified you have not had health coverage outside of NYSOH for 2017.

4) You testified you currently reside at [redacted].

5) Your NYSOH account shows that your address information has not changed since your September 5, 2017 application and all notice issued after this date have been issued to the address you testified was accurate.

6) NYSOH received return mail from your mailing address on September 11 and September 29, 2017.

7) You were disenrolled from Medicaid and your Medicaid Managed Care plan effective November 1, 2017.

8) The record supports NYSOH did not receive return mail from your address after September 29, 2017.

9) You testified you are seeking Medicaid retroactively from August 1, 2017 through August 31, 2017.

10) The record shows you submitted a request for help paying medical bills for the prior three months in your application on September 11, 2017.

11) You testified you expect to file your 2017 federal income taxes as single and claim no dependents.

12) You provided income documentation on August 23, 2017 in the form of paystubs with check dates of August 4, 11, and 18, 2017 in gross amounts of $304.50, $672.00, and $189.00 respectively ([redacted]

13) On September 13, 2017, you provided a letter from your employer to NYSOH, dated September 8, 2017, stating your last day of work was August 8, 2017 and your year to date wages were $14,268.00 [redacted]

14) You testified you did not receive any other income from unemployment benefits or disability benefits in the month of August 2017.

15) You reside in Rockland County, NY.

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 through NYSOH can be provided 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); N.Y. Soc. Serv. 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 Federal Register 8831).

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)).

Under 42 CFR § 435.403 Medicaid must be provided to “eligible residents of the State” (42 CFR § 435.403(a)). A person shall not be eligible for Medicaid unless he or she is a resident of the state, or, while temporarily in the state, requires immediate medical care which is not otherwise available (N.Y. Soc. Serv. Law § 366(1)(d)(1)).

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 that you were no longer eligible for health insurance through NYSOH and disenrolled from Medicaid and your Medicaid Managed Care plan, effective November 1, 2017.

You were found eligible for Medicaid, effective September 1, 2017 and were subsequently enrolled into Medicaid Managed Care plan as of November 1, 2017.

Generally, an individual remains eligible for Medicaid for twelve continuous months unless the person becomes otherwise ineligible. If a person lacks state residence or is unable to prove state residence during those twelve months, then they become ineligible for Medicaid and continuous coverage.

On October 3, 2017, NYSOH issued an eligibility determination notice stating you were no longer eligible for health insurance and your Medicaid Managed Care plan was to terminate as of November 1, 2017, because NYSOH received return mail notices from your address. This return mail triggered your ineligibility and disenrollment based on lack of state residency.

However, you credibly testified that you have remained a New York State resident for all of 2017.

NYSOH received return mail notices from the address listed in your account on September 11, 2017 and September 29, 2017. The record shows NYSOH did not receive return mail from your address after September 29, 2017. You testified and the record shows your address had not changed since your September 5, 2017 application.

As there is sufficient evidence in the record to conclude you have continuously retained New York State residency during the relevant time in question, you were improperly disenrolled from Medicaid and your Medicaid Managed Care plan as of November 1, 2017 for failure to meet residency requirements. There are no

other facts present in the record that would support you being ineligible for Medicaid for the remainder of your twelve-month period of eligibility.

Therefore, the October 3, 2017 eligibility determination and disenrollment notices are RESCINDED, because they improperly determined you ineligible for and disenrolled you from Medicaid and your Medicaid Managed Care plan effective November 1, 2017.

Accordingly, your case is RETURNED to NYSOH to reinstate you into your Medicaid Managed Care plan for the remaining months of your eligibility until August 31, 2018, provided no disqualifying events occur before then.

The second issue under review is whether NYSOH properly determined that you were not eligible for Medicaid retroactively from August 1, 2017 through August 31, 2017.

You are in a one-person household for purposes of this analysis. This is because you file your taxes with a tax filing status of single and claim no dependent on your tax return.

You applied for financial assistance on September 11, 2017 and requested help in paying for medical bills, in part, from August 1, 2017 through August 31, 2017.

When an individual files 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.

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 2017, 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 income documentation on August 23, 2017 in the form of paystubs with check dates of August 4, 11, and 18, 2017 in gross amounts of $304.50, $672.00, and $189.00 respectively [redacted] You

also provided a letter from your employer, dated September 8, 2017, stating your last day of work was August 8, 2017, and your year to date wages were $14,268.00[redacted] During your hearing, you testified you did not receive any other income from unemployment benefits or disability benefits in the month of August 2017.

Therefore, the record indicates that in the month of August, you had a monthly household income of $1,165.50.

Since your income of $1,165.50 was less than the $1,387.00 monthly Medicaid limit for August, NYSOH incorrectly determined that you were not eligible for Medicaid coverage during that month. Therefore, the September 12, 2017 eligibility determination notice is RESCINDED.

Since the record now contains a more accurate representation of what your income was for the month of August 2017, your case is RETURNED to NYSOH to consider your request for retroactive coverage for August 2017, based on a household size of one and household income of $1,165.50.

Decision

The October 3, 2017 eligibility determination and disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to reinstate you into your Medicaid Managed Care plan for the remaining months of your eligibility until August 31, 2018, provided no disqualifying events occur before then.

The September 12, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for August 2017, based on a household size of one and household income of $1,165.50.

Effective Date of this Decision: January 10, 2018

How this Decision Affects Your Eligibility

You should have remained eligible for and enrolled in your Medicaid Managed Care plan until August 31, 2018, unless you experience a disqualifying event.

Your case is being sent back to NYSOH to enroll you in your Medicaid Managed Care plan.

This decision is not a final determination of your eligibility for Medicaid fee for service for the month of August 2017. Your case is being sent back to NYSOH to consider your request based on the information noted adobe and as adduced at hearing. NYSOH will notify you of its redetermination.

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).

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 3, 2017 eligibility determination and disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to reinstate you into your Medicaid Managed Care plan for the remaining months of your eligibility until August 31, 2018, provided no disqualifying events occur before then.

The September 12, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for August 2017, based on a household size of one and household income of $1,165.50.

You should have remained eligible for and enrolled in your Medicaid Managed Care plan until August 31, 2018, unless you experience a disqualifying event.

Your case is being sent back to NYSOH to enroll you in your Medicaid Managed Care plan.
This decision is not a final determination of your eligibility for Medicaid fee for service for the month of August 2017. Your case is being sent back to NYSOH to consider your request based on the information noted adobe and as adduced at hearing. NYSOH will notify you of its redetermination.

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.

□□□□□ (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).