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

Notice of Decision

Decision Date: February 02, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000023856

On December 21, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 7, 2017, October 29, 2017, and November 1, 2017 eligibility determinations.

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: February 02, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000023856

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 November 1, 2017?

Procedural History

On December 13, 2016, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective December 1, 2016.

Also on December 13, 2016, NYSOH issued an enrollment notice confirming you were enrolled in a Medicaid Managed Care plan, effective January 1, 2017.

On April 6, 2017, NYSOH received your updated application for financial assistance.

On April 7, 2017, NYSOH issued an eligibility determination notice stating you remained eligible for Medicaid, effective April 1, 2017.

On September 8, 2017, NYSOH issued a notice requesting additional information to confirm your eligibility. You were requested to submit proof of your most recent federal income tax return by September 23, 2017.

On October 7, 2017, NYSOH issued an eligibility determination notice stating you were newly eligible to purchase a full cost qualified health plan, effective November 1, 2017. The notice stated that you no longer qualified for Medicaid

through NYSOH as of October 31, 2017. The notice stated that you qualified for a qualified health plan as you did not meet the eligibility requirements for Medicaid. This was because your original eligibility was determined by an eligibility specialist at NYSOH.

Also on October 7, 2017, NYSOH issued a disenrollment notice stating your Medicaid Managed Care plan coverage would end on October 31, 2017, because you were no longer eligible for that plan.

On October 28, 2017, NYSOH received your updated application for financial assistance.

On October 29, 2017, NYSOH issued an eligibility determination notice, based on your October 28, 2017 updated application, stating you were newly eligible to purchase a full cost qualified health plan, effective November 1, 2017. The notice stated that you qualify for a qualified health plan and you did not meet the eligibility requirements for Medicaid. This was because your original eligibility was determined by an eligibility specialist at NYSOH.

On October 31, 2017, NYSOH received your updated application for financial assistance. At this time, you also uploaded a copy of your 2016 income tax return. That day, a preliminary eligibility determination was prepared stating that you were not eligible to receive help paying for your health insurance coverage. However, you could purchase a qualified health plan through NYSOH at full cost.

Also on October 31, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility finding that you were not eligible for financial assistance.

On November 1, 2017, NYSOH issued an eligibility determination notice, based on your October 31, 2017 application, stating that you were eligible to purchase a qualified health plan at full cost, effective November 1, 2017.

Also on November 1, 2017, NYSOH issued an enrollment notice confirming you were enrolled in a bronze-level qualified health plan, with a plan enrollment start date of November 1, 2017.

On November 7, 2017, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, for a limited time until a decision was made on your appeal, effective November 1, 2017. You were subsequently reenrolled into your Medicaid Managed Care plan, effective November 1, 2017.

On December 21, 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 December 26, 2017, NYSOH Appeals Unit received via secure facsimile your two-page submission.

This document was marked as Appellant's Exhibit # 1 and is incorporated into the record. The record closed at that time.

Findings of Fact

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

1) You were originally determined eligible for Medicaid, effective December 1, 2016. You enrolled into a Medicaid Managed Care plan, effective January 1, 2017.

2) You were again determined eligible for Medicaid effective April 1, 2017, following an April 6, 2017 updated application attesting to an annual household income of $13,500.00.

3) On September 8, 2017, NYSOH issued a notice requesting you submit a copy of your most recent federal tax return by September 23, 2017.

4) You testified that you never received the September 8, 2017 notice.

5) You testified that you received the October 7, 2017 eligibility determination and disenrollment notices stating that you no longer qualified for Medicaid and that your Medicaid Managed Care plan would end on October 31, 2017.

6) According to your NYSOH account and your testimony, you updated your application for financial assistance on October 28, 2017 and attested to a household income of $31,816.00.

7) According to your NYSOH account and your testimony, you updated your application for financial assistance on October 31, 2017 and attested to a household income of $-32,184.00.

8) You testified that the income amounts listed on your October 31, 2017 application of $3,000.00 as a [redacted], $50,000.00 for [redacted] and $20,000.00 for miscellaneous income such as dividends and interest is generally accurate.

9) You testified that your 2016 income tax return is generally reflective of your 2017 expected income.

10) Your 2016 income tax return indicates that your adjusted gross income was $118,623.00.

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11) You submitted a copy of your 2016 federal tax return Schedule A, itemized deductions (*see* Document [redacted]).

12) You testified and the record reflects that on your 2016 income tax return, your Schedule A, itemized deductions, totaled $102,491.00.

13) You testified that you have $93,684.00 in deductions for [redacted] you have to pay for your child that are not covered by health insurance. You testified that this amount should be taken into consideration in the determination of your eligibility for financial assistance.

14) According to your October 31, 2017 application, you expect to file your 2017 federal income tax return as Head of Household (with qualifying individual) and claim two dependents.

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

16) You were granted aid to continue and reenrolled in your Medicaid Managed Care plan pending the decision on your appeal, effective November 1, 2017.

17) You testified that you reside in Kings County.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

<u>Medicaid for Adults between the Ages of 19 and 65</u>

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); NY Social Services Law § 366(1)(b)).

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)).

Notice

Any required notice issued by NYSOH must include an explanation of the action referenced in the notice, including the effective date of the action, and the factual and legal basis for such action (45 CFR § 155.230).

Legal Analysis

The issue under review is whether NYSOH properly determined you were no longer eligible for Medicaid, effective November 1, 2017.

According to your account, you were determined eligible for Medicaid, effective December 1, 2016 and enrolled into a Medicaid Managed Care plan, effective January 1, 2017. On April 6, 2017 you updated your application and on April 7, 2017, NYSOH issued an eligibility determination stating you remained eligible for Medicaid, effective April 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 April 1, 2017, barring the occurrence of certain events, your eligibility for Medicaid should not have end prior to March 31, 2018.

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 have determined you were ineligible for Medicaid, effective November 1, 2017, prior to the end of your 12-month period of continuous coverage. because you were eligible for 12 months of continuous coverage, regardless of any change in income.

Thus, the October 7, 2017, October 29, 2017 and November 1, 2017 eligibility determination notices stating that you were eligible for a full cost qualified health

plan effective November 1, 2017, and ineligible for Medicaid, are MODIFIED to reflect that you were eligible for continuous coverage Medicaid until March 31, 2017, barring other circumstances. It follows that the October 7, 2017, disenrollment notice stating that your Medicaid Managed Care plan ended October 31, 2017 is RESCINDED.

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

Decision

The October 7, 2017, October 29, 2017 and November 1, 2017 eligibility determination notices are MODIFIED to reflect that you were eligible for continuous coverage Medicaid until March 31, 2017.

The October 7, 2017, disenrollment notice stating that your Medicaid Managed Care plan ended October 31, 2017 is RESCINDED.

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

Effective Date of this Decision: February 02, 2018

How this Decision Affects Your Eligibility

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

Your case is being sent back to NYSOH to reinstate you in your Medicaid coverage effective November 1, 2017 and it is to run until March 31, 2017 unless a disqualifying event occurs before that date.

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

- By fax: 1-855-900-5557

Summary

The October 7, 2017, October 29, 2017 and November 1, 2017 eligibility determination notices are MODIFIED to reflect that you were eligible for continuous coverage Medicaid until March 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).

The October 7, 2017, disenrollment notice stating that your Medicaid Managed Care plan ended October 31, 2017 is RESCINDED.

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

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

Your case is being sent back to NYSOH to reinstate you in your Medicaid coverage effective November 1, 2017 and it is to run until March 31, 2017 unless a disqualifying event occurs before that date.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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 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.

(Urdu)اردو

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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