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

Notice of Decision

Decision Date: February 16, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000024148

On January 2, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 27, 2017 eligibility determination and disenrollment notices, and November 8, 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).

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

Decision

Decision Date: February 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024148

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 and your spouse were no longer eligible for Medicaid, effective November 1, 2017?

Procedural History

On January 20, 2017, NYSOH issued an eligibility determination notice, based on your January 19, 2017 updated application, stating you and your spouse remained eligible for Medicaid, effective March 1, 2017.

Also on January 20, 2017, NYSOH issued an enrollment notice confirming you and your spouse were enrolled in a Medicaid Managed Care plan since March 1, 2015.

On October 6, 2017, NYSOH issued a notice indicating that additional information was required to confirm the eligibility for members of your household. The notice directed you to submit a copy of your most recent signed federal tax return by October 21, 2017 or you might lose your insurance or receive less help paying for your coverage.

On October 26, 2017, NYSOH systematically redetermined the eligibility of you and your spouse.

On October 27, 2017, NYSOH issued an eligibility determination notice stating you and your spouse were newly eligible to purchase a full cost qualified health

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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 and your spouse did not meet the eligibility requirements for Medicaid, because your original eligibility was determined by an eligibility specialist at NYSOH.

Also on October 27, 2017, NYSOH issued a disenrollment notice stating the Medicaid Managed Care plan coverage for you and your spouse would end on October 31, 2017, because you were no longer eligible for that plan.

On November 7, 2017, NYSOH received an updated application for financial assistance submitted on behalf of you and your spouse. That day a preliminary eligibility determination was prepared finding you and your spouse eligible to purchase a full cost qualified health plan.

Also on November 7, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility finding insofar as you and your spouse were no longer eligible for Medicaid.

On November 8, 2017, NYSOH issued an eligibility determination notice stating you and your spouse were newly eligible to purchase a full cost qualified health plan, effective November 1, 2017. The notice stated that you and your spouse did not meet the eligibility requirements for Medicaid, because your original eligibility was determined by an eligibility specialist at NYSOH.

On November 15, 2017, NYSOH issued an eligibility determination notice stating you and your spouse were eligible for Medicaid, for a limited time until a decision was made on your appeal, effective November 1, 2017. You and your spouse were subsequently reenrolled into your Medicaid Managed Care plan, effective November 1, 2017.

On January 2, 2018, 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 January 13, 2018, the Appeals Unit received your documentation which was marked as Appellant's Exhibit # 1 and incorporated into the record. The record closed thereafter.

Findings of Fact

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

1) An updated application was submitted on behalf of you and your spouse on January 25, 2017. That application listed combined self-employment income for you and your spouse of $5,702.00 including $52,538.00 in deductions.

2) According to your account, NYSOH determined you and your spouse remained eligible for Medicaid, effective March 1, 2017.

3) Your account confirms that you and your spouse had been enrolled in a Medicaid Managed Care plan since March 1, 2015.

4) NYSOH issued a notice dated October 6, 2017 directing you to submit a copy of your most recent singed federal tax return by October 21, 2017.

5) You testified that you received the October 6, 2017 notice and that you submitted a copy of your 2016 tax return before the due date.

6) According to your account, a copy of a signed 2016 joint federal tax return for you and your spouse was posted to your NYSOH account on October 26, 2017. That document contained a facsimile time stamp dated October 20, 2017.

7) On October 26, 2017, NYSOH systematically redetermined the eligibility of you and your spouse. Notes in your account on that date include: "overrode eligibility of 2 household member [redacted] and [redacted] to full pay QHP for failure to submit requested tax return."

8) You and your spouse were determined ineligible for financial assistance and disenrolled from your Medicaid Managed Care plan, effective October 31, 2017.

9) On November 7, 2017, NYSOH received an updated application submitted on behalf of you and your spouse. That application increased your attested annual household income to $45,000.00.

10) You testified that the income information in your November 7, 2017 application was accurate for 2017 as well as 2018.

11) You testified that you will make more in 2017 and 2018 than you did in 2016 so your 2016 tax return is not representative of your current household income.

12) According to your account, NYSOH still determined you and your spouse ineligible for financial assistance.

13) The November 8, 2017 eligibility determination notice indicated that you were not eligible for Medicaid, because your original eligibility was determined by an "eligibility specialist" at NYSOH.

14) You appealed insofar as you and your spouse were no longer eligible for Medicaid.

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

16) You were directed to submit updated self-employment income documentation for determination of your current eligibility. The Appeals Unit received a “Profit and Loss” statement on January 13, 2018. That documentation was posted to your NYSOH account on January 17, 2018 [redacted].

17) You testified that neither you nor your spouse moved counties, became incarcerated, or became eligible for third party health insurance in 2017.

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); 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 and your spouse were no longer eligible for Medicaid, effective November 1, 2017.

According to your account, you and your spouse had been enrolled in a Medicaid Managed Care plan since March 1, 2015. On January 25, 2017, an updated application was submitted on behalf of you and your spouse to renew your coverage for 2017. According to your account, NYSOH determined you and your spouse remained eligible for Medicaid and the January 27, 2017 eligibility determination notice confirmed that your eligibility was effective March 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 March 1, 2017, barring the occurrence of certain events, the eligibility of you and your spouse for Medicaid should not have ended prior to February 28, 2018.

Although NYSOH issued eligibility determination notices finding you and your spouse ineligible for Medicaid, effective November 1, 2017, it is concluded that it was improper for NYSOH to have determined you and your spouse ineligible for Medicaid prior to the end of your 12-month period of continuous coverage, because there is no evidence in your account that you or your spouse entered prison or another facility that provides medical care, moved out of state, or failed to provide a valid Social Security number.

It is further noted that both the October 27, 2017 and the November 8, 2017 eligibility determination notices failed to comply with the above cited regulations as they both failed to provide the factual and legal basis for the change in eligibility for you and your spouse.

Therefore, the October 27, 2017 and November 8, 2017 eligibility determination notices stating you and your spouse were eligible for a full cost qualified health plan, effective November 1, 2017, and ineligible for Medicaid, are MODIFIED to reflect that you and your spouse were eligible for continuous coverage Medicaid until February 28, 2018, barring other circumstances. It follows that the October 27, 2017, disenrollment notice stating that the Medicaid Managed Care plan coverage for you and your spouse ended October 31, 2017 is RESCINDED.

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

It is noted that following the hearing you submitted updated documentation of your self-employment income. Thus, your case is RETURNED to NYSOH to review that documentation, [redacted], for a determination of the current eligibility of you and your spouse and notify you in the event that further documentation is required.

Decision

The October 27, 2017, and November 8, 2017 eligibility determination notices are MODIFIED to reflect that you and your spouse were eligible for continuous coverage Medicaid until February 28, 2018.

The October 27, 2017, disenrollment notice is RESCINDED.

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

Your case is also RETURNED to NYSOH to review your updated income documentation, [redacted], for a determination of the current eligibility of you and your spouse and to notify you in the event further documentation is required.

Effective Date of this Decision: February 16, 2018

How this Decision Affects Your Eligibility

You and your spouse should not have been disenrolled from your Medicaid Managed Care plan on October 31, 2017.

Your case is being sent back to NYSOH to reinstate you and your spouse in your Medicaid coverage effective November 1, 2017 and it is to run until February 28, 2018 unless a disqualifying event occurs before that date.

You will receive an updated written determination of the current eligibility of you and your spouse based on the updated income documentation you submitted.

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 27, 2017 and November 8, 2017 eligibility determination notices are MODIFIED to reflect that you and your spouse were eligible for continuous coverage Medicaid until February 28, 2018.

The October 27, 2017, disenrollment notice is RESCINDED.

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

Your case is also RETURNED to NYSOH to review your updated income documentation, , for a determination of the current eligibility of you and your spouse and to notify you in the event further documentation is required.

You and your spouse should not have been disenrolled from your Medicaid Managed Care plan on October 31, 2017.

Your case is being sent back to NYSOH to reinstate you and your spouse in your Medicaid coverage effective November 1, 2017 and it is to run until February 28, 2018 unless a disqualifying event occurs before that date.

You will receive an updated written determination of the current eligibility of you and your spouse based on the updated income documentation you submitted.

Legal Authority

We are sending you this notice in accordance with 45 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).

A Copy of this Decision Has Been Provided To:

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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 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.

(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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