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

Notice of Decision

Decision Date: May 11, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027548

[redacted]

Dear [redacted]

On April 17, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 17, 2017 eligiblity determination notice, December 6, 2017 eligiblity determination and disenrollment notices, and January 23, 2018 eligiblity 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: May 11, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027548

[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 eligible for Medicaid effective October 1, 2017?
>
> Did NY State of Health properly determine that you were no longer eligible to enroll in health insurance through NYSOH or to remain enrolled in your Medicaid Managed Care plan, effective December 31, 2017?

Procedural History

On October 17, 2017, NY State of Health (NYSOH) issued an eligibility determination notice stating that, effective October 1, 2017, you were eligible for Medicaid because your household income of $3,640.00 was at or below the allowable income limit. You subsequently enrolled in a Medicaid Managed Care plan as of December 1, 2017.

On December 6, 2017, NYSOH issued a notice stating you were no longer eligible to enroll in health insurance through NYSOH, effective December 6, 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 December 6, 2017, NYSOH issued a disenrollment notice ending your coverage in your Medicaid Managed Care plan as of December 31, 2017.

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On January 22, 2018, you updated your application for financial assistance with your health insurance. That day, a preliminary eligibility determination was prepared stating you were eligible to purchase a qualified health plan at full cost, effective March 1, 2018.

Also on January 22, 2018, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you were determined no longer eligible for financial assistance.

On January 23, 2018, NYSOH issued a notice stating you updated your mailing address in your account.

On January 23, 2018, NYSOH issued an eligiblity determination notice stating you were eligible to purchase a qualified health plan at full cost, effective March 1, 2018.

On February 8, 2018, NYSOH issued an eligiblity determination notice stating you were eligible for Medicaid through NYSOH for a limited time, effective February 1, 2018. The notice stated you were granted Aid to Continue until a decision was made on your appeal.

On February 8, 2018, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective January 1, 2018.

On April 17, 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 15 days for you to provide supporting documentation. On April 26, 2018, NYSOH's Appeals Unit received your supporting documentation via a two-page fax that was made part of the record as Appellant's Exhibit 1. The record was then closed that day.

Findings of Fact

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

1) You testified that you filed your 2017 taxes as married filing single with no dependents. You testified this would be correct for 2018 as well because you do not currently reside with your husband and have been separated since [redacted].

2) You testified that you do not have a signed decree of divorce or legal separation agreement from a judge.

3) According to the October 16, 2017 application, you attested to an expected annual household income of $3,640.00. You testified at the

time you submitted your application, this income was an accurate reflection of your expected income for the 2017 tax year as you were no longer working at your previous employer as of [redacted].

4) You were disenrolled from Medicaid and your Medicaid Managed Care plan as of December 31, 2017.

5) According to the notice issued on December 6, 2017 you were no longer eligible to enroll in health insurance through NYSOH 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.

6) Your NYSOH account does not contain any notices which were sent back as undeliverable from your address.

7) According to your NYSOH account, your address did not change between your application on October 16, 2017, and the date of your telephone hearing on April 17, 2018.

8) You testified you did not move or change your address in 2017 and still currently reside at the address as listed in your account and noted on the address line above, and have remained a NY State resident for all of 2017.

9) According to your updated application on January 22, 2018, your income increased to an annual expected income for 2018 of $25,368.00 consisting of Social Security Disability benefits. You testified this was correct.

10) You testified that you only first were determined eligible for Social Security Disability benefits in November 2017, after being certified [redacted] and [redacted].

11) You provided supporting income documentation in the form of a letter from the Social Security Administration, dated April 23, 2018, stating beginning December 2017 your full monthly benefit before any deductions is $2,114.70 per month (*see* Appellant's Exhibit 1, [redacted]).

12) Your application states you reside in [redacted], NY.

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

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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)).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

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).

On the date of your updated application, that was the 2018 FPL, which is $12,140.00 for a one-person household (83 Fed. Reg. 2642).

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, citizenship status, 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)).

Household Size

"Family size" means the number of persons counted as members of an individual's household. The household of a taxpayer who expects to file a return, and does not expect to be claimed as a tax dependent by anyone else, consists of the taxpayer plus all people the taxpayer expects to claim as tax dependents (42 CFR § 435.603(f)(1)).

In the case of a married couple living together, each spouse is included in the Medicaid household of the other spouse, regardless of whether they expect to file a joint tax return (42 CFR § 435.603 (f)(4)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for Medicaid effective October 1, 2017.

You are in a one-person household because, according to the record, you expect to file your 2017 tax return as married filing single and claim no dependents. The household of a taxpayer who expects to file a return, and does not expect to be claimed as a tax dependent by anyone else, consists of the taxpayer plus all people the taxpayer expects to claim as tax dependents. Married couples living together must be included in the Medicaid household of the other spouse regardless of if they expect to file a joint tax return. However, you testified you have not resided with your spouse since [redacted]. Therefore, for purposes of this analysis and the determination by NYSOH on October 16, 2017 you have a one-person tax household.

On your October 16, 2017, application, you attested to an expected household income of $3,640.00. You credibly testified that the income you provided of $3,640.00 in this application was an accurate reflection at that time of your expected 2017 household income as you had separated from your employer on [redacted]. At the time of your October 16, 2017 application, you were not in receipt of Social Security Disability benefits.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 64 who meet the non-financial requirements and have a household MAGI that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $12,060.00 for a one-person household. Since $3,640.00 is 30.18% of the 2017 FPL, NYSOH properly found you to be eligible for Medicaid on an expected annual income basis, using the information provided in your application.

Since the October 17, 2017 eligibility determination notice properly stated that, based on the information you provided, you were eligible for Medicaid, effective October 1, 2017, it is correct and is AFFIRMED.

The second issue under review is whether NYSOH properly determined you were no longer eligible to enroll in health insurance through NYSOH or to remain enrolled in your Medicaid Managed Care plan, effective December 31, 2017.

You were found eligible for Medicaid effective October 1, 2017, and were subsequently enrolled into Medicaid Managed Care plan that was effective December 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, they become ineligible for Medicaid and continuous coverage.

On December 6, 2017, NYSOH issued an eligibility determination notice stating you were no longer eligible for health insurance and your Medicaid Managed Care plan was terminated as of December 31, 2017, because NYSOH received return mail notices from your address.

You credibly testified that you have remained a New York State resident for all of 2017. Furthermore, your NYSOH account does not contain any return mail notices from your address and your address has not changed in your account from the date of your October 16, 2017 application to the time of your telephone hearing on April 17, 2018.

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 December 31, 2017 for failure to meet state residency requirements. There are no other facts presented in the record that would support you being ineligible for Medicaid for the remainder of your twelve-month period of eligibility.

You were certified disabled as of November 2017, and began to receive Social Security Disability payments effective December 2017 (*see* Appellant's Exhibit 1, [redacted] This increased your annual expected income in your updated application on January 22, 2018 to $25,368.00. However, as discussed previously since you were properly determined eligible for Medicaid as of October 1, 2017, you were guaranteed 12 months of Medicaid coverage, even if you would lose Medicaid eligibility because of any changes or updates you make to your NYSOH account. Even though your income increased above the Medicaid limit allowed for your household size, you should have remained covered under Medicaid for a 12-month period based on the start date of October 1, 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).

Therefore, the December 6, 2017 eligibility determination notice and the December 6, 2017 disenrollment notice are RESCINDED because NYSOH improperly disenrolled you from Medicaid and Medicaid Managed Care plan effective December 31, 2017.

The January 23, 2018 eligibility determination notice is MODIFIED to state that although you are no longer eligible for Medicaid, your Medicaid coverage will continue for your twelve-month period until September 30, 2018, barring the occurrence of any disqualifying events during this period.

Accordingly, your case is RETURNED to NYSOH to reinstate you into your Medicaid Managed Care plan as of January 1, 2018, for the remaining months of your eligibility until September 30, 2018, barring any disqualifying events.

Decision

The October 17, 2017 eligibility determination notice is AFFIRMED.

The December 6, 2017 eligibility determination notice and the December 6, 2017 disenrollment notice are RESCINDED.

The January 23, 2018 eligibility determination notice is MODIFIED to state that although you are no longer eligible for Medicaid, your Medicaid coverage will continue for your twelve-month period until September 30, 2018, barring the occurrence of any disqualifying events during this period.

Your case is RETURNED to NYSOH to reinstate you into your Medicaid Managed Care plan as of January 1, 2018, for the remaining months of your eligibility until September 30, 2018, barring any disqualifying events.

Effective Date of this Decision: May 11, 2018

How this Decision Affects Your Eligibility

Your Medicaid coverage, which began on October 1, 2017, continues until September 30, 2018, barring any disqualifying events causing your eligibility to end.

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.

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 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

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Summary

The October 17, 2017 eligibility determination notice is AFFIRMED.

The December 6, 2017 eligibility determination notice and the December 6, 2017 disenrollment notice are RESCINDED.

The January 23, 2018 eligibility determination notice is MODIFIED to state that although you are no longer eligible for Medicaid, your Medicaid coverage will continue for your twelve-month period until September 30, 2018, barring the occurrence of any disqualifying events during this period.

Your case is RETURNED to NYSOH to reinstate you into your Medicaid Managed Care plan as of January 1, 2018, for the remaining months of your eligibility until September 30, 2018, barring any disqualifying events.

Your Medicaid coverage, which began on October 1, 2017, continues until September 30, 2018, barring any disqualifying events causing your eligibility to end.

Legal Authority

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

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A Copy of this Decision Has Been Provided To:

[redacted]

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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.

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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