



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

## Notice of Decision

Decision Date: April 19, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000014622

[REDACTED]

Dear [REDACTED],

On March 30, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 18, 2016 disenrollment notice and November 28, 2016 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 NY State of Health 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: April 19, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000014622

[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 that you were disenrolled from your Medicaid Managed Care plan, effective November 30, 2016?

## Procedural History

On February 19, 2016, NYSOH redetermined your eligibility for financial assistance with health insurance.

On February 20, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid because your household income was at or below the allowable income limit. This eligibility was effective as of February 1, 2016.

On May 18, 2016, NYSOH issued an enrollment confirmation notice, confirming your selection of a Medicaid Managed Care plan, with an enrollment start date of July 1, 2016.

On October 9, 2016, NYSOH issued a notice that it was time to renew your health insurance for the upcoming coverage year. That notice stated that based on information from federal and state sources, NYSOH could not make a decision about whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by November 15, 2016 or you might lose the financial assistance you were currently receiving.

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On October 17, 2016, you updated your application for financial assistance.

On October 18, 2016, NYSOH issued a disenrollment notice stating that your coverage with your Medicaid Managed Care plan would end effective November 30, 2016.

On November 27, 2016, the system ran an application on your behalf.

On November 28, 2016, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost, effective January 1, 2017.

On December 23, 2016, you updated your application for financial assistance.

On December 24, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan for a limited time, effective February 1, 2017.

Also on December 24, 2016, NYSOH issued an enrollment confirmation notice stating that you were enrolled in the Essential Plan, effective February 1, 2017.

On January 5, 2017, you spoke to NYSOH's Account Review Unit and appealed the December 24, 2016 eligibility determination and enrollment confirmation insofar as your eligibility for the Essential Plan was not effective until February 1, 2017.

On March 30, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. 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 were determined eligible for Medicaid, effective February 1, 2016.
- 2) There is no indication in the record that you were incarcerated, permanently moved, or obtained health insurance outside of NYSOH in 2016.
- 3) You testified that you are looking for any type coverage for yourself for the months of December 2016 and January 2017.
- 4) You testified, and your application states, that you reside in [REDACTED].

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

## **Applicable Law and Regulations**

### Medicaid

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 FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 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 2016 FPL, which is \$11,880.00 for a one-person household (81 Federal Register 4036).

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, 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 that you were disenrolled from your Medicaid Managed Care plan, effective November 30, 2016.

On February 20, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective February 1, 2016. That determination has not been appealed and is not under review.

On October 9, 2016, NYSOH issued a renewal notice requesting that you update your NYSOH account by November 15, 2016 in order for your eligibility to be determined.

You updated your application for financial assistance on October 17, 2016. As a result, on October 18, 2016, a disenrollment notice was issued terminating your coverage under a Medicaid Managed Care plan.

However, under New York State law, once a person is found eligible for Medicaid, that eligibility generally continues for 12 months, even if the household income rises above 138% of the FPL. This provision is called “continuous coverage”.

The record reflects that there were no events that would have been a basis for your Medicaid coverage to have been terminated prior to the end of the 12 months of coverage, such as a permanent move or incarceration. Since you were determined eligible for Medicaid based on the application submitted on February 19, 2016, effective February 1, 2016, you remained eligible for Medicaid for 12 continuous months, regardless of any increases in your household income. As a result, you were improperly disenrolled from Medicaid and your Medicaid Managed Care plan, effective November 30, 2016.

Since NYSOH determined you were eligible for Medicaid as of February 1, 2016, and therefore eligible for continuous coverage, the October 18, 2016 disenrollment notice is RESCINDED.

Since you should have remained eligible for Medicaid until January 31, 2016, the November 28, 2016 eligibility determination notice find you eligible to purchase a full cost qualified health plan, effective January 1, 2017 is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you into your Medicaid Managed Care plan for the months of December 2016 and January 2017.

## **Decision**

The October 18, 2016 disenrollment notice is RESCINDED.

The November 28, 2016 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid Managed Care plan for the months of December 2016 and January 2017.

**Effective Date of this Decision:** April 19, 2017

## **How this Decision Affects Your Eligibility**

Your case is being sent back to NYSOH to reinstate you in your Medicaid Managed Care plan for the months of December 2016 and January 2017.

## **If You Disagree with this Decision (Appeal Rights)**

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services. 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.

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).

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 18, 2016 disenrollment notice is RESCINDED.

The November 28, 2016 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Medicaid Managed Care plan for the months of December 2016 and January 2017.

### **Legal Authority**

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



**A Copy of this Decision Has Been Provided To:**



## 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 مجاناً.

### 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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye bεtumi ama wo obi a okyerε 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 کرم 1-855-355-5777 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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