



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

## Notice of Decision

Decision Date: May 16, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000018682

[REDACTED]

Dear [REDACTED],

On May 15, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 13, 2017 disenrollment notice and April 27, 2017 notice of invalid documentation.

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.

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## Decision

Decision Date: May 16, 2017

NY State of Health Account ID [REDACTED]  
Appeal Identification Number: AP000000018682

[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 your eligibility and enrollment in your Medicaid Managed Care plan ended effective April 30, 2017?

## Procedural History

On May 3, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective May 1, 2016.

On June 4, 2016, NYSOH issued an enrollment confirmation notice confirming your enrollment in a Medicaid Managed Care plan, effective July 1, 2016.

On March 3, 2017, NYSOH issued a renewal notice, stating 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 determine whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by April 15, 2017 or the financial assistance you were getting might end.

On April 12, 2017, you updated your NYSOH application.

On April 13, 2017, NYSOH issued a notice stating that the income information in your April 12, 2017 application did not match what NYSOH received from state and federal sources. The notice directed you to provide proof of your household

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income by April 27, 2017. The notice stated that if you missed the due date, NYSOH would not be able to determine your eligibility for health coverage.

Also on April 13, 2017, NYSOH issued a disenrollment notice stating that your coverage in your Medicaid Managed Care plan would end effective April 30, 2017.

On April 26, 2017, you uploaded income documentation to your NYSOH account.

On April 27, 2017, NYSOH issued a notice stating that the documentation reviewed did not confirm the information in your application. The notice directed you to provide income information by April 27, 2017.

Also on April 27, 2017, NYSOH issued a notice stating that the income information in your April 12, 2017 application did not match what NYSOH received from state and federal sources. The notice directed you to provide proof of your household income by April 27, 2017. The notice stated that if you missed the due date, NYSOH would not be able to determine your eligibility for health coverage.

On May 2, 2017, you uploaded income documentation to your NYSOH account.

On May 3, 2017, NYSOH issued a notice of eligibility redetermination stating that you were eligible for the Essential Plan, effective June 1, 2017.

On May 4, 2017, you spoke to NYSOH's Account Review Unit and appealed your eligibility insofar as your Medicaid Managed Care plan ended effective April 30, 2017.

On May 5, 2017, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in an Essential Plan, effective June 1, 2017.

On May 15, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, [REDACTED] acted as your Authorized Representative and assisted you with your testimony. 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) On April 12, 2017, you updated the annual household income in your NYSOH account.
- 2) On April 13, 2017, NYSOH issued a notice directing you to provide proof of your household income by April 27, 2017. The notice indicated that for

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Social Security Benefits to provide an "Award Letter or Certificate." It did not state that such a letter had to be contemporaneously dated.

- 3) Your Authorized Representative testified that you were certified disabled on [REDACTED].
- 4) Also on April 26, 2017, you uploaded to your NYSOH account a Notice of Award from the Social Security Administration dated December 26, 2016. The award notice indicated that you would receive \$1,546.00 every month beginning January 2017 and that you would receive \$1,546.00 each month thereafter ([REDACTED]).
- 5) NYSOH records reflect that the December 26, 2016 Notice of Award ([REDACTED]) was deemed invalid proof of income on April 26, 2017 because it was "not current."
- 6) On May 2, 2017, your Authorized Representative uploaded a notice from the Social Security Administration dated May 1, 2017 to your NYSOH account. The notice indicated that you would receive \$1546.00 every month beginning December 2016 and that you would receive \$1546.00 each month thereafter ([REDACTED]).
- 7) NYSOH records reflect that the notice from the Social Security Administration dated May 2, 2017 ([REDACTED]) was deemed valid proof of income by NYSOH on May 2, 2017.
- 8) Your Authorized Representative testified that she did not understand why the first notice from the Social Security Administration was not valid because both notices contained the same monthly disability amount for 2017.
- 9) Your Authorized Representative testified that you were deemed eligible for and enrolled in an Essential Plan, effective June 1, 2017.
- 10) Your Authorized Representative testified that you have medical bills that were incurred in May 2017.
- 11) Your Authorized Representative testified that you are seeking coverage for the month of May 2017.

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

## **Applicable Law and Regulations**

### Medicaid Renewal

In general, NYSOH must review Medicaid eligibility once every 12 months or “whenever it receives information about a change in a beneficiary’s circumstances that may affect eligibility” (42 CFR § 435.916(a)(1), (d)). NYSOH must make its “redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual’s account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency” (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates that may have been provided by the individual (45 CFR § 155.335(h)).

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b); Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13 ADM-03(III)(F)).

Medicaid Managed Care (MMC) plan enrollments received on or before the fifteenth day of the month are effective the first day of the following month. Enrollments received after the fifteenth day of the month are effective the first day of the second following month (Medicaid Managed Care Model Contract (Appendix H(6)(b)(ii) & (iii), effective 3/1/2014 – 2/28/2019; NY Social Services Law § 364-j(1)(c); 18 NYCRR § 360-10.3(h); Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13 ADM-03(III)(F)).

## **Legal Analysis**

The issue under review is whether NYSOH properly determined that your eligibility and enrollment in your Medicaid Managed Care plan ended effective April 30, 2017.

You were found eligible for Medicaid effective May 1, 2016.

Generally, NYSOH must redetermine a qualified individual’s eligibility for Medicaid once every 12 months without requiring information from the individual if able to do so based on reliable information contained in the individual’s account or other more current information available to the agency. NYSOH’s March 3, 2017 renewal notice stated that there was not enough information to determine

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whether you were eligible to continue your financial assistance for health insurance, and that you needed to supply additional information by April 15, 2017, or your financial assistance might end.

On April 12, 2017 you updated the annual household income in your NYSOH account. On April 13, 2017, NYSOH issued a notice stating that the income information in your April 12, 2017 application did not match what NYSOH received from state and federal sources. The notice directed you to provide proof of your household income by April 27, 2017. The notice indicated that for Social Security Benefits you should provide an "Award Letter or Certificate." It did not state that such a letter had to be contemporaneously dated.

Also on April 13, 2017, NYSOH issued a disenrollment notice stating that your coverage in your Medicaid Managed Care plan would end effective April 30, 2017.

On April 26, 2017, you uploaded a Notice of Award from the Social Security Administration (SSA) dated December 26, 2016 to your NYSOH account. The award notice indicated that you would receive \$1,546.00 in disability benefits for the month of January 2017 and that you would receive \$1,546.00 each month thereafter. NYSOH records reflect that the December 26, 2016, Notice of Award was deemed invalid proof of income on April 26, 2017 by NYSOH as being "not current."

On April 27, 2017, NYSOH issued a notice stating that the documentation reviewed did not confirm the information in your application. The notice directed you to provide income information by April 27, 2017.

On May 2, 2017, your Authorized Representative uploaded a notice from the SSA dated May 1, 2017 to your NYSOH account. The notice also indicated that you would receive \$1,546.00 per month in disability benefits beginning December 2016 and that you would receive \$1,546.00 each month thereafter. On May 2, 2017 NYSOH deemed the May 2, 2017 SSA notice valid proof of income.

The December 26, 2016 Notice of Award from the SSA contained the identical income information as the May 1, 2017 notice from the SSA, specifically that you would be receiving disability benefits in the amount of \$1,546.00 per month during 2017. NYSOH could have utilized this monthly income amount from the first SSA notice which you provided, to determine your financial eligibility.

Further, NYSOH's April 13, 2017 notice requesting documentation directs you to submit an SSD award letter to provide proof of your monthly disability benefits. The notice does not specify how recent the correspondence needed to be, and the document you submitted complies with the parameters described in the notice sent to you.

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Therefore, the Appeals Unit finds that because the document submitted complied with the instructions you were given, NYSOH should have provided an extension of your coverage to provide you with sufficient time to produce any necessary clarification, and NYSOH should have been more explicit as to what was required from the onset.

As such, NYSOH incorrectly invalidated your first submission and should have determined that your coverage would continue pending the submission of additional information, which has since been submitted.

Therefore, the April 13, 2017 disenrollment notice and April 27, 2017 notice of invalid documentation are RESCINDED.

Your case is RETURNED to NYSOH to facilitate correcting your enrollment in your Medicaid Managed Care plan for the month May 2017.

## **Decision**

The April 13, 2017 disenrollment notice is RESCINDED.

The April 27, 2017 notice of invalid documentation is RESCINDED.

Your case is RETURNED to NYSOH to facilitate correcting your enrollment in your Medicaid Managed Care plan for the month May 2017.

**Effective Date of this Decision: May 16, 2017**

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

Your case is RETURNED to NYSOH to facilitate correcting your enrollment in your Medicaid Managed Care plan for the month May 2017.

NYSOH incorrectly determined that your eligibility and enrollment in your Medicaid Managed Care plan ended effective April 30, 2017.

## **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.

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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 April 13, 2017 disenrollment notice is RESCINDED.

The April 27, 2017 notice of invalid documentation is RESCINDED.

Your case is RETURNED to NYSOH to facilitate correcting your enrollment in your Medicaid Managed Care plan for the month May 2017.

NYSOH incorrectly determined that your eligibility and enrollment in your Medicaid Managed Care plan ended effective April 30, 2017.

## **Legal Authority**

We are issuing this determination in accordance with 45 CFR § 155.545.

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

[REDACTED]

[REDACTED]

## 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 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&btumi ama wo obi a okyerE 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 דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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