



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

## Notice of Decision

Decision Date: September 8, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000019057

[REDACTED]

Dear [REDACTED],

On August 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 28, 2017 eligibility and disenrollment notices, and May 5, 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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## Decision

Decision Date: September 8, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000019057

[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 no longer eligible for Medicaid and disenrolled from your Medicaid Managed Care plan, effective May 1, 2017?

## Procedural History

On February 4, 2017, NYSOH issued a renewal notice stating that your action was required and that you must select a different health plan between February 16, 2017 and March 15, 2017 to continue your coverage. The notice stated that you now qualified for a tax credit of up to \$239.57 per month and cost-sharing reductions, effective April 1, 2017.

On March 20, 2017, NYSOH received your application for financial assistance with health insurance. That day, you also updated the address on your account.

Also on March 20, 2017, the February 4, 2017 renewal notice was returned to NYSOH as undeliverable.

On March 21, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid because your household income of \$0.00 was at or below the allowable income limit. This eligibility was effective as of April 1, 2017.

Also on March 21, 2017, NYSOH issued an enrollment confirmation notice stating that you were enrolled in a Medicaid Managed Care plan, effective May 1, 2017.

Finally, on March 21, 2017, NYSOH sent a notice confirming that you changed your mailing address on your NYSOH account.

On April 3, 2017, the March 21, 2017 change in mailing address notice was returned to NYSOH as undeliverable.

On April 20, 2017, the returned mail NYSOH received on March 20, 2017 was uploaded to your NYSOH account.

On April 28, 2017, NYSOH issued an eligibility determination notice stating that you were no longer eligible for health insurance through NYSOH, effective April 28, 2017, because notices sent to your address had been returned as undeliverable. You were directed to update your mailing address.

Also on April 28, 2017, NYSOH issued a disenrollment notice, stating that your coverage through a Medicaid Managed Care plan would end effective May 1, 2017 because you were no longer eligible to enroll in health insurance through NYSOH.

On May 4, 2017, NYSOH received your updated application for health insurance; specifically, the income information was updated and your address was confirmed.

On May 5, 2017, NYSOH sent a notice confirming that you changed your mailing address on your NYSOH account.

Also on May 5, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to \$326.00 in advance payments of the premium tax credit, and eligible to receive cost-sharing reductions if you enrolled in a silver-level qualified health plan, effective June 1, 2017. The notice stated that you were not eligible for Medicaid because your income was over the allowable income limit for that program.

On May 17, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as your enrollment in Medicaid had been discontinued.

On August 14, 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 April 1, 2017.
- 2) There is no indication in the record that you were incarcerated, or obtained health insurance outside of NYSOH since you were determined eligible for Medicaid.
- 3) On March 20, 2017 and April 3, 2017, NYSOH received returned mail.
- 4) You testified that you have lived at your current address since 2008.
- 5) The record reflects that only two notices were returned.
- 6) On May 4, 2017, you confirmed your address. The record reflects that your address did not change.
- 7) You testified that you are seeking Medicaid coverage.
- 8) Your application states that you reside in [REDACTED].

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 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 (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 May 1, 2017.

On March 21, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective April 1, 2017. That determination has not been appealed and is not under review.

On April 28, 2017, NYSOH issued an eligibility determination notice stating that your eligibility for Medicaid ended on April 28, 2017 because notices mailed to the address provided in your account had been returned as undeliverable. Also on April 28, 2017, NYSOH issued a disenrollment notice stating that your enrollment in a Medicaid Managed Care plan would end on May 1, 2017.

You credibly testified that you have lived at your current address since 2008. You updated your application for financial assistance and confirmed your address on May 4, 2017. The record reflects that your address did not change. As a result, on May 5, 2017, you were determined eligible for advance payment of the premium tax credit, based on the income information you provided.

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”.

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 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 March 20, 2017, effective April 1, 2017, 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 May 1, 2017.

Since NYSOH determined you were eligible for Medicaid as of April 1, 2017, and therefore eligible for continuous coverage, the April 28, 2017 eligibility determination notice and disenrollment notice is RESCINDED.

Since you should have remained eligible for Medicaid until March 31, 2018, the May 5, 2017 eligibility determination notice stating that you were eligible to receive up to \$326.00 in advance payments of the premium tax credit and eligible to receive cost-sharing reductions if you enroll in a silver-level qualified health plan is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you into your Medicaid Managed Care plan as of May 1, 2017 and to continue your coverage until the end of your 12 month continuous coverage period, that is until March 31, 2018 barring any subsequent disqualifying events.

## **Decision**

The April 28, 2017 eligibility determination notice is RESCINDED.

The April 28, 2017 disenrollment notice is RESCINDED.

The May 5, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you into your Medicaid Managed Care plan as of May 1, 2017 and to continue your coverage until the end of your 12 month continuous coverage period, that is until March 31, 2018 barring any subsequent disqualifying events.

**Effective Date of this Decision:** September 8, 2017

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

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 were improperly disenrolled from your Medicaid Managed Care coverage.

Your case is being sent back to NYSOH to reinstate you in your Medicaid Managed Care plan as of May 1, 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.

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):**

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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Albany, NY 12211
- By fax: 1-855-900-5557

## **Summary**

The April 28, 2017 eligibility determination notice is RESCINDED.

The April 28, 2017 disenrollment notice is RESCINDED.

The May 5, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you into your Medicaid Managed Care plan as of May 1, 2017 and to continue your coverage until the end of your 12 month continuous coverage period, that is until March 31, 2018 barring any subsequent disqualifying events.

Your case is being sent back to NYSOH to reinstate you in your Medicaid Managed Care plan as of May 1, 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)

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).

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।

### **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 नि:शुल्क 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 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 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.

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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