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

# Notice of Decision

Decision Date: December 01, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021289

[redacted]

[redacted]

On October 18, 2017, you appeared by telephone with the aid of a Creole language interpreter at a hearing on your appeal of NY State of Health's August 2, 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: December 01, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021289

[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 you were no longer eligible for Medicaid, effective September 1, 2017?

## Procedural History

On July 28, 2016, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective August 1, 2016. You subsequently enrolled in a Medicaid Managed Care plan.

On June 20, 2017, NYSOH issued a notice stating your coverage was being automatically renewed for the 2017 coverage year. The notice indicated that based on income information from state and federal data sources, you were eligible to enroll in the Essential Plan with no monthly premium, effective August 1, 2017.

Also on June 20, 2017, NYSOH issued an enrollment confirmation notice stating you were automatically enrolled into an Essential Plan, effective August 1, 2017.

On July 18, 2017, NYSOH received several updated applications for financial assistance with health insurance submitted on your behalf.

On July 19, 2017 and July 20, 2017, NYSOH issued eligibility determination notices stating you remained eligible for Medicaid, effective August 1, 2017.

Also on July 19, 2017, NYSOH issued a disenrollment notice stating your Essential Plan coverage would end on August 31, 2017, because you were no longer eligible to enroll in the plan.

On August 1, 2017, NYSOH received an updated application submitted on your behalf.

On August 2, 2017, NYSOH issued an eligibility determination notice stating you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective September 1, 2017. The notice indicated that you no longer qualified for Medicaid, because the household income you provided was over the allowable income limit for that program.

On August 8, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as you were no longer eligible for Medicaid.

On August 9, 2017, NYSOH issued an enrollment notice confirming you were enrolled in an Essential Plan, effective September 1, 2017.

On October 18, 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 testified you are appealing your eligibility only.

2) You were determined eligible for Medicaid, effective August 1, 2016, following a July 27, 2016 application listing your household income as $42,071.64.

3) On June 19, 2017, your eligibility for the upcoming coverage year was systematically redetermined and you were found eligible for the Essential Pan, effective August 1, 2017, based on income information obtained from state and federal data sources.

4) On July 18, 2017, several applications were submitted on your behalf listing your household income as $42,068.00. You were determined eligible for Medicaid, effective August 1, 2017. You did not enroll into a Medicaid Managed Care plan at that time.

5) You were disenrolled from your Essential Plan, effective August 31, 2017.

6) On August 1, 2017, an updated application was submitted on your behalf. That application increased your household income to $48,932.00.

7) Based in the income information in the August 1, 2017 application, you were determined eligible for the Essential Plan with a $20.00 monthly premium, effective September 1, 2017.

8) You appealed that determination insofar as you were no longer eligible for Medicaid.

9) You testified, and your application indicates, you will file your 2017 tax returned with a tax filing status of married filing jointly and you will claim four dependents on that tax return.

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)).

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 you were no longer eligible for Medicaid, effective September 1, 2017.

According to your account, you were determined eligible for Medicaid, effective August 1, 2016. On July 18, 2017, several applications for financial assistance were submitted on your behalf to renew your coverage for the upcoming coverage year. The applications listed your household income as $42,068.00. Following those application, NYSOH issued eligibility determination notices on July 19, 2017 and July 20, 2017 stating you were eligible for Medicaid, effective August 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 August 1, 2017, your eligibility for Medicaid should not have ended prior to July 31, 2018, barring the occurrence of certain events.

Although you updated your application on August 1, 2017, increasing your attested household income amount, since you had already been determined eligible for Medicaid, you were eligible to continue your coverage for 12 months despite any subsequent income disqualification.

Because there is no evidence in your account that you entered prison or another facility that provides medical care, moved out of state, or failed to provide a valid Social Security number, it was improper for NYSOH to determined you ineligible for Medicaid, effective August 1, 2017.

Thus, the August 2, 2017 eligibility determination notice stating you were eligible for the Essential Plan, effective September 1, 2017, and ineligible for Medicaid, is MODOFIED to reflect you were eligible for continuous Medicaid coverage until July 31, 2018, barring certain disqualifying events, which are currently not in evidence here.

Your case is RETURNED to NYSOH to assist you in enrolling into a health plan. You have the option of enrolling into a Medicaid Managed Care plan, effective September 1, 2017, the date your Essential Plan enrollment became effective, or you can choose to enroll into a Medicaid Managed Care plan going forward.

## Decision

The August 2, 2017 eligibility determination notice is MODIFIED to reflect you were eligible for continuous Medicaid coverage until July 31, 2018.

Your case is RETURNED to NYSOH to assist you in enrolling into a health plan. You have the option of enrolling into a Medicaid Managed Care plan, effective September 1, 2017, the date your Essential Plan enrollment became effective, or you can choose to enroll into a Medicaid Managed Care plan going forward.

## **Effective Date of this Decision:** December 01, 2017

## How this Decision Affects Your Eligibility

Your Medicaid coverage, effective August 1, 2017, should have continued for a twelve-month period ending July 31, 2018.

Your case is being sent back to NYSOH to assist you in enrolling into a health plan.

## 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 August 2, 2017 eligibility determination notice is MODIFIED to reflect you were eligible for continuous Medicaid coverage until July 31, 2018.

Your case is RETURNED to NYSOH to assist you in enrolling into a health plan. You have the option of enrolling into a Medicaid Managed Care plan, effective September 1, 2017, the date your Essential Plan enrollment became effective, or you can choose to enroll into a Medicaid Managed Care plan going forward.

Your Medicaid coverage, effective August 1, 2017, should have continued for a twelve-month period ending July 31, 2018.

Your case is being sent back to NYSOH to assist you in enrolling into a health plan.

## 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:

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).

## 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 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 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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