



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
PO Box 11729  
Albany, NY 12211

## Notice of Decision

Decision Date: January 9, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000022158

[REDACTED]

On December 8, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 17, 2017 discontinuance and disenrollment notices and the August 23, 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  
PO 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: January 9, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000022158



## 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 for Medicaid and enrollment in your Medicaid Managed Care plan ended effective August 1, 2017?

## Procedural History

On May 21, 2016, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective May 1, 2016. You enrolled into a Medicaid Managed Care plan.

On March 3, 2017, NYSOH issued a renewal notice indicating your coverage was being automatically renewed for the upcoming coverage year and you were still eligible for Medicaid, effective May 1, 2017, based on income information obtained from state and federal data sources.

On March 17, 2017, NYSOH issued an enrollment notice confirming your enrollment in a Medicaid Managed Care plan since March 1, 2016.

On June 18, 2017, NYSOH issued another renewal notice stating it was time to renew your coverage for the upcoming coverage year. The notice stated that based on information from state and federal data sources, NYSOH was unable to decide whether you qualified for financial help paying for your health coverage. The notice directed you to update your account by July 15, 2017 or you might lose the financial assistance you were receiving.

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).

No updates were made to your account by July 15, 2017.

On July 17, 2017, NYSOH issued a discontinuance notice stating you were no longer eligible for health insurance through NYSOH, effective August 1, 2017, because you did not respond to the renewal notice and complete your renewal within the required time frame.

Also on July 17, 2017, NYSOH issued a disenrollment notice stating your Medicaid Managed Care plan coverage would end on July 31, 2017, because you were no longer eligible to enroll in the plan.

On August 22, 2017, NYSOH received an updated application for financial assistance with health insurance submitted on your behalf.

On August 23, 2017, NYSOH issued an eligibility determination stating you were eligible for a tax credit of up to \$278.00 per month, effective October 1, 2017. The notice stated that you were not eligible for Medicaid, because the income you provided was over the allowable limit for that program.

On September 6, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were no longer eligible for Medicaid.

On September 12, 2017, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, for a limited time, effective August 1, 2017, until a decision could be made on your appeal. You were reenrolled into a Medicaid Managed Care plan, effective August 1, 2017.

On December 8, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed thereafter.

## **Findings of Fact**

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

- 1) You were determined eligible for Medicaid, effective May 1, 2016 and you enrolled into a Medicaid Managed Care plan.
- 2) Your Medicaid coverage was automatically renewed for another year, beginning May 1, 2017, because NYSOH was able to obtain satisfactory income information from state and federal data sources.
- 3) NYSOH issued another renewal notice on June 18, 2017 directing you to update your account by July 15, 2017 or you might lose your financial assistance.

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- 4) No updates were received by NYSOH by the July 15, 2017 deadline.
- 5) You were subsequently determined ineligible for health coverage through NYSOH on the grounds you failed to renew your coverage by the deadline. Your Medicaid Managed Care plan coverage was terminated, effective July 31, 2017.
- 6) Your application was updated on August 22, 2017 increasing your attested annual income.
- 7) You were determined eligible for tax credits, effective October 1, 2017.
- 8) The eligibility determination notice issued by NYSOH on August 23, 2017 indicated you were not eligible for Medicaid, because your income was over the allowable limit for that program.
- 9) You were granted aid to continue in your Medicaid Managed Care plan pending the decision in your appeal. You were reenrolled, effective August 1, 2017.
- 10) You testified you were seeking eligibility for Medicaid for yourself.
- 11) You testified you have not moved counties in 2017, become incarcerated, or become eligible for third-party health insurance or Medicare.
- 12) You live in Kings County.

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)).

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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)).

### Medicaid – Continuous Coverage

Generally, most adults determined eligible for Medicaid are guaranteed twelve 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 your eligibility for Medicaid and enrollment in your Medicaid Managed Care plan ended, effective August 1, 2017.

According to your account, you were determined eligible for Medicaid, effective May 1, 2016 and you enrolled into a Medicaid Managed Care plan. Your Medicaid coverage was automatically renewed, based on income information obtained by NYSOH from state and federal data sources, for the coverage year beginning May 1, 2017, as confirmed by the March 3, 2017 renewal notice.

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 May 1, 2017, barring the occurrence of certain events, your eligibility for Medicaid should not have ended prior to April 30, 2018.

Although NYSOH issued another renewal notice on June 18, 2017 directing you to update your account by July 15, 2017 or the financial assistance you were receiving might end, this was contrary to the regulations because your coverage had already been renewed within the last 12 months.

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 determine you were ineligible for Medicaid, effective August 1, 2017.

Therefore, the July 17, 2017, discontinuance and disenrollment notices stating your eligibility for Medicaid and your enrollment in your Medicaid Managed Care plan ended on July 31, 2017 were not correct and must be RESCINDED.

Your case is RETURNED to NYSOH to reinstate you in your Medicaid Managed Care plan coverage, effective August 1, 2017.

Additionally, the subsequent August 23, 2017 eligibility determination notice finding you eligible for a tax credit and ineligible for Medicaid, effective October 1, 2017, based on an August 22, 2017 updated application increasing your attested income, is not supported by the regulations as you were eligible to continue your Medicaid coverage for 12 months despite any subsequent income disqualification. Thus, that determination is MODIFIED to reflect you were eligible for continuous Medicaid coverage until April 30, 2018, barring other disqualifying events.

## **Decision**

The July 17, 2017 discontinuance and disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to reinstate you in your Medicaid Managed Care plan, effective August 1, 2017.

The August 23, 2017 eligibility determination notice is MODIFIED to reflect you were eligible for continuous Medicaid coverage until April 30, 2018, barring other disqualifying events.

**Effective Date of this Decision: January 9, 2018**

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

Your Medicaid coverage should not have been terminated on July 31, 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).

Your case is being sent back to NYSOH to reinstate you in your Medicaid coverage.

## **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

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- By mail at:  
NY State of Health Appeals  
P.O. Box 11729  
Albany, NY 12211
- By fax: 1-855-900-5557

## **Summary**

The July 17, 2017 discontinuance and disenrollment notices are **RESCINDED**.

Your case is **RETURNED** to NYSOH to reinstate you in your Medicaid Managed Care plan, effective August 1, 2017.

The August 23, 2017 eligibility determination notice is **MODIFIED** to reflect you were eligible for continuous Medicaid coverage until April 30, 2018, barring other disqualifying events.

Your Medicaid coverage should not have been terminated on July 31, 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 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 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 srε wo, frε 1-855-355-5777. ye&εtumi 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.