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

Notice of Decision

Decision Date: January 4, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023298

On December 6, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 13, 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

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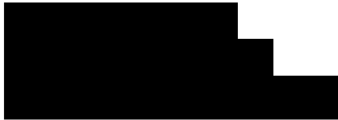


Issue

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 November 1, 2017?

Procedural History

On June 4, 2016, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective June 1, 2016. You subsequently enrolled into a Medicaid Managed Care plan.

On April 6, 2017, NYSOH issued a renewal notice indicating your coverage was being automatically renewed for the upcoming coverage year and that you were still eligible for Medicaid, effective June 1, 2017, based on income information obtained from state and federal data sources.

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

On October 12, 2017, NYSOH received an updated application submitted on your behalf. That day a preliminary eligibility determination was prepared stating you were eligible to enroll in the Essential Plan with no monthly premium, effective November 1, 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).

Also on October 12, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as you were no longer eligible for Medicaid.

On October 13, 2017, NYSOH issued an eligibility determination stating you were eligible for the Essential Plan with no monthly premium, effective November 1, 2017. The notice stated that you were not eligible for Medicaid, because the household income you provided was over the allowable limit for that program.

Also on October 13, 2017, NYSOH issued a disenrollment notice stating your Medicaid Managed Care plan coverage would end on October 31, 2017, because you were no longer eligible for that plan.

Additionally, on October 13, 2017, NYSOH issued an enrollment notice, based on your October 12, 2017 plan selection, confirming you were enrolled in an Essential Plan, effective November 1, 2017.

On December 6, 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 testified you are only appealing your eligibility, not your child's.

2) You were determined eligible for Medicaid, effective June 1, 2016 and you enrolled into a Medicaid Managed Care plan.

3) Your Medicaid coverage was automatically renewed for another year, beginning June 1, 2017, because NYSOH was able to obtain satisfactory income information from state and federal data sources.

4) You contacted NYSOH on October 12, 2017 to update your application.

5) You testified that you were calling to report that you had received a raise.

6) An updated application was submitted on October 12, 2017, increasing your attested household income to $23,888.54.

7) NYSOH determined you were eligible for the Essential Plan, based on the income information in your application.

8) You were disenrolled from your Medicaid Managed Care plan, effective October 31, 2017.

9) You enrolled into an Essential Plan, effective November 1, 2017.

10) You testified you are appealing insofar as you are no longer eligible for Medicaid, because your Essential Plan does not include vision and dental coverage.

11) You testified you have not moved counties in 2017, become incarcerated, or become eligible for third party health insurance.

12) You testified, and your applications indicate, you will file your 2017 tax return with a tax filing status of head of household and you will claim one dependent.

13) You live in Washington County.

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 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 twelve-month period. This twelve-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 November 1, 2017.

According to your account, you were determined eligible for Medicaid, effective June 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 June 1, 2017, as confirmed by the April 6, 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 June 1, 2017, barring the occurrence of certain events, your eligibility for Medicaid should not have ended prior to May 31, 2018.

Although you updated your application on October 12, 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 determine you ineligible for Medicaid as of November 1, 2017.

Thus, the October 13, 2017 eligibility determination notice stating you were eligible for the Essential Plan, is MODIFIED to reflect you were eligible for continuous Medicaid coverage until May 31, 2018.

Your case is RETURNED to NYSOH to reinstate you in your Medicaid Managed Care plan coverage as early as November 1, 2017, if you choose.

Decision

The October 13, 2017 eligibility determination notice is MODIFIED to reflect you were eligible for continuous Medicaid coverage until May 31, 2018.

Your case is RETURNED to NYSOH to reinstate you in your Medicaid Managed Care plan coverage as early as November 1, 2017, if you choose.

Effective Date of this Decision: January 4, 2018

How this Decision Affects Your Eligibility

Your Medicaid coverage should not have been terminated on October 31, 2017.

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
- By mail at:

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

Summary

The October 13, 2017 eligibility determination notice is MODIFIED to reflect you were eligible for continuous Medicaid coverage until May 31, 2018.

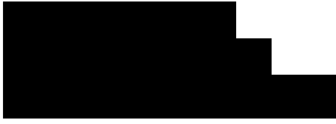
Your case is RETURNED to NYSOH to reinstate you in your Medicaid Managed Care plan coverage as early as November 1, 2017, if you choose.

Your Medicaid coverage should not have been terminated on October 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:



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।

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).

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 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 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.

(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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