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

Notice of Decision

Decision Date: May 2, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013720

[redacted]

Dear [redacted],

On March 31, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 19, 2016 eligibility determination notice and August 19, 2016 disenrollment 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: May 2, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000013720

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NYSOH properly determine that your daughter was eligible to purchase coverage in a qualified health, only at full cost, effective October 1, 2016, and disenroll her from her CHP coverage effective September 30, 2016?

Procedural History

On November 25, 2015, NYSOH issued an eligibility determination notice stating that your daughter was eligible for Medicaid, effective November 1, 2015.

Also, on November 25, 2015, NYSOH issued a notice of enrollment confirmation stating that your daughter was enrolled in a Medicaid Managed Care plan, effective January 1, 2016.

On July 8, 2016, you updated the income information in your NYSOH account.

On July 9, 2016, NYSOH issued a notice of eligibility determination stating that your daughter was no longer eligible for Medicaid. However, her Medicaid coverage would continue until October 31, 2016 because certain individuals determined eligible for Medicaid remain eligible for benefits for 12 continuous months from the date that they were determined eligible. This eligibility was effective as of July 1, 2016. The notice directed you to provide income information for your daughter by July 23, 2016. The notice stated that if you missed the due date, you might lose your insurance coverage or receive less assistance paying for your coverage.

Also, on July 9, 2016, NYSOH issued a notice of enrollment confirmation stating that your daughter remained enrolled in a Medicaid Managed Care plan, effective January 1, 2016.

On August 8, 2016, you updated your NYSOH application.

On August 9, 2016, NYSOH issued an eligibility determination stating that your daughter was no longer eligible for Medicaid. However, her Medicaid coverage would continue until October 31, 2016 because certain individuals determined eligible for Medicaid remain eligible for benefits for 12 continuous months from the date that they were determined eligible. This eligibility was effective as of August 1, 2016. The notice directed you to provide income information for your daughter by August 22, 2016.

Also on August 9, 2016, NYSOH issued a notice of enrollment confirmation stating that your daughter remained enrolled in a Medicaid Managed Care plan, effective January 1, 2016.

On August 18, 2016, you submitted a non-financial assistance application to NYSOH.

On August 19, 2016, NYSOH issued an eligibility determination notice stating that your daughter was newly eligible to purchase a qualified health plan at full cost, effective October 1, 2016.

On August 19, 2016, NYSOH issued a disenrollment notice stating that your daughter's coverage in her Medicaid Managed Care plan would end effective September 30, 2016. The notice stated that she was no longer eligible to be enrolled in her current plan.

On October 11, 2016, NYSOH issued an eligibility determination stating that your daughter was eligible for Child Health Plus, effective November 1, 2016.

On December 1, 2016, you spoke to NYSOH's Account Review Unit and appealed your daughter's loss of coverage from her Medicaid Managed Care plan for the month of October 2016.

On March 31, 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 expect to file your 2016 federal income tax return as married filing jointly and claim one dependent.

2) Your daughter was born on [redacted]

3) According to the November 25, 2015 eligibility determination notice, your daughter was deemed eligible for Medicaid, effective November 1, 2015.

4) According to the November 25, 2015 enrollment confirmation notice, your daughter was enrolled in a Medicaid Managed Care plan, effective January 1, 2016.

5) On July 8, 2016, you updated the income information in your NYSOH account.

6) On August 18, 2016, you submitted a non-financial assistance application to NYSOH resulting in your daughter being determined eligible for a full cost qualified health plan and her coverage in her Medicaid Managed Care plan ending effective September 30, 2016.

7) You testified that you spoke to a representative from NYSOH who advised you that your child's coverage in her Medicaid Managed Care plan would be in effect during the month of October 2016.

8) You testified that you have medical costs for your daughter which were incurred during October 2016.

9) You testified that you updated your NYSOH account on October 7, 2016 and selected a Child Health Plus plan for your daughter on that date. You testified that your daughter's Child Health Plus plan was effective November 1, 2016.

10) You testified that you are seeking that your daughter's coverage in her Medicaid Managed Care plan be reinstated for the month of October 2016.

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

Applicable Law and Regulations

<u>Medicaid Continuous Coverage</u>

Generally, individuals 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 your daughter was eligible to purchase coverage in a qualified health at full cost, effective October 1, 2016, and properly disenrolled her from her CHP coverage effective September 30, 2016.

NYSOH records reflect that that you updated your application and increased your expected annual household income to $37,440.00 in your July 8, 2016 application.

On July 9, 2016 and August 9, 2016, NYSOH issued notices of eligibility determination stating that your daughter was no longer eligible for Medicaid. However, her Medicaid coverage would continue until October 31, 2016 because certain individuals determined eligible for Medicaid remain eligible for benefits for 12 continuous months from the date that they were determined eligible.

On August 18, 2016, you submitted a non-financial assistance application to NYSOH resulting in your daughter being eligible for a full cost qualified health plan and her coverage in her Medicaid Managed Care plan ending effective September 30, 2016.

You testified credibly that you thought her coverage under her Medicaid Managed Care plan would continue until the end of October 2016.

Under New York State law, once a person is eligible for Medicaid, that eligibility continues for 12 months, even if the household income rises above 138% of the FPL. This provision is called “continuous coverage.” In addition, with limited exception, such as incarceration, lack of state residency, or no valid Social Security number, as well as having third party health insurance, an individual remains eligible for Medicaid throughout this 12 months of continuous coverage.

The credible evidence of record confirms that your daughter was eligible for Medicaid effective November 1, 2015. Even though your estimated annual

income increased after your initial application, your daughter remained eligible for Medicaid for the remainder of the 12-month period.

Since there is nothing in the record to indicate that your child experienced any of the limited exceptions that would disqualify her from continuing her Medicaid coverage until the end of the 12-month period, the August 19, 2016 disenrollment notice and the August 19, 2016 eligibility determination notice are to reflect that your daughter's eligibility for and enrollment in Medicaid and her Medicaid Managed Care plan ended effective October 31, 2016.

Your case is RETURNED to NYSOH to reinstate your daughter's coverage in her Medicaid Managed Care plan for the month of October 2016, and to notify you accordingly.

Decision

The August 19, 2016 disenrollment notice and the August 19, 2016 eligibility determination notice are MODIFIED to reflect that your daughter's eligibility for and enrollment in Medicaid and her Medicaid Managed Care plan ended effective October 31, 2016.

Your case is RETURNED to NYSOH to reinstate your daughter's Medicaid Managed Care plan for the month of October 2016, and to notify you accordingly.

Effective Date of this Decision: May 2, 2017

How this Decision Affects Your Eligibility

Your case is RETURNED to NYSOH to reinstate your daughter's Medicaid Managed Care plan for the month of October 2016 and to notify you accordingly.

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 19, 2016 disenrollment notice and the August 19, 2016 eligibility determination notice are MODIFIED to reflect that your daughter's eligibility for and enrollment in Medicaid and her Medicaid Managed Care plan ended effective October 31, 2016.

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 RETURNED to NYSOH to reinstate your daughter's Medicaid Managed Care plan for the month of October 2016, and to notify you accordingly.

Legal Authority

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

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A Copy of this Decision Has Been Provided To:

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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.

(Urdu)اردو

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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