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

Notice of Decision

Decision Date: April 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014386

[redacted]

Dear [redacted]

On March 23, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 9, 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 at the top of this letter.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(b).

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: April 24, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000014386

Issue

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

> Did New York State of Health (NYSOH) properly end your child's Medicaid Managed Care (MMC) coverage effective November 30, 2016?

Procedural History

On December 4, 2015, NYSOH issued an eligibility determination notice stating your child was eligible for Medicaid effective as of January 1, 2016.

Also on December 4, 2015, NYSOH issued an enrollment notice confirming that as of November 27, 2015, your child was enrolled in a MMC plan, with a plan enrollment start date of January 1, 2016.

On October 15, 2016, NYSOH issued a renewal notice stating that it was time to renew your child's health insurance. That notice stated that based on the information from federal and state sources, NYSOH could not make a decision about whether your child qualified for financial help paying for their health coverage, and that you needed to update your account by December 15, 2016 or you might lose the financial assistance your child was currently receiving.

On November 8, 2016, NYSOH systemically redetermined your child's eligibility.

On November 9, 2016, NYSOH issued a notice stating, in relevant part, that the income information in your application did not match what NYSOH received from state and federal data sources and more information was needed to confirm your eligibility. The notice directed you to submit additional income documentation by November 23, 2016 to confirm your child's eligibility.

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Also on November 9, 2016, NYSOH issued a disenrollment notice stating, in relevant part, that your child's MMC coverage would terminate November 30, 2016.

On November 12, 2016, your NYSOH account was updated.

On November 13, 2016, NYSOH issued an eligibility determination notice stating, in relevant part, that your child was eligible for Child Health Plus with a monthly premium of $15.00 for a limited time, effective as of December 1, 2016.

On November 14, 2016, your NYSOH account was updated.

On November 15, 2016, NYSOH issued an eligibility determination notice stating, in relevant part, that your child was eligible for Child Health Plus with a monthly premium of $15.00 for a limited time, effective as of December 1, 2016.

On December 3, 2016, NYSOH issued an enrollment notice confirming, in relevant part, that your child was enrolled in a Child Health Plus plan with an enrollment start date of January 1, 2017.

On December 28, 2016, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as your child not being enrolled in health insurance coverage in December 2016.

On March 23, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during that hearing, and the record was 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 the fact that your [redacted]-old child did not have health insurance coverage in December 2016.

2. According to your NYSOH account, your child was found eligible for Medicaid effective January 1, 2016.

3. According to your NYSOH account, your child was enrolled in a MMC plan with a plan enrollment start date of January 1, 2016.

4. You testified that you found out that your child's MMC plan was going to be discontinued when you received a disenrollment notice from NYSOH.

5. According to your NYSOH account, your child's coverage ended November 30, 2016.

6. According to your NYSOH account, your child was enrolled in a Child Health Plus plan on December 2, 2016, with an enrollment start date of January 1, 2017.

7. You testified that you incurred approximately $180.00 in medical expenses for your child in December 2016 and want the health insurance coverage to be reinstated to cover the outstanding expenses.

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

Applicable Law and Regulations

Medicaid:

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the FPL for the applicable family size (42 CFR § 435.118(c); New York Department of Health Administrative Directive 13 OHIP ADM-03).

Continuous Coverage:

A child under the age of nineteen who is determined eligible for medical assistance shall remain eligible for such assistance until the last day of the month which is twelve months following the determination or redetermination of eligibility for such assistance (N.Y. Soc. Serv. Law § 366(4)(b)(3)(i)).

Legal Analysis

The issue under review is whether NYSOH properly ended your child's MMC coverage effective November 30, 2016.

On December 4, 2015, NYSOH issued notices stating your child was eligible for Medicaid and enrolled in a MMC plan effective as of January 1, 2016.

Generally, once individuals are determined eligible for Medicaid, they are guaranteed 12 months of Medicaid coverage, even if they lose Medicaid eligibility because of any changes or updates made to their NYSOH account. This twelve-month period is based on the start date of the original Medicaid eligibility determination.

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When your child's MMC coverage was discontinued on November 30, 2016, the twelve-month period of Medicaid eligibility that began on January 1, 2016, had not expired. Furthermore, the record does not contain any evidence that your child's eligibility should have been discontinued before the end of their twelve-months of eligibility. Therefore, your child's MMC coverage should not have ended effective November 30, 2016.

The November 9, 2016 disenrollment notice is RESCINDED.

Your child's case is RETURNED to NYSOH to reinstate their MMC coverage for the month of December 2016.

Decision

The November 9, 2016 disenrollment notice is RESCINDED.

Your child's case is RETURNED to NYSOH to reinstate their MMC coverage for the month of December 2016.

Effective Date of this Decision: April 24, 2017

How this Decision Affects Your Eligibility

Your child's MMC coverage was improperly discontinued effective November 30, 2016.

Your child's case has been returned to NYSOH to reinstate their MMC coverage from December 1, 2016 through December 31, 2016.

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 November 9, 2016 disenrollment notice is RESCINDED.

Your child's case is RETURNED to NYSOH to reinstate their MMC coverage for the month of December 2016.

Your child's MMC coverage was improperly discontinued effective November 30, 2016.

Your child's case has been returned to NYSOH to reinstate their MMC coverage from December 1, 2016 through December 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).

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(a).

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.

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).

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।

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)

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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 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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