



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

Notice of Decision

Decision Date: June 13, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000016155

[REDACTED]

Dear [REDACTED],

On June 1, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 28, 2017 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 NY State of Health 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: June 13, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000016155



Issue

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

Did New York State of Health (NYSOH) properly terminate your child's Medicaid Managed Care (MMC) plan effective January 31, 2017?

Procedural History

On April 9, 2016, NYSOH issued an eligibility determination notice stating, in relevant part, that your child was eligible for Medicaid effective as of March 1, 2016.

Also on April 9, 2016, NYSOH issued a plan enrollment notice confirming that your child was enrolled in a MMC plan with an enrollment notice of May 1, 2016.

On January 5, 2017, NYSOH issued a notice stating, in relevant part, that it was time to renew your child's health insurance. That notice stated that, based on information from federal and state sources, NYSOH could not decide whether your youngest child would qualify for financial help paying for health coverage, and that you needed to update your account by February 15, 2017 or they might lose the financial assistance they were currently receiving.

On January 27, 2017, you updated your NYSOH account.

On January 28, 2017, NYSOH issued an eligibility determination notice stating, in relevant part, that your child was newly eligible to purchase a qualified health plan at full cost, effective as of March 1, 2017.

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On January 28, 2017, NYSOH issued a disenrollment notice stating, in relevant part, that your child's MMC coverage would end on January 31, 2017, because they were no longer eligible to enroll in that health plan.

On February 9, 2017, your NYSOH account was updated.

On February 10, 2017, 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, effective as of March 1, 2017.

On February 16, 2017, NYSOH issued a plan enrollment notice confirming that as of February 9, 2017, your child was enrolled in a Child Health Plus plan with an enrollment start date of March 1, 2017.

On February 23, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal relative to the termination date of your child's MMC coverage.

On June 1, 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 proceeding.

Findings of Fact

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

- 1) You testified you want your youngest child to be enrolled in a MMC plan for the month of February 2017.
- 2) Your youngest child was born on [REDACTED].
- 3) According to your NYSOH account, your child was determined eligible for Medicaid effective March 1, 2016, and enrolled in a MMC plan with an enrollment start date of May 1, 2016.
- 4) You testified that your username for your NYSOH account was accurate.
- 5) According to your NYSOH account, on January 27, 2017, you changed your application from a Financial Assistance to a Non-Financial Assistance application.
- 6) You testified that you found out at a doctor's appointment in February 2017 that your child's MMC coverage was not active.

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

Applicable Law and Regulations

Medicaid – Generally

Individuals whose eligibility for Medicaid is determined using MAGI-based income must be renewed once every 12 months, and no more frequently than once every 12 months (see 42 CFR § 435.916(a)).

Medicaid - Children

A child who is under one year of age 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 223% of the FPL for the applicable family size. (42 CFR § 435.118(c); New York Department of Health Administrative Directive 13 OHIP/ADM-04).

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 terminated your youngest child's MMC plan coverage effective January 31, 2017.

The record reflects that that your youngest child was determined eligible for Medicaid effective March 1, 2016, and enrolled in a MMC plan with an enrollment start date of May 1, 2016.

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

The record reflects that on January 27, 2017, your account was changed from a financial assistance application to a non-financial assistance application. Based on this change to your account, your youngest child's MMC plan coverage was terminated January 31, 2017.

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NYSOH can only determine an individual's financial eligibility for Medicaid once every twelve months. Once an individual is determined eligible for Medicaid, their eligibility continues for 12 months, regardless of any changes to the individual's household income.

When your child's Medicaid coverage terminated on January 31, 2017, the twelve-month period of Medicaid eligibility, that was effective on March 1, 2016, had not expired.

Therefore, the January 28, 2017, disenrollment notice is MODIFIED to state that your youngest child's MMC coverage would end effective February 28, 2017.

Your case is RETURNED to NYSOH to reinstate your youngest child's MMC plan from February 1, 2017 through February 28, 2017, and to notify you accordingly.

Decision

The January 28, 2017, disenrollment notice is MODIFIED to state that your youngest child's MMC coverage would end effective February 28, 2017.

Your case is RETURNED to NYSOH to reinstate your youngest child's MMC plan from February 1, 2017 through February 28, 2017, and to notify you accordingly.

This Decision has no effect on any subsequent eligibility determination or enrollment notices issued by NYSOH.

Effective Date of this Decision: June 13, 2017

How this Decision Affects Your Eligibility

Your youngest child's MMC plan will be reinstated by NYSOH from February 1, 2017 through February 28, 2017. NYSOH will notify you once this has been done.

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.

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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

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The January 28, 2017, disenrollment notice is MODIFIED to state that your youngest child's MMC coverage would end effective February 28, 2017.

Your case is RETURNED to NYSOH to reinstate your youngest child's MMC plan from February 1, 2017 through February 28, 2017, and to notify you accordingly.

This Decision has no effect on any subsequent eligibility determination or enrollment notices issued by NYSOH.

Your youngest child's MMC plan will be reinstated by NYSOH from February 1, 2017 through February 28, 2017. NYSOH will notify you once this has been done.

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 مجاناً.

বাংলা (Bengali)

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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)

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 sre wo, fre 1-855-355-5777. ye&tumi ama wo obi a okyerE 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.

שׂוֹדֵשׁ (Yiddish)

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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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