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

Notice of Decision

Decision Date: November 14, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020570

[redacted]

[redacted]

On November 1, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 18, 2017 eligibility determination and plan disenrollment notices.

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: November 14, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020570

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Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health (NYSOH) properly determine that you and your youngest child's Medicaid eligibility and coverage in your Medicaid Managed Care plans terminated effective July 31, 2017?
>
> Did NYSOH properly determine that you were eligible to enroll in the Essential Plan and your youngest child was eligible to enroll in a Child Health Plus plan, both effective September 1, 2017?

Procedural History

On April 6, 2017, NY State of Health (NYSOH) issued an eligibility determination stating that you and your youngest child were eligible for Medicaid and enrolled into a Medicaid Managed Care plan, effective June 1, 2017.

On April 17, 2017, NYSOH issued a plan enrollment notice confirming your and your youngest child's enrollment in your Medicaid Managed Care plans, effective June 1, 2016.

On July 17, 2017, NYSOH received your updated application for financial assistance with health insurance. That day a preliminary eligibility determination was prepared finding you eligible for the Essential Plan with a $20.00 monthly premium and your youngest child eligible to enroll in a Child Health Plus plan with a $9.00 monthly premium, both effective September 1, 2017.

Also on July 17, 2017, you spoke to NYSOH's Accounts Review Unit and requested an appeal of the eligibility determination insofar as you and your youngest son were no longer eligible for Medicaid.

On July 18, 2017, NYSOH issued an eligibility determination stating, in part, that you were eligible for the Essential Plan with a $20.00 monthly premium and that your youngest child was eligible to enroll in a Child Health Plus plan with a $9.00 monthly premium, both effective September 1, 2017.

Also on July 18, 2017, NYSOH issued a plan disenrollment notice stating that your and your youngest child's Medicaid Managed Care plan coverage would end on July 31, 2017.

On July 27, 2017, NYSOH issued an eligibility determination stating that you and your youngest child were eligible for Medicaid, for a limited time, effective August 1, 2017. This notice stated that you and your youngest child have been granted Aid-to-Continue until a decision is made on your appeal.

Also on July 27, 2017, NYSOH issued a plan enrollment notice confirming your and your youngest son's enrollment in a Medicaid Managed Care plan, effective August 1, 2017.

On November 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 that you are only appealing your and your youngest child's eligibility.

2) According to your NYSOH account and testimony, on April 6, 2017, NYSOH found you and your youngest child eligible for Medicaid and you and your youngest child were enrolled into a Medicaid Managed Care plan, effective June 1, 2017.

3) You testified that you updated your NYSOH account on July 17, 2017 to indicate that your two other children needed health insurance coverage through NYSOH and to update your income information.

4) The record indicates that after this update you and your youngest child were found no longer eligible for Medicaid.

5) The record indicates that you were eligible for the Essential Plan with a $20.00 monthly premium and your youngest child was eligible to enroll into a Child Health Plus plan with a $9.00 monthly premium.

6) The record indicates that you and your youngest child were disenrolled from your Medicaid Managed Care plans as of July 31, 2017.

7) You testified that you were under the impression that your and your youngest child's Medicaid coverage would continue until May 31, 2018.

8) You testified that you would like you and your youngest child to be found eligible for Medicaid and enrolled back into your Medicaid Managed Care plans until May 31, 2018.

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

Applicable Law and Regulations

Medicaid Eligibility

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 FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

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 federal poverty level (FPL) for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

Medicaid Continuous Coverage:

Most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, unless the adult loses Medicaid eligibility because of citizenship status, lack of state residence, or failure to provide a valid social security number, before the end of 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 (*see* 42 CFR § 435.916(a); N.Y. Soc. Serv. Law § 366(4)(c)).

Legal Analysis

The issue under review is whether NYSOH properly determine that you were eligible to enroll in the Essential Plan and your youngest child was eligible to enroll in a Child Health Plus plan, effective September 1, 2017, and that you and your youngest child's Medicaid eligibility and coverage in your Medicaid Managed Care plans terminated effective July 31, 2017.

On April 6, 2017, NYOSH issued an eligibility determination stating that you and your youngest child were eligible for Medicaid and enrolled in a Medicaid Managed Care plan, effective June 1, 2017.

The record reflects that on July 17, 2017, you updated your account to indicate that your two other children needed health insurance through NYSOH and to update your income. As a result, you were found eligible to enroll in the Essential Plan and your youngest child was found eligible for to enroll in a Child Health Plus, effective August 1, 2017. NYSOH also issued a plan disenrollment notice stating that you and your youngest child were no longer eligible to remain enrolled in your Medicaid Managed Care plans, and that your coverage would end on July 31, 2017.

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

Credible evidence confirms that you and your youngest were eligible for Medicaid effective June 1, 2017, and that even though your estimated annual income increased when you modified your application on July 17, 2017, you and your youngest child should have remained enrolled in Medicaid for the remainder of your 12-month eligibility period; that is, until May 31, 2018.

Therefore, the July 18, 2017 eligibility determination notice is RESCINDED in part as it pertains to your and your youngest child's eligibility.

The July 18, 2017 plan disenrollment notice is also RESCINDED.

Your case is RETURNED to NYSOH to reinstate your and your youngest child's Medicaid eligibility and Medicaid Managed Care plan enrollments from August 1, 2017 through the end of your twelve-month eligibility period, unless a disqualifying event occurs.

Decision

The July 18, 2017 eligibility determination is RESCINDED, in part, as it pertains to your and your youngest child's eligibility.

The July 18, 2017 plan disenrollment is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your and your youngest child's Medicaid eligibility and Medicaid Managed Care plan from August 1, 2017 through the end of your twelve-month eligibility period, unless a disqualifying event occurs.

Effective Date of this Decision: November 14, 2017

How this Decision Affects Your Eligibility

Your case is being sent back to NYSOH to reinstate your and your youngest child's eligibility for Medicaid and enrollment in your Medicaid Managed Care plans as of August 1, 2017, which will continue until May 31, 2018, barring a valid reason to end your coverage. 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.

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 July 18, 2017 eligibility determination is RESCINDED, in part, as it pertains to your and your youngest child's eligibility.

The July 18, 2017 plan disenrollment is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your and your youngest child's Medicaid eligibility and Medicaid Managed Care plan from August 1, 2017 through the end of your twelve-month eligibility period, unless a disqualifying event occurs.

Your case is being sent back to NYSOH to reinstate your and your youngest child's eligibility for Medicaid and enrollment in your Medicaid Managed Care plans as of August 1, 2017, which will continue until May 31, 2018, barring a valid reason to end your coverage. NYSOH will notify you once this has been done.

Legal Authority

We are sending you this notice in accordance with 45 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).

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.

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).

□□□□□ (Bengali)

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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 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.

اردو (Urdu)

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.

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).

(Yiddish) אידיש

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.

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).