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

Notice of Decision

Decision Date: October 18, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020706

[redacted]

Dear [redacted],

On October 4, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's July 21, 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 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: October 18, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020706

[redacted]

Issue

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

> Did NY State of Health properly determine that you and your children were not eligible for Medicaid, effective September 1, 2017?

Procedural History

On November 4, 2016, NY State of Health (NYSOH) issued an eligibility determination stating that you and your children were eligible for Medicaid, effective November 1, 2016.

On November 8, 2017, NYSOH issued a plan enrollment notice stating that you and your children were enrolled in Medicaid Managed Care plans, effective December 1, 2016.

On July 2, 2017, NYSOH issued an eligibility determination notice stating that it was time to renew your and your family's health insurance coverage through NYSOH. This notice stated that if the information in your application was still accurate, that NYSOH had determined that you and your child were eligible for up to $400.55 per month in advanced premium tax credits (APTC), and that your youngest child was eligible to enroll in a Child Health Plus plan with a $30.00 monthly premium, effective September 1, 2017. This notice further directed you to log on to your NYSOH account between July 16, 2017 and August 15, 2017 to pick a plan for you and your oldest child, as NYSOH had already enrolled your youngest child into a plan.

On July 17, 2017, NYSOH issued a plan disenrollment notice stating that you and your children had been disenrolled from your Medicaid Managed Care plans, effective August 31, 2017. This notice stating that this was because you and your children were no longer eligible to remain in your current coverage.

On July 20, 2017, NYSOH received your family's updated application for financial assistance with health insurance. That day a preliminary eligibility determination was prepared stating that you and your oldest child were eligible for up to $501.00 per month in APTC, and cost-sharing reductions if you enrolled into a silver-level qualified health plan, and that your youngest child was eligible to enroll into a Child Health Plus plan with a $9.00 monthly premium.

Also on July 20, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as your family was not eligible for a more affordable healthcare program.

On July 21, 2017, NYSOH issued a notice of eligibility determination, based on your July 20, 2017 application, stating that you and your oldest child were eligible to receive up to $501.00 in APTC and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective September 1, 2017. That notice also stated that you and your oldest child were not eligible for the Essential Plan or Medicaid because you and your oldest child's household income was over the allowable income limits for those programs. That notice further stated that your youngest child was eligible to enroll in a Child Health Plus plan with a $9.00 monthly premium, effective September 1, 2017. That notice also stated that your youngest child was not eligible for Medicaid because your child's household income was over the allowable income limit for that program.

Also on July 21, 2017, NYSOH issued a plan enrollment notice confirming your youngest child's enrollment into a Child Health Plus plan with a $9.00 monthly premium, effective September 1, 2017.

On July 25, 2017, NYSOH issued an eligibility determination stating that you and your children were eligible for Medicaid, effective August 1, 2017. This notice stating that you and your children had been granted Aid to Continue until a decision is made on your appeal.

Also on July 25, 2017, NYSOH issued a plan enrollment notice confirming your and your children's enrollment in a Medicaid Managed Care plan, effective August 1, 2017.

On October 4, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open until October 19, 2017, to allow you to submit supporting documents.

On October 10, 2017, NYSOH received a nine-page fax from you which included the requisite supporting documentation. The nine-page fax was made part of the record as “Appellant’s Exhibit #1”, and the record was closed that day.

Findings of Fact

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

1) You testified that you expect to file your 2017 taxes with a tax filing status of head of household. You will claim two dependents on that tax return.

2) You are seeking insurance for yourself and your children.

3) You testified that you were confused as to what had happened because you were told that you and your children were eligible for Medicaid late last year.

4) The record indicates that on November 3, 2016, you and your children were found eligible for Medicaid, effective November 1, 2016.

5) According to your NYSOH account, on July 2, 2017, NYSOH issued an eligibility determination notice stating that you and your children were no longer eligible for Medicaid, effective September 1, 2017.

6) According to your NYSOH account, the application that was submitted on July 20, 2017 stated that your household’s annual expected income was $44,798.01; which consisted of $33,800.01 you earn from your employment and $10,998.00 your oldest child earns from her employment.

7) You testified, and submitted supporting documentation, that you were out of work for a period of time between June 2017 and September 2017, and your only income during that time was short term disability benefits.

8) You testified that you have recently returned to work.

9) You testified that your oldest child works part time, and is paid biweekly.

10) You testified that you would like your family to be found eligible for Medicaid because the program you and your children are eligible for now costs too much with your expenses.

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

Applicable Law and Regulation

Medicaid for Adult and Children

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)).

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).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

In an analysis of Medicaid eligibility, the determination is based on the FPL “for the applicable budget period used to determine an individual's eligibility” (42 CFR § 435.4). On the date of your application, that was the 2017 FPL, which is $12,060.00 for a three -person household (82 Fed. Reg. 8831).

Generally, most 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 NY State of Health properly determine that you and your oldest child were eligible to receive up to $501.00 per month in advance payments of the premium tax credit, that your youngest child was eligible for a Child Health Plus plan with a $9.00 monthly premium, and that you and your children were not eligible for Medicaid, effective September 1, 2017.

The record indicates that you and your children were found eligible for Medicaid, effective November 1, 2016.

You updated your NYSOH account on July 20, 2017. This application stated that your household's annual expected income was $44,798.01; which consisted of $33,800.01 you earn from your employment and $10,998.00 your oldest child earns from her employment. This income amount is above the Medicaid limit.

Under New York State law, however, once a person is eligible for Medicaid, that eligibility continues for 12 months, even if the household income rises above 138% or 153% of the FPL. This provision is called "continuous coverage."

Credible evidence confirms that you and your children were eligible for Medicaid effective November 1, 2016, and that even though your estimated annual income increased when you modified your application on July 20, 2017, you and your children should have remained in Medicaid for the remainder of the 12-month eligibility period; that is, until October 31, 2017. As such, NYSOH erred in terminating you and your children from your Medicaid Managed Care plan as of August 31, 2017.

Therefore, NYSOH's July 21, 2017 eligibility determination notice insofar as it states you and your oldest child were eligible to receive up to $501.00 per month in advance payments of the premium tax credit, that your youngest child was eligible for a Child Health Plus plan with a $9.00 monthly premium, effective September 1, 2017, is RESCINDED; and the July 21, 2017 plan enrollment notice confirming your youngest child's enrollment into a Child Health Plus plan with a $9.00 monthly premium, effective September 1, 2017, is RESCINDED.

Ordinarily, the July 21, 2017 eligibility determination would MODIFIED to the extent that it states you and your children are not eligible for Medicaid to state that, although you and your children are no longer eligible for Medicaid based on your July 20, 2017 application, your and your children's Medicaid coverage would continue for 12 months; that is, until October 31, 2017.

It would also follow that your case would be RETURNED to NYSOH to fully enroll you and your children into your Medicaid Managed Care plans from September 1, 2017 until October 31, 2017, to ensure 12 months of continuous coverage.

However, since by the date of this Decision and through no fault of your own, you will not have adequate time to renew your or your children's coverage to prevent a gap in coverage for the month of November 2017. Therefore, your case is RETURNED to NYSOH to contact you and assist you in completing an application for financial assistance with health insurance to determine your and your children's eligibility as of December 1, 2017. In the meantime, your family's Aid to Continue in your Medicaid Managed Care plan will remain in full force and effect until such eligibility and enrollment is effectuated. NYSOH may require that you provide up-to-date proof of household income to do so.

Decision

The July 21, 2017 eligibility determination notice insofar as it states that you and your oldest child were eligible to receive up to $501.00 per month in advance payments of the premium tax credit and your youngest child was eligible for a Child Health Plus plan with a $9.00 monthly premium, effective September 1, 2017, is RESCINDED.

The July 21, 2017 plan enrollment notice confirming your youngest child's enrollment into a Child Health Plus plan with a $9.00 monthly premium, effective September 1, 2017, is RESCINDED.

Ordinarily, the July 21, 2017 eligibility determination would MODIFIED to the extent that it states you and your children are not eligible for Medicaid to state that, although you and your children are no longer eligible for Medicaid based on your July 20, 2017 application, your and your children's Medicaid coverage would continue for 12 months; that is, until October 31, 2017.

However, since by the date of this Decision and through no fault of your own, you will not have adequate time to renew your or your children's coverage to prevent a gap in coverage for the month of November 2017. Therefore, your case is RETURNED to NYSOH to contact you and assist you in completing an application for financial assistance with health insurance and to determine your and your children's eligibility as of December 1, 2017. In the meantime, your family's Aid to Continue in your Medicaid Managed Care plan will remain in full force and effect until such eligibility and enrollment is effectuated. NYSOH may require that you provide up-to-date proof of household income to do so.

Effective Date of this Decision: October 18, 2017

How this Decision Affects Your Eligibility

NYSOH erred in terminating your and your children's coverage in your Medicaid Managed Care plans as of August 31, 2017, before the 12 months of continuous

coverage had ended; and in redetermining you and your oldest child eligible for APTC and your youngest child eligible for and enrolled in Child Health Plus as of September 1, 2017.

Your and your children's Medicaid Managed Care coverage started November 1, 2016 and should have continued until October 31, 2017.

Your case is being sent back to NYSOH to contact you and assist you in completing an application for financial assistance with health insurance to determine your and your children's eligibility as of December 1, 2017. Since you will not have adequate time to renew your and your children's coverage in a way that would prevent a gap in coverage, NYSOH is directed to maintain your family's Aid to Continue in your Medicaid Managed Care plan until your family's eligibility for financial assistance and enrollment in a health plan is determined.

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 21, 2017 eligibility determination notice insofar as it states that you and your oldest child were eligible to receive up to $501.00 per month in advance payments of the premium tax credit and your youngest child was eligible for a Child Health Plus plan with a $9.00 monthly premium, effective September 1, 2017, is RESCINDED.

The July 21, 2017 plan enrollment notice confirming your youngest child's enrollment into a Child Health Plus plan with a $9.00 monthly premium, effective September 1, 2017, is RESCINDED.

Ordinarily, the July 21, 2017 eligibility determination would MODIFIED to the extent that it states you and your children are not eligible for Medicaid to state that, although you and your children are no longer eligible for Medicaid based on your July 20, 2017 application, your and your children's Medicaid coverage would continue for 12 months; that is, until October 31, 2017.

However, since by the date of this Decision and through no fault of your own, you will not have adequate time to renew your or your children's coverage to prevent a gap in coverage for the month of November 2017. Therefore, your case is RETURNED to NYSOH to contact you and assist you in completing an application for financial assistance with health insurance and to determine your and your children's eligibility as of December 1, 2017. In the meantime, your family's Aid to Continue in your Medicaid Managed Care plan will remain in full

force and effect until such eligibility and enrollment is effectuated. NYSOH may require that you provide up-to-date proof of household income to do so.

NYSOH erred in terminating your and your children's coverage in your Medicaid Managed Care plans as of August 31, 2017, before the 12 months of continuous coverage had ended; and in redetermining you and your oldest child eligible for APTC and your youngest child eligible for and enrolled in Child Health Plus as of September 1, 2017.

Your and your children's Medicaid Managed Care coverage started November 1, 2016 and should have continued until October 31, 2017.

Your case is being sent back to NYSOH to contact you and assist you in completing an application for financial assistance with health insurance to determine your and your children's eligibility as of December 1, 2017. Since you will not have adequate time to renew your and your children's coverage in a way that would prevent a gap in coverage, NYSOH is directed to maintain your family's Aid to Continue in your Medicaid Managed Care plan until your family's eligibility for financial assistance and enrollment in a health plan is determined.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

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.

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.

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.

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).