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

Notice of Decision

Decision Date: December 20, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021466

[redacted]

Dear [redacted]

On October 25, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 9, 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 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: December 20, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000021466

Issue

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

> Did NY State of Health (NYSOH) properly determine your child was no longer eligible for Medicaid, effective September 1, 2017?

Procedural History

On May 25, 2017, NYSOH issued an eligibility determination notice stating you and your child were eligible for Medicaid, effective May 1, 2017 and June 1, 2017, respectively.

Also on May 25, 2017, NYSOH issued an enrollment notice confirming you and your child were enrolled in a Medicaid Managed Care plan, effective July 1, 2017.

On August 8, 2017, NYSOH received an updated application for financial assistance with health insurance submitted on behalf of you and your child.

On August 9, 2017, NYSOH issued an eligibility determination notice stating you were no longer eligible for Medicaid, but your coverage would be continued to August 31, 2018. The notice further stated that your child was eligible to enroll in a full cost Child Health Plus plan or a child-only qualified health plan, effective September 1, 2017. The notice indicated your child was no longer eligible for Medicaid, because the household income provided was over the allowable limit for that program.

Also on August 9, 2017, NYSOH issued a disenrollment notice stating your child's Medicaid Managed Care plan coverage would end on August 31, 2017, because she was no longer eligible for that plan.

On August 15, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as your child was no longer eligible for Medicaid.

On August 16, 2017, NYSOH issued an enrollment notice, based on your August 15, 2017 plan selection, confirming your child was enrolled in a full cost Child Health Plus plan, effective September 1, 2017.

On August 19, 2017, NYSOH issued an eligibility determination notice stating your child was eligible for Medicaid, for a limited time, effective September 1, 2017, until a decision was made on your appeal. Your child was subsequently reenrolled into a Medicaid Managed Care plan, effective September 1, 2017.

On October 25, 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 for corroborating documentation. On October 30, 2017, the Appeals Unit received the requested documentation and the record close thereafter.

Findings of Fact

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

1) You testified you are appealing your child's eligibility only.

2) Your child was determined eligible for Medicaid, effective June 1, 2017, following a May 24, 2017 application attesting to annual household income of $11,180.00.

3) According to your account, a Medicaid Managed Care plan was selected for your child on May 24, 2017 and coverage through that plan became effective on July 1, 2017.

4) On August 8, 2017, an updated application was received on behalf of you and your child. That application attested to annual household income of $131,700.02.

5) On August 9, 2017, NYSOH issued an eligibility determination notice stating you were no longer eligible for Medicaid, but your coverage would be continued to August 31, 2018. The notice stated that your child was no longer eligible for Medicaid, effective August 31, 2017,

because the household income was over the allowable limit for that program.

6) Your child was disenrolled from her Medicaid Managed Care plan, effective August 31, 2017.

7) You appealed insofar as your child was not eligible for continuous Medicaid coverage.

8) Your child was granted aid-to-continue in her Medicaid Managed Care plan pending the decision in your appeal. She was reenrolled into her plan, effective September 1, 2017.

9) According to your account, your child was [redacted] at all times relevant to the issues under appeal.

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

Applicable Law and Regulations

<u>Medicaid for Children Between the Ages of 1 and 19</u>

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 State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

Generally, most individuals determined eligible for Medicaid are guaranteed twelve 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 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 (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)).

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Legal Analysis

The issue under review is whether NYSOH properly determined your child was no longer eligible for Medicaid, effective September 1, 2017.

According to your account, your child was determined eligible for Medicaid, effective June 1, 2017. She was enrolled into a Medicaid Managed Care plan, effective July 1, 2017.

Pursuant to the above cited regulations, once a person is determined eligible for Medicaid, that eligibility continues for 12 months, with limited exceptions, even if the applicant's income increases above the allowable Medicaid limit within that period. This provision is called "continuous coverage."

Therefore, having been determined eligible for Medicaid effective June 1, 2017, barring the occurrence of certain events, your child's eligibility for Medicaid should not have ended prior to May 31, 2018.

Although you updated your application on August 8, 2017, increasing your attested household income amount, since your child had already been determined eligible for Medicaid, she was eligible to continue her coverage for 12 months despite any subsequent income disqualification.

Because there is no evidence in your account that your child entered prison or another facility that provides medical care, moved out of state, or failed to provide a valid Social Security number, it was improper for NYSOH to determine her ineligible for Medicaid, effective September 1, 2017.

Thus, the August 9, 2017 eligibility determination notice stating your child was eligible for a full cost Child Health Plus plan, effective September 1, 2017, and ineligible for Medicaid, is MODIFIED to reflect your child was eligible for continuous Medicaid coverage until May 31, 2018.

Your case is RETURNED to NYSOH to reinstate your child in her Medicaid Managed Care plan coverage, effective September 1, 2017.

Decision

The August 8, 2017 eligibility determination notice is MODIFIED to reflect your child was eligible for continuous Medicaid coverage until May 31, 2018.

Your case is RETURNED to NYSOH to reinstate your child in her Medicaid Managed Care plan coverage, effective September 1, 2017.

Effective Date of this Decision: December 20, 2017

How this Decision Affects Your Eligibility

Your child's Medicaid coverage should not have been terminated on September 1, 2017.

Your case is being sent back to NYSOH to reinstate your child in her Medicaid coverage.

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):

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- 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 8, 2017 eligibility determination notice is MODIFIED to reflect your child was eligible for continuous Medicaid coverage until May 31, 2018.

Your case is RETURNED to NYSOH to reinstate your child in her Medicaid Managed Care plan coverage, effective September 1, 2017.

Your child's Medicaid coverage should not have been terminated on September 1, 2017.

Legal Authority

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

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.

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 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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