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

Notice of Decision

Decision Date: January 08, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022722

On December 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 23, 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 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: January 08, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000022722

Issue

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

> Did NY State of Health properly determine your newborn child's enrollment in their Medicaid Managed Care plan ended October 31, 2017?

Procedural History

On May 27, 2017, NY State of Health (NYSOH) issued an eligibility determination notice stating that your newborn child (child) was eligible for Medicaid because your household income of $0.00 was at or below the allowable income limit for that program. This eligibility was effective as of July 1, 2017.

On May 27, 2017, NYSOH issued a plan enrollment notice based on your child's enrollment as of May 26, 2017, with a Medicaid Managed Care plan, effective July 1, 2017.

On July 22, 2017, NYSOH issued an eligibility determination notice stating in relevant part that your child was no longer eligible for Medicaid coverage; however, coverage would continue until May 31, 2018. This was because certain individual who qualified for Medicaid get coverage for twelve continuous months from the date they were last determined eligible. The eligibility was effective July 1, 2017. The notice stated the income in your application was $36,950.00.

On September 22, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of the October 31, 2017 end date of your child's Medicaid Managed Care plan insofar as you wanted it to end as of August 1, 2017.

On September 23, 2017, NYSOH issued a notice stating your child's Medicaid Manage Care Plan would end on October 31, 2017. The notice stated this was because records showed your child had other health insurance or Medicare.

On December 7, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open until December 22, 2017, to allow you to submit supporting documentation.

On December 7, 2017, three documents were uploaded to your NYSOH account [redacted]. The documents have been made part of the record as Appellant's Exhibit 1, 2, and 3, respectively. The record was considered complete and closed as of that date.

Findings of Fact

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

1) You expect to file your 2017 federal income tax return as Head of Household, and claim one dependent.

2) According to the May 26, 2017 application, you attested to an expected annual household income of $0.00. You testified that this income was not an accurate representation of your household income.

3) Your child was born [redacted].

4) According to your NYSOH account, your child became eligible for Medicaid effective July 1, 2017, and was enrolled in a Medicaid Managed Care Plan with a start date of July 1, 2017.

5) You testified your child became eligible for your employer sponsored insurance as of August 1, 2017.

6) According to your NYSOH account, your child was disenrolled from their Medicaid Managed Care plan effective October 31, 2017.

7) You testified you contacted NYSOH multiple times prior to the August 1, 2017 start date of their employer sponsored insurance.

8) According to your NYSOH account and your testimony, on July 21, 2017, you called to update your child's application to show they were eligible for employer sponsored insurance as of August 1, 2017.

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9) You testified that, when you contacted NYSOH to disenroll your child from their Medicaid Managed Care Plan, you were told NYSOH had to rerun their eligibility. You testified that NYSOH never requested proof of your child's third-party health insurance.

10) You testified you need your child's Medicaid Managed Care plan to end as of August 1, 2017, because their physician's office will not submit medical bills due to your child having two active insurance plans.

11) You provided a copy of your child's health plan card on September 12, 2017, showing they had coverage through your employer sponsored insurance plan.

12) Your request for your child's disenrollment from their Medicaid Managed Care plan was processed on September 12, 2017, after you provided their health insurance cards.

13) You and your child reside in Dutchess County, NY.

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</u>

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 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).

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 $16,240.00 for a two-person household (82 Federal Register 8831).

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).

A child under the age of nineteen who is determined eligible for medical assistance under Medicaid, remains eligible for such assistance until the last day

of the twelfth month following the eligibility determination for such assistance (N.Y. Soc. Serv. Law § 366(4)(b)(3)(i)). This twelve-month period is referred to as "continuous coverage."

A person who has primary medical or health care coverage available from or under a third-party insurance provider is not permitted to enroll into a Medicaid Managed Care plan (NY SSL § 364-j(3)(e)(xx); Medicaid Managed Care Model Contract (Appendix H-6), effective 3/1/2014 – 2/28/2019). However, they will remain eligible for fee-for-service Medicaid with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, or failing to provide a valid social security number (NY SSL § 366(4)(c)).

Legal Analysis

The issue presented for review is whether NYSOH properly determine your child's enrollment in their Medicaid Managed Care plan ended October 31, 2017.

In the May 27, 2017 eligibility determination notice your child was found eligible for Medicaid, effective July 1, 2017. Your child was subsequently enrolled in a Medicaid Managed Care plan as of July 1, 2017.

Generally, when an individual, here a child, is eligible for Medicaid through NYSOH, they are required to enroll in a Medicaid Managed Care plan. Applicants determined eligible will remain enrolled in their Medicaid plan with limited exceptions. Additionally, any person who has primary medical or health care coverage available from or under a third-party insurance provider is not permitted to enroll into a Medicaid Managed Care plan.

The credible evidence of the record confirms your child became eligible for your employer sponsored insurance as of August 1, 2017. You testified you contacted NYSOH multiple times prior to the August 1, 2017 start date of your newborn's employer sponsored insurance. Specifically, on July 21, 2017, you contacted NYSOH representatives to update your child's application to state she was now eligible for employer sponsored insurance as of August 1, 2017. The record supports this request was not completed until September 12, 2017 after you provided their health insurance card. The notice issued on September 23, 2017 states their disenrollment would not be effective until October 31, 2017.

Since the record supports your child became eligible for your employer sponsored insurance as of August 1, 2017, they were no longer permitted to remain enrolled in a Medicaid Managed Care plan. As a result, NYSOH's September 23, 2017 disenrollment notice is MODIFIED to reflect your child's Medicaid Managed Care plan disenrollment became effective August 1, 2017.

Your case is RETURNED to NYSOH to effectuate a disenrollment date of August 1, 2017, for your child's Medicaid Managed Care plan and notify you once this has been completed.

Decision

The September 23, 2017 disenrollment notice is MODIFIED to reflect your child's Medicaid Managed Care plan disenrollment became effective August 1, 2017.

Your case is RETURNED to NYSOH to effectuate a disenrollment date of August 1, 2017 for your child's Medicaid Managed Care plan and notify you once this has been completed.

Effective Date of this Decision: January 08, 2018

How this Decision Affects Your Eligibility

The effective date of your child's disenrollment from their Medicaid Managed Care plan is August 1, 2017.

Your child remains eligible for Medicaid Fee-For-Service for the end of their twelve-month continuous coverage period barring any disqualifying events.

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 September 23, 2017 disenrollment notice is MODIFIED to reflect your child's Medicaid Managed Care plan disenrollment became effective August 1, 2017.

Your case is RETURNED to NYSOH to effectuate a disenrollment date of August 1, 2017 for your child's Medicaid Managed Care plan and notify you once this has been completed.

The effective date of your child's disenrollment from their Medicaid Managed Care plan is August 1, 2017.

Your child remains eligible for Medicaid Fee-For-Service for the end of their twelve-month continuous coverage period barring any disqualifying events.

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Legal Authority

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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 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 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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