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

Notice of Decision

Decision Date: March 2, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025531

[redacted]

Dear [redacted]

On February 13, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's September 22, 2017 eligibility determination and October 19, 2017 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
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Decision

Decision Date: March 2, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025531

[redacted]

Issue

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

> Did New York State of Health (NYSOH) properly end your, your spouse and child's (family) Medicaid Managed Care (MMC) plan coverage as of November 30, 2017?

Procedural History

On May 25, 2016, NYSOH issued an eligibility determination notice stating that you and your child were eligible for Medicaid, effective as of June 1, 2016.

Also on May 25, 2016, NYSOH issued an enrollment notice confirming that as of May 24, 2016, you and your child were enrolled in a MMC plan with an enrollment start date of July 1, 2016.

On December 1, 2016, your spouse was added to your NYSOH account.

On December 2, 2016, NYSOH issued three notices:

(1) An eligibility determination notice stating, in relevant part, that you and your child were no longer eligible for Medicaid; however, your Medicaid coverage would continue until April 30, 2017, because certain individuals who qualified for Medicaid get coverage for twelve continuous months;
(2) A notice stating, in relevant part, that your spouse's application had been reviewed; however, the income information in your application did not

match what NYSOH received from state and federal data sources. The notice instructed your spouse to provide proof of income by December 16, 2016, to confirm their eligibility;

(3) An enrollment notice confirming that you and your child were enrolled in a MMC plan with an enrollment start date of July 1, 2016.

On January 18, 2017, NYSOH issued an eligibility determination notice stating that you and your child remained eligible for Medicaid, effective as of January 1, 2017. Further, that your spouse was eligible for Medicaid, effective as of February 1, 2017.

On January 20, 2017, NYSOH issued an enrollment notice confirming, in relevant part, that as of January 19, 2017, your spouse was enrolled in a MMC plan with an enrollment start date of March 1, 2017.

On April 15, 2017, NYSOH issued an eligibility determination notice stating that you, your spouse, and child remained eligible for Medicaid, effective as of April 1, 2017.

On April 16, 2017, NYSOH issued an enrollment notice confirming that you and your child were enrolled in a MMC plan with a start date of July 1, 2016, and your spouse was enrolled in a MMC plan with a start date of March 1, 2017.

On September 22, 2017, NYSOH issued a renewal notice stating that it was time to renew your family's health insurance for the upcoming coverage year. The notice stated that you and your spouse were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective December 1, 2017. Further, the notice stated that your child qualified for Child Health Plus with a $0.00 monthly premium, effective December 1, 2017.

On October 17, 2017, your NYSOH account was updated.

On October 18, 2017, NYSOH issued a notice stating, in relevant part, that your family's application had been reviewed; however, the income information in your application did not match what NYSOH received from state and federal data sources. The notice instructed you to provide proof of income by November 1, 2017, to confirm your family's eligibility.

On October 19, 2017, NYSOH issued a disenrollment notice stating that your family's MMC coverage would end on November 30, 2017.

On December 2, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible to enroll in the Essential Plan, with a $20.00 monthly premium, effective January 1, 2018.

Further, the notice stated that your child qualified for Child Health Plus with a $9.00 monthly premium, effective January 1, 2018.

Also on December 2, 2017, NYSOH issued an enrollment notice confirming that as of December 1, 2017, you and your spouse were enrolled in an Essential Plan, and your child was enrolled in a Child Health Plus plan, all with plan enrollment start dates of January 1, 2018.

On December 8, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal relative to your family's MMC coverage ending as of November 30, 2017.

On February 13, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing and the record was fully developed. The record was 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 family's Medicaid coverage to continue through December 31, 2017.

2) According to your NYSOH account, your child was born on [redacted]

3) According to your NYSOH account, you and your child were initially determined eligible for Medicaid as of June 1, 2016. Further, you and your child were redetermined eligible for Medicaid as of January 1, 2017, and April 1, 2017.

4) According to your NYSOH account, you and your child were enrolled in a MMC plan from July 1, 2016, through November 30, 2017.

5) According to your NYSOH account, your spouse was determined eligible for Medicaid as of February 1, 2017, and redetermined eligible for Medicaid as of April 1, 2017.

6) According to your NYSOH account, your spouse was enrolled in a MMC plan from March 1, 2017, through November 30, 2017.

7) According to your NYSOH account, your family was not enrolled in any health insurance coverage through NYSOH during the month of December 2017.

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

Applicable Law and Regulations

Medicaid Eligibility - Adults

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)).

Medicaid Continuous Coverage - Adults:

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)).

In the following situations, individuals are not entitled to receive continuous coverage:

- Unable to locate;
- Death;
- Consumer requests to have his/her Medicaid closed;
- Failure to provide or cooperate in obtaining a Social Security Number, if otherwise required;
- Failure to provide documentation of citizenship after the reasonable opportunity period;
- Moved out of State;
- Coverage established under MAGI in error;
- Undocumented pregnant women (only get 60 days post-partum);
- Failure to comply with absent parent (IV-D) requirements; and
- Individuals receiving treatment in a setting where Medicaid eligibility is not available

(*see* 42 CFR § 435.916(a); N.Y. Soc. Serv. Law § 366(4)(c); GIS 15 MA/22).

Medicaid – Children

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 Department of Health Administrative Directive 13 OHIP ADM-03).

Medicaid Continuous Coverage - Children:

A child under the age of nineteen, who is determined eligible for Medicaid, 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); 42 CFR § 435.926).

Legal Analysis

The issue under review is whether NYSOH properly ended your family's coverage in the MMC plan you were all enrolled in, as of November 30, 2017.

Generally, once individuals are determined eligible for Medicaid, they are guaranteed 12 months of Medicaid coverage, even if the individual loses 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 you and your child were initially determined eligible for Medicaid as of June 1, 2016, and were redetermined eligible for Medicaid as of January 1, 2017, and April 1, 2017. Your spouse was initially determined eligible for Medicaid as of February 1, 2017, and was redetermined eligible for Medicaid as of April 1, 2017.

On September 22, 2017, and October 19, 2017, NYSOH issued notices stating that you and your spouse were eligible to enroll in the Essential Plan, and your child qualified for Child Health Plus, effective December 1, 2017. Further, that your family's MMC coverage would end on November 30, 2017.

You testified you want your family's Medicaid coverage to continue through December 31, 2017. Your NYSOH account reflects that your family was not enrolled in any health insurance coverage during the month of December 2017.

Once a person is eligible for Medicaid, that eligibility continues for 12 months, even if the household income subsequently exceeds the income threshold. When your family's MMC coverage ended on November 30, 2017, the twelve-month period of Medicaid eligibility had not expired.

Therefore, the September 22, 2017, eligibility determination notice is RESCINDED.

The October 19, 2017, disenrollment notice is MODIFIED to state that your family's MMC coverage would end on December 31, 2017.

Your case is RETURNED to NYSOH to reinstate your family's MMC coverage from December 1, 2017, through December 31, 2017.

Decision

The September 22, 2017, eligibility determination notice is RESCINDED.

The October 19, 2017, disenrollment notice is MODIFIED to state that your family's MMC coverage would end on December 31, 2017.

Your case is RETURNED to NYSOH to reinstate your family's MMC coverage from December 1, 2017, through December 31, 2017.

Effective Date of this Decision: March 2, 2018

How this Decision Affects Your Eligibility

You, your spouse and child's Medicaid coverage will be reinstated from December 1, 2017, through December 31, 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.

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 22, 2017, eligibility determination notice is RESCINDED.

The October 19, 2017, disenrollment notice is MODIFIED to state that your family's MMC coverage would end on December 31, 2017.

Your case is RETURNED to NYSOH to reinstate your family's MMC coverage from December 1, 2017, through December 31, 2017.

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).

You, your spouse and child's Medicaid coverage will be reinstated from December 1, 2017, through December 31, 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:

[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)

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).

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 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.

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)

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).

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).