



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

Notice of Decision

Decision Date: March 5, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025718

[REDACTED]

Dear [REDACTED]

On February 14, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's September 15, 2017 discontinuance 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 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: March 5, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025718

[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 your adopted child was no longer eligible for health insurance through NYSOH resulting in her being disenrolled from her Medicaid Managed Care plan effective September 30, 2017?

Procedural History

On December 14, 2016, you added your adopted child (hereinafter referred to as "child") to your NY State of Health (NYSOH) account and submitted an updated application for financial assistance with health insurance.

On December 15, 2016, NYSOH issued an eligibility determination notice stating, in part, that your child was conditionally eligible for Medicaid effective December 1, 2016. This notice further directed you to submit proof of your child's citizenship status and Social Security number by March 14, 2017.

Also on December 15, 2016, NYSOH issued a plan enrollment notice confirming your child's enrollment in a Medicaid Managed Care plan, effective January 1, 2017.

On March 21, 2017, NYSOH issued a discontinuance notice stating that your child was no longer eligible for health insurance through NYSOH because you did not provide information about her citizenship status and Social Security number to NYSOH by the deadline. This eligibility was effective April 1, 2017.

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Also on March 21, 2017, NYSOH issued a plan disenrollment notice stating that your child's Medicaid Managed Care coverage would end as of March 31, 2017.

On April 12, 2017, NYSOH received your updated application for financial assistance with health insurance. You also uploaded five documents to your NYSOH account that day.

On April 13, 2017, NYSOH issued an eligibility determination notice stating, in part, that your child was conditionally eligible for Medicaid, effective April 1, 2017. This notice further directed you to submit proof of her citizenship status and Social Security number by July 11, 2017.

Also on April 13, 2017, NYSOH issued a plan enrollment notice confirming your child's enrollment in her Medicaid Managed Care plan, effective May 1, 2017.

On September 14, 2017, NYSOH issued a discontinuance notice stating that, effective October 1, 2017, your child was no longer eligible for health insurance through NYSOH because you did not provide information about her citizenship status and Social Security number to NYSOH by the deadline.

Also on September 14, 2017, NYSOH issued a plan disenrollment notice stating that your child's Medicaid Managed Care plan would end as of September 30, 2017.

On November 2, 2017, NYSOH received your updated application for financial assistance with health insurance.

On November 3, 2017, NYSOH issued an eligibility determination notice stating that your child was conditionally eligible for Medicaid, effective November 1, 2017. This notice further directed you to submit proof of her citizenship status and Social Security number by January 30, 2018.

Also on November 3, 2017, NYSOH issued a plan enrollment notice stating that your child was enrolled in a Medicaid Managed Care plan, effective December 1, 2017.

On December 13, 2017, you spoke to NYSOH's Account Review Unit and appealed the termination of your child's Medicaid coverage and Medicaid Managed Care plan as of September 30, 2017.

On February 14, 2018, 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 hearing.

Findings of Fact

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

1. You testified that you are appealing your child's disenrollment from her Medicaid coverage for the month of October 2017.
2. According to your NYSOH account, your child was added to your NYSOH account on December 14, 2016. The application that was submitted that day indicates that she is a U.S. Citizen, but she did not have a Social Security number because you were in the process of applying for one.
3. You testified that, at the time of the December 14, 2016 application, you and your spouse were in the process of adopting your child.
4. You testified that your child was born on [REDACTED] in [REDACTED] and that you and your spouse started the adoption process prior to her birth.
5. According to your NYSOH account, your child was found eligible for Medicaid, effective December 1, 2016 and was enrolled into a Medicaid Managed Care plan, effective January 1, 2017.
6. On April 12, 2017, you uploaded a notarized adoption affidavit signed by you indicating that you had an adoption case on file with the [REDACTED] and that your child's Social Security number was pending. You also uploaded a Record of Birth from [REDACTED] and the Certification of Birth indicating that your child was born on [REDACTED].
7. According to your NYSOH account, on September 14, 2017, your child was disenrolled from her Medicaid coverage, effective September 30, 2017, because NYSOH had not received the requested documentation regarding your child's citizenship status and Social Security number by the deadline.
8. You testified that, in the [REDACTED], there is a six-month waiting period before an adoption can be finalized.
9. You testified that you and your spouse have had physical and legal custody of your child since her birth.
10. You testified that, in order to apply for a Social Security number for your child, you had to wait for an amended birth certificate to be issued. You testified that a birth certificate could not be issued until the adoption was complete.

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11. You testified, and submitted documentation indicating, that the adoption was finalized on [REDACTED] (see Document # [REDACTED]).
12. You testified that you were able to apply for a Social Security number for your child after receiving the amended birth certificate in November 2017.
13. You testified that you were able to obtain your child's Social Security number in December 2017. However, as of the date of the hearing, you are still not in receipt of a physical Social Security card.
14. According to your NYSOH account and your testimony, you did upload your child's Social Security number on a document from the Social Security Administration to NYSOH on December 29, 2017.

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

Applicable Law and Regulations

Medicaid – Newborns

Medicaid can be provided through NYSOH to children who: (1) are under one year of age (2) meet the non-financial criteria, (3) and fall at or below 223% of the (42 CFR § 435.118(c)).

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).

As a condition of eligibility for Medicaid, an individual, including children, must furnish their Social Security Number and evidence of their citizenship or status as a qualified immigrant or PRUCOL alien to NY State of Health for verification purposes (42 CFR § 435.910(a) and (b)(3); 42 CFR § 457.340(b); 18 NYCRR § 360-3.2(j)(2) and (3); *see generally* 18 NYCRR § 360-3.2(j)).

NYSOH must require an applicant who has a Social Security number to provide the number but does not require an applicant's Social Security Number as a condition of enrollment for Medicaid if the applicant is not eligible to receive one or his or her number is not yet available (42 CFR § 457.340(b), 42 CFR § 435.910(h)(1)).

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 NYSOH properly determined that your child was no longer eligible for health insurance through NYSOH such that her Medicaid Managed Care coverage was terminated as of September 30, 2017.

NYSOH is required to determine whether an individual is eligible to enroll in coverage through the Marketplace, and must confirm, among other things, that the applicant has a valid Social Security number. However, NYSOH does not require an applicant's Social Security Number as a condition of enrollment for Medicaid if the applicant is not eligible to receive one or his or her number is not yet available.

On April 13, 2017, NYSOH issued an eligibility determination notice stating that your child was conditionally eligible for Medicaid, effective April 1, 2017. This notice further directed you to provide documentation of her Citizenship Status and Social Security number to NYSOH before July 11, 2017.

You testified that you and your spouse were in the process of adopting your child since her birth on [REDACTED]. Your child was born in the [REDACTED]. You further testified that you and your spouse have had physical and legal custody of your child since her birth. However, you testified that in [REDACTED] there is a six-month waiting period before an adoption can be finalized. You testified and submitted documentation indicating that the adoption was finalized on [REDACTED] (see Document # [REDACTED]).

You testified that before the adoption was finalized you were unable to obtain an amended birth certificate for your child. You credibly testified that without a birth certificate, the Social Security Administration would not issue your child a Social Security number.

Based on the credible evidence on the record, it is reasonable to conclude that, while your child was in the process of being formally adopted by you and your spouse, she was in a unique situation in terms of her ability to obtain a Social Security number. The record supports a finding that the requirement to obtain and provide Social Security numbers in order to receive Medicaid coverage through the NYSOH does not apply to her because your child was not eligible to receive a Social Security number and her Social Security number was not available until the adoption was finalized.

Therefore, the September 15, 2017 discontinuance notice and September 15, 2017 plan disenrollment notices are RESCINDED.

Your case is RETURNED to the NYSOH to re-enroll your child into her Medicaid Managed Care plan for the month of October 2017, and to notify you accordingly.

Decision

The September 15, 2017 discontinuance notice is RESCINDED.

The September 15, 2017 plan disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to re-enroll your child into her Medicaid Managed Care plan for the month of October 2017, and to notify you accordingly.

This Decision does not affect any subsequent NYSOH eligibility determinations or enrollments regarding your child.

Effective Date of this Decision: March 5, 2018

How this Decision Affects Your Eligibility

Your case is being sent back to NYSOH to re-enroll your child into her Medicaid Managed Care plan for the month of October 2017. NYSOH will notify you once this has been completed.

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 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).

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 15, 2017 discontinuance notice is RESCINDED.

The September 15, 2017 plan disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to re-enroll your child into her Medicaid Managed Care plan for the month of October 2017, and to notify you accordingly.

This Decision does not affect any subsequent NYSOH eligibility determinations or enrollments regarding your child.

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).

Your case is being sent back to NYSOH to re-enroll your child into her Medicaid Managed Care plan for the month of October 2017. NYSOH will notify you once this has been completed.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:



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 مجاناً.

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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&etumi ama wo obi a okyerE 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 کرم 1-855-355-5777 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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