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

Notice of Decision

Decision Date: May 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026886

[redacted]

Dear [redacted]

On May 3, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 1, 2017 and January 9, 2018 eligibility redetermination 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: May 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026886

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Was your appeal of NY State of Health's November 1, 2017 eligibility redetermination notice timely?
>
> Did NY State of Health properly determine that your daughter was no longer eligible for Medicaid, but would continue to receive Medicaid coverage until January 31, 2019?

Procedural History

On February 3, 2017, NY State of Health (NYSOH) issued a renewal notice, stating that your daughter still qualified for coverage with Child Health Plus, effective April 1, 2017. The notice further stated that she was re-enrolled into her current plan.

On October 31, 2017, you submitted an updated application for financial assistance with health insurance to NYSOH.

On November 1, 2017, NYSOH issued an eligibility redetermination, based on the November 1, 2017 application, stating that your daughter was eligible to enroll in Medicaid, effective November 1, 2017. The notice further stated that your daughter no longer qualified for Child Health Plus, effective October 31, 2017, because the household income of $0.00 is at or below the allowable income limit.

Also on November 1, 2017, NYSOH issued an enrollment confirmation notice, based on a plan selection made October 31, 2017, stating that your daughter was enrolled in a Medicaid Managed Care plan, with a start date of December 1, 2017.

On January 8, 2018, you submitted an updated application for financial assistance with health insurance to NYSOH. The same day, a preliminary eligibility determination was prepared with regard to that application, stating that your daughter was no longer eligible for Medicaid. However, NYSOH would continue her Medicaid coverage.

Also on January 8, 2018, you contacted NYSOH's Account Review Unit and requested an appeal insofar as your daughter's enrollment in Medicaid had been continued.

On January 9, 2018, NYSOH issued an eligibility redetermination notice, based on the January 8, 2018 application, stating that your daughter was no longer eligible for Medicaid. However, her Medicaid coverage would continue until January 31, 2019 because certain individuals determined eligible for Medicaid remain eligible for benefits for 12 continuous months from the date that they were determined eligible. This eligibility was effective as of January 1, 2018.

On May 3, 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 seeking for your daughter to be re-enrolled into her previous Child Health Plus plan.

2) On October 31, 2017, you submitted an updated application for financial assistance with health insurance to NYSOH. That application indicated that your mailing address was [redacted] The application further indicated that the address for your wife and daughter was [redacted]

3) You testified that you selected a Medicaid Managed Care plan for your daughter to enroll in on October 31, 2017.

4) On January 8, 2018, you submitted an updated application for financial assistance with health insurance to NYSOH. That application indicated

that you, your wife, and your daughter had a shared mailing address of [redacted].

5) You testified that you and your wife began the legal separation process toward the end of 2016 and beginning of 2017 and your wife filed a divorce application around the same time. You also testified that you moved out of your shared household [redacted] and that you have not lived with your daughter and wife since. You further testified that your wife and daughter moved to [redacted] in July or August 2017.

6) Your October 31, 2017 application indicated an annual expected household income of $37,000.00, consisting of income you earn from employment. The application further indicated that your daughter and wife had an expected annual income of $0.00.

7) Your January 8, 2018 application indicated an annual expected household income of $39,000.00, consisting of income you earn from employment. The application further indicated that your daughter and wife had an annual expected annual income of $0.00.

8) You testified that you are self-employed and that you do not know for certain what your income for 2018 will be, but that the income listed on your applications for yourself were accurate at the times reported. You further testified, however, that you do not and did not know what your wife's expected annual income was.

9) Your October 31, 2017 and January 8, 2018 applications indicated that you and your wife planned to file your taxes as married filing jointly, and that you would claim your daughter as a dependent on that return.

10) You testified that you and your wife filed your 2017 taxes as married filing separately and that you and your wife would file as single in 2018 if your divorce was finalized by the 2018 filing deadline, or again as married filing separately if the divorce was not finalized. You also testified that your wife claimed your daughter as a dependent on her 2017 tax return and so you could not claim her yourself. You further testified that you were unsure who would claim your daughter as a dependent for 2018.

11) You testified that you and your wife share joint legal custody with your daughter, but that your wife has physical custody and is the primary caregiver for your daughter. You further testified that you provide financial support to your wife and daughter, including court mandated child support payments of about $1,100.00 a month implemented in

July or August 2017, but that you have fallen behind on these payments.

12) You testified, and the record reflects, that you live in [redacted]. The record reflects that your wife and daughter also live in [redacted].

13) You testified that your daughter needs specialist medical care. You further testified that all of her doctors accepted her Child Health Plus plan but not her Medicaid Managed Care plan and you are unable to afford the out-of-pocket costs required for her non-covered care.

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

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR §155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

However, where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe as determined by NYSOH that failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal (45 CFR §155.520(d)(2)(i)(D)).

Medicaid – Continuous Coverage

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 first issue under review is whether your appeal of NYSOH’s November 1, 2017 eligibility redetermination notice was timely.

The record reflects that on November 1, 2017, NYSOH issued an eligibility redetermination notice, stating that your daughter was eligible for Medicaid, effective November 1, 2017. On January 8, 2018, you contacted NYSOH’s Account Review Unit to request an appeal.

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of the notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of your daughter’s eligibility for Medicaid, effective November 1, 2017, as stated in the November 1, 2017 eligibility redetermination notice, an appeal should have been filed by December 31, 2017. The record reflects that the appeal for this issue was not made until January 8, 2018, well after the 60-day timeframe to appeal the November 1, 2017 eligibility redetermination had expired

Where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe as determined by NYSOH that failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal. However, in this case, there is no evidence in the record that your failure to submit the appeal in a timely manner was due to exceptional circumstances. Thus, there is no justification present to toll the deadline in which to appeal that determination. Since there has been no timely appeal of the November 1, 2017 eligibility redetermination notice, your appeal of your daughter’s Medicaid eligibility, effective November 1, 2017, must be DISMISSED.

The second issue is whether NYSOH properly determined that your daughter was no longer eligible for Medicaid, but would continue to receive Medicaid coverage until January 31, 2019.

You updated your application on January 8, 2018. Following this update, your annual household income and household size placed your daughter above the Medicaid limit.

Under New York State law once an individual, including a child who is at least one year old but younger than nineteen, is eligible for Medicaid, that eligibility continues for 12 months, even if the household income rises above 154% of the FPL. This provision is called “continuous coverage.”

Your daughter was determined eligible for Medicaid, effective November 1, 2017, and an appeal of this eligibility is not timely. Therefore, your daughter will remain enrolled in Medicaid for the remainder of her 12-month eligibility period, which should end October 31, 2018.

However, during the hearing, you testified that the information in both your October 31, 2017 and January 8, 2018 applications, including addresses, tax filing status selections, number of dependents claimed and by whom, and annual household income, was inaccurate and known by you to be inaccurate when submitted. As a result, NYSOH’s determinations were not based on accurate and complete information.

Therefore, the January 8, 2018 eligibility determination notice is not supported by the record and is RESCINDED.

Your case is RETURNED to NYSOH for NYSOH to follow up with you to collect the information necessary to redetermine eligibilities for your family based on accurate information, and then to notify you accordingly.

Decision

Your appeal of your daughter’s Medicaid eligibility, effective November 1, 2017, is DISMISSED as untimely.

The January 8, 2018 eligibility redetermination notice is RESCINDED.

Your case is RETURNED to NYSOH for NYSOH to follow up with you to collect the information necessary to redetermine the eligibilities for your family based on accurate information, and then to notify you accordingly.

Effective Date of this Decision: May 10, 2018

How this Decision Affects Your Eligibility

This is not a final determination of your daughter's eligibility for financial assistance. Your case is being sent back to NYSOH for NYSOH to follow up with you to collect the information necessary to redetermine the eligibilities for your family based on accurate information, and then to notify you accordingly.

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):

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 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

Your appeal of your daughter's Medicaid eligibility, effective November 1, 2017, is DISMISSED as untimely.

The January 8, 2018 eligibility redetermination notice is RESCINDED.

This is not a final determination of your daughter's eligibility.

Your case is RETURNED to NYSOH for NYSOH to follow up with you to collect the information necessary to redetermine the eligibilities for your family based on accurate information, and then to notify you accordingly.

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.

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