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

Notice of Decision

Decision Date: May 31, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000028246

[redacted]

Dear [redacted]

On April 24, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's August 16, 2017 eligibility determination notice and February 2, 2018 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).

This page intentionally left blank.

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

Decision

Decision Date: May 31, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028246

[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 (NYSOH) August 16, 2017 eligibility determination timely?
>
> Did NYSOH properly determine that your children were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until February 28, 2019?

Procedural History

On August 16, 2017, NYSOH issued a notice of eligibility determination stating that your children were eligible for Medicaid because your household income of $0.00 was at or below the allowable income limit. This eligibility was effective as of August 1, 2017.

Also on August 17, 2017, NYSOH issued a notice of enrollment confirming your children's enrollment in a Medicaid Managed Care plan, effective October 1, 2017.

On February 1, 2018, NYSOH received your updated application for health insurance; specifically, the 2018 expected annual household income information attested to was increased. On that date a preliminary eligibility determination was prepared stating that you and your children were no longer eligible for Medicaid; however, your children's Medicaid coverage would continue until February 28, 2019.

Also on February 1, 2018, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as your children's Medicaid coverage was continued and they were not found eligible for Child Health Plus.

On February 2, 2018, NYSOH issued a notice of eligibility determination stating that your children were no longer eligible for Medicaid. However, their Medicaid coverage would continue until February 28, 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 February 1, 2018.

On April 24, 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) According to the August 15, 2017 application, you attested to an expected annual household income of $0.00. You testified that this amount was accurate.

2) According to your NYSOH account, your three children are [redacted] and [redacted]

3) NYSOH records reflect that your children were determined eligible for Medicaid, effective August 1, 2017, and subsequently enrolled in a Medicaid Managed Care plan.

4) On February 1, 2018, you increased your 2018 expected annual household income from $0.00 to $36,000.00 for you, and $72,000.00 for your domestic partner.

5) On February 2, 2018, NYSOH determined that your children were no longer eligible for Medicaid, but that their Medicaid coverage would continue until February 28, 2019.

6) You testified that you believe that your children should be determined eligible for Child Health Plus because you can afford to pay the premiums.

7) Your application indicates that you reside in Monroe County.

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) a failure by NYSOH to provide timely notice of an eligibility determination 45 CFR § 155.505; and (4) 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)).

Medicaid for 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 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 $24,600.00 for a four-person household (82 Federal Register 8831).

Generally, most adults 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 SSL § 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 SSL § 366(4)(c), *see also* GIS 15 MA/22: Continuous Coverage for MAGI Individuals (12/23/15), https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/15ma022.pdf, retrieved 5/24/18).

Legal Analysis

The first issue under review is whether your appeal of NYSOH's August 16, 2017 eligibility determination was timely.

On August 16, 2017, NYSOH issued a notice of eligibility determination stating that your children were eligible for Medicaid, effective August 1, 2017.

The record reflects that the first time you called NYSOH to file a complaint regarding your children's eligibility for Medicaid was on February 1, 2018. The record indicates that a formal appeal was also filed on February 1, 2018.

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

For an appeal to have been valid on the issue of your children's eligibility for Medicaid, as stated in the August 16, 2017 eligibility determination notice, an appeal should have been filed by October 16, 2017. According to the credible evidence in the record, you did not contact NYSOH until February 1, 2018 to file a formal appeal, which is beyond 60 days from the August 16, 2017 eligibility determination notice.

As such there has been no timely appeal of the August 16, 2017 eligibility determination notice, and your appeal on the issue of your children's eligibility for Medicaid, as stated in the August 16, 2017 eligibility determination notice is DISMISSED.

The second issue is whether NYSOH properly determined that your children were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until February 28, 2019.

Once a person is found eligible for Medicaid, he or she will generally remain eligible for Medicaid for 12 continuous months, regardless of whether their income increases. This is referred to as "continuous coverage."

NYSOH records reflect your children were determined eligible for Medicaid, effective August 1, 2017. Therefore, your children should remain eligible to continue their Medicaid coverage until July 31, 2018, all other things remaining the same.

Since the February 2, 2018 eligibility determination incorrectly stated that your children would continue to receive Medicaid coverage until February 28, 2019, it is MODIFIED to state that your children's Medicaid coverage will be continued until July 31, 2018, barring a change in circumstances, and your case is RETURNED to NYSOH to confirm that your children's Medicaid coverage will be continued until July 31, 2018.

Decision

Your appeal of the August 16, 2017 eligibility determination notice is untimely and is DISMISSED.

The February 2, 2018 eligibility determination notice is MODIFIED to state that your children's Medicaid coverage will be continued until July 31, 2018, barring a change in circumstances.

Your case is being RETURNED to NYSOH to confirm that your children's Medicaid coverage will be continued until July 31, 2018.

Effective Date of this Decision: May 31, 2018

How this Decision Affects Your Eligibility

Your appeal of the August 16, 2017 eligibility determination notice is untimely.

Your case is being RETURNED to NYSOH to confirm that your children's Medicaid coverage will be continued until July 31, 2018.

Your children will continue to receive Medicaid until July 31, 2018.

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.

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).

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

Your appeal of the August 16, 2017 eligibility determination notice is untimely and is DISMISSED.

Your case is being RETURNED to NYSOH to confirm that your children's Medicaid coverage will be continued until July 31, 2018.

Your children will continue to receive Medicaid until July 31, 2018.

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.

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).