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

Notice of Decision

Decision Date: July 3, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015386

[redacted]

Dear [redacted],

On May 5, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 28, 2017, 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).

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DEPARTMENT OF HEALTH
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Decision

Decision Date: July 3, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015386

[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 you and your child were no longer eligible for Medicaid for failing to provide proof of your household composition effective February 28, 2017?

Procedural History

On June 22, 2016, NY State of Health (NYSOH) issued an eligibility determination notice based on your June 21, 2016 application. The notice stated you and your child were eligible for Medicaid effective June 1, 2016.

You then enrolled yourself and your child into a Medicaid Managed Care plan with a start date of August 1, 2016.

On December 29, 2016, NYSOH issued a letter requesting more information about your household size. The letter asked you to provide proof of your household composition by January 13, 2017.

On January 28, 2017, NYSOH issued an eligibility determination notice stating you and your child were eligible to purchase a qualified health plan at full cost effective March 1, 2017. The notice stated this was because your original eligibility was determined by an eligibility specialist at NYSOH. You do not meet the eligibility requirements for Medicaid.

On January 28, 2017, NYSOH issued a disenrollment notice stating your and your child's Medicaid Managed Care plan would end on February 28, 2017.

On January 31, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of your and your child's disenrollment from your Medicaid Managed Care plan effective February 28, 2017.

On February 11, 2017, NYSOH issued an eligibility determination notice stating you and your child were eligible for Medicaid for a limited time due to being granted Aid to Continue until a decision is made on your appeal. The determination was effective March 1, 2017.

You and your child were enrolled into a Medicaid Managed Care plan starting March 1, 2017 through Aid to Continue.

On May 5, 2017, 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 expect to file your 2016 federal income tax return as Head of Household, and claim one dependent.

2) Your application states you have an expected household income of $14,300.00. You testified this was correct.

3) On February 7, 2017, a NYSOH representative made a notation in your NYSOH account that NYSOH "received information via Child Support Referral Information form that [redacted], Parent of [redacted], resides in HH. Sent letter requesting proof of HH comp to verify current HH composition. Proof due 1/13/17."

4) On January 27, 2017, a NYSOH representative made a notation in your NYSOH account stating "failed to submit HH comp. Discontinued from MA and overrode to full pay QHP eff 3/1/17. Sent manual discontinuance notice. DOH."

5) A letter dated December 29, 2016 from NYSOH was issued stating additional information was required to confirm eligibility for members of your household. You were asked to provide proof of your household composition by January 13, 2017.

6) The December 29, 2016, letter from NYSOH states you could provide proof of household composition by providing a statement from non-relative landlord, School Records, or Statement from other persons.

7) You testified you received the December 29, 2016 letter from NYSOH requesting proof of household composition. You testified in response to the letter you contacted NYSOH on January 9, 2017 to ask what information you could provide to show this. You explained the representative told you it was a mistake, and you did not need to provide any proof of your household composition size.

8) A document was uploaded to your account on March 3, 2017. The document is a four-page fax with a fax date of February 7, 2017. On page four of the letter is a form with the title "Child Support Referral Information." The letter states [redacted] name and includes as a mailing address which is your current address. See Document [redacted].

9) You and your child were disenrolled from your Medicaid Managed Care plan and Medicaid effective February 28, 2017. You were both determined eligible to purchase a qualified health plan at full cost effective March 1, 2017.

10) You testified you are seeking for you and your child to be found eligible for Medicaid.

11) You testified you have been divorced from your former husband for five years with a final decree of divorce from a judge.

12) You testified you reside with only your child.

13) You testified your child's father does not reside with you.

14) You testified your only source of income is from your part-time employment.

15) The record supports you reside in [redacted], 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 Adults between the Ages of 19 and 65</u>

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 federal poverty level (FPL) for the applicable family size (42 CFR §§ 435.119(b), 435.911(b)(1), 435.603(d)(4); NY Social Services Law § 366(1)(b)).

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 2016 FPL, which is $16,020.00 for a two-person household (81 Fed. Reg. 4036).

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 FPL for the applicable family size (42 CFR § 435.118(c); New York Department of Social Services Administrative Directive 13ADM-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 2016 FPL, which is $16,020.00 for a two-person household and $24,300.00 for a four-person household (81 Fed. Reg. 4036).

Continuous Coverage

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 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)).

An adult or child who has been determined eligible for and is receiving Medicaid under continuous coverage can lose such eligibility if it is determined they failed to comply with absent parent (IV-D) requirements (GIS 15 MA/022: Continuous Coverage for MAGI Individuals, See http://www.health.ny.gov/health_care/medicaid/publications/gis/15ma022.htm).

Household Composition

Generally, a child who is claimed as a tax dependent by their custodial parent has the same household size as the parent that is claiming them (42 CFR § 435.603(f)(2).

In the case where a child is claimed by a non-custodial parent, the child's family includes the following persons, if living with the child: (1) the child's parents, (2) the child's spouse, (3) the child's children and siblings under the age of 19, or 21 if a full-time student (42 CFR § 435.603(f)(2)(iii)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you and your child were no longer eligible for Medicaid for failing to provide proof of your household composition effective February 28, 2017.

You and your child were eligible for Medicaid effective June 1, 2016. You then enrolled yourself and your child into a Medicaid Managed Care plan with a start date of August 1, 2016.

On December 29, 2016, NYSOH issued a letter requesting more information about your household size. The letter asked you to provide proof of your household composition by January 13, 2017. This notice was in response to NYSOH receiving information by a Child Support Referral Information form that your child's father resides in your household.

NYSOH did not receive sufficient documentation in order to confirm your and your child's household size before the January 13, 2017 deadline. As a result, you and your child were disenrolled from your Medicaid coverage effective February 28, 2017.

Under New York State law, once a person is eligible for Medicaid, that eligibility continues for 12 months, unless a triggering event occur that would make that person no longer eligible for Medicaid. This provision is called "continuous coverage." NYSDOH has determined that an adult or child who has been determined eligible for and is receiving Medicaid can lose their coverage despite being eligible for continuous coverage if it is determined they failed to comply with absent parent requirements.

Although you testified your spouse does not reside with you, you failed to provide the requested absent parent documentation as requested in the December 29, 2016 notice. Since NYSOH was unable to confirm whether or not your child's father resides with you, it was proper for you and your child's Medicaid eligibility to be terminated prior to the end of the 12-month eligibility period.

Therefore, the January 28, 2017, eligibility determination notice finding you and your child no longer eligible for Medicaid effective February 28, 2017, and eligible to purchase a qualified health plan at full cost effective March 1, 2017 is correct and is AFFIRMED.

During the hearing, you testified that you have been divorced from your former husband for five years with a final decree of divorce from a judge and that he does not reside with you. Therefore, your case is RETURNED to NYSOH to assist you in updating your NYSOH account and to inform you of the proper documentation needed in order to confirm your and your child's household composition.

Decision

The January 28, 2017, eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to assist you in updating your NYSOH account and to inform you of the proper documentation needed in order to confirm your and your child's household composition.

Effective Date of this Decision: July 3, 2017

How this Decision Affects Your Eligibility

You and your child were eligible to purchase a qualified health plan at full cost effective March 1, 2017.

Your case is being sent back to assist you in confirming your household size. If necessary, your and your child's eligibility will be redetermined 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.

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 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

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Summary

The January 28, 2017, eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to assist you in updating your NYSOH account and to inform you of the proper documentation needed in order to confirm your and your child's household composition.

You and your child were eligible to purchase a qualified health plan at full cost effective March 1, 2017.

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)

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).

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