



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

Notice of Decision

Decision Date: June 14, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000015487

[REDACTED]

Dear [REDACTED],

On April 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 20, 2017 plan enrollment 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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Decision

Decision Date: June 14, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000015487



Issues

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

Did New York State of Health (NYSOH) fail to determine your youngest child eligible for Medicaid as of December 6, 2016?

Did NYSOH properly determine that your youngest child was enrolled in a Child Health Plus plan with an enrollment start date of March 1, 2017?

Procedural History

On December 6, 2016, you submitted an application for financial assistance through NYSOH for your youngest child.

Also on December 6, 2016, income documentation was uploaded to your NYSOH account (see Documents [REDACTED]).

On December 7, 2016, NYSOH issued a notice stating that your application for your youngest child was reviewed and the income information in your application did not match what NYSOH received from state and federal data sources. The notice directed you to submit proof of income and benefit information for third party health insurance by December 21, 2016.

On December 21, 2016, your NYSOH account was updated.

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On December 22, 2016, NYSOH issued a notice stating that your application for your youngest child was reviewed and the income information in your application did not match what NYSOH received from state and federal data sources. The notice directed you to submit proof of income by December 21, 2016.

On January 4, 2017, additional income documentation was uploaded to your NYSOH account (see Documents [REDACTED]).

On January 8, 2017, NYSOH issued a notice stating that the documentation reviewed did not confirm the information in your application. The notice directed to provide additional income documentation for your youngest child by February 4, 2017.

On January 9, 2017, your NYSOH account was systemically updated.

Also on January 9, 2017, additional income documentation was uploaded to your account (see Document [REDACTED]).

On January 10, 2017, NYSOH issued a notice stating that your application for your youngest child was reviewed and the income information in your application did not match what NYSOH received from state and federal data sources. The notice directed you to submit proof of income and benefit information for third party health insurance by February 4, 2017.

On January 12, 2017, and January 17, 2017, additional income documentation was uploaded to your account (see Documents [REDACTED]).

On January 19, 2017, your NYSOH account was updated.

On January 20, 2017, NYSOH issued an eligibility determination notice stating in part that your youngest child was eligible for Child Health Plus with a \$15.00 monthly premium for a limited time, effective as of March 1, 2017. The notice directed you to submit additional proof of income by March 20, 2017.

Also on January 20, 2017, NYSOH issued a plan enrollment notice confirming in part that your youngest child was enrolled in a Child Health Plus plan with an enrollment start date of March 1, 2017.

On February 2, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as disagreed with the March 1, 2017 enrollment start date of youngest child's Child Health Plus plan.

On April 7, 2017, you and your witness, [REDACTED], had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and the closed at the end of the proceeding.

Findings of Fact

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

- 1) You testified that you want your youngest child to be enrolled in health insurance for the months of January 2017 and February 2017.
- 2) You testified that you are seeking to be reimbursed for the approximately \$530.00 of medical expenses that were incurred for your youngest child in January 2017 and February 2017.
- 3) According to your account and testimony, your youngest child was born on [REDACTED].
- 4) According to your December 6, 2016 application, you attested to an expected yearly household income of \$49,077.61 and a current monthly income of \$4,548.33.
- 5) According to your December 6, 2016 application, you attested to the following sources of income: (1) [REDACTED] for yourself; (2) [REDACTED] for your spouse; and (3) Unemployment Insurance Benefits (UIB) for your spouse.
- 6) On December 6, 2016, you uploaded the following income documentation to your NYSOH account:
 - (a) Your spouse's Official Benefit Payment History of UIB from NYS Department of Labor (Document [REDACTED]);
 - (b) Your spouse's paychecks stubs from [REDACTED] for the weekly check dates of 11/10/16; 11/18/16; 11/23/16; 12/2/16 (Document [REDACTED]);
 - (c) Your paycheck stubs from [REDACTED] for the biweekly check dates of 11/18/16 and 12/2/2016 (Document [REDACTED]).
- 7) On December 7, 2016, NYSOH issued a notice directing you to submit proof of income and included a list of acceptable documentation. The list included paychecks stubs for the last four weeks and a printout of recipient's account information from NYS Department of Labor's website (see Document [REDACTED]).

- 8) According to your NYSOH account, Document [REDACTED] uploaded on January 4, 2017 was invalidated by NYSOH on January 7, 2017 on the following basis:

Invalid Proof of Income. [Spouse] submitted UIB Award letter. [Spouse] also attested to being employed. [Spouse] and [Appellant] submitted 2 weekly paystubs each. 4 weekly paystubs dated within 30 days of [12/31/2016] or more recent are required for both [REDACTED] and [REDACTED]. Refer to the Acceptable Documents list for additional acceptable income documents. Due date extended. [REDACTED]

- 9) According to your NYSOH account, Document [REDACTED] uploaded on December 6, 2016 was invalidated by NYSOH on January 19, 2017.
- 10) You testified that you were told by a NYSOH representative that your youngest child should have been determined eligible for Medicaid, if the December 6, 2016 documentation had been properly reviewed.
- 11) According to your NYSOH account, you attested to filing your 2016 federal income tax return, jointly with your spouse, and expected to claim your two children as dependents on that tax return.
- 12) According to your earnings statements from [REDACTED], you were issued gross pay of:
- (a) \$1,280.00 on 12/02/2016;
 - (b) \$1,280.00 on 12/16/2016;
 - (c) \$1,280.00 on 12/30/2016
- (see Documents [REDACTED])
- 13) According to the Official Record of Benefit Payment History, your spouse was issued unemployment insurance benefits of:
- (a) \$210.50 on the release date of 12/08/2016;
 - (b) \$315.75 on the release date of 12/08/2016;
 - (c) \$315.75 on the release date of 12/13/2016
- (see Document [REDACTED]).
- 14) According to the earnings statements from [REDACTED], your spouse was issued gross earnings of:
- (a) \$163.56 on 12/02/2016;
 - (b) \$163.56 on 12/09/2016;

(c) \$ 81.78 on 12/16/ 2016

(see Document [REDACTED]).

- 15) Your spouse's assignment for [REDACTED] [REDACTED] began on December 21, 2016 and he was issued \$247.50 in gross taxable wages from [REDACTED] on 12/30/2016 (see Documents [REDACTED] and [REDACTED]).

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

Applicable Law and Regulations

Medicaid – Eligibility

A child, who is under one year of age, 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 223% of the FPL for the applicable family size. (42 CFR § 435.118(c); New York Department of Health Administrative Directive 13 OHIP/ADM-03).

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).

“Family size” means the number of persons counted as members of an individual's household. The household of a taxpayer who expects to file a return, and does not expect to be claimed as a tax dependent by anyone else, consists of the taxpayer plus all people the taxpayer expects to claim as tax dependents (42 CFR § 435.603(f)(1)).

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 \$24,300.00 for a four-person household (81 Fed. Reg. 4036).

Child Health Plus - Eligibility

A child who meets the eligibility requirements for CHP may be eligible to receive a subsidy payment if the child resides in a household with a household income at or below 400% of the federal poverty level (FPL) (New York Public Health Law (NY PHL) § 2511(2)(a)(iii)).

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To be eligible for CHP, the child:

- Must be under 19 years of age;
- Must be a New York State Resident;
- Must not have other health insurance coverage; and
- Must not be eligible for, or enrolled in, Medicaid

(NY PHL § 2511(2)(a)-(e)).

Child Health Plus – Income Verification

NYSOH is required to verify the eligibility of an applicant for CHP subsidy payments, which includes verifying the applicant's household income. If NYSOH is unable to verify the applicant's household income using available data sources, then NYSOH must request additional information from the applicant. NYSOH must provide the applicant with a reasonable period of time to furnish such information (42 CFR § 457.380; 42 CFR § 435.952(c)).

Child Health Plus – Start Date

“A State must specify a method for determining the effective date of eligibility for [Child Health Plus], which can be determined based on the date of application or through any other reasonable method that ensures coordinated transition of children between [Child Health Plus] and other insurance affordability programs as family circumstances change and avoids gaps or overlaps in coverage” (42 CFR § 457.340(f)).

The State of New York has provided that a child's period of eligibility for Child Health Plus begins on the first day of the month during which a child is eligible. A child will become eligible on the first day of the next month, if the application is received by the 15th of the month; applications received after the 15th day of the month will be processed for the first day of the second following month (see e.g. State Plan Amendment (SPA) NY-14-0005, approved February 3, 2015 and effective January 1, 2014).

Legal Analysis

The first issue under review is whether NYSOH failed to determine your youngest child to be eligible for Medicaid as of December 6, 2016.

The record reflects that you filed a 2016 federal income tax return jointly with your spouse, and claimed your two children as dependents on that return. Therefore, your youngest child was in a four-person household for purposes of this analysis.

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An applicant's financial eligibility for Medicaid is based on their current monthly household income and family size. To be determined eligible for Medicaid, your youngest child, who is [REDACTED], would need a household income no greater than 223% of the 2016 FPL, which is \$4,516.00 per month.

The record reflects that you were issued \$3,840.00 in paystubs during December 2016 (\$1,280.00 (+) \$1,280.00 (+) \$1,280.00). Furthermore, your spouse was issued \$1,498.40 in combined earnings and unemployment insurance benefits (\$210.50 (+) \$315.75 (+) \$315.75 (+) \$163.56 (+) \$163.56 (+) \$81.78 (+) \$247.50). Therefore, your household monthly income in December 2016 was \$5,338.40.

Since your household exceeded the \$4,516.00 monthly Medicaid limit for a child under the age of one, NYSOH did not fail to determine your youngest child eligible for Medicaid as of December 6, 2016.

The second issue under review is whether NYSOH properly determined that your youngest child should be enrolled in a Child Health Plus plan with an enrollment start date of March 1, 2017.

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income. If NYSOH cannot verify the income information required to determine eligibility, they must attempt to resolve the inconsistency by giving the applicant the opportunity to submit satisfactory documentary evidence.

On December 6, 2016, you submitted an application for financial assistance through NYSOH for your youngest child. You attested to an expected yearly household income of \$49,077.61 and a current monthly income of \$4,548.33. Furthermore, you attested to the following sources of income: (1) [REDACTED] for yourself; (2) [REDACTED] for your spouse, and (3) Unemployment Insurance Benefits for your spouse.

The household income that you attested to in your application did not match federal and state data sources. As a result, NYSOH issued you a notice on December 7, 2016, directing you to submit additional proof of income to NYSOH to confirm your child's eligibility for financial assistance. The notice included a list of acceptable documentation. The list included paychecks stubs for the last four weeks and a printout of recipient's account information from NYS Department of Labor's website (see Document [REDACTED]).

On December 6, 2016, you uploaded: an Official Benefit Payment History of unemployment insurance benefits from NYS Department of Labor; paychecks stubs from [REDACTED] for the weekly check dates of 11/10/16; 11/18/16; 11/23/16; 12/2/16; paycheck stubs from [REDACTED] for the biweekly check dates of 11/18/16 and 12/2/2016 (see Documents

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[REDACTED]; and [REDACTED]). However, these documents were not verified by NYSOH until January 19, 2017, which it is concluded was not within a reasonable time period.

The date on which a Child Health Plus plan can take effect depends on the day a person selects the plan for enrollment. A plan that is selected between the first day and fifteenth day of a month goes into effect on the first day of the following month. A plan that is selected from the sixteenth day of the month and the end of the month goes into effect on the first day of the second following month.

The record reflects that your NYSOH account contained sufficient documentation to render an eligibility determination for your youngest child as of December 6, 2016. Therefore, your child's Child Health Plus enrollment must take effect on the first day of the first month following December 6, 2016; that is on January 1, 2017.

Therefore, the January 20, 2017, enrollment notice is MODIFIED to state that your child's plan enrollment start date is January 1, 2017.

Your youngest child's case is RETURNED to NYSOH to effectuate her Child Health Plus enrollment from January 1, 2017 through February 28, 2017, and to notify you accordingly.

Decision

The January 20, 2017, enrollment notice is MODIFIED to state that your child's plan enrollment start date is January 1, 2017.

Your youngest child's case is RETURNED to NYSOH to effectuate her Child Health Plus enrollment from January 1, 2017 through February 28, 2017, and to notify you accordingly.

Effective Date of this Decision: June 14, 2017

How this Decision Affects Your Eligibility

Your youngest child was not eligible for Medicaid as of December 6, 2016.

Your youngest child's Child Health Plus enrollment is being made effective January 1, 2017. NYSOH will notify you once this is done.

You will be responsible to the health insurance premiums for January 2017 and February 2017 to effectuate the health insurance coverage those months.

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 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

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- By fax: 1-855-900-5557

Summary

The January 20, 2017, enrollment notice is MODIFIED to state that your child's plan enrollment start date is January 1, 2017.

Your youngest child's case is RETURNED to NYSOH to effectuate their Child Health Plus enrollment from January 1, 2017 through February 28, 2017, and to notify you accordingly.

Your youngest child was not eligible for Medicaid as of December 6, 2016.

Your youngest child's Child Health Plus enrollment is being made effective January 1, 2017. NYSOH will notify you once this is done.

You will be responsible to the health insurance premiums for January 2017 and February 2017 to effectuate the health insurance coverage those months.

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)

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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 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&tumi 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.

שׂוֹדֵשׁ (Yiddish)

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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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