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

Notice of Decision

Decision Date: July 11, 2017

NY State of Health Number: [redacted]
Appeal Identification Number: AP000000016498

[redacted]

Dear [redacted]

On July 5, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 3, 2017 eligibility determination.

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 at the top of this notice.

Legal Authority

We are sending you this notice in accordance with Code of Federal Regulation 45 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: July 11, 2017

NY State of Health Number: [redacted]
Appeal Identification Number: AP000000016498

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health (NYSOH) properly determine that your son was eligible for Medicaid, effective April 1, 2017?

Procedural History

On March 2, 2017, NYSOH received your application for health insurance. That day, a preliminary eligibility determination was prepared with regard to that application, stating that your [redacted] was eligible for Medicaid, effective March 1, 2017.

Also on March 2, 2017, you spoke to NYSOH's Account Review Unit and appealed that determination insofar as your child was eligible for Medicaid, and not eligible for Child Health Plus.

On March 3, 2017, NYSOH issued an eligibility determination notice stating that your [redacted] was eligible for Medicaid, effective March 1, 2017.

Also on March 3, 2017, NYSOH issued a notice of enrollment confirmation stating that your [redacted] was enrolled in a Medicaid Managed Care plan, effective April 1, 2017.

On July 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 testified that you expected to file your 2017 tax return with a tax filing status of single. You testified that you will be claiming your [redacted] as a dependent on that return and that you believe you will not be claiming your [redacted] as a dependent.

2) The application that was submitted on March 2, 2017 indicates that you will be filing your 2017 tax return with a tax filing status of head of household and will claim your [redacted] as a dependent. This application also indicates that your [redacted] father will be claiming [redacted] as a dependent.

3) You testified that your [redacted] resides part of the time with [redacted] father and that you and your [redacted] father have joint legal custody of your [redacted]. However, you further testified that you have full physical custody of your [redacted] and your [redacted] primary physical residence is with you.

4) The application that was submitted on March 2, 2017 listed annual household income of $13,113.00, consisting of Unemployment Insurance Benefits you were receiving. You testified that this amount was correct. You testified that this may have changed as you are no longer receiving Unemployment Insurance Benefits. You testified that you have not yet returned to work.

5) At the time of the March 2, 2017 application, your child was [redacted].

6) Your application states, and you testified, that you will not be taking any deductions on your 2017 tax return.

7) Your application states, and you confirmed, that you live in [redacted].

8) You testified that you would like your child to be eligible for Child Health Plus, and not Medicaid.

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

Applicable Law and Regulations

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 the case of an individual who expects to file a tax return and does not expect to be claimed by another taxpayer, the household consists of the taxpayer and all persons whom such individual expects to claim as a tax dependent (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 2017 FPL, which is $16,240.00 for a two-person household and $20,420.00 for a three-person household (82 Fed. Reg. 8831).

Child Health Plus

A child who meets the eligibility requirements for Child Health Plus (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 (PHL) § 2511(2)(a)(iii)). To be eligible to enroll in CHP with subsidy payments, a child must not be "eligible for medical assistance"; that is, must not be eligible for Medicaid (NY Public Health Law § 2511(2)(b)).

Household Composition for Children

The household of an individual who expects to be claimed as a tax dependent by another taxpayer consists of the household of the taxpayer claiming the individual as a dependent, except that where a child expects to be claimed as a tax dependent 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)(3)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your child was eligible for Medicaid, effective April 1, 2017.

The application you submitted on March 2, 2017 indicates that you expect to file your 2017 tax return as head of household and will claim your [redacted] on that return and that your [redacted] father will claim your [redacted] as a dependent in 2017.

You testified that your child primarily resides with you.

For children claimed as a dependent by a non-custodial parent, their household consists of the child's parents, the child's spouse, and the child's children and siblings under the age of 19 or 21 if a full time-student, if those persons live with the child.

As your [redacted] lives with one parent and one sibling, your [redacted] is in a three-person household, based on the information in the March 2, 2017 application.

However, you testified that you will be claiming your [redacted] as a dependent in 2017 and that you will not be claiming your [redacted] as a dependent in 2017.

For children claimed by the custodial parent as a dependent, their household consists of the household of the taxpayer claiming the child as a dependent. Therefore, based on your testimony, your [redacted] is in a two-person household.

On your March 2, 2017 application, you attested to an expected household income of $13,113.00. The application also stated that your child is [redacted]. NYSOH relied upon this information.

Medicaid can be provided through NYSOH to children between the ages of one and nineteen who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is at or below 154% of the FPL for the applicable family size. Since $13,113.00 is 80.75% of the 2017 FPL for a two-person household and 64.22% of the 2017 FPL for a three-person household, NYSOH properly found your [redacted] to be eligible for Medicaid.

You testified that you want your child enrolled in health coverage through Child Health Plus and not Medicaid. However, under New York State's Public Health Law, a Medicaid-eligible child does not qualify to enroll in health insurance through Child Health Plus.

Accordingly, the March 3, 2017 notice of eligibility determination that your [redacted] was eligible for Medicaid is correct and is AFFIRMED.

Decision

The March 3, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: July 11, 2017

How this Decision Affects Your Eligibility

Your son remains eligible for Medicaid.

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
- By fax: 1-855-900-5557

Summary

The March 3, 2017 eligibility determination notice is AFFIRMED.

Your [redacted] remains eligible for Medicaid.

Legal Authority

We are sending you this notice in accordance with Code of Federal Regulation 45 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).

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.

□□□□□ (Bengali)

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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 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)

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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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