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

Notice of Decision

Decision Date: July 31, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017558

[redacted]

Dear [redacted],

On July 11, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 21, 2016 renewal notice, and April 1, 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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Decision

Decision Date: July 31, 2017

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000017558

[redacted]

Issues

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

> Did NY State of Health properly determine that your child was eligible for Medicaid effective January 1, 2017?
>
> Did NY State of Health properly determine that your child was no longer eligible for Medicaid, but would continue to receive Medicaid coverage until December 31, 2017?

Procedural History

On December 16, 2015, NY State of Health (NYSOH) issued a notice based on your application on December 15, 2015, stating your child was newly eligible to enroll in Child Health Plus for a cost of $30.00 per month, effective January 1, 2016. The household income listed your application was $58,044.00.

On December 16, 2015, NYSOH issued an enrollment notice confirming your child's enrollment on December 15, 2015 in a Child Health Plus plan for a cost of $30.00 per month starting January 1, 2016.

On October 21, 2016, NYSOH issued a renewal notice. The notice stated your child could not be enrolled in his current health plan for the next coverage year. The notice requested you select a different health plan between November 15, 2016 and December 15, 2016 to continue coverage. The notice stated your child now qualified for Medicaid, effective January 1, 2017 since federal and state data sources show your income was between $0.00 and $31,047.00.

On November 18, 2016, NYSOH issued an enrollment confirmation notice confirming your child's enrollment in a Medicaid Managed Care plan, effective January 1, 2017. The notice stated [redacted] was enrolled in this plan because it was similar to the coverage [redacted] had before with that company.

On November 24, 2016, NYSOH issued a cancellation notice stating your child's Child Health Plus plan was cancelled effective December 31, 2016.

On March 31, 2017, you updated your child's application for financial assistance with NYSOH and changed the income amount in your application. That day, a preliminary eligibility determination was prepared stating your child was no longer eligible for Medicaid, however [redacted] Medicaid coverage would continue until December 31, 2017, this was because certain individuals determined eligible for Medicaid remain eligible for benefits for 12 continuous months from the date they were determined eligible.

Also on March 31, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as your child's Medicaid coverage was continued and [redacted] was not found eligible for Child Health Plus.

On April 1, 2017, NYSOH issued a notice of eligibility determination, based on the March 31, 2017 application, stating that your child was no longer eligible for Medicaid. However, [redacted] Medicaid coverage would continue until December 31, 2017 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 March 1, 2017. The notice stated the income amount listed in the application for your household was $89,999.52.

On July 11, 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 2017 federal income tax return as married filing jointly, and claim one dependent.

2) Your December 15, 2015 application indicates that you requested automatic renewal of your coverage for one year.

3) NYSOH automatically redetermined your child's eligibility on October 5, 2016 based on federal and state data sources. It determined your

child eligible for Medicaid based on an income between $0.00 and $31,047.00 You testified that this income may be accurate if NYSOH received the information from your income tax returns.

4) You testified you don't remember receiving the October 21, 2016 renewal notice stating your child was no eligible for Child Health Plus effective January 1, 2017.

5) You testified that you realized your child had been determined eligible for Medicaid when you tried to bring your child to a doctor a few months ago.

6) According to the March 31, 2017 application, you attested to an increased expected household income for 2017 of $89,999.52.

7) You testified that you reside in [redacted].

8) You testified you want your child's eligibility redetermined to be eligible for Child Health Plus because [redacted] doctor's do not accept Medicaid.

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

Applicable Law and Regulations

Medicaid

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 2016 FPL, which is $20,160.00 for a three-person household (81 Fed. Reg. 4036).

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)).

Legal Analysis

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

Your child is in a three-person household as you and your spouse are filing your 2017 taxes as married filing jointly and will claim [redacted] as a dependent.

NYSOH automatically redetermined your child's eligibility for financial assistance based on information from state and federal data sources on October 5, 2016. The system determined that based on those data sources your household income for the prior year was between $0.00 and $31,047.00. You testified this amount may be accurate if NYSOH received the information from your income tax returns.

Medicaid can be provided through NYSOH to 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.

On the date of your application, the relevant FPL was $31,047.00 for a child in three-person household. NYSOH determined based on your child's age and your household income data sources he was now eligible for Medicaid on an expected annual income basis, effective January 1, 2017.

Therefore, NYSOH's October 21, 2016 renewal notice stating your child was eligible for Medicaid January 1, 2017, is correct and is AFFIRMED.

The second issue is whether NYSOH properly determined that your child was no longer eligible for Medicaid, but would continue to receive Medicaid coverage until December 31, 2017.

You testified the income listed in the October 21, 2016 renewal notice is no longer correct as you now are expecting a higher income for 2017, closer to the amount listed in your March 31, 2017 application of $89,999.52.

Once a person is found eligible for Medicaid, they remain eligible for Medicaid for 12 continuous months whether or not their income increases above the level for their respective age and household income. This is referred to as “continuous coverage.”

Since the credible evidence confirms that your child was eligible for Medicaid effective January 1, 2017, and that even though your estimated annual income for 2017 increased when you modified your application on March 31, 2017, your child remains enrolled in Medicaid for the remainder of your 12-month eligibility period.

Therefore, the April 1, 2017 eligibility determination notice stating your child was no longer eligible for Medicaid, but [redacted] Medicaid coverage would continue until December 31, 2017 is correct and is AFFIRMED.

Decision

The October 21, 2016 renewal notice is AFFIRMED.

The April 1, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: July 31, 2017

How this Decision Affects Your Eligibility

Your child’s Medicaid coverage which began on January 1, 2017 continuous until December 31, 2017 barring subsequent changes in his eligibility.

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 October 21, 2016 renewal notice is AFFIRMED.

The April 1, 2017 eligibility determination notice is AFFIRMED.

Your child's Medicaid coverage which began on January 1, 2017 continuous until December 31, 2017 barring subsequent changes in [redacted] eligibility.

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).

Legal Authority

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A Copy of this Decision Has Been Provided To:

[redacted]

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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.

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