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

Notice of Decision

Decision Date: November 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018945

[redacted]

[redacted],

On November 2, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's May 16, 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 and the NY State of Health 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: November 13, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000018945

Issue

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

> Did NY State of Health properly determine that your youngest child was no longer eligible for Medicaid?

Procedural History

On May 15, 2017, NY State of Health (NYSOH) received an updated application for health insurance submitted on behalf of your youngest child. That day, a preliminary eligibility determination was prepared stating he was eligible to purchase a qualified health plan at full cost, effective June 1, 2017.

Also on May 15, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as your child was no longer eligible for Medicaid.

On May 16, 2017, NYSOH issued a notice of eligibility determination, based on the May 15, 2017 application, stating your youngest child was eligible to purchase a qualified health plan at full cost, effective June 1, 2017. The notice stated that your child was not eligible for Medicaid because the household income amount you provided was over the allowable income limit for that program. The notice further stated that your child was not eligible for Child Health Plus, because you indicated he was enrolled in third-party health insurance (TPHI).

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On November 2, 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, and your applications indicate, you are only seeking insurance for your youngest child.

2) Your youngest child was determined eligible for Medicaid, effective June 1, 2016, following a June 28, 2016 application that listed your annual household income as $0.00.

3) That application indicated that your child was enrolled in TPHI.

4) You testified that your child is enrolled in full coverage health insurance through his father's employer.

5) Your account confirms that your child had fee-for-service Medicaid coverage in 2016, but he was not permitted to enroll in a Medicaid Managed Care plan due to his enrollment in TPHI.

6) On May 15, 2017, NYSOH received several updated applications for health insurance submitted on behalf of your youngest child to renew his coverage for the 2017 coverage year. Each application listed your annual expected income for 2017 as $54,600.01. You testified this was accurate.

7) You testified that you agreed with the income information in your May 15, 2017 applications and you declined to submit proof of your income for the month of May 2017.

8) The May 15, 2017 application listed a "system calculated average monthly income" of $4,550.00.

9) Your application indicated you would file your 2017 tax return with a tax filing status of head of household and you would claim one dependent.

10) You testified that you and your ex-spouse alternate years claiming your three children as dependents on your tax return. You testified that for 2017 you would claim one child as a dependent and your ex-spouse would claim two.

11) Following the May 15, 2017 application, your child was determined eligible to purchase a full cost qualified health plan and ineligible for Medicaid, Child Health Plus, and to receive tax credits.

12) You testified you are seeking eligibility for fee-for-service Medicaid coverage for your child

13) You testified that your child has been diagnosed with various disabilities including severe [redacted] requiring hospitalization that is not covered by your child's primary insurance.

14) You testified you were seeking Medicaid coverage as secondary insurance to cover the costs of your child's hospitalizations.

15) You testified, and your applications indicate, you will not take any deductions on your 2017 tax return.

16) You testified, and your applications indicate, you live in [redacted].

17) Your account indicates your youngest child was [redacted] at the time of the May 15, 2017 applications.

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

Applicable Law and Regulations

<u>Advance Payments of Premium Tax Credit</u>

Advance payments of the premium tax credit (APTC) are generally available to a person who is eligible to enroll in a qualified health plan (QHP) and (1) expects to have a household income between 138% and 400% of the applicable federal poverty level (FPL), (2) expects to file a tax return and claim a personal exemption deduction for a person who meets the eligibility requirements to enroll in a QHP, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)).

<u>Child Health Plus</u>

Child Health Plus is a sliding-scale-premium program for children who are in a household that is over income for regular Medicaid (*see* New York Public Health Law (NY PHL) § 2510 et seq. and 42 USC § 1397aa).

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NY PHL § 2511(2) provides eligibility rules for Child Health Plus, including:

1. Child must have a household income at or below four hundred percent of the Federal Poverty Line; and

2. Child must not be eligible for Medicaid; and

3. Child must not be enrolled in other health care coverage; and

4. Child must be a resident of New York state.

<u>Medicaid Eligibility for Children</u>

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 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 was $16,240.00.00 for a two-person household (81 Federal Register 4036).

If an individual is not eligible for MAGI-based Medicaid through NYSOH, he or she may still be eligible for non-MAGI-based Medicaid coverage through their Local Department of Social Services or the New York City Human Resources Administration (*see* NY Social Services Law § 366(1)(c)).

NYSOH is required to refer an individual who is not eligible for MAGI-based Medicaid because they are in receipt of Medicare, certified disabled, or over the age of 65 to the Local Department of Social Services or the Human Resources Administration. During the referral process, an individual's Medicaid eligibility, including their enrollment in an MMC plan or receipt of Premium Payment Assistance, continues until such a time as their eligibility can be re-determined on a non-MAGI Medicaid basis (*see generally* 42 CFR § 435.1200, 42 CFR § 435.930, 14 OHIP/LCM-2 effective as of December 1, 2014, GIS 16 MA/04 effective as of January 1, 2016).

Legal Analysis

The issue is whether NYSOH properly determined your youngest child was no longer eligible for Medicaid.

The applications submitted on May 15, 2017 listed your annual expected household income for 2017 as $54,600.01. You testified this was accurate and the subject eligibility determination relied upon that information.

The record establishes that you are in a two-person household, because you will file your 2017 tax return with a tax filing status of head of household and you will claim one dependent. You testified you are seeking eligibility for Medicaid for your youngest child.

Pursuant to the regulations, Medicaid can be provided through NYSOH to children between the age of one and nineteen who meet the non-financial criteria and have a household modified adjusted gross income that falls at or below 154% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $16,240.00 for a two-person household. Since $54,600.01 is 336.21% of the 2017 FPL, NYSOH properly found your child ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

Although you declined to submit proof of your monthly income for the month of May 2017, you testified that the income information in your application was accurate. That application listed a “system calculated average monthly income” of $4,550.00. Thus, the evidence establishes that your monthly household income for the month of May was $4,550.00.

To be eligible for Medicaid, your child would need to meet the non-financial criteria and have an income no greater than 154% of the FPL, which is $2,085.00 per month. Since the evidence establishes that you earned $4,550.00 in May 2017, your child does not qualify for Medicaid on the basis of monthly income as of the date of your application.

It is noted that due to your child’s enrollment in TPHI, your child is not eligible to receive tax credits or to enroll in Child Health Plus, pursuant to the above cited regulations.

Since the May 16, 2017 eligibility determination properly stated that, based on the information you provided, your child was eligible to purchase a full cost

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qualified health plan and ineligible for Medicaid, effective June 1, 2017, that determination is correct and is AFFIRMED.

It is further noted that due to your testimony that your child had been diagnosed with various disabilities your case is REFERRED to your LDSS to determine whether your child is eligible for non-MAGI based Medicaid.

Decision

The May 16, 2017 eligibility determination notice is AFFIRMED.

Your case is REFERRED to your LDSS to determine whether your child is eligible for non-MAGI based Medicaid.

Effective Date of this Decision: November 13, 2017

How this Decision Affects Your Eligibility

Your child is not eligible for Medicaid through NYSOH.

Your case is REFERRED to your LDSS to determine whether your child is eligible for non-MAGI based 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 May 16, 2017 eligibility determination notice is AFFIRMED.

Your case is REFERRED to your LDSS to determine whether your child is eligible for non-MAGI based Medicaid.

Your child is not eligible for Medicaid through NYSOH.

Your case is REFERRED to your LDSS to determine whether your child is eligible for non-MAGI based Medicaid.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

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A Copy of this Decision Has Been Provided To:

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)

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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 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.

(Urdu)اردو

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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