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

Notice of Decision

Decision Date: October 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020099

[redacted]

Dear [redacted],

On September 20, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 30, 2016 and June 2, 2017 eligibility determinations.

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: October 12, 2017

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000020099

[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 December 1, 2016?
>
> Did NY State of Health properly determine that your child was no longer eligible for Medicaid, but would continue to receive Medicaid coverage until November 30, 2017?

Procedural History

On December 30, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination stating that your child was eligible for Medicaid because your household income of $35,428.00 was at or below the allowable income limit. This eligibility was effective as of December 1, 2016.

On June 1, 2017, NYSOH received your updated application for health insurance.

On June 2, 2017, NYSOH issued a notice of eligibility determination stating that your child was no longer eligible for Medicaid. However, her Medicaid coverage would continue until November 30, 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 June 1, 2017.

On June 28, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as your child's enrollment in Medicaid had been continued.

On September 20, 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 are seeking Child Health Plus, and not Medicaid coverage for your child for 2017.

2) You expect to file your 2017 federal income tax return as married filing jointly, and claim your child as a dependent.

3) The December 29, 2017 application relied on an expected annual household income of $35,428.00. You testified that, at the time you submitted your application, $30,000.00 was an accurate reflection of your expected income for the 2017 tax year.

4) According to the June 1, 2017 application, you attested to an expected household income of $35,428.00. You testified that this is correct.

5) Your child was born on [redacted].

6) You testified that you updated your application on June 1, 2017, in an attempt to obtain Child Health Plus coverage for your child.

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 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 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).

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 December 12, 2016 application, that was the 2016 FPL, which is $20,160.00 for a three-person household (81 Fed. Reg. 4036). On the date of your June 1, 2017 application, that was the 2017 FPL, which is $20,420.00 for a three-person household (82 Fed. Reg. 8831).

Continuous Coverage

Most applicants determined eligible for Medicaid are guaranteed twelve months of Medicaid coverage, even if the adult loses Medicaid eligibility because of any changes or updates they make to their Marketplace 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 twelve-month period. This twelve-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 (see 42 CFR § 435.916; N.Y. Soc. Serv. Law § 366(4)(c)).

A child under the age of nineteen who is determined eligible for Medicaid will remain eligible for Medicaid until the last day of the twelfth month following the determination or redetermination of eligibility, or the last day of the month in which the child reaches the age of nineteen, whichever is earlier. (N.Y. Soc. Serv. Law § 366(4)(b)(3))

Applicants determined eligible will be enrolled or remain in their Medicaid plan with limited exceptions, including entering prison or another facility that provides medical care, moving out of state, or failing to provide a valid social security number (N.Y. Soc. Serv. Law § 366(4)(c)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your child was eligible for Medicaid effective December 1, 2016.

Your child is in a three-person household. According to the record, you expect to file your 2017 tax return as married filing jointly and claim one child as a dependent.

On December 29, 2016 application, your application contained an expected household income of $35,428.00. You credibly testified that $30,000.00 was an accurate reflection at that time of your expected 2017 household income. As this discrepancy does not affect your child's eligibility, NYSOH was proper to rely on an annual expected income of $35,428.00. Furthermore, your child was born on [redacted]. At the time of your December 29, 2016 application, she was less than [redacted] age.

Medicaid can be provided through NYSOH to a child under one year of age who meets the non-financial requirements and has a household MAGI that is at or below 223% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $20,160.00 for a three-person household. Since $35,428.00 is 175.73% of the 2016 FPL, NYSOH properly found your child to be eligible for Medicaid on an expected annual income basis, using the information provided in your application.

Since the December 30, 2016 eligibility determination properly stated that, based on the information you provided, your child was eligible for Medicaid, it 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 November 30, 2017.

At the time of your December 29, 2016 application, your child was less than one year of age. You updated your application on June 1, 2017, in an attempt to obtain Child Health Plus coverage for your child. On June 1, 2017, your child was over one year of age, but younger than nineteen, and NYSOH determined that she was no longer eligible for Medicaid based on the applicable FPL. You credibly testified that the income listed in that application, $35,428.00, was an accurate representation of your income at that time.

Medicaid can be provided through NYSOH to a child who is at least one year of age but younger than nineteen who meets the non-financial requirements and has a household MAGI that is at or below 154% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $20,420.00 for a three-person household. Since $35,428.00 is 173.5% of the 2017 FPL, NYSOH properly determined that she was no longer eligible for Medicaid.

However, under New York State law, once a child under the age of nineteen is determined eligible for Medicaid, that child will remain eligible for Medicaid until

the last day of the twelfth month following the determination, or the last day of the month in which the child reaches the age of nineteen, whichever is earlier.

Credible evidence confirms that your child was eligible for Medicaid effective December 1, 2016, and that even though her age rendered her no longer eligible for Medicaid based on FPL levels when you modified your application on June 1, 2017, she remained enrolled in Medicaid for the remainder of the 12-month eligibility period. Therefore, the June 2, 2017 eligibility determination is correct and is AFFIRMED.

Decision

The December 30, 2016 eligibility determination is AFFIRMED.

The June 2, 2017 eligibility determination is AFFIRMED.

Effective Date of this Decision: October 12, 2017

How this Decision Affects Your Eligibility

Your child's Medicaid coverage, which began on December 1, 2016, continues until November 30, 2017, barring subsequent changes in your 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 December 30, 2016 and June 2, 2017 eligibility determinations are AFFIRMED.

Your child's Medicaid coverage, which began on December 1, 2016, continues until November 30, 2017, barring subsequent changes in your eligibility.

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)

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।

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).

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 तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई नि:शुल्क 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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