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

Notice of Decision

Decision Date: November 7, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021487

[redacted]

Dear [redacted],

On October 24, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 9, 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 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: November 7, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021487

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly determine that you were ineligible for Medicaid as of August 9, 2017?
>
> Did NYSOH properly determine that you were eligible to enroll in Child Health Plus, with a $0.00 premium per month, as of August 9, 2017?

Procedural History

On August 7, 2017, you submitted an application for financial assistance through NYSOH.

On August 8, 2017, three things occurred:

(1) NYSOH issued a notice stating that your August 7, 2017 application had been received. The notice stated that the income information in your application did not match what NYSOH received from federal and state data sources, and more income documentation was needed by August 22, 2017, to confirm your eligibility;

(2) You uploaded additional documentation to your account (see Documents [redacted]); and

(3) Your NYSOH account was updated.

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On August 9, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Child Health Plus with a premium of $0.00, and you were ineligible for Medicaid because your household income was over the income limit for that program.

Also on August 9, 2017, NYSOH issued a plan enrollment notice confirming that as of August 8, 2017, you were enrolled in a Child Health Plus plan with an enrollment start date of September 1, 2017.

Also on August 15, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal insofar as you were not enrolled in health insurance for the month of August 2017.

On October 24, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was left open to allow you to submit paystubs for the month of August 2017.

On October 24, 2017, you faxed four-pages of documentation to NYSOH's Appeals Unit. That documentation was made part of the record as "Appellant Exhibit A." The record is now complete and closed.

Findings of Fact

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

1) According to your NYSOH account and testimony, you are applying for health insurance for yourself.

2) You testified that you want to be determined eligible for Medicaid in the month of August 2017.

3) You testified that you did not expect to be claimed as a dependent on anyone's 2017 federal income tax return.

4) According to your NYSOH account and testimony, you expect to file a 2017 federal income tax return with the tax status of single and do not expect to claim any dependents on that return.

5) According to your NYSOH account, you were born on [redacted], and are [redacted] as of the date of this Decision.

6) According to your NYSOH account and testimony, you did not expect to claim any deductions on your 2017 federal income tax return.

7) According to your NYSOH account, you reside in [redacted], New York.

8) You testified that your only source of income is from [redacted]

9) On October 24, 2017, you submitted weekly earnings statements for the month of August 2017. You were issued gross pay of:

    (a) $396.53, with year-to-date (YTD) gross pay of $11,698.11, on August 4, 2017;
    (b) $147.78, with YTD gross pay of $11,845.89, on August 11, 2017:
    (c) $319.90, with YTD gross pay of $12,165.79, on September 1, 2017;

    (see Appellant Exhibit A).

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

Applicable Law and Regulations

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term "modified adjusted gross income" means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (see 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income.

Medicaid Eligibility

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 Department of Health Administrative Directive 13 OHIP/ADM-03).

On the date of your application, that was the 2017 FPL, which is $12,060.00 for a one-person household (82 Federal Register 8831).

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).

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 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)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were ineligible for Medicaid as of August 9, 2017.

You testified that you did not expect to be claimed as a dependent on any person's 2017 federal income tax return. Further, you expected to file a 2017 federal income tax return with the tax status of single and do not expect to claim any dependents on that tax return. Therefore, you are in a one-person household.

Medicaid can be provided through NYSOH to children at least 1 year of age and younger than 19 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 154% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $12,060.00 for a one-person household.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size. Therefore, to be eligible for Medicaid, your income could not exceed $18,693.00, which is $1,548.00 per month for a one-person household.

On October 24, 2017, you submitted weekly earnings statements for the month of August 2017. You were issued gross pay of $396.53 on August 4, 2017, and $147.78 on August 11, 2017 (*see* Appellant Exhibit A). Therefore, your August

2017 income of ($396.53 (+) $147.78) $544.31 did not exceed the maximum allowable monthly income amount of $1,548.00, and you did qualify for Medicaid in the month of August 2017.

The second issue is whether NYSOH properly determined that you were eligible for Child Health Plus as of August 9, 2017.

For a child to be determined eligible to enroll in Child Health Plus, they must not be eligible for Medicaid. Based on the analysis above, you should have been determined eligible for Medicaid as of August 9, 2017. Therefore, you were not eligible to enroll in Child Health Plus as of August 9, 2017.

The August 9, 2017, eligibility determination is MODIFIED to state that you were eligible for Medicaid, effective August 1, 2017, and ineligible to enroll in Child Health Plus.

Your case is RETURNED to NYSOH to allow you to enroll in a Medicaid Managed Care (MMC) plan as of August 9, 2017.

Decision

The August 9, 2017, eligibility determination is MODIFIED to state that you were eligible for Medicaid, effective August 1, 2017, and ineligible to enroll in Child Health Plus.

Your case is RETURNED to NYSOH to allow you to enroll in a Medicaid Managed Care (MMC) plan as of August 9, 2017.

Effective Date of this Decision: November 7, 2017

How this Decision Affects Your Eligibility

You were eligible for Medicaid on August 9, 2017.

You were ineligible to enroll in Child Health Plus on August 9, 2017.

NYSOH will change your eligibility and you will have Medicaid Fee-For-Service from August 1, 2017 thorough August 31, 2017, and be enrolled in the MMC plan you select as of September 1, 2017.

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

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Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The August 9, 2017, eligibility determination is MODIFIED to state that you were eligible for Medicaid, effective August 1, 2017, and ineligible to enroll in Child Health Plus.

Your case is RETURNED to NYSOH to allow you to enroll in a Medicaid Managed Care (MMC) plan as of August 9, 2017.

You were eligible for Medicaid on August 9, 2017.

You were ineligible to enroll in Child Health Plus on August 9, 2017.

NYSOH will change your eligibility and you will have Medicaid Fee-For-Service from August 1, 2017 thorough August 31, 2017, and be enrolled in the MMC plan you select as of September 1, 2017.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

Getting Help in a Language Other than English

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).

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।

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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 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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