

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

Notice of Decision

Decision Date: February 16, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000026414



On February 13, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 14, 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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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 two oldest children were eligible for Medicaid effective June 1, 2017?

Did NY State of Health (NYSOH) properly determine that your two oldest children were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until May 31, 2018?

Procedural History

On June 26, 2017, you submitted an application for financial assistance with health insurance.

On June 27, 2017, NYSOH issued a notice of eligibility determination stating, in part, that your two oldest children were eligible for Medicaid, effective June 1, 2017.

Also on June 27, 2017, NYSOH issued an enrollment confirmation notice stating in part, that your two oldest children were enrolled into a Medicaid Managed Care plan, effective August 1, 2017.

On December 13, 2017, you submitted an updated application for financial assistance with health insurance. That day, a preliminary eligibility determination was prepared with regard to that application, stating, in part, that your two oldest

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children were no longer eligible for Medicaid. However, their Medicaid coverage would continue because certain individuals determined eligible for Medicaid remain eligible for benefits for twelve continuous months from the date that they were determined eligible.

On December 14, 2017, NYSOH issued a notice of eligibility redetermination, based on the December 13, 2017 application stating, in part, that your two oldest children were no longer eligible for Medicaid because the household income provided was over the allowable income limit. This eligibility was effective as of December 1, 2017.

On December 28, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as your two oldest children's enrollment in Medicaid had been continued and they were not eligible for Child Health Plus.

On February 13, 2018, 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 expect to file your 2017 federal income tax return as married filing jointly and that you expect to claim your four children as dependents on that tax return, including your two oldest children.
- 2) The application that was submitted on June 26, 2017 which requested financial assistance, listed an annual household income of \$29,456.04 earned from self-employment. You testified that this amount was correct at the time.
- 3) The application that was submitted on December 13, 2017 which requested financial assistance, listed an annual household income of \$60,154.00 earned from self-employment. You testified that this amount is correct for what your household expects to earn in 2018.
- 4) You testified that you were appealing the eligibility determinations for your two oldest children, specifically, because Medicaid does not cover treatment for certain medical needs that they have and you are seeking for your two oldest children to be found eligible for Child Health Plus.

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

Applicable Law and Regulations

Medicaid for Children

Children who are at least one year of age but younger than nineteen are eligible for Medicaid if they meet the non-financial criteria and have 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 Department of Social Services Administrative Directive 13ADM-03).

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).

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 \$32,960.00 for a six-person household (82 Fed. Reg. 8831).

Generally, most individuals 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 two oldest children were eligible for Medicaid effective June 1, 2017.

Your two oldest children are in a six-person household. According to the record, you expect to file your 2017 tax return as married filing jointly and claim four children, including your two oldest children, as dependents on that tax return.

On your June 26, 2017 application you attested to an annual household income of \$29,456.04 and you testified that this amount was correct at the time. Therefore, NYSOH was proper to rely on an income of \$29,456.04 as the basis for the eligibility determinations of your two oldest children.

Children who are at least one year of age but younger than nineteen are eligible for Medicaid if they 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 \$32,960.00 for a six-person household. Since \$29,456.04 is 89.37% of the 2017 FPL, NYSOH properly found your two oldest children to be eligible for Medicaid on an expected annual income basis, using the information provided in your application.

The second issue is whether NYSOH properly determined that your two oldest children were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until May 31, 2018.

On December 13, 2017, you submitted an updated application for financial assistance. Since the 2017 FPL is \$32,960.00 for a six-person household, your two oldest children would qualify for Medicaid at an income up to \$50,758.40. You attested to an annual income of \$60,154.00, which is over the Medicaid limit of 154% of the FPL.

Under New York State law, once children are eligible for Medicaid, that eligibility continues for 12 months, even if the household income rises above 154% of the FPL. This provision is called “continuous coverage.”

Credible evidence confirms that your two oldest children were properly determined eligible for Medicaid effective June 1, 2017, therefore your two oldest children remain enrolled in Medicaid for the remainder of their 12-month eligibility period. Accordingly, the December 14, 2017 eligibility determination is correct and is AFFIRMED.

Decision

The December 14, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: February 16, 2018

How this Decision Affects Your Eligibility

Your two oldest children's Medicaid coverage, which began on June 1, 2017, continues until May 31, 2018, barring subsequent changes in their 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):

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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- By fax: 1-855-900-5557

Summary

The December 14, 2017 eligibility determination is AFFIRMED.

Your two oldest children's Medicaid coverage, which began on June 1, 2017, continues until May 31, 2018, barring subsequent changes in their 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:



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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 مجاناً.

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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&etumi ama wo obi a okyerE 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 کرم 1-855-355-5777 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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