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

Notice of Decision

Decision Date: May 3, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029430

[redacted]

Dear [redacted]

On April 25, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 27, 2018 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: May 3, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000029430

[redacted]

Issue

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

> Did NY State of Health (NYSOH) properly determine that your child was eligible for Medicaid, effective March 1, 2018?

Procedural History

On February 15, 2018, you submitted an updated application for financial assistance with health insurance.

On February 16, 2018, NYSOH issued an eligibility determination notice stating that, if your child qualified for a special enrollment period, he was eligible to purchase a qualified health plan at full cost, effective March 1, 2018.

On February 26, 2018, an application for financial assistance was submitted on your behalf.

On February 27, 2018, NYSOH issued an eligibility determination notice, stating that your child was eligible for Medicaid, effective March 1, 2018. The notice stated that he qualified for Medicaid because his eligibility was determined by an eligibility specialist at NYSOH.

Also on February 27, 2018, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as you do not want Medicaid for your child.

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On March 1, 2018, NYSOH issued a plan enrollment confirming your child's enrollment in a Medicaid Managed Care plan, effective April 1, 2018.

On April 25, 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 tax return for 2018 with a tax filing status of head of household. According to your application, you will claim two dependents on that tax return; specifically, your child and your sister.

2) You further testified that when you completed your application, your sister was residing with you. You testified that she may not reside with you for the full year and, therefore, the number of dependents you will be claiming may change.

3) You are seeking health insurance for your child, who was [redacted] years old at all times relevant.

4) The application that was submitted on February 26, 2018, listed your annual income of $37,200.00, consisting of income you earn from your employment. You testified that this amount was correct.

5) You testified that you think your income may increase this year from last year.

6) Your application states that you will not be taking any deductions on your 2018 tax return. You testified that you may be taking business expense deductions on your tax return.

7) You testified that you are seeking coverage other than Medicaid for your child because Medicaid does not cover his prescriptions and treatment.

8) Your application states that your child lives with you in [redacted], NY.

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

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Applicable Law and Regulations

Medicaid for Children

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 application, that was the 2018 FPL, which is $20,780.00 for a three-person household (83 Federal Register 2642).

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).

Requirement for Individuals to Report Changes

NYSOH must require an applicant to report any change which may affect eligibility, such as citizenship status, incarceration, residency, household size, and income within 30 days of such change (45 CFR §155.330(b), 45 CFR §155.305, 42 CFR §435.403, 42 CFR §435.406, 42 CFR §425.603).

Legal Analysis

The issue under review is whether NYSOH properly determined that your [redacted] child was eligible for Medicaid, effective March 1, 2018.

The application that was submitted on February 26, 2018, listed an annual household income of $37,200.00. You testified that this is correct. The eligibility determination relied upon this amount.

Your child is in a three-person household for purposes of this analysis. This is because your application states that you expect to file your 2018 income tax return as head of household and claim two dependents on that tax return.

Medicaid can be provided 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 FPL for the applicable family size. On the date of your application, the relevant FPL was $20,780.00 for a three-person household. Since $37,200.00 is 179.02% of the 2018 FPL and above 154% of the FPL to qualify for Medicaid, NYSOH improperly found your child to be eligible for Medicaid on an expected annual income basis, using the information provided in your application.

Since the February 27, 2018 eligibility determination notice improperly stated that, based on the information you provided, your child was eligible for Medicaid, it is incorrect and is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your child's eligibility based on the information in your February 26, 2018 application; specifically, using a three-person household, for a child residing in Columbia County, with an annual expected household income of $37,200.00. The effective date of eligibility will be based on an application date of February 26, 2018.

Your case is further RETURNED to NYSOH to assist you in selecting an appropriate health plan for your child depending on his eligibility for financial assistance, as redetermined, as of February 26, 2018 or, in the alternative, as of the date of this Decision, based on which date you select.

You testified that the number of dependents you will claim on your tax return may change. You further testified that you expected your income for the year to increase, and that you may be taking additional deductions. Please note that you are required to report any change which may affect eligibility, such as citizenship status, incarceration, residency, household size, and income within 30 days of such change. If the information in your application is no longer correct, including household size and income, you must contact NYSOH to update your account with the correct information immediately.

Decision

The February 27, 2018 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH for a redetermination of your child's eligibility based on the information in your February 26, 2018 application, using a three-person household, for a child residing in Columbia County, with an annual expected household income of $37,200.00. The effective date of eligibility will be based on an application date of February 26, 2018.

Your case is further RETURNED to NYSOH to assist you in selecting an appropriate health plan for your child depending on his eligibility for financial

assistance, as redetermined, as of February 26, 2018 or, in the alternative, as of the date of this Decision, based on which date you select.

Effective Date of this Decision: May 3, 2018

How this Decision Affects Your Eligibility

Your child was improperly determined eligible for Medicaid.

This is not a final determination of your child's eligibility.

Your case is being sent back to NYSOH to redetermine your child's eligibility based on the information in the February 26, 2018 application. NYSOH will notify you of the outcome and will assist you in selecting a health plan for your child as of February 26, 2018, or the date of this Decision, based on which date you select.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the 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 February 27, 2018 eligibility determination notice is RESCINDED.

Your child was improperly determined eligible for Medicaid.

Your case is RETURNED to NYSOH for a redetermination of your child's eligibility based on the information in your February 26, 2018 application, using a three-person household, for a child residing in Columbia County, with an annual expected household income of $37,200.00. The effective date of eligibility will be based on an application date of February 26, 2018.

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Your case is further RETURNED to NYSOH to assist you in selecting an appropriate health plan for your child depending on his eligibility for financial assistance, as redetermined, as of February 26, 2018 or, in the alternative, as of the date of this Decision, based on which date you select.

This is not a final determination of your child's eligibility.

Your case is being sent back to NYSOH to redetermine your child's eligibility based on the information in the February 26, 2018 application. NYSOH will notify you of the outcome and will assist you in selecting a health plan for your child.

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।

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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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