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

Notice of Decision

Decision Date: June 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: APM28262578

[redacted]

Dear [redacted],

On June 2, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 17, 2017 disenrollment notice, and March 1, 2017 eligibility determination and enrollment notices.

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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Decision

Decision Date: June 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: APM28262578

[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's Medicaid coverage ended effective February 28, 2017?
>
> Did NYSOH properly determine that your child's eligibility for and enrollment in his Child Health Plus plan was effective April 1, 2017, and that your child was not eligible for Medicaid?

Procedural History

On March 16, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination, based on your March 15, 2016 application, stating that your child was eligible for Medicaid, effective March 1, 2016. Your child was subsequently enrolled in a Medicaid Managed Care (MMC) plan, with such coverage beginning on April 1, 2017.

On January 5, 2017, NYSOH issued a notice that it was time to renew your child's health insurance for the upcoming plan year. That notice stated that, based on information from federal and state sources, NYSOH could not make a decision about whether your child would qualify for financial help paying for his health coverage, and that you needed to update your account by February 15, 2017 or your child might lose the financial assistance he was currently receiving.

No updates were made to your account by February 15, 2017.

On February 17, 2017, NYSOH issued an eligibility determination notice stating that your child was not eligible for Medicaid, Child Health Plus, or to receive tax credits or cost-sharing reductions to help pay for the cost of insurance. Your child also could not enroll in a qualified health plan at full cost. This was because you had not responded to the renewal notice and had not completed your child's renewal within the required time frame. Your child's eligibility ended March 1, 2017.

Also on February 17, 2017, NYSOH issued a disenrollment notice confirming that your child's MMC plan coverage would end effective February 28, 2017.

On February 28, 2017, NYSOH received your child's updated application for health insurance. In response to this application, NYSOH prepared a preliminary eligibility determination stating that your child was eligible for coverage through CHP at $9.00 per month, effective April 1, 2017.

Also on February 28, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your child's CHP plan insofar as it did not begin March 1, 2017.

On March 1, 2017, NYSOH issued an eligibility determination notice, based on your February 28, 2017 application, stating that your child was eligible to enroll in Child Health Plus (CHP) with a $9.00 monthly premium, effective April 1, 2017.

Also on March 1, 2017, NYSOH issued an enrollment notice, based on your plan selection on February 28, 2017, stating that your child was enrolled in a CHP plan and that his coverage would start on April 1, 2017.

On June 2, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and remained open as the Hearing Officer directed you to provide as additional evidence to corroborate your testimony: (1) all earning statements issued to you during the month of February 2017 and (2) notice of award issued to your spouse by the Social Security Administration (SSA), reflecting your spouse's monthly benefits, specifically during February 2017. The record was to be closed 15 days after the hearing date, or upon the receipt of the above referenced documents, whichever occurred earlier. No additional documents were received from you by June 17, 2017.

Accordingly, the record was closed on June 17, 2017.

Findings of Fact

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

1) You testified, and the record reflects, that you receive all of your notices from NYSOH by regular mail.

2) You testified that you did not receive any notices telling you that you needed to update your application in order to renew your child's coverage.

3) You testified that you did not know that you needed to update your account until you had received a disenrollment notice reflecting that that your child's MMC coverage would be terminated effective February 28, 2017.

4) The record reflects that on February 28, 2017 NYSOH received your child's updated application for health insurance.

5) You testified that you expect to file your 2017 tax return with a tax filing status of married filing jointly. You will claim your child as your sole dependent on that tax return.

6) The application that was submitted on February 28, 2017 listed annual household income of $44,812.80, consisting of $40,996.80 you earn from your employment with [redacted]., and $318.00 per month your spouse receives in Social Security benefits. You testified that this amount was correct.

7) At the time of your February 28, 2017 application, your child was [redacted].

8) Your application states that you will not be taking any deductions on your 2017 tax return.

9) You live in Schenectady County, New York.

10) You testified that you are seeking that your child to be enrolled in his CHP plan as of March 1, 2017, rather than April 1, 2017, or in the alternative, to be found eligible for Medicaid coverage based on the information contained in your February 28, 2017 application.

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

Applicable Law and Regulations

Medicaid Renewal

In general, NYSOH must review Medicaid eligibility once every twelve months or "whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility" (42 CFR § 435.916(a)(1), (d)). NYSOH must make its "redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency" (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates provided by the individual (45 CFR §155.335(h)).

Child Health Plus

Child Health Plus (CHP) 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). Eligibility rules are set out in NY PHL § 2511(2), as well as in the NYS Department of Health 2008-2012 Contract and Plan Manual.

A child who meets the eligibility requirements for 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 federal poverty level (FPL) (NY 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 PHL § 2511(2)(b)).

The amount of the premium payment, if any, that must be made on behalf of a child who enrolls in a CHP plan depends upon the child's family household income (NY PHL § 2510(9)(d)). No payments are required for eligible children whose family household income is less than 160% of the FPL (NY PHL § 2510(9)(d)(1)). If the family household income is 160% or higher, premiums range from $9.00 per month to $60.00 per month (NY PHL § 2510(9)(d)).

The CHP premium is $9.00 per month for a child whose family household income is between 160% and 222% of the FPL, but no more than $27.00 per month per family (NY PHL § 2510(9)(d)(ii)).

In an analysis of Child Health Plus 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 $20,420.00 for a three-person household (82 Federal Register 8831).

The State of New York has provided that a child's period of eligibility for Child Health Plus begins on the first day of the month during which a child is eligible. A child will become eligible on the first day of the next month, if the application is received by the 15th of the month; applications received after the 15th day of the month will be processed for the first day of the second following month (*see* State Plan Amendment (SPA) NY-14-0005, approved February 3, 2015 and effective January 1, 2014).

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 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 $20,420.00 for a three-person household (82 Fed. Reg. 8831).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your child's Medicaid coverage was terminated effective February 28, 2017.

Your child was originally found eligible for Medicaid, effective March 1, 2016.

Generally, NYSOH must redetermine a qualified child's eligibility for Child Health Plus once every twelve months without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency. NYSOH's January 5, 2017 renewal notice stated that there was not enough information to determine whether your child was eligible to continue their financial assistance for health insurance, and that you needed to supply additional information by February 15, 2017, or his financial assistance might end.

Because there was no timely response to this notice, your child was terminated from his Medicaid plan effective February 28, 2017.

You testified that you did not receive any notice from NYSOH telling you that you needed to update the information in your NYSOH account on your child's behalf. You testified, and your NYSOH account confirms, that you elected to receive notifications via regular mail. However, there is no evidence in the record that any of the notices that were sent to your mailing address were returned as undeliverable.

Therefore, the record reflects that NYSOH properly notified you of your child's annual renewal and that information in your NYSOH account needed to be updated in order to ensure your child's enrollment in his Medicaid plan and eligibility for financial assistance would continue.

Accordingly, the February 17, 2017 disenrollment notice is AFFIRMED.

The second issue under review is whether NYSOH properly determined that your child's eligibility for and enrollment in his Child Health Plus plan was effective April 1, 2017, and that your child was not eligible for Medicaid.

According to the record, you expect to file a joint federal income tax return for the 2017 tax year and claim your one child as a dependent. Therefore, your child is in a three-person household.

In your February 28, 2017 application, you attested to an expected household income of $44,812.80, consisting of $40,996.80 you earn from your employment with [redacted], and $3,816.00 ($318.00 x 12 months) spouse receives in Social Security benefits. The application also stated that your child was [redacted]. NYSOH relied upon this information in issuing its eligibility determination.

A child is eligible to enroll in CHP if they meet the non-financial requirements, are not eligible for Medicaid, and have a household income below 400% of the FPL. Households with an income between 160% and 222% of the FPL are responsible for a $9.00 per month CHP premium payment. On the date of your application, the relevant FPL was $20,420.00 for a three-person household. Since $44,813.00 is 219.46% of the 2017 FPL, NYSOH properly found your child to be eligible for CHP with a $9.00 per month premium payment.

You testified that you contacted NYSOH on February 28, 2017 and enrolled your child into a CHP plan.

The date on which a Child Health Plus plan can take effect depends on the day a person selects the plan for enrollment. A plan that is selected between the first day and fifteenth day of a month goes into effect on the first day of the following month. A plan that is selected from the sixteenth day of the month and the end of the month goes into effect on the first day of the second following month.

Therefore, NYSOH properly determined that your child's CHP coverage began effective April 1, 2017.

Medicaid can be provided through NYSOH to children between the ages of one and nineteen who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is at or below 154.00% of the FPL for the applicable family size. Since $44,813.00 is 219.46% of the 2017 FPL for a three-person household, NYSOH properly found your child to be not eligible for Medicaid.

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

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 $2,621.00 per month. However, your account reflects that you did not provide the requested documentation per the Hearing Officer's instruction prior to the record date of June 17, 2017. Accordingly, we are unable to assess whether your child would be eligible for Medicaid on a monthly household income basis.

Since the March 1, 2017 eligibility determination and enrollment notices properly stated that, based on the information you provided, your child was eligible for CHP with a $9.00 per month premium, effective April 1, 2017, and ineligible for Medicaid, they are correct and AFFIRMED.

Decision

The February 17, 2017 disenrollment notice is AFFIRMED.

The March 1, 2017 eligibility determination notice is AFFIRMED.

The March 1, 2017 enrollment notice is AFFIRMED.

Effective Date of this Decision: June 21, 2017

How this Decision Affects Your Eligibility

This decision does not change your child's eligibility.

The effective date of your child's CHP plan is April 1, 2017.

Your child is not eligible for 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

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).

- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The February 17, 2017 disenrollment notice is AFFIRMED.

The March 1, 2017 eligibility determination notice is AFFIRMED.

The March 1, 2017 enrollment notice is AFFIRMED.

This decision does not change your child's eligibility.

The effective date of your child's CHP plan is April 1, 2017.

Your child is not eligible for Medicaid.

Legal Authority

We are issuing this determination 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 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.

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.

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).