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

Notice of Decision

Decision Date: April 07, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013715

[redacted]

Dear [redacted],

On March 9, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 2, 2016 eligibility determination 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: April 07, 2017

NY State of Health Account ID: [redacted]
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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 (NYSOH) properly determine that your oldest child was not eligible for Medicaid from November 1, 2016 through November 30, 2016?
>
> Did NYSOH properly determine that your oldest child's enrollment in his Child Health Plus (CHP) plan should be effective January 1, 2017?

Procedural History

On December 1, 2016, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for November 2016 for your oldest child. That day, a preliminary eligibility determination was prepared stating that your oldest child was eligible for CHP effective January 1, 2017 and not eligible for Medicaid for November 2016.

Also on December 1, 2016, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination insofar as your oldest child did not have coverage for November or December 2016.

On December 2, 2016, NYSOH issued a notice of eligibility determination stating that your oldest child was eligible for CHP. This eligibility was effective as of January 1, 2017.

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Also on December 2, 2016 NYSOH issued an eligibility determination notice stating that your oldest child was not eligible for Medicaid from November 1, 2016 through November 30, 2016 because the program he was eligible for cannot pay for any care he received in the past.

On March 9, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing held open until March 24, 2017, to allow you to submit paystubs from November and December 2016.

On March 22, 2017 NYSOH received a fax containing four paystubs with an accompanying note, and it was incorporated into the record as Appellant's Exhibit #1. The record remained open until the close of business on March 24, 2017, no additional documentation was received and the record closed that day.

On March 23, 2017, you submitted an updated application for financial assistance and indicated that you were seeking help for paying for medical bills for December 2016 for your oldest child.

On March 24, 2017, NYSOH issued an eligibility determination notice stating that your oldest child remains eligible for Medicaid effective April 1, 2017.

Also on March 24, 2017, NYSOH issued a notice regarding retroactive Medicaid for your oldest child. You were asked to submit documentation confirming your household's income in December 2016 before April 7, 2017.

On March 30, 2017, NYSOH verified the paystubs submitted and an application was run.

On March 31, 2017, NYSOH issued an eligibility determination notice stating that your oldest child was eligible for retroactive Medicaid coverage for the month of December 2016.

Findings of Fact

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

1) You testified that you are seeking coverage for your oldest child for November and December 2016.

2) You testified that you expect to file your 2016 federal income tax return as single, and claim no dependents. Your spouse expects to file his 2017 income tax return as head of household and claim two dependents.

3) In the letter that you faxed to NYSOH Appeals Unit on March 22, 2017 you indicated that your spouse claims you and both children as dependents.

4) You submitted an application for financial assistance on December 1, 2016.

5) You testified that your spouse is paid bi-weekly and on average works forty hours each week.

6) You faxed four paystubs dated November 26, 2016 for a gross pay amount of $1,293.75, December 9, 2106 for a gross pay amount of $1,262.25, December 23, 2016 for a gross pay amount of $1,723.50 and a paystub dated January 6, 2017 for a gross pay amount of $936.00.

7) You testified that you do not plan on taking any deductions on your tax return.

8) Your application states that you reside in [redacted] county.

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 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 2016 FPL, which is $24,300.00 for a four-person household (81 Fed. Reg. 4036).

Retroactive Medicaid

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of an initial application if the individual received medical services that would have been covered under Medicaid and the individual would have been eligible for Medicaid at the time he received the services if he had applied (42 USCA § 1396A(34); 42 CFR § 435.915(a)). The Department of Health may make eligibility effective for fee-for-service Medicaid on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

Child Health Plus - Eligibility

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 federal poverty level (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)).

Child Health Plus – Start Date

"A State must specify a method for determining the effective date of eligibility for [Child Health Plus], which can be determined based on the date of application or through any other reasonable method that ensures coordinated transition of children between [Child Health Plus] and other insurance affordability programs as family circumstances change and avoids gaps or overlaps in coverage" (42 CFR § 457.340(f)).

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 e.g.* State Plan Amendment (SPA) NY-14-0005, approved February 3, 2015 and effective January 1, 2014).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your oldest child was not eligible for Medicaid from November 1, 2016 through November 30, 2016.

Your oldest child is in a four-person household; he resides with you, your spouse, and his one sibling.

An application for financial assistance was submitted on December 1, 2016. In that application, you requested help in paying for medical bills for November 2016.

When an individual files an initial application for Medicaid, his or her eligibility for retroactive Medicaid depends on the date of application. To this end, it does not matter whether or not that initial application resulted in Medicaid going forward. Instead, an individual, who has filed an initial application for Medicaid through NYSOH, has the right to be evaluated for Medicaid for the three months before the month of his or her application.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's initial application if the individual received medical services that would have been covered under Medicaid and if they would have been eligible for Medicaid in those three months had they applied.

You testified that you are seeking Medicaid for November and December 2016 for your oldest child. However, after the hearing, your oldest child was determined eligible for retroactive Medicaid for the month of December 2016. Therefore, this decision will be limited to the issue of coverage for your oldest child for the month of November 2016.

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 in November 2016, your oldest child would have needed to meet the non-financial criteria and have an income no greater than 154% of the FPL, which is $3,119.00 per month. There is no indication in the record that your oldest child would have been ineligible for Medicaid based on non-financial criteria during November 2016.

You testified that your spouse is paid bi-weekly. You were asked to submit all of your spouse's paystubs with a pay date of November and December 2016. On March 22, 2017 you faxed four paystubs dated November 26, 2016 for a gross pay amount of $1,293.75, December 9, 2106 for a gross pay amount of $1,262.25, December 23, 2016 for a gross pay amount of $1,723.50 and a paystub dated January 6, 2017 for a gross pay amount of $936.00. Therefore, you did not provide sufficient documentation to determine your household income for the month of November 2016.

Since you did not provide documentation to prove your household's income in November 2016, NYSOH Appeals Unit is unable to analyze your oldest child's eligibility for retroactive Medicaid for the month of November 2016.

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).

Since the December 2, 2016 eligibility determination properly determined that your oldest child was not eligible for Medicaid for November 2016 based on the December 1, 2016 application, it is correct and AFFIRMED.

The second issue is whether NYSOH properly determined that your child's Child Health Plus plan enrollment start date was January 1, 2017.

You updated your oldest child's eligibility for financial assistance through NYSOH on December 1, 2016, and enrolled your child into a Child Health Plus plan that day.

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 between 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, the December 2, 2016, enrollment notice confirming that your child was enrolled in a Child Health Plus plan with a plan enrollment start date of January 1, 2017, is correct and AFFIRMED.

Decision

The December 2, 2016 eligibility determination stating that your oldest child is not eligible for Medicaid from November 1, 2016 through November 30, 2016 is AFFIRMED.

The December 2, 2016 eligibility determination stating that your oldest child's Child Health Plus plan was effective January 1, 2017 is AFFIRMED.

Effective Date of this Decision: April 07, 2017

How this Decision Affects Your Eligibility

NYSOH properly determined that your oldest child was not eligible for Medicaid in the month of November 2016 based on the December 1, 2016 application.

NYSOH properly determined that your oldest child was enrolled in a Child Health Plus plan effective January 1, 2017.

If You Disagree with this Decision (Appeal Rights)

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 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

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- By fax: 1-855-900-5557

Summary

The December 2, 2016 eligibility determination stating that your oldest child is not eligible for Medicaid from November 1, 2016 through November 30, 2016 is AFFIRMED.

The December 2, 2016 eligibility determination stating that your oldest child's Child Health Plus plan was effective January 1, 2017 is AFFIRMED.

NYSOH properly determined that your oldest child was not eligible for Medicaid in the month of November 2016 based on the December 1, 2016 application.

NYSOH properly determined that your oldest child was enrolled in a Child Health Plus plan effective January 1, 2017.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

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A Copy of this Decision Has Been Provided To:

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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