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

Notice of Decision

Decision Date: July 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000016206

[redacted]

Dear [redacted]

On June 16, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 28, 2017, eligibility determination and plan 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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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).

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

Decision

Decision Date: July 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016206

[redacted]

Issues

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

> Did the NY State of Health (NYSOH) properly determine that your oldest child was eligible for Child Health Plus (CHP) and enrolled in a CHP plan, effective March 1, 2017?
>
> Did the NYSOH properly determine that your oldest child was not eligible for Medicaid?
>
> Did the NYSOH properly determine that your oldest child was not eligible for retroactive Medicaid from January 1, 2017 through January 31, 2017?

Procedural History

On January 28, 2017, NYSOH issued an eligibility determination notice, based on your January 27, 2017 initial application, stating that your oldest child (child) was eligible to enroll in CHP with a $9.00 monthly premium, effective March 1, 2017. That notice further stated that your child is not eligible for Medicaid because the household income you provided is over the allowable income limits for that program.

Also on January 28, 2017, NYSOH issued a plan enrollment notice, based on your plan selection on January 27, 2017, confirming your child's enrollment in a CHP plan with an enrollment start date of March 1, 2017.

On February 24, 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 January 1, 2017.

On February 25, 2017, NYSOH issued an appeal notice confirming your child as the appellant and your reason for appeal as eligibility determination and other.

On June 25, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Your request to amend the appeal to include a redetermination of your child's eligibility for retroactive Medicaid was granted and testimony was received on all issues.

The record was held open until July 12, 2017, for you to submit proof of your income for the month of January 2017.

As of July 12, 2017, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. However, on July 13, 2017, you submitted one bi-weekly paystub, dated January 20, 2017, which was accepted. That document was made part of the record as "Appellant's Exhibit [redacted]." The record is now closed.

Findings of Fact

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

1) You testified that you are appealing only your child's eligibility. You need your child's health insurance to begin on January 1, 2017, because you have medical bills from that month.

2) You submitted an application to NYSOH for financial assistance on January 27, 2017 and enrolled your child into a CHP plan that day. At the time of the application, your child was [redacted].

3) According to your NYSOH account, you expect to file your 2017 tax return with a tax filing status of married filing jointly. You will claim two children as dependents on that tax return.

4) The application that was submitted on January 27, 2017 listed annual household income of $39,104.00, consisting of $28,184.00 you earn from your employment and $10,920.00 your spouse receives in Social Security Disability benefits. You testified that these amounts were correct.

5) According to your NYSOH account, the U.S. Social Security Administration verified that your spouse's annual disability benefits were correct.

6) According to telephone call records dated January 31, 2017 and February 24, 2017 and your testimony, you called in January 2017 and in February 2017 and requested that your child be considered for retroactive Medicaid. Specifically, in the January 31, 2017 telephone call, you were advised that NYSOH does not handle retroactive Medicaid, and on February 24, 2017 an appeal was filed but no eligibility determination was issued.

7) You testified that you did not know what your income was for the month of January 2017, and on July 13, 2017, submitted a single bi-weekly paystub that shows on January 20, 2017 you received a gross year to date pay amount of $1,948.38. This document was made part of the record as "Appellant's Exhibit [redacted]." Your next paystub was due to be issued in February 2017.

8) You testified that your spouse received $910.00 in Social Security Disability benefits in January 2017 and your children each received $183.00 in Social Security benefits in January 2017.

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

10) Your application states that your family lives in [redacted] New York.

11) You testified that your child was previously enrolled in Medicaid coverage through the [redacted] Department of Social Services (OCDSS).

12) You testified that you never received any notice from OCDSS that your child's medical insurance was discontinued. You realized that your child had no coverage when you took him to the doctor for [redacted]

13) You testified that, when you called OCDSS, they told you that your child's case would now be handled by NYSOH.

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

Applicable Law and Regulations

Child Health Plus

Child Health Plus 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 CHP 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 was $24,300.00 for a four-person household (81 Federal Register 4036).

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 2017 FPL, which is $24,600.00 annually for a four-person household, or $2,050.00 per month (82 Fed. Reg. 8831).

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 Effective Date

The State of New York has provided that a child's period of eligibility for CHP 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).

De Novo Review

The Marketplace Appeals Unit must review each appeal de novo and "consider all relevant facts and evidence adduced during the appeals process" (45 CFR § 155.535(f)). "*De novo review* means a review of an appeal without deference to prior decisions in the case" (45 CFR § 155.500).

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)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your child was eligible to enroll in CHP with a $9.00 per month premium.

According to your NYSOH account, you expect to file a joint federal income tax return for the 2017 tax year and claim your two children as dependents. Therefore, your child is in a four-person household for purposes of this analysis.

In your January 27, 2017 application, you attested to an expected household income of $39,104.00. The application also stated that your child is [redacted] NYSOH relied upon this information.

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 $24,300.00 for a four-person household. Since $39,104.00 is 160.92% of the 2016 FPL, NYSOH properly found your child to be eligible for CHP with a $9.00 per month premium payment, based on the information you provided in your application.

The second issue under review is whether NYSOH properly determined that your child was not eligible for Medicaid.

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% of the FPL for the applicable family size. Since $39,104.00 is 158.96% of the 2017 FPL for a four-person household, NYSOH properly found your child to be not eligible for Medicaid.

Since the January 28, 2017 eligibility determination properly stated that, based on the information you provided, your child was eligible for CHP with a $9.00 per month premium and ineligible for Medicaid, it is correct and is AFFIRMED.

The third issue under review is whether NYSOH properly determined that your children's enrollment in their CHP plan was effective March 1, 2017.

You testified that your child was previously enrolled in Medicaid coverage through the [redacted] Department of Social Services (OCDSS) and that you never received any notice from them that your child's medical insurance was discontinued. You realized that your child had no coverage when you took him to the doctor for [redacted].

Since NYSOH's Appeals Unit has no jurisdiction over OCDSS, review is limited to whether NYSOH, the State's Health Exchange, properly determined that your child's enrollment in a CHP plan was effective March 1, 2017.

According to your NYSOH account, the record shows that, on January 27, 2017, you initially applied for health insurance through NYSOH and submitted a request to enroll your child in a CHP plan that day.

The date on which a CHP plan can take effect depends on the day a person selects the plan for enrollment.

A plan that is selected from the first day to and including the fifteenth day of a month goes into effect on the first day of the following month. A plan that is selected after the fifteenth day of a month goes into effect on the first day of the second following month.

Since you selected your child's CHP plan on January 27, 2017, it must take effect on the first day of the second month following January 2017; that is, on March 1, 2017.

Therefore, NYSOH's January 28, 2017 plan enrollment notice is AFFIRMED because it properly began your child's enrollment in his CHP plan on March 1, 2017.

The fourth issue under review is whether NYSOH properly determined that your child was not eligible for Medicaid for January 1, 2017 through January 31, 2017.

The record reflects that you updated your account and requested retroactive Medicaid for your child on January 31, 2017 and February 24, 2017. However, no eligibility determination was issued in this regard.

Although the record contains no eligibility determination notice on the issue of retroactive Medicaid eligibility for January 2017, the record does contain evidence of January 31, 2017 and February 24, 2017 telephone calls in which you requested your child be considered for retroactive Medicaid, along with a February 25, 2017 notice in which NYSOH acknowledges receipt of an appeal request, and identifies your child as the appellant and the issue on appeal as "Eligibility Determination and Other."

Here, the lack of a notice of eligibility determination on the issue of retroactive Medicaid for your child for the month of January 2017 does not prevent the Appeals Unit from reaching the merits of the case or constitute material error. Under 45 CFR § 155.505(b), you are as entitled to appeal NYSOH failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination. The text of the February 25, 2017 notice, which acknowledges the appeal on the issue of your child's eligibility determination, along with the telephone call records and your testimony, in which you stated you wanted help covering the medical expenses you have for the month of January 2017, permits an inference that the NYSOH did deny your request for retroactive Medicaid in the month of January 2017.

You initially submitted an application for health insurance on behalf of your child on January 27, 2017, and on February 24 ,2017 requested help in paying for his medical bills for January 1, 2017 to January 31, 2017. You confirmed through

testimony that you are seeking Medicaid from January 1, 2017 to January 31, 2017.

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.

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 January 2017, your child would have needed to meet the non-financial criteria and have an income no greater than 154% of the applicable FPL of $2,050.00, which is $3,157.00 per month. There is no indication in the record that your child would have been ineligible for Medicaid based on non-financial criteria during January 2017.

You testified that you are paid bi-weekly. You uploaded a paystub, dated January 20, 2017, for a gross pay year to date amount of $1,948.38. Since you are paid bi-weekly and your next paystub was not issued until February 2017, the record indicates that in the month of January 2017, you had a monthly gross income of $1,948.38.

You also testified that your spouse receives a monthly Social Security Disability benefits in the amount of $910.00 and your two children each receive a monthly Social Security benefits of $183.00. Your NYSOH account confirms that your spouse's annual Social Security amount of $10,920.00 for 2017 was verified with the U.S. Social Security Administration, which when divided by 12 months equals $910.00 per month, and your children's Social Security benefits are not considered in household income. As such, it is reasonable to conclude that your spouse's monthly Social Security Disability benefits in 2017 are $910.00 per month.

Therefore, the record indicates that in the month of January 2017, you had a household income of $2,858.38, consisting of your monthly income of $1,948.38 and your spouse's disability benefits of $910.00.

Since the record now contains a more accurate representation of what your income was for the month of January 2017, your case is RETURNED to NYSOH

to consider your request for retroactive coverage for your child based on a household size of four people and household income of $2,858.38 for the month of January 2017.

Decision

The January 28, 2017 eligibility determination and plan enrollment notices are AFFIRMED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for your child based on a household size of four people and household income of $2,858.38 for the month of January 2017, and to notify you accordingly.

Effective Date of this Decision: July 21, 2017

How this Decision Affects Your Eligibility

This decision does not change your child's eligibility.

Your child remains eligible for CHP with a $9.00 per month premium.

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

Your child's eligibility for retroactive Medicaid in the month of January 2017 will be determined by NYSOH based on the household size and monthly income noted above. NYSOH will notify you once it has made its determination.

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
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The January 28, 2017 eligibility determination and plan enrollment notices are AFFIRMED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for your child based on a household size of four people and household income of $2,858.38 for the month of January 2017, and to notify you accordingly.

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 does not change your child's eligibility.

Your child remains eligible for CHP with a $9.00 per month premium.

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

Your child's eligibility for retroactive Medicaid in the month of January 2017 will be determined by NYSOH based on the household size and monthly income noted above. NYSOH will notify you once it has made its determination.

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)

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).

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।

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).

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