



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

Notice of Decision

Decision Date: August 11, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000016619

[REDACTED]

Dear [REDACTED],

On June 22, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 27, 2017 enrollment confirmation notice and the March 2, 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 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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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 the NY State of Health properly determine your child's enrollment in her Child Health Plus plan was effective no earlier than March 1, 2017?

Did NY State of Health properly determine your child was not eligible for retroactive Medicaid coverage for the month of February 2017?

Procedural History

On January 26, 2017, NYSOH received your initial application for health insurance for your child.

On January 27, 2017, NYSOH issued an eligibility determination notice stating your child was eligible for Child Health Plus with a \$9.00 premium, effective March 1, 2017.

Also on January 27, 2017, NYSOH issued an enrollment notice, based on your January 26, 2017 plan selection, confirming your child was enrolled in a Child Health Plus plan with coverage effective March 1, 2017.

On March 1, 2017, NYSOH received your updated application for health insurance for your child. That application indicated you were requesting retroactive health coverage for your child for the month of February 2017.

On March 2, 2017, NYSOH issued an eligibility determination notice stating your child was not eligible for retroactive coverage for the month of February 2017,

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because the program she was eligible for could not pay for any care she received in the past.

On March 6, 2017, you spoke to NYSOH's Account Review Unit and appealed the effective date of your child's Child Health Plus coverage insofar as it did not begin February 1, 2017.

On June 22, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to allow you to submit supporting documents.

On June 27, 2017, NYSOH received the requested documentation and it was incorporated into the record as Appellant's Exhibit #1. The record closed thereafter.

Findings of Fact

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

- 1) According to your account, the first application requesting health insurance on behalf of your child was started on January 5, 2017, but not submitted until January 26, 2017.
- 2) You testified you were unsure why the application was not submitted on January 5, 2017.
- 3) A review of the telephone call recording associated with your account from January 5, 2017 confirms that the application was not submitted on January 5, 2017 because you were unable to provide your child's Social Security number at that time. You were advised by the NYSOH representative to call back when you had your child's Social Security number to complete your application.
- 4) According to your account, the application was not completed until January 26, 2017.
- 5) Your account confirms a request for enrollment in a Child Health Plus plan was submitted on behalf of your child on January 26, 2017. Coverage through that plan became effective March 1, 2017.
- 6) You testified you are appealing the effective date of your child's Child Health Plus plan insofar as it did not become effective February 1, 2017.
- 7) You testified that your child has outstanding medical bills from February 2017.

- 8) You testified that your child was previously enrolled in a Child Health Plus plan through your local county Department of Social Services, but you did not know when coverage through that plan ended.
- 9) On March 1, 2017, an updated application was submitted on behalf of your child. That application indicated you were seeking retroactive coverage for your child for the month of February 2017.
- 10) That application listed your annual income as \$26,880.00. You testified that amount was accurate.
- 11) You testified that you are paid biweekly and your paycheck is always the same, \$1,214.00.
- 12) According to your March 1, 2017 application, you attested to a monthly income for the month of February 2017 of \$1,200.00.
- 13) Your application indicates that you will file your 2017 tax return with a tax filing status of head of household and you will claim one dependent on that tax return. You testified that information is accurate.
- 14) On March 2, 2017, NYSOH issued a notice stating that your child was not eligible for retroactive coverage for the month of February 2017, because the program she was eligible for could not pay for any care she received in the past.
- 15) You testified you are also appealing that eligibility determination insofar as your child was not eligible for retroactive coverage for the month of February 2017. The issue under appeal was amended to include a review of the March 2, 2017 notice denying your child retroactive coverage for the month of February 2017.
- 16) Your account confirms that on March 6, 2017, you uploaded a copy of your biweekly paystub with a pay date of February 15, 2017 in the gross amount of \$1,219.17.
- 17) At the hearing, you were directed to submit documentation of all income received in the month of February 2017.
- 18) On June 27, 2017, a copy of the same February 15, 2017 paystub was uploaded to your account.
- 19) According to your applications, you reside in Bronx County.
- 20) According to your account, your child was ■ at the time of the March 1, 2017 application.

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

Applicable Law and Regulations

Child Health Plus

The “period of eligibility” for Child Health Plus is “that period commencing on the first day of the month during which a child is an eligible child and enrolled or recertified for enrollment on an annual basis based on all required information and documentation and ending on the last day of the twelfth month following such date,” unless the CHP premiums are not timely paid or the child no longer resides in New York State, gains access to or obtains other health insurance coverage, or becomes eligible for Medicaid (NY Public Health Law § 2510(6)).

“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).

Medicaid Eligibility 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

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§ 435.4). On the date of your application, that was the 2017 FPL, which was \$16,240.00 for a two-person household (81 Federal Register 4036).

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).

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 is whether NYSOH properly determined your child's enrollment in her Child Health Plus plan became effective no earlier than March 1, 2017.

Pursuant to the regulations, the date on which a Child Health Plus plan can take effect depends on the day a person selects the plan for enrollment.

Although your account indicates the application requesting health insurance on behalf of your child was started on January 5, 2017, it was not submitted until January 26, 2017. A review of the telephone call recording associated with your account from January 5, 2017 confirms that the application was not submitted on January 5, 2017, because you were unable to provide your child's Social Security number at that time. You were advised by the NYSOH representative to call back when you had your child's Social Security number to complete your application. According to your account, the application was not completed until January 26, 2017. Your account confirms that a request for enrollment in a Child Health Plus plan was submitted on behalf of your child the same day.

According to the regulations, 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.

Since the evidence establishes that you did not select a Child Health Plus plan for your child until January 26, 2017, after the fifteenth day of the month,

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coverage through that plan properly became effective on the first day of the second following month; that is, March 1, 2017.

Therefore, the January 27, 2017 enrollment confirmation notice stating your child's enrollment in her Child Health Plus plan was effective March 1, 2017, is correct and must be AFFIRMED.

The second issued under review is whether NYSOH properly determined your child was not eligible for retroactive coverage for the month of February 2017.

The updated application submitted on March 1, 2017 listed your annual household income as \$26,880.00. You testified that amount was accurate. Additionally, the application indicated you would file your 2017 tax return with a tax filing status of head of household and you will claim one dependent on that tax return. You testified that information was accurate as well.

The application indicated you were requesting retroactive coverage for your child for the month of February 2017 and listed your income for that month as \$1,200.00. The eligibility determination notice issued on March 2, 2017 stated your child was not eligible for retroactive coverage for the month of February 2017, because the program she was eligible for could not pay for any care she received in the past.

Pursuant to the regulations, 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 that initial application resulted in Medicaid going forward. Instead, any 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.

Therefore, the March 2, 2017 notice of eligibility determination stating your child was not eligible for retroactive Medicaid benefits, because the program she was eligible for could not pay for any care she received in the past, was incorrect on that point, based on the application regulations.

However, the evidence establishes that your child was not eligible for retroactive Medicaid coverage for the month of February 2017 based on substantive grounds.

Although the March 1, 2017 application listed your February 2017 monthly income as \$1,200.00, this amount does not appear accurate based on the evidence. You testified, and your application indicates, your annual income is \$26,880.00. Furthermore, you testified that you are paid biweekly and your paycheck is always the same, \$1,214.00. You were directed to submit proof of all the income you received in the month of February 2016; however, your account

confirms you submitted only one paystub with a pay date of February 15, 2017 in the gross amount of \$1,219.17.

Given the totality of the evidence, including your testimony that you are paid the same amount biweekly, and the single paystub submitted indicating it was for the pay period of February 1, 2017 to February 15, 2017, it is concluded you received an additional paycheck in February 2017 in the gross amount of \$1,219.17 that you failed to submit. Accordingly, the evidence establishes your household income for the month of February 2017 was \$2,438.34, and not the \$1,200.00 listed in the application.

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 February 2017 your child would have needed to meet the non-financial criteria and have a household income no greater than 154% of the FPL, which is \$2,085.00 per month for a two-person household. Since the evidence establishes your household income for the month of February 2017 exceeded the income limit to qualify for Medicaid in that month, your child was not eligible for retroactive coverage for the month of February 2017.

Accordingly, the March 2, 2017 eligibility determination notice stating your child was not eligible for retroactive coverage for the month of February 2017, because the program she was eligible for could not pay for any care she received in the past is MODIFIED only to reflect that your child was not eligible for retroactive coverage for the month of February 2017, because the household income for that month was over the allowable limit to qualify for Medicaid.

Decision

The January 27, 2017 enrollment confirmation notice is AFFIRMED.

The March 2, 2017 eligibility determination notice is MODIFIED only to reflect that your child was not eligible for retroactive coverage for the month of February 2017 because the household income for that month was over the allowable limit to qualify for Medicaid.

Effective Date of this Decision: August 11, 2017

How this Decision Affects Your Eligibility

This decision does not change your children's eligibility.

The effective date of your child's Child Health Plus plan is March 1, 2017.

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).

Your child was not eligible for retroactive coverage for the month of February 2017.

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

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- By mail at:
NY State of Health Appeals
P.O. Box 11729
Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The January 27, 2017 enrollment confirmation notice is **AFFIRMED**.

The March 2, 2017 eligibility determination notice is **MODIFIED** only to reflect that your child was not eligible for retroactive coverage for the month of February 2017, because the household income for that month was over the allowable limit to qualify for Medicaid.

This decision does not change your children's eligibility.

The effective date of your child's Child Health Plus plan is March 1, 2017.

Your child was not eligible for retroactive coverage for the month of February 2017.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



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 مجاناً.

বাংলা (Bengali)

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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 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&btumi 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 דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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