



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

## Notice of Decision

Decision Date: April 12, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000017726

[REDACTED]

Dear [REDACTED],

On April 12, 2017, you appeared by telephone at an expedited hearing on your two appeals of NY State of Health's March 21, 2017 eligibility determination and enrollment confirmation 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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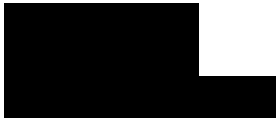


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## Decision

Decision Date: April 12, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000017726



## 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 infant child (child) was not eligible for retroactive Medicaid from November 1, 2016 through January 31, 2017?

Did NYSOH properly determine that your child's enrollment in his Child Health Plus plan was effective May 1, 2017?

## Procedural History

On December 1, 2016, you updated your NYSOH account and added your child to your application.

On December 3, 2016, NYSOH issued an eligibility redetermination notice stating in part that more information was needed to confirm your child's eligibility including proof of income by December 16, 2016 and proof of citizenship status and a valid Social Security number by March 1, 2017.

On December 15, 2016, you provided documentation to NYSOH.

On December 30, 2016, NYSOH issued a letter stating that the income information in your application does not match what was received from state and federal data sources. The notice instructed you to provide addition proof of income for your child be January 15, 2017. The notice also stated that, if you

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miss this due date, NYSOH will not be able to determine your child's eligibility for health coverage.

On January 27, 2017, NYSOH issued an eligibility redetermination notice stating in part that your child was eligible to purchase a qualified health plan at full cost, effective March 1, 2017. The reason stated was because NYSOH had not received the requested income documentation needed by the due date.

On February 3, 2017, NYSOH issued an eligibility redetermination notice, based on your February 2, 2017 updated application, stating in part that your child was conditionally eligible for Medicaid, effective February 1, 2017. The notice informed you that you needed to provide additional information to confirm his eligibility; specifically, proof of benefit information for third party health insurance by February 17, 2017.

Also on February 3, 2017, NYSOH issued an enrollment confirmation notice stating in part that your child needed to pick a qualified health plan for coverage to start.

On March 21, 2017, NYSOH issued an eligibility determination stating that your request for retroactive Medicaid for your child from November 1, 2016 through January 31, 2017 was denied.

On March 21, 2017, NYSOH issued an eligibility redetermination notice stating in part that your child was eligible to enroll in Child Health Plus with a \$15.00 monthly premium, effective May 1, 2017.

Also on March 21, 2017, NYSOH issued an enrollment notice, based on your March 20, 2017 plan selection for your child, stating he was enrolled in a Child Health Plus plan with a \$15.00 monthly premium and an enrollment start date of May 1, 2017.

You appealed NYSOH's denial of retroactive Medicaid for your child and the start date of his Child Health Plus plan insofar as it did not begin April 1, 2017.

On April 12, 2017, you had an expedited telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Through sworn testimony, you waived the right to formal written notice of the hearing and access to review the Evidence Packet before the hearing since it was being conducted on an expedited basis. The record was developed during the hearing and closed at the end of the hearing.

## Findings of Fact

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

- 1) According to your NYSOH account, your child was born [REDACTED]
- 2) According to your NYSOH account, you and your spouse expect to file tax returns as married filing jointly and will claim your three children as dependents on those tax returns.
- 3) You testified that you are appealing only your child's eligibility for retroactive Medicaid and the start date of his enrollment in Child Health Plus.
- 4) You submitted an updated application to NYSOH for financial assistance on December 1, 2016 and requested help paying for your child's medical bills. You requested the same assistance in all subsequently submitted applications.
- 5) According to your NYSOH account, as of December 1, 15, and 29, 2016, NYSOH was not able to make an eligibility determination regarding your child until you provided income documentation.
- 6) On January 27, 2017, your child was redetermined eligible for a qualified health plan at full cost because you had not submitted proof of income by the January 15, 2017 deadline.
- 7) Your child was redetermined conditionally eligible for Medicaid as of February 1, 2017.
- 8) According to your NYSOH account and your testimony, on March 9, 2017, you submitted proof that your child's health insurance coverage through your employer ended January 31, 2017.
- 9) You testified you would have selected a health plan for him in March 9, 2017, if you were able.
- 10) You testified that NYSOH told you the proof of no insurance had to be verified before your child's eligibility could be redetermined and a health plan selected for him.
- 11) According to your NYSOH account and your testimony, you were first able to enroll your child into a Child Health Plus plan on March 20, 2017

- 12) According to your NYSOH account, your child's Medicaid ended March 31, 2017 and his enrollment in Child Health Plus was to begin May 1, 2017, resulting in a gap in coverage for the month of April 2017.
- 13) Because your child was redetermined eligible for Child Health Plus before his previous eligibility in Medicaid ended, the Department of Health was able to backdate his Child Health Plus coverage to start as of April 1, 2017.
- 14) You testified that you understood you will be responsible to pay the monthly premium if this backdate were to occur.

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 under one year of age 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 223% 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 December 1, 2016 application, that was the 2016 FPL, which is \$28,440.00 for a five-person household (81 Fed. Reg. 4036).

On the date of your application, that was the 2017 FPL, which is \$28,780.00 for a five-person household (82 Fed. Reg. 8831).

### 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

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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

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).

## **Legal Analysis**

The first issue under review is whether NYSOH properly denied retroactive Medicaid for your child from November 1, 2016 through January 31, 2016.

Initially, it is noted that your child had health insurance coverage through your employment as of his date of birth, [REDACTED], and through January 31, 2017.

Your child is in a five-person household for purposes of this analysis. This is because he is one of three dependents whom you and your spouse expect to claim on your tax returns.

You submitted an updated application for financial assistance on December 1, 2016 and requested help in paying for medical bills for November 1, 2016. In subsequently submitted applications, you renewed this request. You testified that

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you want your child's eligibility for retroactive Medicaid redetermined from November 1, 2016 through 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 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.

The record reflects that NYSOH was not able to determine your child's eligibility altogether until March 20, 2017, when your household income was verified as being \$65,747.26. Assuming this was your household's income in November 2016 and December 2016, 100% the applicable FPL for a five-person household is \$28,440.00. Since \$65,747.26 is 231.18% of the applicable FPL, your child was correctly determined to be ineligible for retroactive Medicaid those two months. The same outcome would occur using monthly income of \$5,478.94, since the allowable monthly income limit for a five-person household at 223% of the applicable FPL is \$5,288.00.

In addition, 100% the applicable FPL for January 2017 is \$28,780.00 for a five-person household. Since \$65,747.26 is 228.45% of the applicable FPL, your child was correctly determined to be ineligible for retroactive Medicaid that month. The same outcome would occur using monthly income of \$5,478.94, since the allowable monthly income limit for a five-person household at 223% of the applicable FPL is \$5,349.00.

Therefore, the March 21, 2017 eligibility determination notice is correct and must be AFFIRMED.

The second issue under review is whether NYSOH properly determined that your child's enrollment in his Child Health Plus plan was effective May 1, 2017.

You testified that you were not able to enroll your child into a Child Health Plus plan until March 20, 2017, because NYSOH had to verify the end date of his third-party health insurance.

Ordinarily, 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

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the end of the month goes into effect on the first day of the second following month.

However, the record reflects that the proof of no insurance was provided on March 9, 2017 and you credibly testified that you would have selected a plan on that date if you had been able. The record further shows that NYSOH did not redetermine your child's eligibility until March 20, 2017, which necessarily resulted in his Child Health Plus plan taking effect the first day of the second month following March 2017, which is May 1, 2017.

The Department of Health recognized that you provided the insurance information before your child's Medicaid coverage was due to end on March 31, 2017. On this basis, your child's coverage in his Child Health Plus plan was backdated to April 1, 2017, such that no further action by NYSOH is required.

Therefore, the March 21, 2017 enrollment confirmation notice is MODIFIED in part to state that your child's enrollment in his Child Health Plus plan has a start date of April 1, 2017.

You will be responsible to pay directly to the Child Health Plus plan, the April 2017 premium for your child's coverage to become active that month.

## **Decision**

The March 21, 2017 eligibility determination notice denying your child retroactive Medicaid is AFFIRMED.

The Department of Health's Office of Health Insurance Programs backdated your child's coverage in his Child Health Plus plan to April 1, 2017, such that no further action by NYSOH is required.

The March 21, 2017 enrollment confirmation notice is MODIFIED in part to state that your child's enrollment in his Child Health Plus plan has a start date of April 1, 2017.

**Effective Date of this Decision: April 12, 2017**

## **How this Decision Affects Your Eligibility**

This decision does not change your child's eligibility.

Your child was not eligible for retroactive Medicaid from November 1, 2016 through January 31, 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).

The effective date of your child's Child Health Plus plan has been backdated to April 1, 2017.

You will be responsible to pay directly to the Child Health Plus plan, the April 2017 premium for your child's coverage to become active that month.

### **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 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).

## **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 March 21, 2017 eligibility determination notice denying your child retroactive Medicaid is AFFIRMED.

The Department of Health's Office of Health Insurance Programs backdated your child's coverage in his Child Health Plus plan to April 1, 2017, such that no further action by NYSOH is required.

The March 21, 2017 enrollment confirmation notice is MODIFIED in part to state that your child's enrollment in his Child Health Plus plan has a start date of April 1, 2017.

This decision does not change your child's eligibility.

Your child was not eligible for retroactive Medicaid from November 1, 2016 through January 31, 2017.

The effective date of your child's Child Health Plus plan has been backdated to April 1, 2017.

You will be responsible to pay directly to the Child Health Plus plan, the April 2017 premium for your child's coverage to become active that month.

## **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:**



## 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)

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 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 bεtumi ama wo obi a okyerε 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 דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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