STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: October 27, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018845

[redacted]

Dear [redacted],

On August 17, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 25, 2017 and April 4, 2017 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).

This page intentionally left blank.

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
PO Box 11729
Albany, NY 12211

Decision

Decision Date: October 27, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018845

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health properly determine that your family member [redacted] enrollment in his Child Health Plus plan was effective May 1, 2017?
>
> Did NYSOH properly determine that your family member [redacted] was not eligible for retroactive Medicaid assistance for March 2017?

Procedural History

On March 24, 2017, you added [redacted] to your account.

On March 25, 2017, NYSOH issued a notice of eligibility determination stating that your family member [redacted] was eligible for coverage through Child Health Plus, effective May 1, 2017.

Also on March 25, 2017, NYSOH issued a notice of eligibility determination stating that your family member [redacted] was eligible for retroactive Medicaid coverage for February 2017, but only for emergency care and services, because [redacted] was not a citizen, qualified alien or permanently residing in the United States under color of law (PRUCOL).

Also on March 25, 2017, NYSOH issued a notice confirming that [redacted] had been enrolled in a Child Health Plus plan effective May 1, 2017.

Your account was updated on March 27, 2017; March 31, 2017; April 3, 2017; April 7, 2017; and April 27, 2017.

On April 3, 2017, your applications began to request assistance in covering medical expenses for [redacted] from March 2017.

On April 4, 2017 and April 8, 2017, NYSOH issued notices of eligibility determination stating that your family member [redacted] was not eligible for retroactive assistance in paying medical bills for March 2017, because the program in which he was enrolled could not pay for care provided in the past.

On May 10, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as it denied retroactive assistance for your family member [redacted] for March 2017.

On August 17, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit, which was held with the assistance of interpreters #[redacted] and #[redacted]. The record was developed during the hearing held open until August 31, 2017, to allow you to submit supporting documents regarding income for March 2017.

As of August 31, 2017, the Appeals Unit had not received any documents and none were viewable in your NYSOH account. Therefore, the record was closed that same day and this decision is based on the record as developed at the time of the hearing.

Findings of Fact

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

1) You testified that you are appealing only your family member [redacted] eligibility. You further testified that [redacted] is your [redacted] and that you live together, but that you are not his legal guardian. According to your account, [redacted] was born on [redacted] and is currently [redacted] years old.

2) You have submitted seven applications to NYSOH for financial assistance between March 24, 2017 and April 27, 2017. In these applications, you identified your [redacted] as your adoptive child. In several of the applications submitted in April 2017, you requested retroactive assistance for March 2017.

3) [redacted] was found eligible for retroactive assistance for February 2017, based on an application filed in March 2017.

4) You enrolled [redacted] into a Child Health Plus plan effective May 1, 2017.

5) You testified that you wanted [redacted] Child Health Plus plan to begin on March 1, 2017, or that he be found eligible for retroactive Medicaid coverage, because he incurred medical expenses during that month.

6) You testified that neither you nor [redacted] will file a federal income tax return for 2017.

7) You testified that [redacted] goes to school; he does not work and has no earnings.

8) You testified that [redacted] has no immigration status.

9) You testified that you are paid weekly, and that your pay varies. You have earned more than $400.00 per week since November 2016; you earned $400.00 in March 2017 before taxes.

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

Applicable Law and Regulations

Child Health Plus

"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).

Immigration Status and Medicaid Eligibility

A person who meets certain nonfinancial criteria and has a household income that is at or below the applicable Medicaid income standard is eligible for Medicaid benefits (45 CFR § 155.305(c)). One of the non-financial criteria for Medicaid eligibility is the immigration status of the person applying for health

insurance. A person is eligible for Medicaid when his or her immigration status is satisfactory and he or she meets all other requirements for Medicaid.

Generally, no person, except a United States citizen, naturalized citizen, qualified alien, and persons permanently residing in the United States under color of law (PRUCOL), is eligible for medical assistance from the state (NY Soc. Serv. Law § 122(1); 18 NYCRR § 360-3.2).

A PRUCOL alien is a person who is residing in the United States with the knowledge and permission or acquiescence of the federal immigration agency and whose departure from the United States such agency does not contemplate enforcing (18 NYCRR §360-3.2(j)). The New York Department of Health regards aliens who have filed official applications on federal immigration agency forms for one of the many types if immigration statuses or relief to be PRUCOL during the period of time the federal agency is determining whether to approve the application (08 OHIP/INF-4, dated August 4, 2008)).

Emergency Medicaid

In some cases, Medicaid will pay for emergency medical treatment for a person who does not have evidence of citizenship or immigration status, even if the person cannot get full Medicaid coverage (NY Social Services Law § 122(1)(e); 18 NYCRR § 360-3.2(j)(3)(ii)(a)).

The term “emergency medical condition” means:

> A medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
>
> (a) Placing the patient’s health in serious jeopardy;
> (b) Serious impairment of bodily functions; or
> (c) Serious dysfunction of any bodily organ or part

(18 NYCRR § 360-3.2(j)(1)(iii)).

To get treatment for an emergency medical condition, an undocumented alien who is not a temporary non-immigrant must meet all of the other Medicaid eligibility requirements, including proof of identity, income, and State residence (GIS 13 MA/09: Changes to Medicaid Coverage for the Treatment of an Emergency Medical Condition, (2/25/2013)).

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).

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)).

Household

The household size of an individual under the age of 19, who will not be filing a tax return and will not be claimed as a dependent by another person, consists of that person, any spouse, parents, or children living with that individual (42 CFR § 435.603(f)(3)).

Legal Analysis

The first issue is whether NYSOH properly determined that your family member [redacted] enrollment in his Child Health Plus plan was effective May 1, 2017.

You testified that you contacted NYSOH on March 24, 2017 and enrolled [redacted] into a Child Health Plus plan.

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

Therefore, the March 25, 2017 enrollment confirmation notice stating that [redacted] enrollment in his Child Health Plus plan was effective May 1, 2017 is correct and must be AFFIRMED.

The second issue under review is whether NYSOH properly determined that your family member [redacted] was not eligible for retroactive Medicaid assistance for March 2017.

You submitted several applications for financial assistance in April 2017, and requested help in paying for medical bills for [redacted] from the month of March 2017.

When an individual files an initial application for Medicaid, his 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.

You testified that [redacted] does not have any immigration status at this time. However, even if this disqualified [redacted] from receiving full Medicaid benefits, he may still be eligible for retroactive assistance for March 2017 for emergency services.

[redacted] is under the age of [redacted], he does not file a tax return, and he is not claimed as a dependent on any other person's tax return. He does not live with a spouse, parent, or children. Therefore, for the purposes of determining his eligibility for Medicaid or CHP, he is in a one-person household. Further, you testified that he has no income, and is in school.

Since the record now contains a more accurate representation of what [redacted] status and income was for March 2017, this case is RETURNED to NYSOH to consider your request for retroactive coverage for [redacted] for March 2017, based on a household size of one person and household income of $0.

Decision

The March 25, 2017 enrollment confirmation notice is correct and must be AFFIRMED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for [redacted] for March 2017, based on a household size of one person and household income of $0.

Effective Date of this Decision: October 27, 2017

How this Decision Affects Your Eligibility

Coverage through CHP for [redacted] was correctly begun on May 1, 2017.

This is not a final determination of [redacted] eligibility. This case is sent back to NYSOH to redetermine [redacted] eligibility for retroactive coverage for March 2017, based on a household size of one person and household income of $0. NYSOH will send you a new notice of eligibility 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 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
  PO Box 11729
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The March 25, 2017 enrollment confirmation notice is correct and must be AFFIRMED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for [redacted] for March 2017, based on a household size of one person and household income of $0.

Coverage through CHP for [redacted] was correctly begun on May 1, 2017.

This is not a final determination of [redacted] eligibility. This case is sent back to NYSOH to redetermine [redacted] eligibility for retroactive coverage for March 2017, based on a household size of one person and household income of $0. NYSOH will send you a new notice of eligibility 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).

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).