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

Notice of Decision

Decision Date: November 14, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020632

[redacted]

[redacted]

On October 11, 2017, you appeared by telephone at a hearing on your appeal regarding your child not having been found eligible for Medicaid coverage for January 2017, nor eligible for Child Health Plus coverage earlier than February 1, 2017.

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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: November 14, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020632

[redacted]

Issue

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

> Was your July 19, 2017 appeal of NY State of Health's (NYSOH) not having found your child eligible for retroactive Medicaid coverage during the month of January 2017, or that your child's CHP coverage began as of February 1, 2017, timely?

Procedural History

You applied to NYSOH for health insurance coverage and financial assistance for your child on December 29, 2016.

On December 30, 2016, NYSOH issued a notice of eligibility determination stating that your child was eligible for Child Health Plus (CHP) with a $60.00 monthly premium, effective February 1, 2017. Your child was also found ineligible for Medicaid because your income was above the allowable limit for that program.

Also on December 30, 2016, NYSOH issued an enrollment notice confirming your selection of a CHP plan for your child's coverage as of December 29, 2016. Your child's CHP plan coverage began effective February 1, 2017.

No objections were made to either of these notices.

On July 19, 2017, NYSOH received an update to your application for health insurance. In response to this application, NYSOH prepared a preliminary

eligibility determination reflecting that your child was eligible for CHP with a $60.00 monthly premium, for coverage between February 1, 2017 and August 31, 2018.

Also on July 19, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as your child was not found eligible for retroactive Medicaid for the month of January 2017.

On September 6, 2017, NYSOH received a further update to your application for health insurance.

On September 7, 2017, NYSOH issued an eligibility determination notice stating that your child was eligible for CHP with a $60.00 monthly premium, effective October 1, 2017.

On October 11, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and remained open as the Hearing Officer directed you to provide as additional evidence to corroborate your testimony: (1) all earnings statements you received from your employer, [redacted], during January 2017, and (2) all earnings statements received by your spouse from each his employers, [redacted], during the month of January 2017. The record was to be closed 15 days after the hearing date, or upon the receipt of the above referenced documents, whichever occurred earlier.

On October 21, 2017, you provided to the Appeals Unit through facsimile: (1) eight earnings statements issued to you by [redacted] between January 23, 2017 to February 27, 2017, (2) three earnings statements issued to your spouse by [redacted] between January 3, 2017 and January 31, 2017, and (3) two earnings statements issued to your spouse by [redacted]. on January 13, 2017 and January 27, 2017.

Accordingly, the record was closed on October 21, 2017.

Findings of Fact

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

1) At the time of your December 29, 2016 application, your child was [redacted].

2) You testified that you are seeking retroactive Medicaid coverage for your child from January 1, 2017 to January 31, 2017.

3) You testified that you expect to file your 2017 federal income tax return as married filing jointly, and would claim your child as your sole dependent.

4) You submitted an application for financial assistance on December 29, 2016. You testified that you were not asked questions regarding the possibility of coverage for the following month, January 2017.

5) The December 29, 2016 application reflected that you earned approximately $400.00 per week from [redacted], your spouse earned $12.00 per year from his employment with [redacted] and $53,000.00 annually from his employment with [redacted] You also attested in that application to an additional $2,500.00 in income.

6) Your child was found eligible for CHP coverage, effective February 1, 2017.

7) You did not provide an additional update to your NYSOH application until July 19, 2017. There is no record of any objections to your child's lack of coverage during the month of January 2017 until July 19, 2017.

8) You testified that you were seeking retroactive Medicaid coverage for your child during the month of January 2017 due to medical expenses you incurred in connection with her treatment during that month.

9) On October 21, 2017, you provided eight earnings statements issued to you by [redacted] reflecting that you received (1) $391.00 on January 23, 2017 and $802.88 on January 30, 2017.

10) On October 21, 2017, you provided three earnings statements issued to your spouse by [redacted] reflected that your spouse received $1,526.22 on January 3, 2017, January 17, 2017, and January 31, 2017.

11) On October 21, 2017, you provided two earnings statements issued to your spouse by [redacted] reflecting that your spouse received (1) $502.42 on January 13, 2017 and (2) $804.64 on January 31, 2017.

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

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) a failure by NYSOH to provide timely notice of an eligibility determination; and (4) a denial of a request for a special enrollment period (45 CFR § 155.505, 45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH (45 CFR § 155.520(b)(2); 18 NYCRR § 358-3.5(b)(1)).

Legal Analysis

The only issue under review is whether your July 19, 2017 appeal of NYSOH's not having found your child eligible for retroactive Medicaid coverage during the month of January 2017 and not finding that your child's CHP coverage began any earlier than February 1, 2017 was timely.

On December 29, 2016, after you updated your NYSOH account, NYSOH issued an eligibility determination stating your child was eligible for CHP with a $60.00 monthly premium, effective February 1, 2017. On December 29, 2016, you selected a CHP plan for your child's coverage. On December 30, 2016, NYSOH issued an enrollment notice stating that your child's CHP plan coverage would begin, effective February 1, 2017.

The record reflects that you did not provide an additional update to your NYSOH application until July 19, 2017, nor is there any evidence that you appealed the notices issued in December 2016 before July 29, 2017.

You testified that because your child did not have coverage during the month of January 2017, you incurred medical expenses in connection with her treatment during that month. However, the record reflects that you did not contact NYSOH until July 19, 2017 to dispute that your child was not eligible for coverage during the month of January 2017.

You stated that you were not asked questions regarding retroactive Medicaid coverage during January 2017 in your December 29, 2016 application. However, this is no indication that a defect was present in your application, because retroactive Medicaid assistance is only available for the three months prior to

their application, not prior to when their children's CHP plan coverage will take effect. You also did not ask for assistance for the three previous months.

More importantly, individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issues of your child's not having been found eligible for Medicaid or her CHP coverage having begun no earlier February 1, 2017, as indicated in the December 30, 2016 eligibility and enrollment notices, an appeal should have been filed by February 28, 2017. According to the credible evidence in the record, you did not contact NYSOH until July 19, 2017 to file a formal appeal, which is well beyond 60 days from the December 30, 2016 enrollment notice at issue.

Therefore, there has been no timely appeal of NYSOH's not having found your child eligible for retroactive Medicaid coverage during the month of January 2017, and your child's CHP plan coverage having begun as of February 1, 2017, and your appeal on this issue is DISMISSED.

Decision

Your appeal on issue of NYSOH's not having found your child not eligible for retroactive Medicaid coverage during the month of January 2017, and your child's CHP plan coverage having begun as of February 1, 2017, was untimely, and is DISMISSED.

Effective Date of this Decision: November 14, 2017

How this Decision Affects Your Eligibility

Your child's eligibility has not changed.

Your eligibility for CHP was effective as of February 1, 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
- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

Your appeal on issue of NYSOH's not having found your child not eligible for retroactive Medicaid coverage during the month of January 2017, and your child's CHP plan coverage having begun as of February 1, 2017, was untimely, and is DISMISSED.

Your child's eligibility has not changed.

Your eligibility for CHP was effective as of February 1, 2017.

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)

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هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা **(Bengali)**

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

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.

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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.

(Urdu) اردو

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.

(Yiddish) אידיש

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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