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

Notice of Decision

Decision Date: November 15, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020899

[redacted]

On October 10, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 2, 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).

This page intentionally left blank.

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

Decision

Decision Date: November 15, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020899

[redacted]

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 child's enrollment in his Medicaid Managed Care (MMC) plan ended effective April 30, 2017?
>
> Did NYSOH properly determine that your child was enrolled in a Child Health Plus (CHP) plan with an enrollment start date of June 1, 2017?
>
> Did NYSOH properly determine that your child was not eligible for Medicaid for the month of May 2017?

Procedural History

On June 18, 2016, NYSOH issued an eligibility determination notice stating in part, that your newborn child was eligible for Medicaid, effective April 1, 2016. Your newborn child was then enrolled in a MMC plan with a plan start date of April 1, 2016.

On March 3, 2017, NYSOH issued a notice that it was time to renew your child's health insurance. That notice stated that, based on information from federal and state sources, NYSOH could not make a decision about whether your child would qualify for financial help paying for your health coverage, and that you needed to update your account by April 15, 2017, or your child might lose the financial assistance he was currently receiving.

No updates were made to your account by April 15, 2017.

On April 17, 2017, NYSOH issued an eligibility determination notice stating that your child was not eligible for Medicaid, CHP, the Essential Plan, or to receive tax credits or cost-sharing reductions to help pay for the cost of insurance, and could not enroll in a qualified health plan at full cost. This was because you had not responded to the renewal notice and had not completed the renewal within the required time frame. Your child's eligibility ended May 1, 2017.

Also on April 17, 2017, NYSOH issued a disenrollment notice confirming that your child's MMC plan coverage would end on April 30, 2017.

On April 21, 2017, NYSOH received your updated application for health insurance.

On April 22, 2017, NYSOH issued an eligibility determination notice stating in part that your child was eligible to enroll in CHP with a $15.00 monthly premium, effective June 1, 2017.

Also on April 22, 2017, NYSOH issued a plan enrollment notice, based on your plan selection on April 21, 2017, stating that your child was enrolled in a CHP plan, and that his enrollment in the plan would start June 1, 2017.

On June 1, 2017, you submitted an updated application for financial assistance with health insurance and indicated that you were seeking help paying for medical bills for May 2017 for your child.

On June 2, 2017, NYSOH issued an eligibility determination notice stating that your child was not eligible for Medicaid from May 1, 2017 through May 31, 2017, because the program he was eligible for cannot pay for any care he received in the past.

On July 27, 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 May 1, 2017, and he was not eligible for Medicaid for the month of May 2017.

On October 10, 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 for you to submit supporting documentation. That day you submitted via secure facsimile a three-page submission consisting of a cover page and earning statements for the month of May 2017, which were made part of the record collectively as Appellant's Exhibit # 1. The record was closed at that time.

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.

2) According to your NYSOH account and your testimony, you expect to file your 2017 income tax return as head of household and will claim one dependent.

3) According to your NYSOH account and your testimony, you receive all notices from NYSOH by regular mail.

4) You testified that you did not receive any notices telling you that you needed to update your application in order to renew your child's coverage.

5) No notices sent to you at the address listed on your NYSOH account have been returned as undeliverable.

6) You testified that, on April 21, 2017, you received the April 17, 2017 disenrollment notice stating that your child's MMC plan would end on April 30, 2017.

7) According to your NYSOH account and your testimony, you contacted NYSOH on April 21, 2017 and updated your account and your child was found eligible for CHP coverage, effective June 1, 2017.

8) According to your NYSOH and your testimony, you enrolled your child in a CHP plan on April 21, 2017.

9) You testified that you updated your account on June 1, 2017 and requested help paying for medical bills you incurred for your child's care in the month of May 2017.

10) According to your NYSOH account, in the June 1, 2017 updated application, you attested to earning $17.00 an hour and working a steady 36 hours a month. Based on these amounts that you supplied, NYSOH calculated your expected annual household income as $31,824.00 and a monthly income of $2,652.00.

11) You testified that you are paid twice a month and that you received paychecks on May 1, 2017 and May 15, 2017.

12) Following your hearing, your submitted earning statements showing gross pay for May 1, 2017 was $1,442.88 and gross pay for May 15, 2017 was $1,212.44 for a total pay earned in May 2017 of $2,655.32.

13) You testified that your child had [redacted] visits and related [redacted] follow up visits in May 2017 and the bills for which are presently uncovered by health insurance.

14) You testified that you are seeking that your child's CHP plan start May 1, 2017, or that you child be found eligible for retroactive Medicaid for the month of May 2017.

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

Applicable Law and Regulations

Medicaid Renewal

In general, NYSOH must review Medicaid eligibility once every twelve months or "whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility" (42 CFR § 435.916(a)(1), (d)). NYSOH must make its "redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency" (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates provided by the individual (45 CFR §155.335(h)).

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 $16,240.00 for a two-person household (82 Federal Register 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 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* 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 terminated your child's MMC plan coverage, effective April 30, 2017.

Your child was originally found eligible for Medicaid, effective April 1, 2016 and was enrolled in a MMC plan with enrollment start date of April 1, 2016.

Generally, NYSOH must redetermine a qualified individual's eligibility for Medicaid once every twelve months without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency. NYSOH's March 3, 2017 renewal notice stated that there was not enough information to determine whether your child was eligible to continue his financial assistance for health insurance, and that you needed to supply additional information by April 15, 2017, or your financial assistance might end.

Because there was no timely response to this notice, your child's MMC plan coverage was terminated, effective April 30, 2017.

You testified that you did not receive any notice from NYSOH telling you that you needed to update the information in your NYSOH account. You testified, and your NYSOH account confirms, that you elected to receive notifications by regular mail. However, there is no evidence in the record that any of the notices sent to your mailing address were returned as undeliverable.

As such, the record reflects that NYSOH properly notified you that the information in your NYSOH account needed to be updated to ensure your child's enrollment and financial assistance would continue. Therefore, the April 17, 2017 disenrollment notice is AFFIRMED.

The second issue under review is whether NYSOH properly determined that your child was enrolled in a CHP plan with an enrollment start date of June 1, 2017.

Your NYSOH account reflects that after your child's disenrollment from Medicaid, you contacted NYSOH on April 21, 2017 and updated your account. As a result of that update, your child was determined eligible for CHP with a $15.00 monthly premium, effective June 1, 2017. The record reflects that you enrolled your child into a CHP plan on April 21, 2017.

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 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 between 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 you selected your child's CHP plan on April 21, 2017, it properly took effect the first day of the second month following April 2017; that is, on June 1, 2017.

Therefore, NYSOH's April 22, 2017 eligibility determination notice and enrollment confirmation notices are AFFIRMED because those notices properly state that your child's eligibility for and enrollment in CHP began on June 1, 2017.

The third issue under review is whether NYSOH properly determined that your child was not eligible for Medicaid from May 1, 2017 through May 1, 2017.

The financial criteria for Medicaid can be provided through NYSOH to children at least one year of age but younger than nineteen is eligible for Medicaid if they meet 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.

You submitted an application for financial assistance on June 1, 2017 and requested help paying the medical bills for your child incurred in the month of May 2017.

When an individual file, 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.

You testified that you are seeking retroactive Medicaid for the month of May 2017 for your child because he had medical services in that month.

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 May 2017, your child would have needed to meet the non-financial criteria and have an income no greater than 154% of the 2017 FPL, which is $2,085.00 per month for a two-person family. There is no indication in the record that your child would have been ineligible for Medicaid based on non-financial criteria during May 2017.

According to your NYSOH account and your testimony, you are employed earning $17.00 per hour and work a steady 36-hour week. You testified that you are paid twice a month and received two paychecks in the month of May 2017.

You submitted pay statements showing that you earned $1,442.88 and on May 1, 2017 and $1,212.44 on May 15, 2017. Therefore, the record indicates that in the month of May 2017, you had a monthly household income of $2,655.32.

Since your income of $2,655.32 was more than the $2,085.00 monthly Medicaid limit for May 2017, NYSOH properly determined that your child was not eligible for Medicaid coverage during that month.

Therefore, the June 2, 2017 eligibility determination notice stating that your child was not eligible for Medicaid in the month of May 2017 because the program he was eligible for cannot pay for any care he received in the past is MODIFIED to state that your child is not eligible for Medicaid for the month of May 2017 because your household income of $2,655.32 is more than the allowable income of $2,085.00 for that month.

Decision

The April 17, 2017 disenrollment notice is AFFIRMED.

The April 22, 2017 eligibility determination notice is AFFIRMED.

The April 22, 2017 plan enrollment notice is AFFIRMED.

The June 2, 2017 eligibility determination notice stating that your child was not eligible for Medicaid in the month of May 2017 because the program he was eligible for cannot pay for any care he received in the past is MODIFIED to state that your child is not eligible for Medicaid for the month of May 2017 because your household income of $2,655.32 is more than the allowable income of $2,085.00 for that month.

Effective Date of this Decision: November 15, 2017

How this Decision Affects Your Eligibility

This decision does not change your child's eligibility.

Your child's MMC plan ended effective April 30, 2017.

The effective date of your child's CHP plan is June 1, 2017.
Your child was not eligible for retroactive Medicaid during the month of May 2017.

Your child did not have health insurance coverage through NYSOH during the month of May 2017.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services. 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 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 April 17, 2017 disenrollment notice is AFFIRMED.

The April 22, 2017 eligibility determination notice is AFFIRMED.

The April 22, 2017 plan enrollment notice is AFFIRMED.

The June 2, 2017 eligibility determination notice stating that your child was not eligible for Medicaid in the month of May 2017 because the program he was eligible for cannot pay for any care he received in the past is MODIFIED to state that your child is not eligible for Medicaid for the month of May 2017 because your household income of $2,655.32 is more than the allowable income of $2,085.00 for that month.

This decision does not change your child's eligibility.

Your child's MMC plan ended effective April 30, 2017.

The effective date of your child's CHP plan is June 1, 2017.
Your child was not eligible for retroactive Medicaid during the month of May 2017.

Your child did not have health insurance coverage through NYSOH during the month of May 2017.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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)

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।

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).

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 तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई नि:शुल्क 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).