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

Notice of Decision

Decision Date: January 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022028

[redacted]

[redacted]

On December 18, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 26, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: January 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022028

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Is your appeal of NY State of Health's (NYSOH) April 17, 2017 disenrollment notice timely?
>
> Did NYSOH properly determine that your oldest child was not eligible for Medicaid for May 1, 2017 through June 30, 2017?

Procedural History

On March 29, 2016, you submitted your initial application for financial assistance on behalf of your household.

On December 6, 2016, an updated application was submitted to NYSOH on your behalf. In that application, your oldest child's last name was changed from "[redacted] to "[redacted]."

On December 7, 2016, NYSOH issued a notice of eligibility determination stating that your oldest child was eligible for Child Health Plus (CHP) with a $60.00 monthly premium for a limited time, effective January 1, 2017. The notice directed you to submit proof of his citizenship status and Social Security number by March 6, 2017.

Also on December 7, 2016, NYSOH issued a notice of enrollment confirmation, confirming your oldest child's enrollment in a CHP plan, beginning January 1, 2017.

No documentation was received by NYSOH by March 6, 2017.

On March 16, 2017, NYSOH issued a renewal notice stating that, based on information from federal and state data sources, NYSOH could not determine whether your oldest child qualified for financial help paying for health insurance. The notice directed you to update your NYSOH account between March 16, 2017 and April 15, 2017, or the financial assistance your oldest child was receiving could end.

No updates were made to your NYSOH application within the required timeframe.

On April 16, 2017, your oldest child's eligibility was redetermined.

On April 17, 2017, NYSOH submitted a discontinuance notice stating that your oldest child was not eligible to enroll in coverage through NYSOH, effective May 1, 2017. This was because you did not respond to the renewal notice and did not complete the renewal within the required timeframe.

Also on April 17, 2017, NYSOH issued a disenrollment notice, stating that your oldest child was disenrolled from his CHP plan, effective April 30, 2017.

On May 26, 2017, you submitted an updated application for financial assistance with health insurance.

On May 27, 2017, NYSOH issued a notice of eligibility determination, stating that your child was eligible to enroll in CHP with a $60.00 monthly premium for a limited time, effective July 1, 2017. The notice directed you to submit proof of his citizenship status and Social Security number by August 24, 2017.

Also on May 27, 2017, NYSOH issued an enrollment confirmation notice, confirming your oldest child's enrollment in a CHP plan, beginning July 1, 2017.

On June 13, 2017, you uploaded documentation to your NYSOH account. That same day, NYSOH redetermined your household's eligibility.

On June 14, 2017, NYSOH issued a notice of eligibility determination stating that your child was eligible to enroll in CHP with a $60.00 monthly premium, effective July 1, 2017.

Also on June 14, 2017, NYSOH issued a notice of enrollment confirmation, confirming your oldest child's enrollment in a CHP plan, beginning July 1, 2017.

On August 25, 2017, you updated your NYSOH account and indicated that you were seeking help with paying for medical bills for your oldest child for the months of May and June 2017.

On August 26, 2017, NYSOH issued a notice of eligibility determination stating that your oldest child was eligible for CHP with a monthly premium of $45.00, effective October 1, 2017.

That same day, NYSOH issued an eligibility determination notice stating that your oldest child was not eligible for Medicaid for May 1, 2017 through June 30, 2017 because the program he was eligible for could not pay for any care he received in the past.

On August 31, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice, insofar as it denied retroactive Medicaid for your oldest child for the months of May and June 2017.

On December 18, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing closed at the end of the hearing.

Findings of Fact

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

1) You testified that you are seeking coverage for your oldest child for the months of May and June 2017.

2) You testified that you did not realize that your oldest child's coverage ended as of April 30, 2017 until his pediatrician informed you that he had no coverage.

3) You testified that you called NYSOH toward the end of May 2017 and were told that your child's coverage would be backdated to May 1, 2017.

4) You testified that you called again to reenroll your child in coverage when you found out that the coverage had not been backdated.

5) Your NYSOH account reflects that you updated your application on May 26, 2017 and re-enrolled your child in coverage, effective July 1, 2017.

6) You testified that you were informed by NYSOH that your child's coverage ended because you did not submit some documentation.

7) You testified that you never received any notices asking you for any documentation on behalf of your son.

8) You testified, and your NYSOH account confirms that you receive notices from NYSOH by regular mail.

9) No notices sent to you at the address in your NYSOH account have been returned to NYSOH as undeliverable.

10) Your NYSOH account reflects that you were sent a notice on March 16, 2017 stating that you needed to renew your oldest child's application for health insurance by April 15, 2017.

11) Your NYSOH account reflects that no updates were made to your application by April 15, 2017.

12) Your NYSOH account reflects that your oldest child was disenrolled from his CHP coverage in a notice dated April 17, 2017, effective April 30, 2017.

13) You testified that you expect to file your 2017 federal income tax return as married, filing jointly.

14) In May and June 2017, there were five people in your household.

15) You submitted an updated application for financial assistance on August 25, 2017, and requested help paying for medical bills on behalf of your oldest child in the months of May and June 2017

16) Your application submitted on August 25, 2017 states that for the months of May and June 2017, your income was $4,166.67 each month, and your spouse's income was $4,750.00 each month. You testified that amount was correct, based on your annual salaries.

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 the Exchange to provide timely notice of an eligibility determination; and (4) a denial of a request for a special enrollment

period (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 sixty (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)).

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 $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 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 under review is whether your appeal of NYSOH's April 17, 2017 disenrollment notice was timely.

Your NYSOH account was updated and your oldest child's last name was changed on December 6, 2016. As a result, NYSOH requested proof of his citizenship and Social Security number. When this documentation was not submitted by the March 6, 2017 deadline, NYSOH issued a notice informing you

that you needed renew your oldest child's application for health insurance by April 15, 2017. When no renewal was completed, NYSOH issued a disenrollment notice dated April 17, 2017 stating that your oldest child was disenrolled from his CHP coverage, effective April 30, 2017.

An individual has the right to request an appeal of a NYSOH eligibility determination with which they do not agree, and must file that appeal within 60 days of the eligibility determination.

For an appeal of the April 17, 2017 disenrollment notice to have been timely, it would have to have been filed by June 16, 2017. According to the credible evidence in the record, you did not contact NYSOH until August 31, 2017 to file a formal appeal, which is 136 days from the April 17, 2017 disenrollment notice.

You testified during the hearing that you did not receive any documentation asking you for documentation for your oldest child, and that you did not receive the March 16, 2017 renewal notice. You testified that you did not realize that your oldest child had been disenrolled from his coverage until his pediatrician informed you that his coverage was not active.

However, your NYSOH account indicates that you are enrolled to receive notices from NYSOH by regular mail. As none of the notices issued to you by NYSOH has been returned as undeliverable, it is concluded that you received the April 17, 2017 disenrollment notice, and were therefore on notice of your oldest child's disenrollment from his CHP plan coverage.

Therefore, there has been no timely appeal of the April 17, 2017 disenrollment notice, and your appeal on the issue of your oldest child's disenrollment from his CHP plan, as stated in that notice, is DISMISSED.

The second issue under review is whether NYSOH properly determined that your oldest child was not eligible for Medicaid for May 1, 2017 through June 30, 2017.

Your child was in a five-person household in May and June 2017. You applied for financial assistance on August 25, 2017, and requested help in paying for medical bills for your oldest child for the months of May and June 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.

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 and June 2017, your child would have needed to meet the non-financial criteria and have an income no greater than 154% of the FPL, which is $3,693.00 per month. There is no indication in the record that your oldest child would have been ineligible for Medicaid based on any non-financial criteria during May and June 2017.

You testified that you and your spouse have consistent monthly income. NYSOH calculated your monthly income to be $4,166.67, based on an annual gross income of $50,000.00, and your spouse's monthly income to be $4,750.00, based on an annual gross income of $57,000. During the hearing, you confirmed that these monthly income amounts would have been correct during May and June 2017. Therefore, the record indicates that in the months of May and June 2017, you had a gross monthly household income of $8,916.67.

Since your income of $8,916.67 was more than the $3,693.00 monthly Medicaid limit for May and June 2017, the August 26, 2017 notice of eligibility is MODIFIED to state that your oldest child was not eligible for Medicaid in the months of May and June 2017 because your monthly income of $8,916.67 was over the allowable Medicaid income limit.

Decision

Your appeal of the April 17, 2017 disenrollment notice is DISMISSED as untimely.

The August 26, 2017 notice regarding your oldest child's eligibility for retroactive Medicaid is MODIFIED to state that your oldest child was not eligible for Medicaid in the months of May and June 2017 because your monthly household income of $8,916.67 was over the allowable Medicaid income limit for those months.

Effective Date of this Decision: January 16, 2018

How this Decision Affects Your Eligibility

Your appeal of the April 17, 2017 disenrollment notice is being dismissed because it was not filed within 60 days of the notice.

Your oldest child was not eligible for Medicaid in the months of May and June 2017 because your monthly household income was over the allowable income limit for Medicaid coverage.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the 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 of the April 17, 2017 disenrollment notice is DISMISSED as untimely.

The August 26, 2017 notice regarding your oldest child's eligibility for retroactive Medicaid is MODIFIED to state that your oldest child was not eligible for Medicaid in the months of May and June 2017 because your monthly household income of $8,916.67 was over the allowable Medicaid income limit for those months.

Your appeal of the April 17, 2017 disenrollment notice is being dismissed because it was not filed within 60 days of the notice.

Your oldest child was not eligible for Medicaid in the months of May and June 2017 because your monthly household income was over the allowable income limit for Medicaid coverage.

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)

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 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).