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

Notice of Decision

Decision Date: February 2, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023893

[redacted]

[redacted]

On December 27, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 2, 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 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
Albany, NY 12211

Decision

Decision Date: February 2, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023893

[redacted]

Issue

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

> Did NY State of Health properly determine your child was not eligible for retroactive Medicaid coverage for the month of September 2017?

Procedural History

On August 23, 2017, NYSOH received your child's first application for financial assistance with health insurance.

On August 24, 2017, NYSOH issued a notice of eligibility determination stating your child was eligible for Child Health Plus (CHP), effective October 1, 2017.

Also on August 24, 2017, NYSOH issued an enrollment notice, based on your August 23, 2017 plan selection, confirming your child was enrolled in a CHP plan, effective October 1, 2017.

On November 1, 2017, NYSOH received an updated application submitted on behalf of your child requesting retroactive coverage for the month of September 2017. That day a preliminary determination was prepared finding your child eligible for CHP, effective December 1, 2017, and denying your child retroactive coverage.

Also on November 1, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as your child was not eligible for coverage for the month of September 2017.

On November 2, 2017, NYSOH issued an eligibility determination notice stating your child was eligible for CHP, effective December 1, 2017.

Also on November 2, 2017, NYSOH issued a notice denying your child retroactive coverage for the month of September 2017 stating the program she was eligible for could pay for any care she received in the past.

On December 27, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) NYSOH received your child's initial application for health insurance on August 23, 2017.

2) Your child was determined eligible for CHP, effective October 1, 2017.

3) A CHP plan was selected for your child on August 23, 2017 and coverage through that plan became effective on October 1, 2017.

4) You testified that your child did not have prior health coverage, because she was previously living outside the U.S. until August 2017.

5) You testified that you were aware your child's CHP coverage was not starting until October 2017, but she became ill in September 2017 and you had to bring her to [redacted] for treatment. You testified she has outstanding medical bills from that treatment.

6) On November 1, 2017, an updated application was submitted on behalf of your child requesting retroactive coverage for the month of September 2017.

7) That application listed your annual household income for 2017 as $68,000.00 consisting solely of income you earned through your employment. You testified that information was accurate.

8) You testified you were paid weekly on each Friday and your paycheck was always the same. You testified your gross weekly earnings in 2017 were $1,300.00.

9) You testified, and your application indicates, you will file your 2017 tax return with a tax filing status of married filing jointly and you will claim one dependent.

10) You testified, and your application indicates, you will not take any deductions on your 2017 tax return.

11) You testified that you received $1,300.00 in gross income on each Friday in September 2017.

12) You testified you have weekly pretax deductions taken from your gross pay in the amount of $45.00 for a 401K contribution and $15.00 for dental coverage.

13) NYSOH denied your request for retroactive coverage for your child for the month of September 2017 on the grounds that the program she was eligible for could not pay for any care she received in the past.

14) You testified you were seeking review of that denial. You testified you were not appealing the start date of your child's CHP coverage.

15) According to your account, your child turned [redacted] on [redacted]

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

Applicable Law and Regulations

Child Health Plus – Effective Dates of Enrollment

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).

Medicaid Eligibility 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 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 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 $20,420.00 for a three-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)).

Legal Analysis

The issue under review is whether NYSOH properly determined your child was not eligible for retroactive Medicaid coverage for the month of September 2017.

On August 23, 2017, you applied for health insurance on behalf of your child. She was determined eligible for CHP, effective October 1, 2017. A CHP plan was selected on behalf of your child on August 23, 2017 and coverage through that plan properly became effective on the second following month; that is, on October 1, 2017. You testified you were not appealing the effective date of your child's CHP plan coverage.

You testified that you were aware your child's CHP coverage was not beginning until October 2017, but she became ill in September 2017 and you had to bring her to [redacted] for treatment. You testified she has outstanding medical bills from that treatment.

On November 1, 2017, an updated application was submitted on behalf of your child requesting retroactive coverage for the month of September 2017. NYSOH denied your request for retroactive coverage for your child because the program she was eligible for could not pay for any care she received in the past. However, pursuant to the regulations, when an individual applies 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.

Therefore, the basis for the denial of retroactive coverage for your child for the month of September 2017, as stated in the November 2, 2017 notice, is not supported by the regulations. However, notwithstanding, the record establishes that your child was not eligible for retroactive Medicaid coverage for the month of September 2017.

The November 1, 2017 application listed your annual household income for 2017 as $68,000.00 consisting solely of income you earned through your employment. You testified that information was accurate. You testified you were paid weekly on each Friday in 2017 and your gross weekly pay was always the same, $1,300.00. Additionally, you testified you have $60.00 in total pretax deductions taken from your weekly paycheck.

The evidence establishes your child is in a three-person household, because you will file your 2017 tax return with a tax filing status of married filing jointly and you will claim your child as a dependent. Additionally, the evidence establishes your child was [redacted] at the time of the November 1, 2017 request for retroactive coverage.

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 September 2017, your child would have needed to meet the non-financial criteria and have a household income no greater than 154% of the applicable FPL, which is $2,621.00 per month. It is noted that there is no indication in the record that your child would have been ineligible for Medicaid based on non-financial criteria during September 2017.

Based on your testimony that you received $1,240.00 in gross income each Friday in 2017 (accounting for the $60.00 in weekly pre-tax deductions you attested to), your gross taxable household income for September 2017 would

have been $6,200.00. Since this exceeds the $2,621.00 monthly income limit to qualify your child for retroactive Medicaid coverage for the month of September 2017, the record establishes she was not eligible for retroactive Medicaid coverage for September 2017.

Thus, the November 2, 2017 notice denying your child retroactive coverage for the month of September 2017 is MODIFIED only to reflect she was not eligible for retroactive coverage because the monthly household income exceeded the Medicaid income limit.

Decision

The November 2, 2017 notice denying your child retroactive coverage for the month of September 2017 is MODIFIED only to reflect she was not eligible for retroactive coverage because the monthly household income exceeded the Medicaid income limit.

Effective Date of this Decision: February 2, 2018

How this Decision Affects Your Eligibility

This decision does not change your child's eligibility.

Your child was not eligible for retroactive Medicaid coverage for the month of September 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

The November 2, 2017 notice denying your child retroactive coverage for September 2017 is MODIFIED to reflect she was not eligible for this coverage because the monthly household income exceeded the Medicaid income limit.

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 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.

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