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

Notice of Decision

Decision Date: March 27, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027027

[redacted]

Dear [redacted],

On March 12, 2018, you appeared by telephone at a hearing on your appeal of NY State of an 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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nystateofhealth™
The Official Health Plan Marketplace

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

Decision

Decision Date: March 27, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027027

[redacted]

Issue

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

> Did NY State of Health (NYSOH) fail to provide a timely determination of your second child's ([redacted]) eligibility for Medicaid following his December 1, 2017 application for financial assistance?

Procedural History

On December 1, 2017, you updated an application for financial assistance on behalf of you and your family, including your second child (child).

On December 1, 2017, you uploaded documentation to your child's NYSOH account as Documents [redacted]. That day, NYSOH reviewed Document [redacted] and determined it was insufficient to verify your child's income.

On December 2, 2017, NYSOH issued a notice stating, in relevant part, that the documentation reviewed did not match information NYSOH received from state and federal data sources, and that additional documentation was required to confirm your child's eligibility for Medicaid. The notice directed you to provide additional proof of your child's household income by December 31, 2017, to confirm his eligibility.

On December 4, 2017, NYSOH reviewed Document [redacted] and determined it was insufficient to verify your child's income.

On December 5, 2017, you updated an application for financial assistance on behalf of you and your family, including the child at issue.

On December 6, 2017, NYSOH issued a notice stating, in relevant part, that the documentation reviewed did not match information NYSOH received from state and federal data sources, and that additional documentation was required to confirm your child's eligibility for Medicaid. The notice directed you to provide additional proof of your child's household income by December 31, 2017, to confirm his eligibility.

On December 20, 2017, you updated an application for financial assistance on behalf of you and your family, including the child at issue.

On December 21, 2017 and December 22, 2017, NYSOH issued notices stating that your child's income information in the application did not match what NYSOH received from state and federal data sources, and that additional documentation was required to confirm your child's eligibility for Medicaid. The notice directed you to provide additional proof of your child's income by January 4, 2018.

On January 6, 2018, you updated an application for financial assistance on behalf of you and your family, including the child at issue.

On January 7, 2018, issued a notice stating that your child's income information in the application did not match what NYSOH received from state and federal data sources, and that additional documentation was required to confirm your child's eligibility for Medicaid. The notice directed you to provide additional proof of your child's income by January 4, 2018.

Also on January 7, 2018, your child submitted a fax to NYSOH requesting an appeal because he was not found eligible for Medicaid, which was uploaded to your NYOSH account as Documen [redacted].

On January 16, 2018, NYSOH issued a denial notice of financial assistance programs stating, in relevant part, that your child no longer qualified for health insurance through NYSOH because he did not provide the income documentation needed to verify the income listed on his application.

On March 12, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open until March 26, 2018, to allow you time to submit supporting documents.

On March 20, 2018, NYSOH received your supporting documents by fax. The documents were made part of the record as Appellant's Exhibit #1 and the record was closed.

Findings of Fact

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

1) According to your NYSOH account and your testimony, your child is [redacted], he expects to file his 2018 taxes with a tax filing status of single, and will not claim any dependents on that tax return.

2) According to your NYSOH account and your testimony, your child resides with you and your three other children, but you do not claim him as a dependent on your tax return.

3) The applications submitted on December 1, 2017 and December 5, 2017, lists your child's expected yearly income to be $0.00. The application submitted on December 20, 2017, lists your child's expected yearly income to be $8,000.00, consisting of income he earns from employment.

4) You testified that each of these amounts were incorrect. You testified that, at the time you submitted the December 22, 2017 application, you estimated his gross annual income for 2017 to be $8,000.00, but that his income was higher.

5) You testified that you estimated his income at the time of the December 22, 2017 application because he is a full-time student, and only works seasonally between the months of April and September. You further testified that he earns $12.00 per hour, and is paid weekly, but that his paychecks vary based on the number of hours he works.

6) You also testified that your child does not have a second job or any other sources of income because you are ill, and that he has been taking care of you, instead of working during the remaining months.

7) In his written request for an appeal, your child stated that he believed he was eligible for Medicaid because he only works a few months a year, that his income is below the Medicaid level, and that he takes care of you and his siblings (*see* Document [redacted]).

8) You testified, and provided a copy of your child's 2017 W-2 form to show, that your child's gross annual income was for 2017 was $14,936.13 (*see* Appellant's Exhibit #1).

9) Your application states that your child will not be taking any deductions on his 2018 tax return.

10) Your application states that your child lives in Rockland County, New York.

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).

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

Applicable Law and Regulations

Medicaid - Eligibility

Medicaid can be provided through the Marketplace to adults who: (1) are age 19 or older and under age 65; (2) are not pregnant; (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act; (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part; and (5) have a household modified adjusted gross income that is at or below 138% of the federal poverty for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.603(d)(4)), N.Y. Soc. Serv. Law § 366(1)(b)).

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).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

Medicaid – Verification Process

NYSOH may accept self-attestation of information needed to determine the income eligibility of an individual for Medicaid (42 CFR § 435.945(a)). NYSOH must request information relating to financial eligibility from other agencies in the State, other States, and Federal programs to the extent NYSOH determines such information is useful to verifying the financial eligibility for an individual (42 CFR § 435.948(a)).

An individual must not be required to provide additional information or documentation unless information needed by NYSOH cannot be obtained electronically or the information obtained electronically is not reasonably compatible with information provided by or on behalf of the individual (42 CFR § 435.952(c)).

Timely Notice of Medicaid Eligibility

When an individual applies for insurance through NYSOH, NYSOH must determine that person's eligibility promptly and without undue delay (45 CFR § 155.310(e)(1); 42 CFR § 435.1200(b)(3)(iii)).

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To assess whether an eligibility determination was untimely, NYSOH must base the time-period from the date of application to the date NYSOH notifies the applicant of its decision (45 CFR § 155.310(e)(2)). However, if the applicant submits an incomplete application or there is not sufficient information for NYSOH to make an eligibility determination, then NYSOH must notify that applicant that more information is needed to complete the application (45 CFR § 155.310(k)(1)).

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the application (42 CFR § 435.912).

Legal Analysis

The issue under review is whether NYSOH failed to provide your child with a timely eligibility determination following his December 1, 2017 application for financial assistance.

For all individuals whose income is needed to calculate a household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income. If NYSOH cannot verify the income information required to determine eligibility, they must attempt to resolve the inconsistency by giving the applicant the opportunity to submit satisfactory documentary evidence.

On December 1, 2017 you submitted an application for financial assistance for health insurance on behalf of your child, and uploaded income documents into your NYSOH account, as part of that application (*see* Documents [redacted]). NYSOH reviewed the documentation you uploaded, and determined it was insufficient to validate your child's income because it did not match information NYSOH received federal and state data sources.

NYSOH must provide adult applicants notice of their eligibility determination within 45 days from the date of the completed application. To assess whether an eligibility determination was untimely, the time period begins on the date of the completed application and ends on the date NYSOH notifies the applicant of its decision.

After the December 1, 2017 application, NYSOH issued four additional notices on December 2, 2017, December 6, 2017, December 21, 2017 and January 7, 2018. Each of these four notices instructed you to submit additional proof of your child's income in order for NYSOH to determine his eligibility for financial assistance for health insurance.

The record reflects that no additional income documentation was submitted in response to these notices. As a result, on January 16, 2018, NYSOH issued a notice of denial of financial assistance for health insurance, stating that your child

was not eligible for any financial assistance programs or health insurance through NYSOH because he failed to provide the income documentation requested.

Since the documentation submitted on December 1, 2017, was insufficient to verify your child's income and no additional documentation was submitted, NYSOH was unable to verify your child's household income to determine his eligibility for financial assistance for health insurance. Therefore, it is concluded that NYSOH did not fail to issue you a timely eligibility determination.

However, you provided a copy of your child's 2017 W-2 form to show that your child's gross annual income in 2017 was $14,936.13. The credible evidence of record reflects that this is your child's only source of income because he is a student, he works seasonally between the months of April and September, and that he is your primary caregiver for the remainder of the year.

Therefore, your case is RETURNED to NYOSH to determine your child's eligibility for financial assistance based on a one-person household, with an expected household income of $14,936.13, for an individual residing in Rockland County, and to notify you accordingly.

Your case is also RETURNED to NYSOH to conduct outreach to your child to establish his own NYSOH account.

Decision

NYSOH did not fail to issue you a timely eligibility determination.

Your case is RETURNED to NYOSH to determine your child's eligibility for financial assistance based on a one-person household, with an expected household income of $14,936.13, for an individual residing in Rockland County, and to notify you accordingly.

Your case is also RETURNED to NYSOH to conduct outreach to your child to establish his own NYSOH account.

Effective Date of this Decision: March 27, 2018

How this Decision Affects Your Eligibility

NYSOH did not fail to issue a timely notice of eligibility determination since the documentation was insufficient to calculate your child's eligibility for financial assistance.

Your case has been returned to NYSOH to determine your child's eligibility for financial assistance and issue an eligibility determination notice.

Your case has also been returned to NYSOH to assist your child in creating his own NYSOH account.

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):

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).

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

NYSOH did not fail to issue you a timely eligibility determination.

Your case is RETURNED to NYOSH to determine your child's eligibility for financial assistance based on a one-person household, with an expected household income of $14,936.13, for an individual residing in Rockland County, and to notify you accordingly.

Your case is also RETURNED to NYSOH to conduct outreach to your child to establish his own NYSOH account.

NYSOH did not fail to issue a timely notice of eligibility determination since the documentation was insufficient to calculate your child's eligibility for financial assistance.

Your case has been returned to NYSOH to determine your child's eligibility for financial assistance and issue an eligibility determination notice.

Your case has also been returned to NYSOH to assist your child in creating his own NYSOH account.

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।

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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 کرم 1-855-355-5777 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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