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

## Notice of Decision

Decision Date: February 14, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000011772

Dear ,

On January 17, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 25, 2015 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 at the top of this notice.

## Legal Authority

We are sending you this notice in accordance with Code of Federal Regulation 45 CFR § 155.545(b).

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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**Decision**

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NY State of Health Account ID:
Appeal Identification Number: AP000000011772

## Issue

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

> Was your appeal of the NY State of Health's (NYSOH) November 25, 2015 eligibility determination notice timely?

## Procedural History

On November 24, 2015, NYSOH received your updated application for health insurance.

On November 25, 2015, NYSOH issued a notice of eligibility determination stating you were conditionally eligible for Medicaid, effective December 1, 2015. The notice directed you to provide proof of your income by December 9, 2015 to confirm your eligibility.

Also on November 25, 2015, NYSOH issued a disenrollment notice stating your Medicaid Managed Care plan was terminated, effective November 30, 2015, because you were no longer eligible to remain enrolled the plan.

No income documentation was submitted by December 9, 2015.

On August 30, 2016, you spoke with NYSOH's Account Review Unit, and appealed the November 25, 2015 eligibility determination, insofar as you were eligible for presumptive Medicaid rather than full Medicaid in the month of December 2015.

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On January 17, 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) The record reflects you updated your application for health insurance on November 24, 2015. Thereafter, you were determined "conditionally" eligible for Medicaid and NYSOH requested proof of your income by December 9, 2015.

2) You testified, and the application indicates, you were pregnant at this time.

3) The record reflects, as a result of the November 24, 2015 application update, you were determined presumptively eligible for Medicaid, due to your pregnancy, pending a full Medicaid eligibility determination.

4) You testified you received the November 25, 2015 notice directing you to provide proof of your income. You further testified you faxed paystubs to NYSOH in response, but you were unsure of the date this occurred.

5) The record reflects NYSOH did not receive documentation evidencing your income by the December 9, 2015 deadline.

6) You testified, and the record reflects, your child was born [redacted] [redacted].

7) You testified Medicaid did not provide coverage for the hospital expenses resulting from the birth of your child in December 2015 because you were only presumptively Medicaid eligible at the time.

8) You testified you have outstanding medical bills from this time.

9) You first contacted NYSOH on August 30, 2016 to dispute your eligibility for December 2015 and a formal appeal was filed the same day.

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) an eligibility determination for an exemption; (4) a failure by NYSOH to provide timely notice of an eligibility determination; and (5) 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 appeal of NYSOH's November 25, 2015 eligibility determination notice was timely.

On November 25, 2015, after you updated your NYSOH account, NYSOH issued an eligibility determination stating you were conditionally eligible for Medicaid, effective December 1, 2015. The notice directed you to provide proof of your income by December 9, 2015 to confirm your eligibility. You were disenrolled from your Medicaid Managed Care plan, effective, November 30, 2015, but you were still enrolled in Medicaid fee-for-service coverage.

Your account reflects that NYSOH did not receive documentation evidencing your income by the December 9, 2015 deadline. As such, you were only presumptively Medicaid eligible for the month of December 2015 because of your pregnancy and because NYSOH was without sufficient information to make a full Medicaid eligibility determination.

You testified that as a result of your presumptive Medicaid eligibility, the hospital expenses resulting from the birth of your child in December 2015 were not covered by Medicaid, and you have outstanding medical bills from this time. However, you did not contact NYSOH to dispute your eligibility for December 2015 until August 30, 2016.

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 issue of your presumptive Medicaid eligibility beginning December 1, 2016, as indicated in the November 25, 2015 eligibility determination notice, an appeal should have been filed by January 25, 2016. According to the credible evidence in the record, you did not contact NYSOH until August 30, 2016 to file a formal appeal, which is well beyond 60 days from the November 25, 2015 eligibility determination notice at issue.

Therefore, there has been no timely appeal of the November 25, 2015 disenrollment notice, and your appeal on the issue of your presumptive Medicaid eligibility in the month of December 2015 DISMISSED.

## Decision

Your appeal of the November 25, 2015 eligibility determination notice is untimely and is DISMISSED.

## Effective Date of this Decision: February 14, 2017

## How this Decision Affects Your Eligibility

You were eligible for presumptive Medicaid, effective December 1, 2015.

You did not have full Medicaid coverage in the month of December 2015, and your appeal of this issue was untimely.

## 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 date 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 date 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

Your appeal of the November 25, 2015 eligibility determination notice is untimely and is DISMISSED.

You were eligible for presumptive Medicaid, effective December 1, 2015.

You did not have full Medicaid coverage in the month of December 2015, and your appeal of this issue was untimely.

## Legal Authority

We are sending you this notice in accordance with Code of Federal Regulation 45 CFR § 155.545(a).

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## A Copy of this Decision Has Been Provided To:

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