



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

## Notice of Decision

Decision Date: March 31, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000013913

[REDACTED]

Dear [REDACTED]

On March 9, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's May 3, 2016 eligibility determination and May 3, 2016 disenrollment 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 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: March 31, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000013913



## Issues

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

Was your appeal of NY State of Health's (NYSOH) May 3, 2016 eligibility determination notice and May 3, 2016 disenrollment notice timely?

Did NYSOH properly determine that your youngest child's eligibility for Medicaid ended effective May 31, 2016?

## Procedural History

On January 21, 2016, NYSOH issued a notice of eligibility determination stating that your youngest child was eligible to enroll in Medicaid for a limited time, effective February 1, 2016. The notice further directed you to provide documentation confirming her citizenship status and Social Security number by April 19, 2016.

Also on January 21, 2016, NYSOH issued a notice confirming your youngest child's enrollment in Medicaid, effective February 1, 2016.

On May 3, 2016, NYSOH issued an eligibility determination notice stating that your youngest child was not qualified for assistance because NYSOH did not timely receive documentation regarding citizenship status or her Social Security number.

Also on May 3, 2016 NYSOH issued a disenrollment notice stating that your youngest child's enrollment in Medicaid would end as of May 31, 2016, because she was no longer eligible to remain in her plan.

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).

On September 23, 2016 and October 8, 2016 you updated your application for financial assistance. An application was run on October 8, 2016.

On October 11, 2016, NYSOH issued a notice of eligibility determination stating that income documentation was required to determine your youngest child's eligibility. You were asked to submit documentation confirming your household's income before October 23, 2016.

On October 30, 2016, income documentation was faxed to NYSOH.

On November 19, 2016, NYSOH issued a notice of eligibility determination stating that your youngest child was eligible for Child Health Plus, effective January 1, 2017.

On December 7, 2016, NYSOH issued a notice of enrollment confirmation, stating that your youngest child was enrolled in a Child Health Plus plan, effective January 1, 2017.

On December 9, 2016 you spoke to NYSOH's Account Review Unit and appealed the termination of your child's Medicaid as of May 31, 2016.

On March 9, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open to allow the Hearing Officer time to review phone calls that you had with NYSOH between September 2016 and November 2016. Five phone calls were reviewed and the record was closed.

## **Findings of Fact**

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

- 1) You testified, and your NYSOH account confirms, that you received all of your notices from NYSOH by electronic mail.
- 2) Your account preferences were changed on November 30, 2016 from electronic mail notices to regular mail notices.
- 3) You testified that you did not receive any electronic alerts notifying you of any notice in your NYSOH account stating that your youngest child's eligibility was only conditional and that you needed to provide her Social Security number.

- 4) Your NYSOH account indicates that on May 2, 2016, your application was run and your youngest child was found no longer eligible for Medicaid effective May 31, 2016.
- 5) You testified that you did not know that you needed to submit your youngest child's Social Security number until September 23, 2016.
- 6) You testified, and the record confirms, that you placed a phone call to NYSOH on September 23, 2016. During that phone call, the NYSOH representative advised you that your youngest child did not have coverage because her Social Security number had not been provided. You did not have her Social Security number at that time and were unable to apply for coverage for her.
- 7) You placed a phone call to NYSOH on October 8, 2016. During that phone call, you provided NYSOH with your youngest child's Social Security number and a new application was submitted. The NYSOH representative advised you that your child did not yet have coverage because NYSOH required proof of income documentation.
- 8) On October 30, 2016, income documentation was faxed to NYSOH.
- 9) You placed a phone call to NYSOH on November 29, 2016 to ensure coverage for your youngest child was in place. The NYSOH representative advised you that your youngest child was eligible for coverage effective January 1, 2017, but that NYSOH "should be able to backdate" that coverage.
- 10) You placed a phone call to NYSOH on November 30, 2016 to the Account Review Unit. The NYSOH representative advised you that coverage could not be backdated because your youngest child's Social Security number was not timely provided, but that the prior call would be pulled for review. You were advised that a representative would call you after the call was reviewed. Your account preferences were changed from electronic mail notifications to regular mail notifications during this call.
- 11) The record confirms that you filed an appeal on December 9, 2016.
- 12) You testified that you are seeking reinstatement of her coverage effective June 1, 2016.

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 the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) 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)). However, the appeal request may be considered valid if the appellant sufficiently demonstrates that failure to timely submit was due to exceptional circumstances and should not preclude the appeal (45 CFR §155.520(b)(2)(i)(D)).

### 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 FPL for the applicable family size (42 CFR § 435.118(c); New York Department of Social Services Administrative Directive 13ADM-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 2016 FPL, which is \$24,300.00 for a four-person household (81 Fed. Reg. 4036).

### Verification of Social Security Number

NYSOH must review an applicant's Social Security Number (SSN) when applying for Medicaid, as well as case records for those already enrolled to determine whether they contain a beneficiary's SSN, or in the case of families, each family member's SSN. If the case record does not contain the required SSN's, the agency must require the beneficiary to furnish them (42 CFR §§ 435.910, 435.920 (a)(b)).

### Electronic Notices

Applicants may choose to receive notices and information from NYSOH either by electronic alerts or by regular mail. If the applicant elects to receive electronic

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).

notices, NYSOH must send an email or other electronic communication alerting the individual that a notice has been posted to the applicant's account (42 CFR § 600.330(e); 42 CFR § 435.918(b)(4)).

Additionally, if an electronic alert regarding a notice in an individual's NYSOH account fails, NYSOH must send out the notice by regular mail within three days of the failed alert (42 CFR § 435.918(b)(5)).

## **Legal Analysis**

The first issue is whether your appeal of NYSOH's May 3, 2016 eligibility determination notice and May 3, 2016 disenrollment notice was timely.

On December 9, 2016, you filed an appeal to dispute the start date of your youngest child's eligibility for and disenrollment in Medicaid as stated in the May 3, 2016 eligibility determination and May 3, 2016 disenrollment notices.

Individual applicants and enrollees must request a hearing 60 days from the date of their notice of eligibility determination by NYSOH. However, the appeal request may be considered valid if the appellant sufficiently demonstrates that failure to timely submit the request was due to exceptional circumstances and should not preclude the appeal.

You credibly testified that you did not appeal the start date of your youngest child's Medicaid disenrollment prior to December 9, 2016 because you were first aware of her disenrollment on September 23, 2016, and had tried to correct her enrollment via telephone calls first. The record confirms that you called NYSOH on September 23, 2016 and October 8, 2016. When this was not successful, you then filed an appeal with NYSOH.

Therefore, NYSOH Appeals Unit will consider your appeal timely since you had contacted NYSOH regarding your youngest child's eligibility within 60 days of knowledge of her disenrollment.

The second issue under review is whether NYSOH properly determined that your youngest child's Medicaid coverage ended as of May 31, 2016.

NYSOH must verify that individuals applying for coverage have a valid Social Security number and citizenship status. If NYSOH is unable to verify this information, they must send notice to the individual alerting them of any inconsistencies in their account and allowing them sufficient time to submit documentation to resolve the inconsistency.

On January 21, 2016 NYSOH issued a notice of eligibility determination stating your youngest child ,was conditionally eligible for Medicaid effective February 1,

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).

2016. Her eligibility was based on the condition she provide proof of her citizenship status and Social Security number by April 19, 2016.

You did not submit any additional information to confirm your youngest child's Social Security number and citizenship status prior to April 19, 2016.

On May 3, 2016, NYSOH issued an eligibility redetermination notice stating that your youngest child was no longer eligible for Medicaid because you did not provide the information to confirm her citizenship status and Social Security number. She was subsequently disenrolled from her Medicaid Managed Care plan effective May 31, 2016.

However, you testified that you had initially elected to receive alerts regarding notices from NYSOH electronically. You credibly testified that you did not receive an electronic alert regarding the eligibility determination notice, which advised you that your youngest child's eligibility was only conditional and that you needed to submit documentation to confirm your income. There is also no evidence in your account documenting that any email alert was sent to you regarding the need to submit documentation, nor is there any evidence that the notice was sent to you by regular mail.

Therefore, it is concluded that NYSOH did not give you the proper notice that you needed to submit your youngest child's Social Security number in order to confirm her Medicaid eligibility, nor did NYSOH give you proper notice regarding her disenrollment.

Since you were not made aware of and did not receive proper notice that there was an inconsistency in your NYSOH account, the May 3, 2016 eligibility determination and May 3, 2016 disenrollment notices, stating that your youngest child was no longer eligible for Medicaid because you failed to submit her Social Security number are RESCINDED.

Your case is RETURNED to NYSOH to reinstate your youngest child's Medicaid coverage as of June 1, 2016 and continuing until December 30, 2016.

## **Decision**

The May 3, 2016 notice of eligibility determination is RESCINDED.

The May 3, 2016 notice of disenrollment is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your youngest child's Medicaid coverage as of June 1, 2016 and continuing until December 30, 2016.

**Effective Date of this Decision:** March 31, 2017

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).



## **How this Decision Affects Your Eligibility**

NYSOH erred in terminating your youngest child's Medicaid effective May 31, 2016, without the proper notice.

Your case is being sent back to NYSOH to reinstate your youngest child's Medicaid coverage as of June 1, 2016 and continuing until December 30, 2016.

Your youngest child is eligible for and enrolled in Child Health Plus, effective January 1, 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

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).

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 May 3, 2016 notice of eligibility determination is RESCINDED.

The May 3, 2016 notice of disenrollment is RESCINDED.

NYSOH erred in terminating your youngest child's Medicaid effective May 31, 2016, without the proper notice.

Your case is RETURNED to NYSOH to reinstate your youngest child's Medicaid coverage as of June 1, 2016 and continuing until December 30, 2016.

Your youngest child is eligible for and enrolled in Child Health Plus, effective January 1, 2017

.

### **Legal Authority**

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

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



## 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 مجاناً.

### **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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. y&b&tumi ama wo obi a okyer& kasa a woka no ase ama wo kwa a wontua hwee.

## **(Urdu) اردو**

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.

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).