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

Notice of Decision

Decision Date: May 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014783

[redacted]

Dear [redacted]

On April 17, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's alleged failure to issue a timely determination on your eligibility for Medicaid.

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: May 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014783

[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 issue you a timely eligibility determination based on your October 26, 2016 application?

Procedural History

On March 24, 2016, NYSOH issued an eligibility determination notice stating that you and your child were eligible for Medicaid, effective March 1, 2016.

On March 29, 2016, NYSOH issued an enrollment notice confirming your selection of Fidelis Care as you and your child's Medicaid Managed Care (MMC) plan as of March 28, 2016. The notice stated that your MMC plan coverage would begin effective May 1, 2016, and that you son's coverage had begun as of January 1, 2016.

On October 10, 2016, NYSOH issued a renewal and eligibility determination notice based on information about you from state and federal data sources as of September 29, 2016. The notice stated that you and your child had qualified for of up to $301.23 per month in advance payments of the premium tax credit (APTC). The notice also stated that you and your child were no longer eligible for Medicaid. This eligibility determination was effective December 1, 2016.

On October 17, 2016, NYSOH issued a disenrollment notice confirming that you and your child's MMC plan coverage would end effective November 30, 2016.

On October 26, 2016, NYSOH received an update to your application for health insurance in which you attested to an expected yearly income of $18,200.00.

On October 27, 2016, NYSOH issued a notice confirming receipt of your October 26, 2016 application. The notice stated that the information contained in your application did not match what NYSOH received from state and federal data sources, and that more information was needed to confirm the information in your application. You were requested to provide income documentation for you and your son by November 10, 2016.

On October 28, 2016, NYSOH received (1) two earnings statements issued to you by your employer, the [redacted], on October 13, 2016 and October 27, 2016 and (2) two earnings statements issued to your child by his employer, [redacted], on October 13, 2016 and October 27, 2016.

On November 10, 2016, NYSOH issued a notice stating that the documentation you provided does not confirm the information in your application. You were requested to send in additional income documentation for you and your child by November 25, 2016.

You subsequently sent in several additional earnings statements; however, in each case, NYSOH issued notices stating the documentation you provided does not confirm the information in your application.

Also on January 11, 2017, you contacted NYSOH's Account Review Unit and requested an appeal insofar NYSOH failed to issue you a timely eligibility determination based on your October 26, 2016 application

On February 7, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan (QHP) at full cost, effective March 1, 2017. The notice also stated that your child was eligible for Medicaid, effective February 1, 2017.

Also on February 7, 2017, NYSOH issued an enrollment notice confirming that your child's enrollment in an MMC as of February 6, 2017. The notice stated that your child's MMC plan coverage would begin effective March 1, 2017.

On April 17, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Your insurance broker, [redacted], also attended the hearing as your witness. 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) You expect to file your 2016 federal income tax return as single and claim your child as a dependent.

2) You testified that you are appealing only your own eligibility, since your child had subsequently been found eligible for Medicaid, effective February 1, 2017.

3) You had been enrolled in Medicaid during 2016, and were enrolled in an MMC plan effective May 1, 2016.

4) On October 10, 2016, you were found eligible for an APTC of up to $301.23 per month beginning December 1, 2016, as the result of an annual eligibility redetermination.

5) You MMC plan coverage with Fidelis Care was terminated effective November 30, 2016.

6) On October 26, 2016, you revised your application for health insurance, in which you attested to an annual household income of $18,200.00, which was comprised of $700.00 you receive from your employer, the [redacted], once every two weeks, and $1,000.00 your child received from [redacted]. You clarified during the hearing that your child's employer was [redacted], and that his income is received from the [redacted]

7) You live in Livingston County, New York.

8) On October 28, 2016, in response to NYSOH's request for additional income documents, you provided earnings statements reflecting that you received (1) $680.40 on October 13, 2016 and (2) $641.90 on October 27, 2016.

9) On October 28, 2016, you also provided income documents, reflecting that you child received (1) $273.00 on October 13, 2016 and (2) $214.50 on October 27, 2016.

10) While your child was eventually found eligible for Medicaid effective February 1, 2016, you testified that you had not been found eligible for Medicaid even after having provided the requested income documentation. You further testified that you were continuously provided additional income documentation, only to be told the documents were insufficient or too old.

11) You testified that you were seeking for your Medicaid coverage be reinstated.

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

Applicable Law and Regulations

Verification Process

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income (45 CFR § 155.320(c)(1)(i)). If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR § 155.315(f)).

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)).

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).

Medicaid for Adults between the Ages of 19 and 65

Medicaid can be provided through NYSOH 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 (MAGI) that is at or below 138% of the federal poverty level (FPL) for the applicable family size (42 CFR §§ 435.119(b), 435.911(b)(1), 435.603(d)(4); NY Social Services Law § 366(1)(b)).

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).

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 $16,020.00 for a two-person household (81 Federal Register 4036).

Medicaid Start Dates

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

Medicaid Managed Care plan enrollments received on or before the fifteenth day of the month are effective the first day of the following month. Enrollments received after the fifteenth day of the month are effective the first day of the second following month (Medicaid Managed Care Model Contract (Appendix H-6(b)(ii) & (iii), effective 3/1/2014 – 2/28/2019; *see* 42 USC § 1315; § 364-j(1)(c); 18 NYCRR § 360-10.3(h), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

Legal Analysis

The issue under review is whether NYSOH failed to issue you a timely eligibility determination based on your October 26, 2016 application.

For all individuals whose income is needed to calculate the 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 including giving the applicant the opportunity to submit satisfactory documentary evidence.

Your record reflects that you updated your application on October 26, 2016, in which you attested to a household income of $18,200.00, which was comprised of which was comprised of $700.00 you receive from your employer, the [redacted], once every two weeks, and $1,000.00 your child received from [redacted] You clarified during the hearing that your child's employer was [redacted], and that his income is received from the [redacted] as a [redacted].

On October 27, 2016, NYSOH issued a notice requesting you submit income documentation for you and your child by November 10, 2017, to confirm your eligibility because the income information you provided did not match what NYSOH had obtained from State and Federal data sources.

On October 28, 2016, you uploaded to your NYSOH account earnings statements reflecting that you received (1) $680.40 on October 13, 2016 and (2) $641.90 on October 27, 2016, and earning statement reflecting that your child received (1) $273.00 on October 13, 2016 and (2) $214.50 on October 27, 2016.

Therefore, your application is considered to have been complete as of October 28, 2016 for purposes of issuing an eligibility determination.

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the completed application. To assess whether an eligibility determination was untimely, NYSOH must base the time period from the date of the completed application to the date NYSOH notifies the applicant of its decision.

In response to the documentation you provided, NYSOH continued to issue notices requesting additional income documentation. We find, however, that you provided sufficient income documentation to render an eligibility determination as of October 28, 2016.

Accordingly, we find that NYSOH erred in not issuing you an eligibility determination within 45 days after you had provided the requested income documentation.

You are in a two-person household, since you anticipate filing your 2016 tax return as head of household, and claiming your child as your sole dependent.

The credible evidence of record reflects that during the month of October 2016, you had a total household income of $1,809.60.

Accordingly, your case is RETURNED to (1) redetermine your eligibility as of October 28, 2016, based on a two-person household in Livingston County, with an annual household income of $18,200.00, and a monthly income of $1,809.60 during October 2016, (2) facilitate your enrollment in a plan as of October 28, 2016.

Decision

NYSOH erred in not issuing you an eligibility determination within 45 days after you had provided the requested income documentation.

Your case is RETURNED to (1) redetermine your eligibility as of October 28, 2016, based on a two-person household in Livingston County, with an annual household income of $18,200.00, and a monthly income of $1,809.60 during October 2016, (2) facilitate your enrollment in a plan as of October 28, 2016.

Effective Date of this Decision: May 12, 2017

How this Decision Affects Your Eligibility

You will receive a new eligibility determination shortly reflecting eligibility for financial assistance as of October 28, 2016.

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

NYSOH erred in not issuing you an eligibility determination within 45 days after you had provided the requested income documentation.

Your case is RETURNED to (1) redetermine your eligibility as of October 28, 2016, based on a two-person household in Livingston County, with an annual household income of $18,200.00, and a monthly income of $1,809.60 during October 2016, (2) facilitate your enrollment in a plan as of October 28, 2016.

You will receive a new eligibility determination shortly reflecting eligibility for financial assistance as of October 28, 2016.

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।

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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 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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