



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

## Notice of Decision

Decision Date: June 28, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000016639

[REDACTED]

Dear [REDACTED],

On June 20, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's failure to issue an eligibility determination on your January 31, 2017 application.

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

## Decision

Decision Date: June 28, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000016639

[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 eligibility determination after your January 31, 2017 application?

## Procedural History

On March 3, 2016, NYSOH issued a notice of eligibility determination stating that you, your spouse, and your youngest child were eligible for Medicaid. You were subsequently enrolled into a Medicaid Managed Care (MMC) plan.

On January 6, 2017, NYSOH issued a renewal notice stating that it was time to renew your application for health insurance. The notice stated that, based on information from state and federal data sources, NYSOH could not determine whether you and your spouse and youngest child qualified for financial help with paying for your health coverage. The notice directed you to update your NYSOH application between January 16, 2017 and February 15, 2017, or the financial assistance you were currently receiving could end.

On January 31, 2017, NYSOH received your updated application for financial assistance with your health insurance.

On February 1, 2017, NYSOH issued a notice stating more information was needed to make a determination. The notice explained the income information you provided NYSOH did not match what was obtained from state and federal data sources. You were asked to submit income documentation for your

household by February 15, 2017, and proof of your youngest child's Social Security number by May 1, 2017.

That same day, NYSOH issued a disenrollment notice stating that the MMC enrollment for you, your spouse, and your youngest child was ending on February 28, 2017.

Also on February 1, 2017, you uploaded documentation to your NYSOH account.

On February 14, 2017, NYSOH issued a notice stating that the documentation that you provided had been reviewed but did not confirm the information in your application. The notice directed you to submit proof of income by March 2, 2017, and proof of your youngest child's Social Security number.

On February 17, 2017, your NYSOH account was updated.

On February 18, 2017, NYSOH issued a notice stating that more information was needed to make a determination. The notice explained the income information you provided NYSOH did not match what was obtained from state and federal data sources. You were asked to submit income documentation for your household by March 2, 2017, and proof of your youngest child's Social Security number by May 1, 2017.

On February 21, 2017, you uploaded documentation to your NYSOH account.

On March 2, 2017, NYSOH issued notice stating that the documentation that you provided had been reviewed but did not confirm the information in your application. The notice directed you to submit proof of income by March 17, 2017.

On March 6, 2017, you spoke to NYSOH's Account Review Unit and filed an appeal, insofar as you, your spouse, and your youngest child had not yet been found eligible for coverage through NYSOH. You also requested Aid to Continue, pending the outcome of your appeal.

On March 7, 2017, you updated your NYSOH account and uploaded documentation to your NYSOH account.

On March 8, 2017, NYSOH issued a notice stating that more information was needed to make a determination. The notice explained the income information you provided NYSOH did not match what was obtained from state and federal data sources. You were asked to submit income documentation by March 17, 2017.

On March 10, 2017, NYSOH issued an eligibility determination notice stating that you, your spouse, and your youngest child were eligible for Medicaid for a limited

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time, effective March 1, 2017. This was because your request for Aid to Continue pending the outcome of your appeal had been granted.

On March 11, 2017, NYSOH issued a notice of enrollment confirmation, confirming that you, your spouse, and your youngest child were enrolled in an MMC plan, beginning April 1, 2017. This was also pursuant to your request for Aid to Continue.

On June 20, 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) You testified that you are appealing for yourself, your spouse, and your youngest child to be found eligible for Medicaid and to be enrolled in an MMC plan.
- 2) According to your NYSOH account, NYSOH received your updated application for financial assistance on January 31, 2017. A determination as to your eligibility could not be made on that day because the income information in your application did not match the information from state and federal data sources, and because NYSOH needed proof of your youngest child's Social Security number.
- 3) You testified that your application update was completed with the assistance of a facilitator, and that the facilitator also uploaded some income documentation on your behalf.
- 4) On February 1, 2017, the following documentation was uploaded to your NYSOH account:
  - a. A signed letter on [REDACTED] letterhead, dated January 5, 2017, stating that you receive \$3,250.00 income monthly from them, and that you will continue to do so. The letter further stated that they do not cover medical expenses (Document [REDACTED]);
  - b. A signed letter from [REDACTED] dated January 30, 2017 that states, "[REDACTED] ( [REDACTED] ) receive \$500 monthly from me for their monthly expenses" (Document [REDACTED]).

- 5) You testified that you had submitted the same type of income documentation from your employer last year, so you did not expect there to be any problem with submitting it this year.
- 6) You testified that you found out that the documentation was considered insufficient when you received a call from your facilitator. You testified that the facilitator did not know what the problem was with the income documentation, but asked you to submit your youngest child's Social Security number, which you did.
- 7) Your NYSOH account reflects that a copy of your youngest child's Social Security card was uploaded to your NYSOH account on February 21, 2017 (Document [REDACTED]).
- 8) You testified that you called NYSOH to find out why your documentation was not sufficient, and no one could give you an answer.
- 9) Notes entered into your account by a NYSOH employee on February 13, 2017 state, "Invalid proof of income. [REDACTED] submitted letter from employer with out [sic] company name and address. Required documentation letter from employer with company name and address gross amount and frequency of pay. Refer to Acceptable Documents for additional documents. Due date extended. [REDACTED] submitted letter from employer."
- 10) Notes entered into your account by a NYSOH employee on March 1, 2017 state, "Invalid proof of income. [REDACTED] submitted an outdated letter from employer stating monthly income. [REDACTED] must submit a detailed letter from employer dated within 30 days of 2/17/2017 or more recent. Refer to acceptable documents list for additional acceptable documents. Due date extended."
- 11) You testified that NYSOH said maybe the letter regarding the money from your family was a problem, and to try removing that income. You testified that you and your facilitator subsequently tried removing this income from your application, but that did not help.
- 12) You testified that you went to another facilitator who said that there was no reason that you should not be eligible for Medicaid, and advised you to submit your tax return, which you did.
- 13) You testified that you thought everything was resolved because you received the March 11, 2017 notice confirming that you, your spouse, and your child were enrolled in an MMC plan, but that you did not know that this had to do with receiving Aid to Continue.

- 14) You testified that your income is still \$3,250.00 per month from a fellowship, and you still receive \$500.00 per month from family for expenses.
- 15) You testified that you do not understand why there was a problem when you submitted the same documentation that you did last year, and that the process was very frustrating because you called NYSOH many times, and no one could tell you what was wrong with your documentation.

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

## **Applicable Law and Regulations**

### Medicaid

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)).

MMC 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)).

### 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), 42 CFR § 435.945).

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) 42 CFR § 435.952).

### 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).

NYSOH must provide Medicaid applicants who are at least one year of age but younger than nineteen notice of their eligibility determination within 30 days of the date of the application if the household income does not exceed 138% of the federal poverty level (18 NYCRR §360-2.4(a)(3)(ii)).

## **Legal Analysis**

The issue under review is whether NYSOH failed to provide you with a timely determination of eligibility after your January 31, 2017 application for Medicaid on behalf of yourself, your spouse, and your youngest child.

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.

You updated your NYSOH account on January 31, 2017. The income amount that was entered into this application did not match federal and state data sources, but did place you, your spouse, and your youngest child into a "pending Medicaid" status. As a result, NYSOH asked that you submit additional documentation to confirm your income. You were also asked to submit proof of your youngest child's Social Security number.

On February 1, 2017, you uploaded a copy of a letter from your employer stating your monthly income, and a letter from [REDACTED] stating that she provides you with \$500.00 a month to help with living expenses. You testified during the hearing that the amount of income in the letter from your employer is your gross monthly income, and that the amount is still correct. You also testified that amount listed in the letter from [REDACTED] is still correct, and that you have no other income coming into your house.

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It appears from NYSOH's notes that the letter from [REDACTED] was incorrectly invalidated as not containing the required information for a letter from an employer. However, since it was not from an employer, this was not correct. Moreover, it appears that, on the day that this letter was invalidated (February 13, 2017), NYSOH also reviewed the letter from your employer and did not indicate that this letter was invalid. However, because no one could tell you what the problem was with the documentation that you had submitted, you re-uploaded this letter from your employer with the same date, and NYSOH then invalidated it because it was not recent enough. Had the letter been properly reviewed when it was first submitted, it would have been validated, as it contained the information necessary to verify your income.

Therefore, NYSOH incorrectly determined that the documentation you submitted on February 1, 2017 was invalid. Your application should have been considered complete as of February 21, 2017, when you provided documentation of your child's Social Security number, as this was the last piece of documentation that was outstanding.

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the completed application for adults, and within 30 days for a child between the ages of one and nineteen whose income is at or below 138% of the FPL.

As the income you provided should have resulted in a determination that you, your spouse, and your child were eligible for Medicaid, NYSOH should have issued an eligibility determination for your child no later than March 23, 2017, and for you and your spouse, no later than April 7, 2017. Since NYSOH has not issued an eligibility determination to date, the only conclusion that can be reached is that NYSOH has failed to issue a timely eligibility determination following your February 21, 2017 complete application.

Therefore, your case is RETURNED to NYSOH to issue an eligibility determination for you, your spouse, and your youngest child, based on an annual expected income of \$45,000.00 for an eight-person household residing in Queens County, utilizing an application date of February 21, 2017. NYSOH is directed to notify you in writing of your eligibility.

## **Decision**

NYSOH failed to timely issue an eligibility determination on the application for Medicaid that was filed on behalf of you, your spouse, and your youngest child, and that was complete on February 21, 2017.

Your case is RETURNED to NYSOH to determine your, your spouse's, and your youngest child's eligibility as of February 21, 2017, based on an eight-person

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household with an expected annual household income of \$45,000.00, residing in Queens County.

**Effective Date of this Decision:** June 28, 2017

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

Your application for Medicaid on behalf of yourself, your spouse, and your youngest child was complete as of February 21, 2017.

NYSOH failed to issue a timely eligibility determination on this application.

Your case is being sent back to NYSOH to determine your, your spouse's, and your youngest child's eligibility, based on an eight-person household with an annual expected income of \$45,000.00

NYSOH will notify you of your eligibility in writing.

## **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

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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 failed to timely issue an eligibility determination on the application for Medicaid that was filed on behalf of you, your spouse, and your youngest child, and that was complete on February 21, 2017.

Your case is RETURNED to NYSOH to determine your, your spouse's, and your youngest child's eligibility as of February 21, 2017, based on an eight-person household with an expected annual household income of \$45,000.00, residing in Queens County.

Your application for Medicaid on behalf of yourself, your spouse, and your youngest child was complete as of February 21, 2017.

NYSOH failed to issue a timely eligibility determination on this application.

Your case is being sent back to NYSOH to determine your, your spouse's, and your youngest child's eligibility, based on an eight-person household with an annual expected income of \$45,000.00

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NYSOH will notify you of your eligibility in writing.

## **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)

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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 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 okyerE 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.

## **שׂוֹדֵשׁ (Yiddish)**

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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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