



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

## Notice of Decision

Decision Date: July 10, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000017021

[REDACTED]

Dear [REDACTED]

On June 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 31, 2016 disenrollment 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 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: July 10, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000017021



## Issue

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

Did NY State of Health (NYSOH) properly terminate your youngest child's Medicaid Managed Care (MMC) enrollment effective November 30, 2016?

## Procedural History

On October 7, 2016, your youngest child (child) was added to your NYSOH account and an application for financial assistance was submitted on their behalf.

On October 11, 2016, NYSOH issued an eligibility determination notice stating, in relevant part, that your child was conditionally eligible for Medicaid, effective as of October 1, 2016. The notice directed you to submit additional proof of citizenship status and Social Security number (SSN) for your child by January 5, 2017.

Also on October 11, 2016, NYSOH issued a plan enrollment notice confirming that, as of October 10, 2016, your child was enrolled in a MMC plan with an enrollment start date of November 1, 2016. The notice directed you to submit additional proof of citizenship status and a SSN for your child by January 5, 2017.

On October 28, 2016, your NYSOH account was updated.

On October 29, 2016, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal

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).

data sources and more information was needed to confirm the information in your application. The notice directed you to provide proof of income by November 12, 2016, and proof of citizenship status and SSN by January 5, 2017 to confirm your child's eligibility.

On October 31, 2016, NYSOH issued a notice stating that your child's MMC would terminate effective November 30, 2016.

On November 23, 2016, NYSOH account was systematically updated.

On November 24, 2016, NYSOH issued an eligibility determination notice stating that your child was conditionally eligible to purchase a qualified health plan at full cost, effective January 1, 2017. The notice directed you to submit additional proof of citizenship status and a SSN for your child by January 5, 2017.

On December 9, 2016, your NYSOH account was updated.

On December 10, 2016, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal data sources and more information was needed to confirm the information in your application. The notice directed you to provide proof of income for your youngest child by December 16, 2016.

On December 27, 2016, your NYSOH account was systematically updated.

On December 28, 2016, NYSOH issued an eligibility determination notice stating that your child was eligible to purchase a qualified health plan at full cost, effective as of February 1, 2017.

On January 9, 2017, your NYSOH account was systematically updated.

On January 10, 2017, NYSOH issued an eligibility determination notice stating that your child was eligible for Medicaid, effective as of January 1, 2017.

On January 20, 2017, NYSOH issued a plan enrollment notice confirming that, as of January 19, 2017, your child was enrolled in a MMC plan with an enrollment start date of March 1, 2017.

On March 20, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal relative to your child's MMC plan terminating effective November 30, 2016.

On June 28, 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) According to your NYSOH account and testimony, your child was born on [REDACTED].
- 2) According to your NYSOH account, your child was added to the account on October 7, 2016.
- 3) According to your NYSOH account, your youngest child was enrolled in a MMC plan on October 10, 2016, with an enrollment start date of November 1, 2016.
- 4) On October 11, 2016, NYSOH issued a notice that your child was conditionally eligible for Medicaid. Additional proof of citizenship status and their SSN was required by January 5, 2017 to confirm their eligibility. The notice included a list of acceptable documentation, including a copy of a United States birth certificate and a government issued ID card (see Document [REDACTED]).
- 5) On November 16, 2016, your child's Social Security card was uploaded to your account (see Document [REDACTED]).
- 6) On November 16, 2016, your youngest child's Certificate of Birth was uploaded to your account (see Document [REDACTED]).
- 7) Regarding income, on October 10, 2016, you uploaded a letter from your employer, [REDACTED], stating you were on a leave of absence and your last day of work was September 16, 2016 (see Document [REDACTED]).
- 8) According to your NYSOH account, on October 18, 2016 and January 8, 2017, NYSOH verified the letter from your employer and determined it to be valid proof of no income.
- 9) On October 29, 2016, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal data sources and additional proof of income was needed by November 12, 2016 to confirm your youngest child's eligibility (see Document [REDACTED]).
- 10) You testified your child incurred approximately \$170.00 in medical bills in December 2016 that you want the MMC plan to cover.

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

## **Applicable Law and Regulations**

### Medicaid Eligibility - Children

A child who is under one year of age 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 223% of the FPL for the applicable family size. (42 CFR § 435.118(c); New York Department of Health Administrative Directive 13 OHIP/ADM-03).

### Verification Process - Income

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)).

### Verification Process - Social Security Number (SSN)

Generally, NYSOH must require as a condition of eligibility, that each individual (including children) seeking Medicaid furnish each of their SSNs (42 CFR § 435.910(a)).

NYSOH must review case records to determine whether they contain the beneficiary's SSN, or, in the case of families, each family member's SSN. If the case record does not contain the required SSNs, NYSOH must require the beneficiary to furnish them (42 CFR § 435.920(a), (b)).

### Citizenship and Immigration Status

Medicaid must be provided to otherwise eligible residents of the United States who are citizens, nationals, or qualified non-citizens who have provided satisfactory documentary evidence of their qualified non-citizen status (42 CFR § 435.406).

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).

NYSOH must electronically verify the citizenship or immigration status of each applicant (42 CFR § 435.956(a)(1), (2)). If NYSOH cannot promptly verify the citizenship or immigration status of an individual, NYSOH must provide a reasonable opportunity to resolve the inconsistency. During the reasonable opportunity period, NYSOH must continue efforts to complete the verification or request documentation, if necessary. The reasonable opportunity period begins on the date on which the notice is received by the individual. The period ends on the earlier of the date NYSOH verifies the applicant's citizenship or immigration status or 90 days after the receipt of the notice (42 CFR § 435.956(b)(1), (2)).

## Legal Analysis

The issue under review is whether NYSOH properly terminated your child's MMC plan enrollment effective November 30, 2016.

NYSOH must require as a condition of eligibility, that each individual seeking Medicaid furnish their SSN. If the case record does not contain the required SSN, NYSOH must require the beneficiary to furnish it.

Medicaid must be provided to eligible residents of the United States who are citizens, nationals, or qualified non-citizens. If NYSOH cannot promptly verify the citizenship or immigration status of an individual, NYSOH must provide the applicant with a reasonable opportunity to resolve the inconsistency. A reasonable opportunity is 90 days from the date the applicant receives notice of the inconsistency and the need for additional documentation.

On October 11, 2016, NYSOH issued notices stating that your child, a newborn, was conditionally eligible for Medicaid and enrolled in a MMC plan effective November 1, 2016. The notices directed you to submit additional proof of citizenship status and a SSN for your youngest child by January 5, 2017 (see Documents [REDACTED]).

On November 16, 2016, your child's Social Security card and U.S. Birth Certificate were uploaded to your account (see Documents [REDACTED]; [REDACTED]).

The record supports that the documentation submitted to NYSOH on November 16, 2016, was sufficient to satisfy NYSOH's request for a SSN and citizenship status documentation. Since the documentation was submitted before the January 5, 2017 deadline, your child's MMC plan should not have been terminated on that basis.

On October 28, 2016, you submitted an application for your child. In that application you attested to an annual household income of \$0.00.

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).

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.

The income information that was entered into that application did not match federal and state data sources. As a result, on October 29, 2016, NYSOH issued a notice directing you to submit additional income documentation to confirm your child's eligibility by November 12, 2016.

On October 10, 2016, you had uploaded a letter from your employer, [REDACTED], stating you were on a leave of absence and your last day of work was September 16, 2016 (see Document [REDACTED]).

The record reflects that on October 18, 2016, NYSOH determined that letter to be valid proof of no income. Furthermore, the same documentation was re-verified as sufficient proof of income on January 8, 2017.

The record supports that the documentation submitted to NYSOH on October 10, 2016, was sufficient to satisfy NYSOH's request for income documentation to confirm your child's eligibility. Moreover, all the necessary documentation was timely provided to NYSOH. Therefore, your child's MMC plan was improperly terminated, effective November 30, 2016, and the October 31, 2016 disenrollment notice is RESCINDED.

Your child's case is RETURNED to NYSOH to re-instate their coverage in their MMC plan from December 1, 2016 through February 28, 2017, and to notify you accordingly.

## **Decision**

The October 31, 2016 disenrollment notice is RESCINDED.

Your child's case is RETURNED to NYSOH to re-instate their coverage in their MMC plan from December 1, 2016 through February 28, 2017, and to notify you accordingly.

This Decision has no effect on any subsequent eligibility determination or plan enrollment notices issued by NYSOH.

**Effective Date of this Decision:** July 10, 2017



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

NYSOH improperly terminated your child's enrollment in their MMC plan effective November 30, 2016.

Your case is being sent back to NYSOH to re-instate their coverage in their MMC plan from December 1, 2016 through February 28, 2017. NYSOH will notify you once this has been done.

## **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 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).

## **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 October 31, 2016 disenrollment notice is **RESCINDED**.

Your child's case is **RETURNED** to NYSOH to re-instate their coverage in their MMC plan from December 1, 2016 through February 28, 2017, and to notify you accordingly.

This Decision has no effect on any subsequent eligibility determination or plan enrollment notices issued by NYSOH.

NYSOH improperly terminated your youngest child's enrollment in their MMC plan effective November 30, 2016.

NYSOH improperly terminated your child's enrollment in their MMC plan effective November 30, 2016.

Your case is being sent back to NYSOH to re-instate their coverage in their MMC plan from December 1, 2016 through February 28, 2017. NYSOH will notify you once this has been done.

## **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)

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).

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।

### **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 नि:शुल्क 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 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye bɛtumi ama wo obi a okyerɛ 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 איר געבן א דאלמענטשער 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).

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).