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

Notice of Decision

Decision Date: November 20, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020970

[redacted]

Dear [redacted],

On October 16, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 22, 2017 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 NY State of Health 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: November 20, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020970

[redacted]

Issue

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

> Did NY State of Health (NYSOH) properly determined you were no longer eligible to enroll in a Medicaid Managed Care plan, effective August 31, 2017?

Procedural History

On September 16, 2016, NYSOH issued a notice stating you were eligible for Medicaid, effective September 1, 2016. You enrolled into a Medicaid Managed Care plan, effective October 1, 2016.

On July 2, 2017, NYSOH issued a notice stating it was time to renew your coverage for the 2017 coverage year. The notice indicated that based on information from state and federal data sources, NYSOH was unable to determine whether you qualified for financial help paying for your health coverage. You were directed to update your account by August 15, 2017 or you might lose the financial assistance you were currently receiving.

On July 21, 2017, NYSOH received an updated application for financial assistance with health insurance, submitted on your behalf.

On July 22, 2017, NYSOH issued a notice stating the income information in your application did not match the information received from state and federal data sources. The notice directed you to submit proof of your income before August 5,

2017 or NYSOH would be unable to determined your eligibility for health coverage.

Also on July 22, 2017, NYSOH issued a disenrollment notice stating your Medicaid Managed Care plan coverage would end, effective August 31, 2017, because you were no longer eligible to enroll in the plan.

On July 25, 2017, NYSOH issued a notice, based on your July 24, 2017 updated application, stating the income information in your application did not match the information received from state and federal data sources. The notice directed you to submit proof of your income before August 5, 2017 or NYSOH would be unable to determined your eligibility for health coverage.

On July 31, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were no longer eligible for Medicaid.

On August 3, 2017 and August 23, 2017, NYSOH issued notices indicating that the documentation you submitted was insufficient to confirm the income information in your application. You were directed to submit additional income documentation.

On September 30, 2017, NYSOH issued an eligibility determination notice, based on a September 29, 2017 systematic eligibility redetermination, stating you were eligible to purchase a qualified health plan at full cost, effective November 1, 2017. The notice indicated that you were not eligible to receive financial assistance, because NYSOH did not receive the income documentation needed to verify the information in your application.

On October 16, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to allow you to submit supporting documentation. On October 20, 2017, NYSOH received the requested documentation which was marked as Appellant's Exhibit 1 and incorporated into the record. The record closed thereafter.

Findings of Fact

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

1) You were determined eligible for Medicaid, effective September 1, 2016 and you enrolled into a Medicaid Managed Care plan.

2) You were due to renew your health coverage by August 15, 2017 for the 2017 coverage year.

3) On July 21, 2017, NYSOH received an updated application submitted on your behalf. That application contained the same income information as the prior application listing your weekly income as $310.00.

4) According to your account, NYSOH was unable to verify the income information listed in your July 21, 2017 application.

5) You were directed to submit documentation of your income by August 5, 2017 and disenrolled from your Medicaid Managed Care plan, effective August 31, 2017.

6) You testified that you submitted a letter from your employer, but you were later advised by a NYSOH representative that the letter had not been received, so you resubmitted the same document.

7) According to your account, on August 1, 2017, NYSOH received a letter from your employer, dated July 24, 2017, stating you had been working for the employer since April 2016. The notice further stated you were a “part-time/seasonal” employee and that you earned $13.00 per hour.

8) According to your account, NYSOH invalidated your employer letter, because it did not state the number of hours worked.

9) NYSOH issued a notice on August 3, 2017 indicating the income documentation received was insufficient and directing you to submit additional documentation of your income.

10) You testified that you do not recall whether you received the August 3, 2017 notice.

11) Your account confirms that the August 3, 2017 notice was addressed to the same mailing address listed in your account and there is no record of any notices issued to you by NYSOH being returned as undeliverable.

12) On August 21, 2017, a copy of the same employer letter was uploaded to your NYSOH account.

13) On September 29, 2017 NYSOH systematically redetermined your eligibility and found you ineligible for financial assistance on the grounds you failed to submit sufficient documentation of your income.

14) You did not enroll in a health plan following that determination.

15) You testified, and your account confirms, you have not been enrolled in health coverage since August 31, 2017.

16) You testified that you are seeking reinstatement into your Medicaid Managed Care plan.

17) You testified that you are a “seasonal” worker. You testified that you work for [redacted] and you work full-time hours in the summer, but you work fewer hours in the winter time. You testified that you are paid weekly.

18) You testified that you submitted a letter from your employer, because your paystubs were not representative of your average weekly income, because you were currently working more hours than you do in the winter.

19) You testified that you received a $1.00 an hour raise in 2017 so your income in 2017 will be more than it was in 2016.

20) At the hearing, you were directed to submit your four most recent weekly paystubs. On October 25, 2017, copies of the following weekly paystubs were uploaded to your account:

    a. Pay date of September 22, 2017 in the gross amount of $701.70.

    b. Pay date of September 29, 2017 in the gross amount of $714.98.

    c. Pay date of October 6, 2017 in the gross amount of $901.05.

    d. Pay date of October 13, 2017, for the pay period ending October 8, 2017, in the gross amount of $681.68 with a year-to-date amount of $25,999.26.

21) Your applications indicate you will file your 2017 tax return with a tax filing status of single and you will claim no dependents.

22) Your applications indicate you reside in Bronx County.

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

Applicable Law and Regulations

Medicaid Renewal

In general, NYSOH must review Medicaid eligibility once every 12 months or “whenever it receives information about a change in a beneficiary’s circumstances that may affect eligibility” (42 CFR § 435.916(a)(1), (d)). NYSOH must make its “redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the

individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency" (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates that may have been provided by the individual (45 CFR §155.335(h)).

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).

Legal Analysis

The issue is whether NYSOH properly determined you were no longer eligible to enroll in a Medicaid Managed Care plan, effective August 31, 2017.

You were determined eligible for Medicaid, effective September 1, 2017 and you enrolled into a Medicaid Managed Care plan.

Pursuant to the regulations, NYSOH must review Medicaid eligibility once every 12 months or "whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility." NYSOH must make its "redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency."

According to your account, you were due to renew your health coverage by August 15, 2017 for the upcoming coverage year. Although, your account confirms that you timely updated your application on July 21, 2017, it also confirms that NYSOH was unable to verify the income information listed in that 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 it must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence. The notice issued on July 22, 2017 indicated that the income information in your application did not match the information received from state and federal data sources. That notice directed you to submit proof of your income by August 5, 2017 or NYSOH would be unable to determined your eligibility for health coverage.

Although your account confirms that on August 1, 2017, NYSOH received a letter from your employer stating that you were a "part-time/seasonal" employee and that you earned $13.00 per hour, that letter was invalidated by NYSOH because it did not state the number of hours worked. The Appeals Unit finds that NYSOH properly invalidated the employer letter, because it did not contain sufficient information to verify your income.

Since the record establishes that NYSOH was without sufficient information to confirm the attestations in your July 21, 2017 application, the resulting July 24, 2017 disenrollment notice stating that your enrollment in your Medicaid Managed Care plan would end on August 31, 2017, because you were no longer eligible to enroll in that plan, was correct and is AFFIRMED.

It is noted that, since the hearing, NYSOH has received additional documentation of your income in the form of four weekly paystubs. You testified that the gross weekly income in the paystubs submitted were not representative of your average weekly income, because you were currently working more hours than you did in the winter time.

You requested that your annual income be calculated based on the year-to-date income amount listed in your paystubs which would account for income received since January 1, 2017, which would include several winter months during which you worked fewer hours.

Based on the year-to-date gross income amount of $25,999.26, listed in the October 13, 2017 paystub for the pay period ending October 8, 2017, it is concluded that your average weekly gross income for the first 40 weeks of 2017 was $649.98. This would amount to an annual income of $33,799.04.

As discussed above, using your year-to-date income rather than the average weekly income in the paystubs provided accounts for income fluctuations occurring throughout the first 40 weeks of 2017. It is concluded that this is the most accurate calculation of your annual income given your testimony of seasonal income fluctuations as well as testimony that your income in 2016 is not

representative of your income in 2017 and your previous year's tax return is insufficient documentation of your current income.

Therefore, your case is RETURNED to NYSOH to redetermine your current eligibility for financial assistance with health insurance based on the now developed record, based on estimated gross annual income for 2017 of $33,799.04 for a one-person household in Bronx County.

Decision

The July 22, 2017 disenrollment notice is AFFIRMED.

However, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance with health insurance based on the now developed record, based on estimated gross annual income for 2017 of $33,799.04 for a one-person household in Bronx County.

Effective Date of this Decision: November 20, 2017

How this Decision Affects Your Eligibility

Your Medicaid Managed Care plan coverage ended August 31, 2017.

Your case is being sent back to NYSOH to redetermine your current eligibility for financial assistance based on recently submitted income documentation.

You will receive an updated determination of your eligibility going forward.

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

The July 22, 2017 disenrollment notice is AFFIRMED.

However, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance with health insurance based on the now developed record, based on estimated gross annual income for 2017 of $33,799.04 for a one-person household in Bronx County.

Your Medicaid Managed Care plan coverage ended August 31, 2017.

Your case is being sent back to NYSOH to redetermine your current eligibility for financial assistance based on recently submitted income documentation.

You will receive an updated determination of your eligibility going forward.

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 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 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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