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

Notice of Decision

Decision Date: February 15, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025452

[redacted]

[redacted]

On February 9, 2018, you and your authorized representative appeared by telephone at a hearing on your appeal of NY State of Health's November 16, 2017 eligibility determination notice and November 16, 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 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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Decision

Decision Date: February 15, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025452

[redacted]

[redacted]

Issue

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

> Did NY State of Health (NYSOH) properly determine that you and your spouse were no longer eligible for health insurance through NYSOH effective December 1, 2017 and disenrolled from your Medicaid and Medicaid Managed Care plan effective November 30, 2017?

Procedural History

On October 23, 2016, NYSOH issued a notice of eligibility determination stating that you and your spouse were eligible for Medicaid effective December 1, 2016.

Also on October 23, 2016, NYSOH issued a notice of enrollment confirmation stating that you and your spouse were enrolled in a Medicaid Managed Care plan.

On September 21, 2017, NYSOH issued a notice that it was time to renew your and your spouse's health insurance. That notice stated that, based on information from federal and state sources, NYSOH could not make a decision about whether you and your spouse would qualify for financial help paying for your health coverage, and that you needed to update your account by November

15, 2017 or you and your spouse might lose the coverage and financial assistance you were receiving.

On October 21, 2017, you updated your application for financial assistance.

On October 22, 2017, NYSOH issued a notice of eligibility determination stating that you and your spouse were conditionally eligible for Medicaid, effective December 1, 2017. This notice directed you to submit proof of your household's income by November 5, 2017 to confirm your and your spouse's eligibility for financial assistance.

Also on October 22, 2017, NYSOH issued a notice of enrollment confirmation stating that you and your spouse were enrolled in a Medicaid Managed Care plan.

On November 1, 2017, you updated your application for financial assistance.

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

On November 2, 2017, NYSOH issued a notice of eligibility determination stating that you and your spouse remained conditionally eligible for Medicaid, effective December 1, 2017. This notice directed you to submit proof of your household's income by November 5, 2017 in order to confirm your and your spouse's eligibility for financial assistance.

On November 2, 2017, NYSOH issued a notice of enrollment confirmation stating that you and your spouse were enrolled in a Medicaid Managed Care plan.

On November 2, 2017, NYSOH reviewed the income documents you uploaded on November 1, 2017 and referred the documents for translation as some of the documents you submitted were [redacted]

On November 15, 2017, NYSOH redetermined your eligibility for financial assistance.

On November 16, 2017, NYSOH issued a notice of eligibility determination stating that that you and your spouse were no longer eligible for health insurance through NYSOH, effective December 1, 2017. This was because NYSOH did not receive the income documentation needed to verify the income listed in your application.

On November 16, 2017, NYSOH issued a disenrollment notice stating that your and your spouse's coverage in your Medicaid and Medicaid Managed Care plan would end on November 30, 2017. This was because you and your spouse were no longer eligible to enroll in health insurance through NYSOH.

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On December 6, 2017, you spoke to NYSOH's Account Review Unit and appealed the termination of your and your spouse's Medicaid and Medicaid Managed Care plan as of November 30, 2017.

On January 10, 2018, you updated your application for financial assistance.

On January 11, 2018, NYSOH issued a notice stating that the income information in your application did not match what NYSOH had received from state and federal data sources and that additional information was needed to determine your and your spouse's eligibility for financial assistance. This notice directed you to submit proof of your household income by January 25, 2018.

On January 24, 2018, you updated your application for financial assistance.

On January 25, 2018, NYSOH issued a notice stating that the income information in your application did not match what NYSOH had received from state and federal data sources and that additional information was needed to determine your and your spouse's eligibility for financial assistance. This notice directed you to submit proof of your household income by March 11, 2018.

On February 9, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, [redacted] acted as your authorized representative. [redacted] translated. 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) Your authorized representative testified that on or around October 21, 2017, you updated your application for insurance and were advised at that time that you would need to submit documentation of your household income.

2) Your authorized representative testified, and the record reflects, that you have elected to receive all of your notices from NYSOH via electronic alert.

3) Your authorized representative testified that you received e-mail alerts regarding the October 22, 2017 eligibility determination and the November 2, 2017 eligibility determination which directed you to submit proof of your household income.

4) On November 1, 2017 you uploaded income documents to your NYSOH account [redacted] The documents that you submitted were in Chinese with an English translation attached.

5) Your authorized representative testified that the documents you uploaded on November 1, 2017 included an English translation by a Chinese government official.

6) On November 2, 2017, an NYSOH representative reviewed the documentation you uploaded on November 1, 2017 and noted that a portion of the submission was in Chinese. NYSOH then forwarded the documents for translation. To date, there is no indication that NYSOH has either verified or invalidated these documents.

7) You testified that you have never received any correspondence from NYSOH indicating that the income documentation you submitted on November 1, 2017 was insufficient.

8) There is no notice in your NYSOH account advising you that the income documentation you submitted on November 1, 2017 was insufficient proof of your household income.

9) On November 15, 2017, NYSOH redetermined your and your spouse's eligibility for financial assistance. As a result, you and your spouse were determined ineligible for health insurance through NYSOH, effective December 1, 2017.

10) Your authorized representative testified that you and your spouse did not have any income for several years, so you did not have to file a tax return.

11) Your authorized representative testified that beginning in 2017 you and your spouse began receiving a pension [redacted] and that you and your spouse had filed a tax return for 2017.

12) Your authorized representative testified that you and your spouse filed your 2017 tax return as married filing jointly and claimed no dependents on that tax return.

13) Your authorized representative testified that your income consists of a pension of [redacted] which, based on current exchange rates, is $575.00 per month.

14) Your authorized representative testified that your spouse's income consists of a pension of [redacted] per month which, based on current exchange rates, is $770.00 per month.

15) Your authorized representative testified that you and your spouse will continue to receive the same pension amount each month in 2018, however, the effective amount in U.S. dollars may change based on exchange rates.

16) Your authorized representative testified that you and your spouse reside in Saratoga County.

17) On January 24, 2018, you uploaded a copy of your 2017 1040 to your NYSOH account which indicates that you and your spouse had total income of $16,140.00 in 2017.

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 twelve 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 provided by the individual (45 CFR §155.335(h)).

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)).

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)).

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)).

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).

Legal Analysis

The issue under review is whether NYSOH properly determined that you and your spouse were no longer eligible for health insurance through NYSOH effective December 1, 2017 and disenrolled from your Medicaid and Medicaid Managed Care plan effective November 30, 2017.

You and your spouse were found eligible for Medicaid effective December 1, 2016.

Generally, NYSOH must redetermine a qualified individual's eligibility for Medicaid once every 12 months 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. NYSOH's September 21, 2017 renewal notice stated that there was not enough information to determine whether you and your spouse were eligible to continue your financial assistance for health insurance, and that you needed to supply additional information by November 15, 2017, or your and your spouse's financial assistance might end.

You updated your NYSOH account on October 21, 2017 and November 1, 2017. The income amount that was entered into this application did not match federal and state data sources. As a result, NYSOH found you and your spouse conditionally eligible for Medicaid and directed you to submit additional documentation to confirm your household income.

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.

On November 1, 2017, you uploaded income documentation to your NYSOH account. On November 2, 2017, an NYSOH representative reviewed this documentation. As a portion of this documentation was [redacted], NYSOH sent this documentation to be translated. NYSOH has never verified or invalidated this documentation.

On November 15, 2017, NYSOH redetermined your and your spouse's eligibility for financial assistance and determined that you and your spouse were no longer eligible for coverage through NYSOH as you had failed to submit income documentation by the deadline.

However, the record reflects that you had submitted income documentation prior to the November 5, 2017 deadline, and it was the delay by NYSOH in verifying or invalidating this documentation that resulted in you and your spouse being found ineligible for and disenrolled from your Medicaid and Medicaid Managed Care plans.

Therefore, the November 16, 2017 eligibility determination notice and the November 16, 2017 disenrollment notice are RESCINDED.

You have subsequently provided sufficient documentation of your household income as well as testimony confirming the information in the documentation you submitted.

Therefore, your case is RETURNED to NYSOH to reinstate you and your spouse into Medicaid and your Medicaid Managed Care plan as of December 1, 2017. NYSOH is directed to update your and your spouse's eligibility based on a household of two residing in Saratoga County with an annual expected income of $16,140.00.

Decision

The November 16, 2017 eligibility determination notice is RESCINDED.

The November 16, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you and your spouse into Medicaid and your Medicaid Managed Care plan as of December 1, 2017. You have subsequently provided sufficient documentation of your household income as well as testimony confirming the information in the documentation you submitted. NYSOH is directed to update your and your spouse's eligibility based on a household of two residing in Saratoga County with an annual expected income of $16,140.00.

Effective Date of this Decision: February 15, 2018

How this Decision Affects Your Eligibility

You and your spouse are being reinstated into your Medicaid and Medicaid Managed Care plan as of December 1, 2017 as NYSOH failed to timely verify or invalidate the income documentation you submitted.

As you have now submitted sufficient proof of your household income, your case is being sent back to NYSOH to redetermine your and your spouse's eligibility based on this documentation and the testimony you provided at your hearing.

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.

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).

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

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).

The November 16, 2017 eligibility determination notice is RESCINDED.

The November 16, 2017 disenrollment notice is RESCINDED.
You and your spouse are being reinstated into your Medicaid and Medicaid Managed Care plan as of December 1, 2017 as NYSOH failed to timely verify or invalidate the income documentation you submitted.

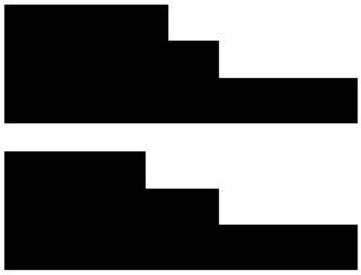
As you have now submitted sufficient proof of your household income, your case is being sent back to NYSOH to redetermine your and your spouse's eligibility based on this documentation and the testimony you provided at your hearing.

Your case is RETURNED to NYSOH to reinstate you and your spouse into Medicaid and your Medicaid Managed Care plan as of December 1, 2017 and to redetermine your and your spouse's eligibility based on a household of two residing in Saratoga County with an annual expected income of $16,140.00.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



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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।

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 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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