



STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: March 14, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025566

[REDACTED]

Dear [REDACTED],

On February 22, 2018, you and your Authorized Representative, [REDACTED], appeared by telephone at a hearing on your appeal of NY State of Health's alleged failure to issue a timely Medicaid eligibility determination from your August 8, 2017, September 18, 2017, and December 8, 2017 applications.

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
PO 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(b).

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: March 14, 2018

NY State of Health Account ID: [REDACTED]
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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 a timely Medicaid eligibility determination for your household from your August 8, 2017, September 18, 2017, and December 8, 2017 applications?

Procedural History

On August 15, 2015, NYSOH issued a disenrollment notice stating that your silver-level qualified health plan (QHP) was ending effective January 1, 2015 for non-payment of premiums.

On August 8, 2017, NYSOH received an application for financial assistance with health insurance.

On August 9, 2017, NYSOH issued a notice stating that the information contained in your application did not match information NYSOH received from state and federal sources. The notice further stated that additional documentation was needed to confirm the information in your application. You were requested to provide income documentation to NYSOH by August 23, 2017 so that an appropriate eligibility determination could be issued.

On September 3, 2017, NYSOH redetermined your eligibility for financial assistance with health insurance.

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On September 4, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan (QHP) at full cost, effective October 1, 2017. You were found not eligible for Medicaid because NYSOH did not receive the requested information to verify your income by the due date.

On September 18, 2017, NYSOH received an update to your application for financial assistance with health insurance.

On September 19, 2017, NYSOH issued a notice stating that the information contained in your application did not match information NYSOH received from state and federal sources. The notice further stated that additional documentation was needed to confirm the information in your application. You were requested to provide income documentation to NYSOH by October 3, 2017 so that an appropriate eligibility determination could be issued.

On October 13, 2017, NYSOH redetermined your eligibility for financial assistance with health insurance.

On October 14, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan (QHP) at full cost, effective November 1, 2017. You were found not eligible for Medicaid because NYSOH did not receive the requested information to verify your income by the due date.

On December 1, 2017, NYSOH received (1) several receipts and invoices for [REDACTED] received and [REDACTED] during August 2017 and (2) a hand-written note reflecting your income and expenses during the months of January through July 2017, which also reflected that your [REDACTED] was sustained on [REDACTED], and that you did not receive any additional income between July 17, 2017 and August 6, 2017.

On December 4, 2017, NYSOH received (1) a duplicate copy of your handwritten note reflecting your income and expenses during the months of July and August 2017, and (2) three statements of account issued to you by [REDACTED] between January 31, 2017 and April 30, 2017.

On December 7, 2017, NYSOH received (1) duplicate copies of statements of account issued to you by [REDACTED] between January 31, 2017 and April 30, 2017, and (2) additional copies of receipts and invoices for [REDACTED] received and [REDACTED] during August 2017.

On December 12, 2017, NYSOH received additional statements of account issued to you by [REDACTED].

Between December 13, 2017 and December 16, 2017, NYSOH received (1) a letter from you in support of your application for Medicaid, (2) duplicate copies of

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receipts and invoices for [REDACTED] received and [REDACTED] during August 2017, and (3) duplicate copies of invoices issued to you by [REDACTED]

On December 8, 2017, NYSOH received an update to your application for financial assistance with health insurance. In response to this application, NYSOH prepared a preliminary eligibility determination stating that the information you provided in your application did not match information NYSOH received from state and federal sources, and that NYSOH would not be able to make an eligibility determination without additional documentation.

Also on December 8, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you had not been found eligible for Medicaid, specifically for the month of August 2017.

On December 9, 2017, NYSOH issued a notice stating that the information contained in your application did not match information NYSOH received from state and federal sources. The notice further stated that additional documentation was needed to confirm the information in your application. You were requested to provide income documentation to NYSOH by December 23, 2017 so that an appropriate eligibility determination could be issued.

On February 21, 2017, NYSOH received (1) a copy of your income tax return for 2016, reflecting an adjusted gross income of \$6,038.00, and (2) a record of calls made from your [REDACTED] reflecting that several calls had been made to NYSOH.

On February 22, 2017, you and your Authorized Representative 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 support the following findings of fact:

- 1) You testified that you wanted [REDACTED], to act as your Authorized Representative during the hearing.
- 2) Your QHP plan coverage ended effective January 1, 2015 due to non-payment of premiums.
- 3) According to your NYSOH account, NYSOH received your initial application for financial assistance during 2017 on August 8, 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.

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- 4) You testified that you submitted your initial application on August 8, 2017, which was [REDACTED] days after you had [REDACTED] and were [REDACTED] on [REDACTED].
- 5) Your NYSOH account reflects that a notice was issued on August 9, 2017 requesting that you provide additional income documentation to NYSOH by August 23, 2017 to confirm your eligibility.
- 6) You testified that you do not have a computer and requested all notices issued by NYSOH to be sent to you by regular mail.
- 7) No notices were returned to NYSOH as undeliverable.
- 8) Your Authorized Representative stated that you did not know that you needed to provide additional income documentation, and would have requested an extension if you knew this option was available to you.
- 9) You updated your NYSOH account again on September 18, 2017.
- 10) Your NYSOH account reflects that a notice was issued on September 19, 2017 requesting that you provide additional income documentation to NYSOH by October 3, 2017 to confirm your eligibility.
- 11) Your Authorized Representative again stated that you did not know that you needed to provide additional income documentation at that time, and would have asked for an extension. She further stated that once you became aware that you need to provide additional documentation, you could not due to your [REDACTED].
- 12) You testified, and your NYSOH account reflects, that you are single, have no children, and would be filing your 2017 tax return as single, and not claiming any dependents.
- 13) Your August 8, 2017 and September 18, 2017 applications reflected that you expected annual household income for 2017 was \$18,731.00. However, you further revised your application on December 8, 2017 where you decreased your expected annual household for 2017 to be \$12,000.00. You testified that this was the result of [REDACTED] and not having received any income since July [REDACTED] 2017.
- 14) On December 1, 2017, you provided to NYSOH a hand-written note reflecting your income and expenses during the months of January through July 2017, which also reflected that [REDACTED] was sustained on [REDACTED], and that you did not receive any additional income between July 17, 2017 and August 6, 2017. This set of documents reflected that you had an income, after expenses, of \$1,525.66 during May 2017, -\$285.74 during June, and -\$955.96 during July 2017. These

documents further reflect that you received no income between July 17, 2017 and August 6, 2017.

- 15) You updated your NYSOH account again on December 8, 2017.
- 16) Your NYSOH account reflects that a notice was issued on December 9, 2017 requesting that you provide additional income documentation to NYSOH by December 23, 2017 to confirm your eligibility.
- 17) Your Authorized Representative testified that you were seeking to be found eligible for Medicaid, specifically for the month of August 2017 during which you incurred substantial [REDACTED].

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 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).

Legal Analysis

The issue under review is whether NYSOH failed to provide you with a timely determination of eligibility after your August 8, 2017, September 18, 2017 and December 8, 2017 applications for Medicaid.

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 August 8, 2017. The income amount that was entered into this application did not match federal and state data sources, but did place you into a "pending Medicaid" status. As a result, NYSOH asked that you submit additional documentation to confirm your income by August 23, 2017.

No income documentation was provided by the August 23, 2017 deadline, and no extension request to provide documents was received.

Since no documents were received to verify the information you provided in your August 8, 2017 application. You were found eligible to purchase a QHP at full cost, effective September 1, 2017.

You further updated your NYSOH account on September 18, 2017. The income amount that was entered into this application did not match federal and state

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data sources, but did place you into a “pending Medicaid” status. As a result, NYSOH asked that you submit additional documentation to confirm your income by October 3, 2017.

No income documentation was provided by the October 3, 2017 deadline, and no extension request to provide documents was received.

Since no documents were received to verify the information you provided in your September 18, 2017 application. You were found eligible to purchase a QHP at full cost, effective November 1, 2017.

The record reflects that you provided income documentation on December 1, 2017, which included hand-written notice reflecting that your business income, after expenses, was \$1,525.66 during May 2017, -\$285.74 during June 2017, and \$-955.96 during July 2017. However, this documentation was determined by NYSOH to be invalid to confirm your eligibility because the NYSOH representative erroneously concluded that you were an employee, and not the owner. Accordingly, your application would have been complete as of the date you provided the documentation on December 1, 2017.

Therefore, we find that while NYSOH acted properly in not issuing you an eligibility determination based on the information contained in the August 8, 2017 and September 18, 2017 applications, there was sufficient information in your account to determine your eligibility for Medicaid as of December 1, 2017. Accordingly, we find that NYSOH has failed to issue a timely eligibility determination following your December 8, 2017 application.

Your case is RETURNED to NYSOH to redetermine your eligibility for Medicaid as of December 1, 2017, based on a one-person household with an annual household income of \$1,135.84.

Decision

NYSOH acted properly in not issuing you an eligibility determination based on the information contained in the August 8, 2017 and September 18, 2017 applications.

NYSOH has failed to issue a timely eligibility determination following your December 8, 2017 application.

Your case is RETURNED to NYSOH to redetermine your eligibility for Medicaid as of December 1, 2017, based on a one-person household with an annual household income of \$1,135.84.

Effective Date of this Decision: March 14, 2018

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How this Decision Affects Your Eligibility

This is not your final determination of eligibility.

You will receive an eligibility determination notice based on the information contained in your account as of December 1, 2017.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the 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

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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
PO Box 11729
Albany, NY 12211
- By fax: 1-855-900-5557

Summary

NYSOH acted properly in not issuing you an eligibility determination based on the information contained in the August 8, 2017 and September 18, 2017 applications.

NYSOH has failed to issue a timely eligibility determination following your December 8, 2017 application.

Your case is RETURNED to NYSOH to redetermine your eligibility for Medicaid as of December 1, 2017, based on a one-person household with an annual household income of \$1,135.84.

This is not your final determination of eligibility.

You will receive an eligibility determination notice based on the information contained in your account as of December 1, 2017.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

[REDACTED]

[REDACTED]

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، يرجى الاتصال بالرقم 1-855-355-5777. يمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجاناً.

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 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. ye&btumi ama wo obi a okyerε 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 איך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.