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

Notice of Decision

Decision Date: April 23, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028025

[redacted]

[redacted]

On March 29, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's January 10, 2018 eligibility determination 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
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Decision

Decision Date: April 23, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028025

[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 do not qualify for health coverage through NYSOH because you did not provide income documentation needed to verify the income listed in your application?

Procedural History

On December 15, 2017, NYSOH received your application for financial assistance with your health insurance.

On December 16, 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 December 30, 2017.

No documentation was received by NYSOH within the required time frame.

On January 10, 2018, NYSOH issued an eligibility determination notice stating that you did not qualify for health insurance through NYSOH. You did not qualify for Medicaid, the Essential Plan, premium tax credits and cost sharing reductions, or a qualified health plan at full cost because you did not provide income documentation to verify the income information in your application.

On January 25, 2018, you faxed an appeal request to NYSOH requesting an appeal of that eligibility determination.

On March 29, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open for 15 days to allow you time to submit a letter from your employer outlining what your pay was for 2017 as well as paystubs from your spouse for December 2017. On April 12, 2018, you uploaded a letter from your employer and it was incorporated into the record as Appellant's Exhibit #1. The record remained open up until April 13, 2018 but no further documentation was received. The record is now closed.

Findings of Fact

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

1) You testified that you are appealing your eligibility for Medicaid.

2) On December 15, 2017, you submitted an application for financial assistance to NYSOH that listed your expected annual income as $6,000.00.

3) You testified that in December 2017, you faxed in income documentation to NYSOH.

4) You testified that you did not save a copy of the documents you faxed in and did not save the fax confirmation sheet from that fax transmission.

5) There is no indication in the record that NYSOH ever received any faxed submission of income documentation from you prior to the December 30, 2017 deadline.

6) You testified that you are currently married and file taxes separately from your spouse.

7) You testified that you have no dependents.

8) On January 25, 2018, you faxed a letter to NYSOH to request an appeal. In that letter you stated that your 2017 income fluctuates because your job is commission based. You also submitted the following:

    a. A paystub for check date May 31, 2017 for a gross pay amount of $5,124.60, and a year to date amount of $12,374.60.
    b. A paystub for check date September 29, 2017 for a gross pay amount of $7,309.87, and a year to date amount of $19,684.47.

9) On April 12, 2018, you uploaded a letter to NYSOH account from your employer stating that your last commission check was on 9/29/2017 and that your total year to date income for 2017 was $19,684.47.

10) You testified that you expect your 2018 income to be similar to your 2017 income.

11) You did not provide copies of your spouse's paystubs for the month of December 2017.

12) Your eligibility was redetermined by NYSOH on April 13, 2018 and you were found eligible for Medicaid based on the information contained in your application.

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

Applicable Law and Regulations

Medicaid

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), N.Y. Soc. Serv. Law § 366(1)(b)).

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 is whether NYSOH properly determined that you do not qualify for health coverage through NYSOH because you did not provide income documentation needed to verify the income listed in your application.

You testified that you are specifically appealing your eligibility for Medicaid.

On December 15, 2017, you submitted an application for financial assistance to NYSOH that listed your expected annual income as $6,000.00. On December 16, 2017, NYSOH issued a notice stating more information was needed to make a determination based on the application you submitted. 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 December 30, 2017.

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 testified that in December 2017, you faxed in income documentation to NYSOH. However, there is no indication in the record that NYSOH ever received any faxed submission of income documentation from you prior to the December 30, 2017 deadline. You testified that you did not save a copy of the documents you faxed in and did not save the fax confirmation sheet from that fax transmission.

Therefore, the credible evidence in the record indicates that you did not submit sufficient income documentation to NYSOH in order to verify the income information listed in your December 15, 2017 application before the December 30, 2017 deadline.

Accordingly, the January 10, 2018 eligibility determination notice stating that you were not eligible for Medicaid because NYSOH did not receive the income documentation needed to verify the income listed in your application is AFFIRMED.

After the hearing, you submitted income documentation for yourself. Typically, we would return your case to NYSOH for a redetermination of eligibility based on the available information now in your account. However, your eligibility was redetermined by NYSOH on April 13, 2018 and you were found eligible for Medicaid based on the information contained in your application. Since the decision has no effect on any subsequent eligibility redeterminations made by NYSOH we decline to return your case for redetermination.

Decision

The January 10, 2018 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: April 23, 2018

How this Decision Affects Your Eligibility

NYSOH properly determined that you did not qualify for coverage through NYSOH because you did not submit sufficient documentation to confirm the income in your December 15, 2017 application by the required deadline.

This decision has no effect on any subsequent eligibility redeterminations made by NYSOH.

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 January 10, 2018 eligibility determination notice is AFFIRMED.

NYSOH properly determined that you did not qualify for coverage through NYSOH because you did not submit sufficient documentation to confirm the income in your December 15, 2017 application by the required deadline.

This decision has no effect on any subsequent eligibility redeterminations made by NYSOH.

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 तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई 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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