



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

Notice of Decision

Decision Date: May 31, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000028292



Dear [REDACTED]

On April 26, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's January 30, 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
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).

This page intentionally left blank.

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

Decision

Decision Date: May 31, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000028292



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 child were eligible to enroll in a full cost qualified health plan and full cost Child Health Plus plan, respectively, and not eligible for Medicaid, effective March 1, 2018?

Procedural History

On January 2, 2018, NYSOH received an update to your application for financial assistance with health insurance.

On January 3, 2018, NYSOH issued an eligibility determination notice stating that you and your child were conditionally eligible for Medicaid, effective February 1, 2018. The notice requested that you provide income documents to NYSOH by January 17, 2018 to confirm the eligibility for you and your child.

Also on January 3, 2018, NYSOH issued an enrollment notice confirming your selection of a Medicaid Managed Care (MMC) plan for you and your child's coverage on January 2, 2018, with such coverage beginning effective February 1, 2018.

On January 14, 2018, NYSOH received your letter, dated January 14, 2018, stating that you would be closing your business, [REDACTED] in February 2018.

On January 16, 2018, NYSOH redetermined the eligibility of you and your child for financial assistance with health insurance.

On January 17, 2018, NYSOH issued an eligibility determination notice stating that you and your child were newly eligible to enroll in a qualified health plan (QHP) and Child Health Plus (CHP) plan at full cost, effective February 1, 2018. The notice also stated that you and your child were not eligible for Medicaid because your household income was over the income limit for that program.

Also on January 17, 2018, NYSOH issued a disenrollment notice confirming that the MMC plan enrollment for you and your child would end effective February 1, 2018.

On January 24, 2018, NYSOH received an update to your application for financial assistance with health insurance. Your tax filing status was changed to "married filing single."

Also on January 24, 2018, NYSOH received your Form SSA-1099 – Social Security Benefit Statement issued for your child for 2017.

On January 25, 2018, NYSOH issued an eligibility determination notice stating that you and your child were conditionally eligible for Medicaid, effective February 1, 2018. The notice requested that you provide income documents to NYSOH by February 8, 2018 to confirm the eligibility for you and your child.

Also on January 25, 2018, NYSOH issued an enrollment notice confirming your selection of an MMC plan for you and your child's coverage on January 24, 2018, with such coverage beginning effective March 1, 2018.

On January 26, 2018, NYSOH issued a notice stating that that income documentation you provided did not confirm the information in your application. The notice requested that you provide additional income to confirm your eligibility February 23, 2018.

Also on January 26, 2018, NYSOH received your duplicate copy of (1) your letter, dated January 14, 2018, stating that you would be closing your business, [REDACTED] in February 2018, and (2) the Form SSA-1099 – Social Security Benefit Statement issued for your child for 2017.

On January 29, 2018, you provided a copy of your 2016 federal tax return, which you filed jointly with another individual, claiming one dependent, reflecting an adjusted gross income of \$79,369.00.

Also on January 29, 2018, NYSOH redetermined the eligibility of you and your child for financial assistance with health insurance.

On January 30, 2018, NYSOH issued an eligibility determination notice stating that you and your child were newly eligible to enroll in a QHP and CHP plan at full cost, effective February 1, 2018. The notice also stated that you and your child were not eligible for Medicaid because your household income was over the income limit for that program.

Also on January 30, 2018, NYSOH issued a disenrollment notice confirming that the MMC plan enrollment for you and your child would end effective March 1, 2018.

On February 2, 2018, you spoke to NYSOH's Account Review Unit and appealed insofar as you and your child were not found eligible for Medicaid.

On April 26, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and remained open as the Hearing Officer directed you to provide as additional evidence to corroborate your testimony: spreadsheet reflecting gross income and expenses from your business during months of December 2017, January 2018 and February 2018. The record was to be closed on May 4, 2018, or upon the receipt of the above referenced documents, whichever occurred earlier. No additional documents were received from you by May 4, 2018

Accordingly, the record was closed on May 4, 2018.

Findings of Fact

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

- 1) You testified that you are appealing both your eligibility and the eligibility of your child.
- 2) You testified, and your NYSOH account reflects, that you updated your application on January 2, 2018. This application reflected that you were not receiving any income from your business and you were claiming \$6,000.00 in deductions for the year. You also indicated that you would be filing a tax return with the status of head of household, and claiming your daughter as a qualifying individual.
- 3) Based on the information contained in your January 2, 2018 application, NYSOH issued an eligibility determination notice on January 3, 2018 finding you and your child conditionally eligible for Medicaid, effective February 1, 2018. You were requested to provide additional income documentation to confirm the eligibility of you and your child by January 17, 2018.

- 4) On January 14, 2018, you provided to NYSOH your letter, dated January 14, 2018, stating that you would be closing your business, [REDACTED] [REDACTED] [REDACTED] [REDACTED] in February 2018.
- 5) On January 24, 2018, NYSOH received your Form SSA-1099 – Social Security Benefit Statement issued for your child for 2017.
- 6) On or about January 25, 2018, the income documentation you provided was not considered to be valid since this was not an official form confirming the dissolution of your business. You were requested to provide additional income documentation to confirm eligibility for you your child.
- 7) On January 29, 2018, you provided to NYSOH a copy of your federal tax return for 2016 reflecting that you had an adjusted gross income of \$79,369.00. This tax return was filed jointly by you and your spouse, claiming one dependent.
- 8) Based on the information contained in your application as of January 29, 2018, NYSOH found you and your child newly eligible enroll in a QHP and CHP at full cost, respectively, and not eligible for Medicaid, effective March 1, 2018.
- 9) You testified that you were seeking for you and your child to be reinstated in your Medicaid coverage from February 1, 2018 through at least June 2018 when you anticipated leaving New York State.
- 10) You testified that your 2016 tax return was not representative of your current expected earnings since your business was closing, and you would not have the benefit of your spouse's income.
- 11) The Hearing Officer requested that you provide a spreadsheet or table reflecting your gross income and expenses from your business during months of December 2017, January 2018 and February 2018 by May 4, 2018. However, no further documentation was received from you by May 4, 2018.

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

Applicable Law and Regulations

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).

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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you and your child were eligible to enroll in a qualified health plan and Child Health Plus at full cost, respectively, and not eligible for Medicaid, effective March 1, 2018.

According to your NYSOH account and your testimony, on January 2, 2018 you submitted to NYSOH an updated application for health insurance that included your children and attested to an annual household income of \$0.00. Based on the information contained in that application, you and your child were found conditionally eligible for Medicaid, pending receipt of income documentation to confirm your eligibility by January 17, 2018.

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.

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 testified and your account reflects that on January 14, 2018 you submitted a letter confirming that your business would be closing during the month of February 2018. On January 16, 2018, NYSOH reviewed and invalidated that documentation. On January 26, 2018, NYSOH issued a notice stating that the documentation you submitted did not confirm the information in your application and requested to provide additional income documentation.

Your NYSOH account reflects that on January 29, 2018, you provided to NYSOH a copy of your federal tax return for 2016 reflecting that at that time, you and your spouse had an adjusted gross income of \$79,369.00.

Also on January 29, 2018, NYSOH issued an eligibility determination notice stating that you and your child were newly eligible to enroll in a QHP and CHP plan at full cost, effective March 1, 2018. The notice also stated that you and your child were not eligible for Medicaid because your household income was over the income limit for that program. However, you testified that the 2016 tax return was not representative of your current expected earnings since your business was closing, and you would not have the benefit of your spouse's income.

If NYSOH remains unable to verify the attestation of the applicant, NYSOH must redetermine an individual's eligibility based on the information available from the data sources unless the applicant demonstrates that they are unable to provide the required documentation.

Your eligibility was redetermined on January 30, 2018 based on information you provided to NYSOH on January 29, 2017 reflecting that your anticipated household income was \$79,369.00, and you and your child were found no longer eligible for financial assistance through NYSOH since this amount was above the income thresholds for Medicaid. As a result, you were disenrolled from your respective MMC plans, effective February 28, 2018.

At the hearing, the Hearing Officer requested that you provide a spreadsheet reflecting gross income and expenses from your business during months of December 2017, January 2018 and February 2018 no later than May 4, 2018. Since no additional income documentation was provide to NYSOH Appeals Unit by May 4, 2018, we are unable to return your case to the Marketplace for a redetermination your eligibility.

Therefore, NYSOH's January 30, 2018 eligibility determination notice finding you and your child eligible to enroll in a QHP and CHP at full cost, respectively, and not eligible for Medicaid, effective March 1, 2018, must be AFFIRMED.

Decision

The January 30, 2018 eligibility determination notice is AFFIRMED.

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).

Effective Date of this Decision: May 31, 2018

How this Decision Affects Your Eligibility

You and your child remain eligible to enroll in a QHP and CHP at full cost, respectively, and not eligible for Medicaid, effective March 1, 2018.

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

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 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

The January 30, 2018 eligibility determination notice is AFFIRMED.

You and your child remain eligible to enroll in a QHP and CHP at full cost, respectively, and not eligible for Medicaid, effective March 1, 2018.

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. 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 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 אייך געבן א דאלמעטשער 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).