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

Notice of Decision

Decision Date: May 5, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014529

[redacted]

Dear [redacted],

On April 4, 2017, Mrs. Murphy appeared by telephone at a hearing on your appeal of NY State of Health's February 8, 2017 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
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: May 5, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014529

[redacted]

Issue

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

> Did NY State of Health provide a timely determination of your family's Medicaid eligibility as of February 8, 2017?

Procedural History

On November 14, 2016, you updated your family's application for health insurance.

On November 15, 2016, based upon NYSOH's request, you submitted four consecutive weekly pay stubs for you and your spouse to your NYSOH account, which were later invalidated by NYSOH on December 1, 2016 [redacted]).

On November 17, 2016, NYSOH issued a notice stating that more information was needed to confirm your family's eligibilities. That notice asked you to provide further proof of income for your family by November 13, 2016.

On November 29, 2016, December 5, 2016, December 7, 2016, December 13, 2016, December 28, 2016, and January 3, 2017, you submitted additional pay stubs for you and your spouse to your NYSOH account. These documents were invalidated by NYSOH on February 8, 2017.

On December 2, 2016 and December 22, 2016, NYSOH issued two notices stating that more information was needed to confirm your family's eligibilities.

Those notices asked you to provide further proof of income by December 28, 2016 and January 12, 2017, respectively.

On January 3, 2017, you contacted the NYSOH Account Review Unit and requested an appeal of the timeliness of your eligibility determination.

On January 4, 2017, NYSOH issued a notice stating that more information was needed to confirm your family's eligibilities. That notices asked you to provide further proof of income for your spouse and child by January 12, 2017 and for yourself by January 27, 2017.

On February 8, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in a qualified health plan at full cost, effective March 1, 2017. This was because you did not provide proof of your income.

On February 9, 2017, NYSOH issued a notice stating that more information was needed to confirm your family's eligibilities. That notices asked you to provide further proof of income by February 23, 2017.

On March 17, 2017, you submitted additional pay stubs for you and your spouse to your NYSOH account. These documents were invalidated by NYSOH on February 8, 2017 and March 27, 2017, respectively.

On April 4, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, your spouse appeared on your behalf. The record was held open until April 19, 2017 for submittal of proof of income.

On April 4, 2017, you submitted your W-2 statements along with a letter from your employer stating that you were no longer employed as of February 24, 2017. No further documentation was received as of April 19, 2017 and the record closed that day.

On April 14, 2017, NYSOH verified the W-2 statements and letter from your employer you uploaded as documentation and a new application was submitted on your behalf.

On April 15, 2017, NYSOH issued an eligibility determination notice stating that your family was eligible for Medicaid effective March 1, 2017.

On April 18, 2017, NYSOH issued an enrollment notice, based on your April 17, 2017 plan selection, confirming your selection of a Medicaid Managed Care plan, effective June 1, 2017.

Findings of Fact

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

1) According to your NYSOH account and your spouse's testimony, you will file your 2016 income tax return as married filing jointly and will claim one dependent on that tax return.

2) The application that was submitted on November 14, 2016 listed an expected gross household income of $20,800.00, consisting of $10,400.00 you earn in income and $10,400.00 your spouse earns in income.

3) On November 15, 2016, based on NYSOH's request, you submitted four consecutive weekly pay stubs for you and your spouse to your NYSOH account. These documents were invalidated by NYSOH on December 1, 2016, on the basis that only three of your spouse's paystubs were visible to NYSOH [redacted]).

4) A review of those documents shows that all of your and your spouse's paystubs submitted on November 15, 2016 were visible and legible. These paystubs show that you earned between $362.14 and $454.21 per week from mid-September 2016 through the first week in November 2016. Your spouse's paystubs show that in October 2016, she earned between $412.50 and $434.50 per week. Your spouse's paystubs further indicate that she earned $1,694.00 in the month of October 2016. When multiplied by 12 months, her expected annual income for 2016 is $20,328.00.

5) Your spouse testified that your total 2016 gross household income was $30,128.00 consisting of $14,076.00 income you earned from employment and $16,052.00 income your spouse earned from employment. Your 2016 W-2 Wage Statements were submitted, but your spouse's were not.

6) Your 2016 W-2 statements show you earned $13,716.47 and $360.00, totaling $14,076.47 in earnings.

7) According to your NYSOH account, you submitted additional paystubs and letters after NYSOH invalidated your proof of income on December 1, 2016. You received your first notice of eligibility determination on February 8, 2017.

8) According to your NYSOH account and your spouse's testimony, you are appealing the timeliness of your eligibility determination because your family has not had health insurance since October 31, 2016.

9) Your spouse testified, and submitted documentation, to show you had a change in income since you first appealed as you have been unemployed since February 24, 2017.

10) According to your NYSOH account, your family was found eligible for Medicaid, effective March 1, 2017 and will be enrolled in a Medicaid Managed Care plan as of June 1, 2017.

11) According to your NYSOH account and your spouse's testimony, your family resides in Saratoga County, New York.

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).

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 first issue under review is whether NYSOH's provided you with a timely determination of your family's Medicaid eligibility on February 8, 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 updated your family's NYSOH account on November 14, 2016. The income amount that was entered into this application did not match information obtained from federal and state data sources. As such, NYSOH asked that you submit additional documentation to confirm your household income.

On November 15, 2016, based on NYSOH's request, you uploaded your and your spouse's four consecutive current weekly paystubs. These were invalidated on December 1, 2016 because "only three [of your spouse's] paystubs were visible." However, a review of your account reflects that all your and your spouse's paystubs were visible and, therefore, NYSOH should have been able to ascertain your total gross household income as of that date.

Since NYSOH erred in not validating your proof of income on December 1, 2016, your application is considered complete as of November 15, 2016 for purposes of issuing a timely eligibility determination.

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the completed application. To assess whether an eligibility determination was untimely, NYSOH must base the time-period from the date of the completed application to the date NYSOH notifies the applicant of its decision.

NYSOH issued an eligibility determination notice on February 8, 2017 that stated your family was eligible for a qualified health plan at full cost effective March 1, 2017.

Since NYSOH issued an eligibility determination 85 days from the date your application was considered complete, the February 8, 2017 eligibility determination is untimely and must be RESCINDED.

According to your NYSOH account and your spouse's testimony, you will file your 2016 income tax return as married filing jointly and will claim one dependent on

that tax return. Therefore, you have a three-person household for purposes of this analysis.

Your spouse testified that your total 2016 gross household income was $30,128.00 consisting of $14,076.00 income you earned from employment and $16,052.00 income she earned from employment. However, your spouse submitted only your 2016 W-2 wage statements and not her own. Therefore, for purposes of this analysis, your 2016 gross household income is $34,404.00, consisting of $14,076.00 you earned in income for 2016, as reflected in your 2016 W-2 Wage Statements, and $20,328.00 your spouse earned in income for 2016, based on a twelve-month calculation using her October 2016 earnings as stated on her paystubs for that month.

Now that the record is more fully developed, your case is being RETURNED to NYSOH to redetermine your family's eligibility for financial assistance as of December 1, 2016, based on an annual household income of $34,404.00 and a household size of three persons, for a family living in Saratoga County. NYSOH is to notify you of its redetermination and is being directed to assist you in enrolling in a health plan that correlates with your family's eligibility redetermination with an effective start date of December 1, 2016, if you so choose.

If applicable, you will be responsible for any insurance premiums for the months of December 2016, January 2017, and February 2017.

Decision

The February 8, 2017 eligibility determination was untimely and is RESCINDED.

Your family's case is being RETURNED to NYSOH to redetermine your family's eligibility for financial assistance as of December 1, 2016, based on an annual household income of $34,404.00 and a household size of three persons, for a family living in Saratoga County and to notify you accordingly.

NYSOH is directed to assist you in enrolling your family in an appropriate health plan(s), effective December 1, 2016, if you so choose.

If applicable, you will be responsible for any insurance premiums for the months of December 2016, January 2017 and February 2017.

This decision does not affect your family's current eligibility for Medicaid Fee-For Service and Medicaid Managed Care.

Effective Date of this Decision: May 5, 2017

How this Decision Affects Your Eligibility

Your case is being sent back to NYSOH to redetermined your family's eligibility for financial assistance as of December 1, 2016 based on an annual household income of $34,404.00 and a household size of three persons, for a family living in Saratoga County, and to notify you accordingly.

NYSOH will assist you in enrolling your family in an appropriate health plan(s) for the months of December 2016, January 2017 and February 2017, if you so choose.

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 February 8, 2017 eligibility determination notice was untimely and is RESCINDED.

Your family's case is being RETURNED to NYSOH to redetermine your family's eligibility for financial assistance as of December 1, 2016, based on an annual household income of $34,404.00 and a household size of three persons, for a family living in Saratoga County and to notify you accordingly.

NYSOH is directed to assist you in enrolling your family in an appropriate health plan(s), effective December 1, 2016, if you so choose.

If applicable, you will be responsible for any insurance premiums for the months of December 2016, January 2017 and February 2017.

This decision does not affect your family's current eligibility for Medicaid Fee-For Service and Medicaid Managed Care.

Your case is being sent back to NYSOH to redetermined your family's eligibility for financial assistance as of December 1, 2016 based on an annual household income of $34,404.00 and a household size of three persons, for a family living in Saratoga County, and to notify you accordingly.

NYSOH will assist you in enrolling your family in an appropriate health plan(s) for the months of December 2016, January 2017 and February 2017, if you so choose.

Legal Authority

We are issuing this determination in accordance with 45 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).

A Copy of this Decision Has Been Provided To:

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।

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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