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

Notice of Decision

Decision Date: August 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015733

[redacted]

Dear [redacted],

On August 9, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's failure to issue an eligibility determination of your December 1, 2016 request for retroactive Medicaid coverage for the months of September and October 2016.

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 NY State of Health 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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DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: August 24, 2017

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000015733

[redacted]

Issue

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

> Did NY State of Health (NYSOH) provide you with a timely determination of your eligibility for retroactive Medicaid coverage for the months of September and October 2016 following your December 1, 2016 updated application?

Procedural History

On December 1, 2016, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for September, October, and November 2016.

On December 2, 2016, NYSOH issued a notice stating the income information in your application did not match information received from state and federal data sources. The notice directed you to submit proof of your income by December 20, 2016 or NYSOH would not be able to determine your eligibility for health care. The notice included a "Documentation List" which provided various forms of acceptable documentation to prove specific types of income. The list indicated that to prove self-employment income an applicant must submit three months of records of detailed earnings and expenses, or three months of business payrolls and records, or a filed tax return from the previous year if representative of attested income.

On December 29, 2016, NYSOH issued a notice stating the income information submitted was insufficient to confirm the income information in your application.

The notice directed you to submit additional documentation of your income by February 3, 2017.

On January 19, 2017, you submitted an updated application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for the three previous months.

On January 20, 2017, NYSOH issued a notice stating the income information in your application did not match information received from state and federal data sources. The notice directed you to submit proof of your income by February 3, 2017 or NYSOH would not be able to determine your eligibility for health coverage.

On February 8, 2017, NYSOH issued a notice of eligibility determination stating you were eligible for Medicaid, effective February 1, 2017.

Also on February 8, 2017, NYSOH issued an eligibility determination notice stating you were eligible for retroactive Medicaid coverage for the period of December 1, 2016 through January 31, 2017, because your monthly household income of $783.33 was at or below the allowable monthly income limit of $1,367.00. The notice indicated that additional information was required to determined your eligibility for retroactive coverage for the month of November 2016. The notice directed you to submit proof of your income for the month of November 2016 by February 22, 2017.

On February 11, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were not determined eligible for retroactive Medicaid for the months of September, October, and November 2016.

On March 4, 2017, NYSOH issued an eligibility determination notice stating you were eligible for retroactive Medicaid coverage for the month of November 2016, because your monthly household income of $451.00 was at or below the allowable monthly income limit of $1,367.00.

On August 9, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing held open to August 23, 2017, to allow you to submit supporting documents.

On August 21, 2017, NYSOH received the requested documentation and it was incorporated into the record as Appellant's Exhibit #1, the record was closed that day.

Findings of Fact

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

1) You were disenrolled from your Medicaid Managed Care plan, effective August 1, 2016, because you did not renew your health coverage by the deadline provided.

2) An updated application for health insurance was submitted on your behalf on September 21, 2016.

3) According to your account, NYSOH was unable to verify the income information listed in your application and income documentation was requested in order to verify your income to determine your eligibility.

4) You submitted various documents throughout September, October, and November 2016 that were invalidated by NYSOH as insufficient proof of your income, and additional documentation was requested.

5) An updated application was submitted on your behalf on December 1, 2016. That application requested help paying for medical bills from the previous three months. The application indicated you were self-employed and listed your annual expected income as $9,188.04. The application listed your monthly income as $765.67 for each month of September, October, and November 2016.

6) You testified you were unsure about the monthly income amounts listed in the December 1, 2016 application. You testified that it must have been your annual income divided by 12, but that your monthly income was not always the same.

7) You testified that you are a self-employer [redacted] and that all your income is generated intermittently and difficult to predict.

8) According to your account, on December 1, 2016, you uploaded a business income and expense spreadsheet for the months of September, October, and November 2016 listing only the gross sales for each month. The document indicated your gross sales were $456.00 in September 2016, $0.00 in October 2016, and $1,840.00 in November 2016.

9) According to your account, on December 28, 2016, NYSOH invalidated the spreadsheet you uploaded on December 1, 2016 as insufficient proof of your annual income. NYSOH requested additional income documentation.

10) On January 19, 2017, an updated application was submitted on your behalf. That application requested help paying for medical bills from the previous three months and listed your monthly income as $833.33 for each month of October, November, and December 2016.

11) According to your account, NYSOH was unable to verify the income information listed in your application and income documentation was requested.

12) On February 7, 2017, you uploaded a business income and expense spreadsheet for the months of November, December, and January 2016 listing gross income, various business expenses, and net income for each of those months. Based on that documentation, NYSOH determined you eligible for Medicaid, effective February 1, 2017.

13) On February 8, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for retroactive Medicaid coverage for the months of December 2016 and January 2017, because your income for those months was below the allowable monthly limit of $1,367.00. The notice directed you to submit additional documentation of your income for the month of November 2016.

14) You appealed insofar as you were not determined eligible for retroactive Medicaid coverage for the months of September, October, and November 2017.

15) On March 4, 2017, you were determined eligible for retroactive Medicaid coverage for the month of November 2016.

16) You testified you are seeking retroactive Medicaid coverage for the months of September and October 2016 only.

17) You testified, and your applications indicate, you intend to file your 2016 and 2017 tax returns with a tax filing status of single and you will claim no dependents.

18) Your applications indicate you live in [redacted].

19) On August 21, 2017, you uploaded a business income and expense spreadsheet for the months of September and October 2016 listing gross income, business expenses, and net income for each of those months ([redacted]).

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

Applicable Law and Regulations

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).

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)). 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)).

Medicaid for Adults between the Ages of 19 and 65

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)), NY Social Services Law § 366(1)(b)).

In an analysis of Medicaid eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR § 435.4). On the date of your application, that was the 2016 FPL, which is $11,880.00 for a one-person household (81 Fed. Reg. 4036).

Retroactive Medicaid

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of an initial application if the individual received medical services that would have been covered under Medicaid and the individual would have been eligible for Medicaid at the time he received the services if he had applied (42 USCA § 1396A(34); 42 CFR § 435.915(a)). The Department of Health may make eligibility effective for fee-for-service Medicaid on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

Legal Analysis

The issue under review is whether NYSOH provided you with a timely determination of your eligibility for retroactive Medicaid coverage for the months of September and October 2016 following your December 1, 2016 updated application.

You updated your application on December 1, 2016. In that application, you requested help paying for medical bills from the previous three months. The application listed your monthly income as $765.67 for each month of September, October, and November 2016; however, you testified that you were unsure about the monthly income amounts listed in the application and that your monthly income was not always the same. According to your account, NYSOH was unable to verify the income information listed in your application.

Pursuant to the above regulations, NYSOH must request data to verify the household's income for all individuals whose income is needed to calculate the household's eligibility. 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. Following your updated application, NYSOH issued a notice on December 2, 2017, requesting proof of your income, by December 20, 2016, to confirm your eligibility for health insurance.

On December 1, 2017, you uploaded a business income and expense spreadsheet for the months of September, October, and November 2016 listing only the gross sales for each month. According to your account, NYSOH invalidated this documentation on December 28, 2016 as insufficient proof of your annual income and additional income documentation was requested.

On January 19, 2017, you submitted another updated application for health insurance. That application requested retroactive coverage for the months of November, December, and January 2017. According to your account, on February 7, 2017, you uploaded a business income and expense spreadsheet for

the months of November, December, and January 2016 listing gross income, various business expenses, and net income for each of those months. Based on that documentation, NYSOH determined you eligible for Medicaid, effective February 1, 2017. NYSOH also determined you eligible for retroactive Medicaid coverage for the months of December 2016 and January 2017, and later November 2016, as requested in your January 19, 2017 application. However, your account confirms that NYSOH never issued a determination of your eligibility for retroactive Medicaid coverage for the months of September and October 2016 as requested in your December 1, 2016 application. You testified you are seeking retroactive coverage for the months of September and October 2017.

Pursuant to the regulations, when an individual applies for insurance through NYSOH, NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the application. 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. 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.

Although you requested retroactive coverage for the months of September and October 2016 in your December 1, 2016 application and uploaded a spreadsheet the same day purporting to show your income for those months, NYSOH issued multiple notices indicating the income documentation submitted was insufficient and requested additional documentation. The only information contained in the spreadsheet uploaded on December 1, 2016 was gross income for the months of September through November 2016. Accordingly, it is concluded that the spreadsheet uploaded on December 1, 2016 did not constitute three months of *detailed* records required to prove self-employment income, and, therefore, the documentation submitted was insufficient to establish your income for those months.

Although the record establishes that NYSOH failed to issue a determination of your eligibly for retroactive Medicaid coverage for the months of September and October 2016 as requested in your December 1, 2016 application, it also establishes that the documentation you submitted of your income for those months was insufficient. Therefore, your application, as to your request for retroactive coverage for the months of September and October 2016, was never deemed completed. Thus, the deadline by which NYSOH is required to issue a determination, under the regulations, did not begin to run until NYSOH received sufficient proof of your income for the months in question.

Your account confirms that on August 21, 2017, you uploaded a business income and expense spreadsheet for the months of September and October 2016

providing details such as gross income, business expenses, and net income for each of those months. It is concluded that this document constitutes sufficient evidence of your income for the months of September and October 2016, thereby completing your December 1, 2017 application and triggering NYSOH's duty to provide a timely determination of your eligibility for retroactive Medicaid coverage for those months.

Therefore, your case is RETURNED to NYSOH to issue a determination of your eligibly for retroactive Medicaid coverage for the months of September and October 2016 as requested in your December 1, 2017, based on the income documentation uploaded on August 21, 2017.

Decision

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for September and October 2016 based on the income documentation uploaded to your account on August 21, 2017.

Effective Date of this Decision: August 24, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your eligibility based on the evidence now available in the record.

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

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for September and October 2016 based on the income documentation uploaded to your account on August 21, 2017.

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your eligibility based on the evidence now available in the record.

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:

[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।

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 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 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.

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).